

**Where Mental Health and Probation Collide:
Optimizing Forensic Mental Health Services for
Persons on Probation Order in British Columbia**

by

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Abstract

Using Practice Audit methodology this study identifies and compares best practices for mental health services for persons on Probation Order with care provided through the British Columbia Forensic Psychiatric Services Commission (FPSC). Currently, due to an increase in referrals, unclear referrals, and a lack of coordination with BC Community Corrections, it is unknown whether clients are receiving optimal care to reduce risks, improve health, and ensure the safety of the broader public. Current services are identified through FPSC policies and procedures, survey data, an interactive staff forum, and a review of recent referrals. Deficiencies indicated through the practice audit include: a collaborative assessment process and the need to provide assertive community treatment for all clients. Policy options to address deficiencies were subsequently evaluated using selected criteria. Outcomes indicate that deficiencies may be addressed through improved assessment procedures.

Keywords: probation; referral; assessment; discharge; forensic; mental health; offenders' treatment

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List of Acronyms

ACT	Assertive Community Treatment
BCMHAS	British Columbia Mental Health and Addictions
FACT	Forensic Assertive Community Treatment
FPSC	Forensic Psychiatric Services Commission
ICM	Intensive Case Management
PHSA	Provincial Health Services Authority
RNR	Risk Need Responsivity

Executive Summary

Across Canada, the mental health treatment needs of persons involved with the criminal justice system are increasing. Persons on probation order requiring mental health treatment as a condition of their probation represent a specialized category of offender with complex needs. The British Columbia Forensic Psychiatric Services Commission (FPSC), an agency of British Columbia Mental Health and Addictions (BCM HAS), is mandated to work with persons under court order requiring mental health treatment. Rates of referral to FPSC services, for this particular group of offenders on probation, from BC Community Corrections has increased by approximately 30% since 2004. FPSC aims to continually evaluate and improve services for all patients, and as such provide optimal treatment. With the high needs of this particular group, FPSC needs to evaluate its service to ensure optimal care for both the offender and the broader public.

This research project forms one component of a larger quality review of FPSC services afforded to persons referred on probation. This project identifies and outlines best practices for this specialized group of offender; identifies the current service provided and conducts a practice audit to evaluate fidelity to best practice. Current services are identified through FPSC policies and guidelines, a staff survey, staff forum and a review of recent referrals. Policy options are identified that help to bridge the gap between areas where best practices and current practices differ. Each policy option is evaluated and recommendations provided to improve FPSC mental health services to persons on probation order in BC.

Results of this project indicate that an improved, collaborative assessment process is essential for optimal care, in addition to providing more assertive case management. Collaboration with BC Community Corrections should be implemented immediately during the assessment. Assertive Community Treatment, may be introduced once collaborative assessments and housing are addressed as barriers to optimal care. Finally, substance use issues must be considered throughout care provided to this population of offender.

1. Introduction

Public policy can be defined as a course of action, or inaction, by public authorities to address a problem or interrelated set of problems (Pal, 2001). British Columbia Community Corrections, and the British Columbia Forensic Psychiatric Services Commission (FPSC), a component of BC Mental Health and Addictions (BCMHAS) and the Provincial Health Services Authority (PHSA) – one of six health authorities in British Columbia – are responsible for public safety and health needs of the community. Specifically, BC Community Corrections is responsible for the supervision of persons under court order residing in the community, and the assurance that these persons adhere to the conditions of this order. Under the legislative mandate of the Forensic Psychiatry Act, BC FPSC is responsible for providing forensic psychiatric services, both inpatient and outpatient to persons under court order.

The BC FPSC is facing increasing numbers of referrals¹ from BC Community Corrections for offenders on Probation Order with conditions requiring mental health treatment. Referrals to FPSC for mental health treatment are often unclear and undefined, leaving FPSC to respond without direction to a specialized population with complex needs. In many cases, the mental health conditions of this population are often intertwined with their criminal behaviour and thus they are left at high risk in the community to re-offend or return to ill health, without appropriate care. The problem, however, is that while FPSC has responded to the increasing needs of probation referrals, without ongoing evaluation and direction from BC Corrections, it is unknown whether clients are receiving *optimal* care, according to best practices. With respect to overall safety and health of the general public and offenders, ensuring that persons

¹ Approximate 30% increase in referral volumes between 2004 and 2011 (FPSC Probation Forum Report)

involved in the criminal justice system attain appropriate treatment for their mental health needs is an important public policy issue that must be addressed.

This project will begin by providing an introduction to the current needs and services offered in the province of British Columbia for persons on probation order requiring mental health services. From a literature review, a series of best practice guidelines are outlined that form the backbone of a Practices Audit. These best practices are then compared with the current services offered through BC FPSC. Current services are identified through the in house policies and procedural guidelines, a staff survey, a staff forum, and a review of recent referrals. Policy options are identified that help to bridge the gap between areas where best practices and current practices differ. Each policy option is evaluated and recommendations provided to improve FPSC mental health services to persons on probation order in BC.

2. The Need for Optimal Forensic Mental Health

Approximately ten percent of Canadians report symptoms of mental illness such as major depression, mania, panic disorder, social phobia, agoraphobia, and substance abuse (Stats Can, 2003). The mental health treatment needs of Canadians are particularly evident in vulnerable populations, such as children and youth, homeless persons or persons stigmatized by a criminal history (Tschopp et al., 2007; MHCC 2009; CIHI 2009; Jacobs et al, 2010). Ten percent of the total in-custody offender population has been diagnosed with a mental illness at admission, with approximately sixteen percent already taking prescription medication for a mental illness at admission (Riordan, 2004). Thirty percent of homeless persons had spent time in police stations or jails and in the year immediately prior to their homelessness, six percent had been in a psychiatric facility, twenty percent had received services for substance abuse problems, and twenty-five percent had received psychiatric outpatient services (Jacobs et al, 2010; MHCC, 2009; CIHI, 2009).

Treatment needs for these involved with the justice system are often more complex than the general population – requiring more therapies, support and medication. Specifically, Offenders with existing mental health disorders tend to have fewer personal resources to help cope with stressors, resulting in the potential exacerbation of their symptoms (Moloughney, 2004). Individuals already in the criminal justice system struggling with mental health issues are considered to be at a “higher” risk for re-offending (Barret et al., 2009), suicide (Moloughney, 2004), and violence (Scott & Resnick, 2006). In a study of forensic versus non forensic admissions to psychiatric inpatient stays, the most common diagnosis for forensic patients was schizophrenia (54%) and substance related disorders (38%) which is in contrast to non forensic patients where admissions were most commonly diagnosed with mood disorders (53%) followed by schizophrenia (33%) (CIHI, 2008). Psychosis, for example, while not considered a risk factor for violence alone, in combination with the presence of other violence risk factors, such as previous violence or the presence of substance abuse,

becomes a significant influence on the likelihood of future violent behaviour (Scott & Resnick, 2006). The risk of re-offending remains a crucial aim of corrections programming, yet, the intrusion of mental health needs add complications to the rehabilitation of offenders.

With all of this in mind, the need for mental health treatment amongst those involved with the criminal justice system is rising. Between 1997 and 2001 the proportion of in-custody offenders struggling with mental illness at admission, increased even though the overall rate of federal incarceration declined (Riordan, 2004). According to Sinha (2009) the number of offenders with mental disorders admitted to federal institutions was sixty percent higher in 2004 than in 1967. In 2006 almost one in ten male offenders had a psychiatric illness, up 71% in the previous nine years. These rates are even higher, up to approximately 84% when substance abuse is included (Sinha, 2009).

The mental health needs of offenders are placing an increasing burden on our public services as well. Nearly ninety percent of costs associated with mental health are incurred in sectors outside of health and social care (Friedli and Parsonage, 2008). Untreated or inappropriately treated mental health and substance use issues may result in a drain on resources in the Criminal Justice System, resulting in broader public health and public safety concerns (Reynolds, Dziegielewski & Sharp, 2004; Taxman et al., 2008; Gretton & Clift, 2011). Ultimately, forensic psychiatric services must adapt to these rising needs, a population with higher risks, more intensive treatment requirements and the long term social implications of a population that places a burden on multiple systems. By attempting to improve the care of persons on probation requiring mental health services we may be able to reduce this burden of illness for both the offender and the broader health care, social services and criminal justice system. Through collaborative and comprehensive efforts, we may be able to lower rates of re-offending, and improve help-seeking and service utilization, improving the burden of illness for all.

3. Mental Health & Probation in BC

The mental health needs and risks of offenders in British Columbia are considered at every stage of criminal justice processing. During the police process, police officers may choose to informally divert an individual away from the criminal justice system to alternative resources such as mental health assessment and treatment. Alternatively, the police may choose to charge individuals and proceed to court where fitness to stand trial assessment or a *not criminally responsible on account of mental disorder* (NCRMD) defense may be considered. If and when an accused is able to stand trial and is found criminally responsible, the courts may then consider their mental health condition during sentencing.

In Canada, provincial and territorial correctional services are responsible for accused persons remanded to custody, offenders sentenced to custody for less than 2 years and offenders sentenced to the community or conditionally released into the community. In BC, community corrections works with persons convicted of a criminal offence who are serving sentences in the community because (a) a judge has ordered a community sentence (i.e., conditional sentence, probation), or (b) a parole board has granted release from a correctional institution (Livingston et al., 2008). If a person is on probation they must follow the conditions outlined in their Probation Order². The Probation Order outlines the conditions and timeframe of the probation term while it is being served in the community. Violating the conditions of the Probation Order is a criminal offence and may result in imprisonment. Individuals sentenced to community supervision, on probation, are supervised by Probation Officers under the mandate of

² www.justicebc.ca

the BC Corrections Branch of the Ministry of Public Safety and Solicitor General.

Probation Officers are responsible for:

- Monitoring compliance with the probation order;
- Assessing risk of reoffending and determining appropriate resources to prevent re-offending and addressing those risks and needs as part of a case management plan;
- Preparing reports and assessments about offenders and victims and provide sentencing options for the court;
- Offering programs addressing needs and risks related to offending; and
- Reviewing client response to the steps taken and adjust case management plans where necessary

Across Canada the number of adults under community supervision has increased by about six percent, 112,000 to 120,000 (1991 – 2008) with community sentences the most prominent (80%)³. In 2009/2010, probation was the most frequent sentence for all offenders imposed in fifty-five percent of all guilty cases followed by custody (39%), a fine (16%), a conditional sentence (5%), and restitution (4%)⁴ In BC, probation was ordered in fifty-five percent of provincial criminal court convictions (11,997 in 2010), and was accompanied by a median sentence of one year⁵.

Probation refers to a type of correctional method through which convicted offenders are supervised in the community after a period of imprisonment or instead of imprisonment. Arguably, the absence of an adequate transition from correctional services to community-based treatment or support programs often puts offenders, particularly released offenders with mental health issues looking for a means of alleviating symptoms, such as self-medication with illegal drugs (Sinha, 2009).

³ Statistics Canada 2010

⁴ Statistics Canada 2009/2010

⁵ Statistics Canada 2006 – 2010

Community Mental Health services, provided through individual health authorities, in most cases choose to offer services only to individuals who are *voluntary*. Persons on probation orders with conditions for mental health treatment are not considered voluntary and thus Community Mental Health may refuse to offer treatment services. With this refusal of services, offenders on probation order may be unable to receive timely and proper treatment, thus impacting case management and planning (Sinha, 2009). Research suggests that this population also has difficulty obtaining housing, employment and experiences social isolation (www.publicsafety.gc.ca). The Forensic Psychiatric Services Commission (FPSC), with in-house psychiatry, psychology and case management staff, is able to offer immediate assessment, treatment and case management services and thus help to fill the gap for persons on probation. Persons on Probation Order requiring treatment as a condition of their probation are often referred to FPSC Regional clinics for community treatment, as FPSC is mandated to work with persons under court order. Notably, at the conclusion of the probation order, clients are not required to continue treatment and due to refusal of service by Community Mental Health programs, may be left without appropriate community case management, thus appropriate care during the probation time period is essential.

3.1. The BC Forensic Psychiatric Services Commission

According to the British Columbia *Forensic Psychiatry Act*⁶, the current function of the Forensic Psychiatric Services Commission, as defined in legislation, is:

- (a) to provide forensic psychiatric services to the courts in British Columbia and to give expert forensic psychiatric evidence;
- (b) to provide forensic psychiatric services for
 - (i) accused persons remanded for psychiatric examination,
 - (ii) persons held at the direction of the Lieutenant Governor in Council under the Criminal Code or the Mental Health Act,
 - (iii) persons in need of psychiatric care or assessment while in custody, and
 - (iv) persons held under a court order;
- (c) to provide inpatient and outpatient treatment for persons referred to in paragraph (b) and other persons the minister may designate
- (d) to plan, organize and conduct, either alone or with other persons and organizations,
 - (i) research respecting the diagnosis, treatment and care of forensic psychiatric cases, and
 - (ii) educational programs respecting the diagnosis, treatment and care of forensic psychiatric cases;
- (e) to consult with ministries, departments and agencies of the federal and provincial governments, and municipal departments, or agencies, mental health centres and other persons or organizations about the advancement of the objectives set out in this section;
- (f) to perform other duties, responsibilities, research and educational programs respecting forensic psychiatry as directed by the Lieutenant Governor in Council.
(BC Laws, 2011, para 5)

Accordingly, FPSC is legislated to provide assessment and treatment to persons under court order. BC Community Corrections is responsible for the supervision of persons under court order – not assessment and treatment.

⁶ www.bclaws.ca

3.2. BC Community Corrections

The British Columbia *Correction Act* (www.bclaws.ca, para 4(2)), identifies the powers and duties of probation officers. According to the legislation, a Probation Officer is responsible for the supervision of

- (a) persons placed on probation by a court, and
- (b) persons subject to conditional sentences imposed by a court

Further, the BC *Offence Act* (www.bclaws.ca, para 89) outlines the nature in which probations orders are decided upon. Notably,

(2) If a defendant is convicted of an offence and it appears to the justice that, having regard to the defendant's age, character and antecedents, to the nature of the offence, and to any extenuating circumstances surrounding the commission of the offence, it is expedient that the defendant be released on probation, the justice may, instead of sentencing the defendant to punishment, suspend the passing of sentence and direct that the defendant be released on entering into a recognizance, in Form 18, with or without sureties,

(a) to keep the peace and be of good behaviour during a period set by the justice, and

(b) on breach of the recognizance, to appear and to receive sentence when called on to do so during the period set under paragraph (a).

(3) A justice who suspends the passing of sentence may specify, as conditions of the recognizance, that the defendant must

(a) make restitution and reparation to any person aggrieved or injured for the actual loss or damage caused by the commission of the offence, and

(b) provide for the support of a spouse and any other dependants whom he or she is liable to support.

The BC Community Corrections and Corporate Programs division of the Ministry of Public Safety and Solicitor General operates 49 community corrections offices, employs close to 670 staff (450 probation officers), and has an annual budget of \$47 million (BC Auditor General, 2011). According to the BC Corrections *Strategic Plan 2010*

– 2013 (MPSSG, 2010) the overall mandate is to enforce all court orders (including remand, bail, custody and conditional sentences, immigration holds, probation and recognizance orders). BC Corrections goals (MPPSSG, 2010, 3) are to:

Supervise and enforce custody and/or community orders of adult offenders in a safe manner;

Manage all aspects of correctional supervision through the application of evidence based, consistent, and best practice policies;

Encourage learning and development for all members of BC Corrections;

Adhere to high standards in research, program development and evaluation, and technology;

Collaborate with other ministries, academic institutions, private and non-profit associations and organization in justice reform initiatives.

As noted above, the judge takes into consideration, antecedents and extenuating circumstances surrounding the commission of an offence. With the increase of probation conditions that include mental health treatment requirements, perhaps there is more awareness of potential interplay between mental health issues and criminal offences. This awareness may then be resulting in probation officers having to enforce such probation conditions and turning to FPSC in increasing numbers for access to mental health care.

3.3. Where FPSC & BC Corrections Collide: Probation

Individual responsibilities for both BC Corrections and the Forensic Psychiatric Services Commission (FPSC) are clearly outlined in both their own organizational documentation, however, there is very little, if any, clearly defined methodology for the way in which both organizations work together to provide appropriate treatment. There is a significant gap in knowledge regarding *how* community corrections and community treatment *should* interact.

In 2004/2005, admissions to provincial or territorial correctional programs totalled 342,018 (240,786 custodial supervision and 101,232 community supervision) (CIHI, 2008). Moreover, the criminal justice system is the largest source of referrals for mental health treatment including substance abuse (SAMHSA, 2009). However, probation agencies have been criticized for a lack of interagency cooperation with the police, treatment and service providers (BC Auditor General, 2011). In a recent audit of British Columbia Community and Corporate Programs branch of the Ministry of Public Safety and Solicitor General, the Auditor General noted that fifty-six percent of all offenders under correctional supervision in BC have been diagnosed with substance abuse issues or a mental health disorder, and seventy-four percent of all sentenced offenders under community supervision are assessed as medium or high risk to re-offend (BC Auditor General, 2011). Perhaps, more significant in terms of providing appropriate service to persons on probation order, the report found that:

- Probation officers do not consistently complete the appropriate training before supervising offenders in the community
- Probation officers' case management work is not regularly reviewed by local managers to ensure it complies with policy;
- Probation officers do not consistently identify strategies that address offenders' risks and needs and subsequently ensure offenders complete assigned interventions;
- Insufficient documentation is contained in offender files, specifically as it pertains to risk/ needs assessments and breach decisions, to confirm the appropriateness of probation officers' judgments.

(BC Auditor General, 2011, 8)

Clearly, there is a need to address case management for probationers in the community. Moreover, even though there is a clear connection between the criminal justice system and the mental health system, namely the offenders, there is also a need to outline cooperation amongst systems. While FPSC has worked with persons on probation in the community before, with the increasing number of referrals, requests, mandated treatment requirements and mental health needs it is crucial that the BC FPSC reviews its current model of care to respond to the changing landscape of forensic mental health services.

4. Introducing a New Model of Care

A model of care refers to the way *care* services are organized and delivered (CLEary, 2010; Levine 2012). In this case, the model refers to the structure, procedures and processes that occur as part of the service provision. For instance the number of staff, identified roles and responsibilities, and the systemic procedures are all considered elements of the model. The notion of *care* in this context is the ideology of service provided through the FPSC. As part of the mental health system in British Columbia, BC Mental Health and Addictions provides health care services to better the underlying health of individuals. Care, then, includes both pharmacological (medication) and therapeutic (e.g. group therapy, counselling) treatment, as well as case management (Smith & Newton, 2007). For the purpose of this project, the model of care for persons referred to the FPSC on Probation Order includes the assessment process, treatment during probation (including type, intensity and duration and case management models) and the discharge process (termination of service). In order to ensure that the treatment provided by FPSC for clients referred on Probation Order is optimal, with increasing referrals and dependence on the mental health system to work with the criminal justice system, a review of current best practices and standards of care needs to be conducted.

Box 1 – Model of Care

Assessment – Treatment – Discharge

5. Research Questions

1. What are best practices for mental health treatment for persons on probation order in the community?
2. What is the current model of care in place for persons referred to FPSC on Probation Order? (assessment process, treatment & case management, discharge process)
3. Within this model of care, what current gaps exist between services offered by FPSC and services requested and/or services needed as described in the available literature?

6. Best Practices Review

6.1. Mental Health Services

The role of Probation Officers and Community Corrections in regards to the mental health of persons on probation order has been extensively studied (Skeem, Machak & Peterson, 2011; Skeem & Eno Loudon, 2006; Loudon, 2010) However, in terms of the services offered through mental health professionals as a separate entity from community corrections, there is very little available research evidence and no identified standards of care for this particular population. With the literature that is available, we can draw conclusions as to what would outline best practices for mental health professionals offering required services to adults on probation order. Through available research in offender populations, mental health populations and policy documents we can draw further conclusions as to appropriate principles on which to base a model of care for persons on probation order in the community requiring mental health treatment.

Corrigan and colleagues (2008) recommended the critical (i.e. minimal) components of a solid foundation of mental health service including:

- Medical management (including psychopharmacology);
- Family support and education;
- Supported employment;
- Training in psychiatric self-management;
- Crisis response services;
- Housing; and
- Inpatient psychiatric hospital services (when needed).

Each of these minimal components must then be complemented by specialized concurrent disorders services wherever necessary. Further, as with any specialized service, to understand what additional complements (not just those for concurrent disorders) should be added we must understand the population we are dealing with.

6.2. Specialized Population of Offender

Persons on probation order requiring mental health treatment make up a specialized population of offender whose characteristics must be considered when designing a model of care for this group. For example, persons on probation are under legal supervision in the community and must abide by a series of rules and regulations or risk incarceration. In many cases recognition of mental health issues are relevant in sentencing – thus resulting in mandated treatment conditions of probation. In this case, the mental health issues rendered the offender responsible for their crime, but these issues were considered when assessing sentencing. Mitigating the risk of re-offending is the overall goal of Corrections and therefore, when mental health treatment is a condition of probation, the probationers' particular mental health issues are integrated within the criminogenic factors of re-offending. This final note also highlights the close connection that the justice system and mental health system have in regards to this particular offender.

Unlike mental health services that are embedded in prison or jail as a component of the corrections system, the forensic mental health system is a separate entity from community corrections. And, this particular offender must attend or receive treatment within the community. Ultimately, what renders this offender different than others is threefold, the way in which their criminal behaviour is affected by their mental health issues, the way their treatment is mandated, and that they must attend treatment in the community. For the sake of providing mental health services, it is important to further understand the complexity of this offender's mental health and criminal behaviour.

6.3. Complexities of the Offender

Persons on probation order requiring mental health treatment are more likely to have contacted mental health services before, have drug problems, have poor physical health and significantly recognized as having emotional instability, relationship problems, and discriminated against (Keene, Janacek & Howell, 2003), than other offender populations. Mental health probationers disproportionately use all services, including community health, accident and emergency services (Rodriguez & Keene, 2006). On

average, each such probationer contacts 3.6 different agencies for help (Ibid). Additionally, it takes longer for persons with mental health issues and criminal justice involvement to engage with employment services (Frounfelker et al., 2010). Mental Health Probationers assessed to have mental health problems were also more likely to: be male and younger; experience emotional problems, intellectual disabilities, social and physical problems; be homeless; commit violent, aggravated, and alcohol related offences (Rodriguez & Keene, 2006). Further, research indicates that up to eighty five percent of this population has experienced some traumatic even in their lifetime (Owens, Rogers & Whitesell, 2011). All in all, this suggests that these offenders are particularly vulnerable, and at an increased need of support and treatment compared to the general population.

6.4. Mandated Treatment Considerations

The notion of using the criminal justice system to “force” community mental health treatment through the use of probation orders represents a particularly controversial, yet under-studied area. Notably, there is very little research on the use of coercion in the community, how it is perceived by those upon whom it is imposed and what distinguishes an “offer” of treatment versus the “threat” of sanction (Petrila, 2003). Similarly, there is little research examining how individuals who would have previously been treated through psychiatric hospitalization are now treated through criminal sanctions, treated in the community, and more importantly who is responsible for overseeing such treatment.

Box 2 - Probation & Mental Health Risks the Same

The best predictors of probation or parole revocation for people with mental illnesses are similar to predictors of revocation for people without mental illnesses (for example, criminal history, substance use, problematic circumstances at home), but people with mental illnesses have more of these risk factors. In addition, people with mental illnesses face unique risk factors related to their clinical conditions (consensusproject.org).

The criminalization hypothesis asserts that, deinstitutionalization era policy

changes resulted in a significant portion of individuals with mental illness being controlled by the criminal justice system, rather than treated through hospitalization (Davis, 1998). Moreover, the issue of mental disorder is being raised more often in court (Latimer, 2006), suggesting that the mandated treatment of mental health is also increasing. While research does not yet outline how probation, or other court orders, might affect mental health treatment and outcomes, there is evidence outlining how probation services work with persons requiring mental health treatment.

In a descriptive study examining various demographic, psychiatric and offending variables for a sample of patients on probation order, the authors found both extensive comorbidity with drug and alcohol, and personality problems, as well as problems of inter-agency communication (Richardson, McInnes & Davies, 2003). Research examining issues associated with mandated treatment found that persons who have mandated community treatment as a condition of probation or parole have higher levels of acute symptomatology (Redlich et al., 2006), and are twice as likely as people without mental illnesses to have their community supervision revoked (Ibid). All of this infers that this vulnerable group of persons has more complex problems and, more importantly, may be unable to adequately advocate for their own needs.

Probation Officers may also treat persons requiring mental health treatment as a condition of probation differently than other probationers. In specialized mental health probation services, probation officers supervise their caseloads differently (Skeem, & Eno Loudon, 2006; Loudon et al., 2012). One study examining the use of threats of incarceration by probation officers, found that probation officers that collaborated with mental health workers were far more likely to use threats of incarceration than if there was no collaboration (Louden et al., 2012). Ultimately, the population at hand is specialized, whereby there is interaction between the criminal justice system and mental health, the clientele is complex, and the clients' ability to advocate for themselves may be hampered. Thus, this group requires careful consideration of the specific details that should be incorporated into a model of care for this population. In this case, the model of care includes the assessment, treatment and discharge processes.

6.5. Assessment

Assessment refers to intake and information gathering activities during the initial phase of contact with mental health services. The assessment is designed to garner enough information with which to make an informed decision outlining treatment needs. From the perspective of the mental health professional, research addressing best practices concerning assessment, at least at a systems level, is minimal. For the probationer requiring mental health treatment, there is one overarching guideline for assessment procedures from the perspective of the mental health professional. Namely, the assessment should be a collaborative process between both Probation and Mental Health Services (Smith, 1999). There is a need for inter-agency collaboration to identify risk and mental health needs of offenders on probation.

What is important to consider with the assessment process is the variation in objectives from the Corrections perspective and from the Mental Health Professional perspective. Corrections, as stated, aims to reduce re-offending while mental health treatment aims to improve mental health. The term risk assessment then takes on various definitions – as will be discussed in length in a later section. What is important to note, is that having two alternate perspectives requires persons involved to work more closely together.

Protection of the public and recognizing and responding to the mental health needs of the offenders results in the necessary cooperation between both corrections and mental health professionals. Effective assessments are necessary for effective treatment. Without interagency collaboration in the assessment process communication between agencies is hampered with differing definitions, lack of communication between disciplines, misunderstanding of roles and responsibilities, institutional constraints, and potential inter-agency conflict (Choi & Pak, 2007; Wischnowski & McCollum, 1995). Collaboration should include an understanding of each others' responsibilities and functions, and a shared risk assessment.

6.6. Assessment & Risk Need Responsivity

In forensic settings, the most common theoretical backdrop of the risk assessment is entitled the Risk-Need-Responsivity (RNR) model. The RNR model was first formalized in 1990 (Andrews, Bonta & Hoge, 1990) with acceptance and use in Canada and throughout the world, and is increasingly used to rehabilitate offenders.

The Risk-Need-Responsivity model is based on three principles:

1. The risk principle asserts that criminal behaviour is predictable and treatment should focus on the higher risk offenders;
2. The need principle notes the importance of criminogenic needs in the design and delivery of treatment; and
3. The responsivity principle describes how treatment should be provided; maximizing the offender's ability to learn from the intervention by providing cognitive behavioural treatment and tailoring the intervention to the learning style, motivation, abilities and strengths of the offender.

The risk-need-responsivity model of risk assessment can also incorporate the notion that all risks must be considered when providing mental health treatment, including personal contextual characteristics such as social support, housing, financial considerations, and history of criminal behaviour. As noted by Smith (1999) forensic mental health assessments should be based on the following characteristics:

1. Differentiate risk and target level of service to the higher risk offenders.
2. Effective treatment depends on good assessment of the needs, that should be differentiated between criminogenic and non or uncertain criminogenic needs. An example of the former would be substance abuse or employment problems. Non criminogenic needs might be high levels of anxiety or low levels of self esteem.
3. The responsivity principle, implies that personality type will influence how responsive the individual is to the treatment delivered.
4. Use of professional discretion.
5. Treatment must be offered in a consistent, structured way, adhering to the above principles and with trained, committed and enthusiastic staff.

As noted in the following discussion, assessment skills that inform case management are arguably the most important component in probation practice.

6.7. Risk Assessment

In the context of providing mental health care, risk is a particularly challenging component of an assessment for persons on probation order in the community, as the term “risk” takes on numerous meanings. For probation officers “risk” refers to the risk to re-offend. Health care organizations generally define risk as the “likelihood of an adverse event or outcome” (NZ MOH, 1998). For mental health professionals in non-forensic settings, risk often refers to the propensity to harm oneself (CMHA, 2009), risk to others (NZ MOH, 1998), or “risk” factors that can be attributed to poor mental health (Robinson et al., 2010). In the forensic mental health setting “risk” must incorporate all of these. For forensic mental health services there is a notion of both needing to understand and prevent criminal or dangerous behaviours and treat mental health issues (Heilbrun et al., 2011). All in all, in the forensic mental health care setting, and in particular, when offenders reside in the community, “risk” can refer to the risk to harm one-self, risk factors leading to poor mental health in addition to the risk for violence, and the risk to re-offend.

While the research addressing clinical risk assessment tools is substantial, there is very little clarity as to how mental health professionals solicited to offer mental health care should be involved in risk assessment – ie which areas of risk are relevant for *treatment*. Arguably, this depends on whether an offenders’ “risk” for future violence, to re-offend, to harm oneself, or to not recover (risk factors) is contextually integrated with one’s mental health issue. For example, if one’s mental health issue is substance abuse, and one’s criminal activity is attributed to this substance abuse, then “risk” falls under the broad concept and treatment must consider all risks – suicide, violence, risk factors for illness (in this case substance abuse) and risk to re-offend. Furthermore, in the context of the risk-need-responsivity model, if we match level of service to the offenders “risk” then *service* must also match risk for suicide, risk for violence, mental health risk factors, as well as the risk to re-offend.

This broad notion of risk is particularly salient, when we consider that mental illness itself does not constitute a risk for criminal activity or violence, yet in addition to other criminogenic risk factors, contributes to overall risk to re-offend (Scott & Resnick, 2006). Thus just assessing and treating the illness alone, without consideration of the

contextual factors that make a particular case a *forensic* one may fail to grasp the tangential factors affecting the illness and overall recovery – increasing the probability to reoffend.

6.8. Risk Assessment Tools

The research outlining clinical risk assessment and particularly tools for risk assessment is far more in-depth than general practice standards of assessment alone. Risk assessments are generally “an integral part of every clinical observation or assessment” (NZ MOH, 1998, page 4), however, risk assessment as a concrete activity is also relevant. Beginning in the 1970s there was growing recognition that assessment of risk (to re-offend) needed to depend more upon evidence-based science and not on professional judgement (Andrews et al., 2006). Essentially, risk assessment tools do a better job of assessing risk to re-offend than professional judgement. However this is from a corrections perspective where preventing criminal activity takes priority.

Validated and reliable screening tools for use on corrections clients should identify co-morbid psychiatric and substance use disorders (Lurigio & Swartz, 2006). Risk assessment tools should also include dynamic risk factors (employment, social support, etc.) in addition to the statistically relevant static risk factors (criminal history, past substance use etc.) (Andrews et al, 2006). Assessment tools supported in the academic literature for use on offenders on probation requiring mental health include the HCR-20, Psychopathy Checklist – Revised, (PCL-R), the Violence Risk Appraisal Guide (VRAG) (Heilbrun et al., 2011; Scott & Resnick 2006), and the Level of Service Case Management Inventory - Revised (LSI-R) – which notably incorporates risk factors that are not measured elsewhere, as well as systematic intervention and monitoring (Andrews et al., 2006). Unlike the PCL-R, the LSI-R does not need to be applied by a trained psychologist, and includes protocol for a correctional plan, progress record and discharge summary. In the Canadian landscape, the Short Term Assessment for Risk and Treatability (START) has recently been introduced (Webster et al., 2006) and focuses on client strengths – that help to improve outcome, in addition to the dynamic risk factors of: risk to others, suicide, self harm, self-neglect, unauthorized leave, substance abuse and victimization.

For violence assessments, research suggests that dangerousness should be divided into five concepts (Scott & Resnick, 2006): magnitude of the potential harm (ie. type of threat), likelihood (past history of acting on threats), imminence, frequency (number of times and act has occurred in a given time period), and situation factors that increase the likelihood for violence (stressors, access to weapons etc.). The history of violence is particularly important as each prior act of violence increases the risk of future violence; as does the use of a weapon, substance use, a diagnosis of antisocial personality disorder, and in conjunction with all of these dangerousness risk factors – psychosis (Ibid).

In examining the scholarly peer-reviewed literature and associated risk assessment tools, only the START aims to inform multiple risk domains, including risk for suicide. From the perspective of a mental health professional, providing treatment to offenders in the community, suicide is a pressing assessment to consider. And, as has already been discussed this particular population of offenders has high rates of suicide, and this must be considered in the assessment process.

Finally, while assessing for “risk” is particularly important; implementing variations in treatment based on these assessments is vital. Bonta & Andrews (2006) identifies some intervention goals associated with common risk factors (see Table 1 Intervention Goals & Risk Factors identified using risk assessment tools).

Table 1 Intervention Goals & Risk Factors

Risk/need factor	Indicators	Intervention Goals
Antisocial Personality	Impulsive, adventurous pleasure seeking, restlessly aggressive and irritable	Self-management skills & anger management
Procriminal Attitude	Rationalizations for crime, negative attitudes towards the law	Counter rationalizations with prosocial attitudes; build prosocial identity
Social Support for Crime	Criminal friends, isolation from prosocial others	Replace procriminal with prosocial friends and associates
Substance Abuse	Abuse of alcohol and/or drugs	Reduce substance abuse, enhance alternatives to substance use
Family/marital Relationships	Inappropriate parental monitoring and disciplining, poor family relationships	Teach parenting skills, enhance warmth and caring
School/work	Poor performance, low levels of satisfactions	Enhance work/study skills, interpersonal relationships within the context of work and school
Pro-social Activities	Lack of involvement in prosocial activities	Encourage participation in prosocial activities, teach prosocial hobbies

(adapted from Bonta & Andrews 2007)

Ultimately, the assessment process should include a “risk assessment” that is much broader than risk to re-offend and should combine the efforts of both probation officers and mental health professionals. The Risk Assessment should incorporate the RNR model and utilize reliable and validated tools – wherever possible. The assessment process is futile if there is a lack of response to, or treatment of, needs and risks.

6.9. Treatment

Treatment generally refers to “the administration or application of remedies or therapies to a patient for a disease or injury”⁷. In this particular case, treatment refers to

⁷ New Hampshire Centre for Excellence

the programming and activities that take place within the mental health services that respond to the needs of the individual. The treatment aims to improve the factors that attributed to identified needs – such as improving mental health symptoms. For the purpose of this particular analysis, treatment here includes treatment programming – or programs specific for persons on probation order requiring mental health treatment (ie substance use, group therapy etc.); in addition to Case Management. Case management, as will be discussed, includes activities that take place to ensure that treatment is provided appropriately and must be considered, due to the involuntary treatment status of the population. Case Management is included as a component of treatment because in some cases it may occur on its own without other treatment programming – such as individual counseling or medication management. As well, case management could be provided by the probation officer, and not necessarily through FPSC. Case Management by FPSC would only be implemented as a response to risks or needs, and not necessarily in every referral.

6.9.1. Treatment Programming

The Risk-Need-Responsivity (RNR) model is designed for use on offender populations and is the most empirically supported model of risk reduction. Empirically supported modes of treatment designed to reduce re-offending are behavioural programs including cognitive-behavioural therapy; social learning; modeling and reinforcement of anti-criminal attitudes; provision for graduated acquisition of skills; role playing to consolidate new skills; providing resources; and concreted verbal suggestions (Cortini, 2006). If reducing re-offending is the aim of treatment in offender populations, targeting factors not associated with offending behaviour, through mental health treatment, does not lead to a reduction in re-offending (Ibid). Mental health issues do not constitute a risk for offending alone, but specific mental health disorders tend to increase the risk to re-offend in addition to other risk factors (White & Gordon, 2006). While there is evidence for treatment to reduce re-offending, there is minimal research supporting specific methods to reduce mental health issues in an offending population – particularly for those mandated to treatment while in the community.

As discussed above, in offending populations treatment should respond to the identified risks and/or needs of the offender. A literature search of scholarly peer

reviewed articles in both Canadian and International Databases did not yield any outcome research addressing programming or individual programs *specifically* for the population under consideration – adults on probation order requiring mental health treatment. There is however, extensive research identifying treatment outcomes specifically targeted for improving mental health, including co-occurring disorders. In an analysis of evidence based practice and methodologies, Prendergast (2011) identifies the Substance Abuse and Mental Health Services Administration (SAMHSA) online National Registry of Evidence Based Programs and Practices (approximately 220 programs in total) for mental health treatment. Individual programs are submitted to the registry for review, and evaluated by experts on the quality of research and readiness for dissemination. Upon further review, this registry yielded twenty-three individual programs that targeted improvements in mental health as an outcome, for adults in a community or outpatient setting. Nine of these programs targeted outcomes of improved substance use in addition to mental health, eight targeted improvements in more than one mental health disorder (not including substance use) such as anxiety or depression, and fourteen considered mental health and a psychosocial outcome (attitude, housing, employment etc.). It is noteworthy that every program, considered to have appropriate research for inclusion in the registry, had more than one outcome – suggesting that interventions should be multifaceted. Further, the population at hand is a complex population, and thus interventions should likely be more complex as well, with multiple outcomes.

In addition to programs with multiple outcome goals, treatment for probationers requiring mental health services may require specialized approaches to engage clients. Sinha, Easton & Kemp (2003) found that younger adult probationers tended to have marijuana use issues, and were less likely to consider treatment, compared to older probationers who are more likely to have alcohol use issues, and would consider treatment. Females are twelve percent less likely than males to have attended a peer recovery support program (Oser et al., 2012). Substance use in addition to a diagnosis of schizophrenia increased the likelihood of refusing mental health treatment (Solomen, & Draine, 1999), implying the need for intensive case management for this particular group.

Specialized, complex programming may be necessary to overcome additional barriers as well. Having been incarcerated (versus community legal order) increases the likelihood of voluntary treatment by sixty-two percent (Solomen et al., 2002). In addition, having used cocaine and heroin/opiates were associated with an increased likelihood of voluntary treatment attendance compared to other substances. In addition, an individual on probation with psychiatric issues was nearly four times more likely to have ever been homeless if they also reported having both an alcohol and drug problem (Ibid). Treatment programs may be difficult for persons to attend if they are homeless.

As discussed, identified effective treatment for mental health conditions as well as co-occurring disorders, tends to aim to improve multiple outcomes. Additionally, the population under consideration has characteristics which must be considered when designing treatment, including a need to focus on sustaining engagement, specialized categories of probationers, and additional barriers – such as housing. Clearly this complex group requires complex treatment. The mandated nature of the treatment in addition to the complexities of the population should inform the mental health case management of this group of offenders.

6.9.2. Case Management

Case management refers to a process, or particular way of working with a person or case by a case manager who has the authority or direction⁸ to guide services and supports. While case management may also refer to the management of offender by a probation officer or through BC Corrections, within the scope of this research project, this discussion is narrowed to case management from the perspective of the mental health service. For the probation population requiring mental health treatment, there are models of case management introduced in the literature that are applicable. Notably, all the models considered are not necessarily focussed on a probation population but from the perspective of the mental health service *could* be used for such a population. Moreover, the models considered for review were those that could be implemented by a

⁸ The European Organisation for Probation

separate mental health service such as the BC FPSC, and that addressed complex treatment needs.

Assertive Community Treatment (ACT)

The Canadian Mental Health Association defines Assertive Community Treatment (ACT) as “a client-centered, recovery-oriented mental health service intended to facilitate psychosocial rehabilitation for persons who have the most serious mental illness and have not benefited from traditional programs”⁹. ACT programs have been intensively studied (Nelson, Lafrance & Aubry, 2007; Stull, McGrew & Stalyers, 2012; Smith & Newton, 2007) and empirically supported (Morrissey, Meyer & Cuddeback, 2007) as a case management model. ACT programs are designed to be more specialized and more intense than typical community mental health programs and are designed to work with clients with higher needs and provide long-term ongoing service¹⁰. Both British Columbia and Ontario have produced ACT Standards of Care. Table 2 ACT Standards Summary provides a brief overview of Assertive Community Treatment best practice standards inherent in each of BC and Ontario ACT Standards, broken down into components of the operationalized model of care (Assessment and Treatment) for this project.

⁹ Canadian Mental Health Association, Ontario Branch

¹⁰ Centre for Addiction and Mental Health

Table 2 ACT Standards Summary

Assessment
<ul style="list-style-type: none"> • Assessment and treatment/service plan are done the day of client’s admission by the team coordinator or psychiatrist with participation by designated team members • Assessment subjectively based on all available information (Psychiatric History, Physical Health, Substance Use, Education and Employment, Social Development and Functioning, Activities of Daily Living, Family Structure and Relationships) • Intake Criteria: Clients with “greatest need”; priority to psychotic disorders and severe and persistent illness; functional impairments; clients who make high use of other services (hospitals, emergency services); co-occurring difficulties (substance use, disability) • Admission Process: Assertive Engagement; with Consent; Documentation of Admission; Documentation of Refusal • It must be noted that both the BC Standards and Ontario Standards address the need to work with persons who come in contact with the criminal justice system.
Treatment/ Case Management
<ul style="list-style-type: none"> • Provide a balance of treatment, rehabilitation and support services; • 24hrs a day, 7 days a week; • Average three contacts per week; • Required minimum staff includes team coordinator, registered nurse, social worker, occupational therapist, substance abuse specialist, vocational specialist. • Multidisciplinary team delivering individualized services. • 75% of client contact in the community, in non-office like settings • Continuity of care established with all services • Client-centered care designed with client; goals to attain: optimum symptom reduction, fulfill personal needs and aspirations, take into account cultural beliefs and realities of individual, improve all aspects of psychosocial functioning that are important to the client. • Key areas for treatment plans include: symptom reduction (psychiatric and pharmacological treatment, substance use), housing, ADLs, daily structure and employment (psychosocial, vocational), family social relationships. • Crisis intervention 24 hrs a day. • Access to crisis stabilization and crisis residential care options

The ACT case management model attempts to address all the complexities of the client while offering more intense management services. For the particular population at hand, there are some notable areas to mention: a focus on assertive engagement, barriers, severe mental illness and substance use, the need to work with clients in conflict with the legal system, and a focus on individualized care. Additionally, staff discretion should be utilized in regards to ensuring quality interactions rather than

just higher intensity of service, avoiding the use of coercion, and intensive case management for persons having attained a particular level of autonomy (Rosen, Mueser & Teesson, 2007). Furthermore, both housing (Nelson, Lafrance & Aubry, 2007) and medication adherence (Rosen, Mueser & Teesson, 2007) have been identified as barriers to implementing ACT case management. The Forensic Assertive Community Treatment (FACT) model, has represents an ACT model with one significant difference - the need to prevent recidivism.

Forensic Assertive Community Treatment (FACT)

Forensic Assertive Community Treatment (FACT) programs developed in response to research indicating that ACT programs prevented hospitalization but failed to prevent recidivism (Morrissey, Meyer & Cuddeback, 2007). The FACT model combines ACT and preventing recidivism. Notably, FACT teams often “strip away some of the high-fidelity elements (such as 24/7 availability, daily team meetings, employment specialists) and adds new elements not found in typical ACT teams (such as a probation, parole, or police officer) (Ibid). The FACT model, shows positive results in reducing criminal behaviour and recidivism (Lamberti, Weisman & Faden, 2004), however, this model has yet to establish standards of best practices to the extent that ACT programming has, and does not yet have consistent models of staffing or care with outcome research for effectiveness (Ibid). Basically, there is no clear structure of how FACT programs should be designed. Skipworth & Humberstone (2006) outline ten clinically based principles of care for FACT teams. The FACT services must:

- Be located in the community
- Provide culturally informed care
- Be mobile (all members of the team)
- Be accessible during weekends and after hours
- A formation of effective therapeutic alliance
- Able to provide a high frequency of contact
- Work with patients family and significant social network
- Have unobstructed access to services, including access to rehospitalisation
- Understand and incorporate recovery as a philosophy of care
- Deliver care based on individual risk management and rehabilitation plans

Arguably, FACT models should be based on ACT standards while incorporating evidence based practices that reduce recidivism – risk management.

Intensive Case Management (ICM)

Intensive case management functions with the same client-centred principles of ACT, but rather than depend on a team – intensive case management services are provided by a single case manager. Differences between principles identified through ACT standards are represented in Table 3 ICM Standards as outlined in the Ontario Intensive Case Management Standards of Care. Most notably, the ICM standards allow for additional time at intake and assessment, and variations in responsibilities due to reductions in staff.

Table 3 ICM Standards

Intake Process
<ul style="list-style-type: none"> The intake process must be initiated within 10 working days after initial contact.
Assessment
<ul style="list-style-type: none"> Upon completion of the intake process, an agency standardized needs assessment for service must be initiated within 10 working days.
Treatment
<ul style="list-style-type: none"> The service plan must identify other services and resources if required to address the full range of a consumer’s needs. Service provision must be managed in a manner that responds to fluctuations/ variations in consumer need. Intensive case management services must be available a minimum of eight hours a day, five days a week. Written protocols must be established for consumers to access service/ support in off-service hours, seven days a week, 24 hours a day, and should be documented in consumer service plans as part of emergency/crisis planning. The service provider agency must develop partnership or service agreements with other agencies or community services or primary care providers to ensure continuity of service provision. The case manager must be knowledgeable about services that are accessible and relevant to consumer interests in order to provide up-to-date information. The case manager must also advocate, on behalf of the consumer, for services that are accessible and relevant to the consumer’s needs.

The ICM model separates intake and assessment. This separation allows for a more manageable time frame for response with limited staff. In addition, this model seems to emphasize a need to collaborate, or integrate with local services and resources – making this model perhaps more integrative than the ACT and FACT models already discussed.

Concurrent Mental Health and Substance Use Disorders Management

Substance use treatment evidence indicates that re-offending is lower for persons successfully completing substance use treatment (Evans et al., 2006). Thus, systems working with persons on probation requiring mental health treatment must consider how to integrate substance use services as these are a likely characteristic of the client and may make an impact on overall re-offending. Moreover, Health Canada (2002) recommends that during the screening process of any mental health service, all people seeking help from:

- Substance abuse be screened for co-occurring mental health disorders.
- Mental health be screened for co-occurring substance use disorders.

For the purposes of this project it is important to examine the effectiveness of treatment models that either incorporate substance use services within a model of care (system integration) versus evidence for integration of substance use methodologies into programs (program integration). Both ACT and FACT models support the notions that specialized intensive services are better than non-specialized, non-intensive services. Yet, the question is whether a forensic mental health system should have substance use programming and staff within a service or should coordinate mental health treatment with substance use programs outside the service. Health Canada (2002) outlines a series of best practice recommendations at the service level (Table 4 Concurrent Disorders Best Practices) core components identified include:

- Concurrent disorders assessments;
- Clinical case management based on stages of treatment;
- Motivational interviewing;
- Harm reduction approach (e.g. flexible goals);
- Cognitive-behavioral substance abuse counseling;

- Concurrent disorders group interventions, including social skills training groups;
- Self-help liaison (e.g. Double Trouble; AA);
- Work with families including behavioral family therapy and psycho-education; and
- Residential options, including housing.

(Health Canada, 2002, 57)

Table 4 Concurrent Disorders Best Practices

Screening/ Assessment
<p>It is recommended that all people seeking help from mental health treatment services be screened for co-occurring substance use disorders. Minimal approaches include:</p> <ul style="list-style-type: none"> • Using an index of suspicion • Asking a few questions • Using a brief screening instrument • Using case manager judgment <p>Validated approaches include the:</p> <ul style="list-style-type: none"> • Dartmouth Assessment of Lifestyle Instrument (DALI) • Short Michigan Alcoholism Screening Test (SMAST) • Drug Abuse Screening Test (DAST) • Alcohol Use Disorders Identification Test (AUDIT) <p>It is recommended that all people seeking help from substance abuse treatment services be screened for co-occurring mental health disorders. Minimal approaches includes:</p> <ul style="list-style-type: none"> • Using an index of suspicion • Asking a few questions <p>Validate Approach includes:</p> <ul style="list-style-type: none"> • Psychiatric sub-scale of the Addiction Severity Index (ASI) device
Treatments/ Support
<p>General considerations:</p> <ul style="list-style-type: none"> • Treatment and ongoing support for all sub-groups of people with concurrent disorders should also include attention to the person’s basic needs for housing, access to food, social support and other aspects of psychosocial circumstance and social functioning; • Integration is about communication, consistency, and coordination of all the various clinicians and support workers and not whether one set of problems (mental health or substance abuse) is addressed before the other; • Both substance abuse and mental health problems can be chronic, recurring health problems, which usually require some immediate interventions as well as ongoing monitoring and support. • There is considerable value in tailoring the intervention for people with concurrent disorders to the motivational level or ‘stage’ that the consumer is at, at that particular point in time. • There is little evidence in support of residential treatment over intensive outpatient care; • Self-help groups such as AA and other 12 Step programs and consumer/survivor initiatives in the mental health field play a critical role in community mental health and addiction systems.

(adapted from Health Canada, 2002)

6.10. Discharge

Discharge refers to the activities associated with the termination of services. Continuity of Care principles underscore the notion of discharge for any mental health service. Continuity of care is a continuous relationship, sustained over time, between patients and their care providers (Holland & Harris, 2008).

Identifying best practices for discharge, is somewhat more difficult as little research exists examining discharge in general, let alone for a narrow population of mental health consumers, such as those on probation. For the purposes of this project then there are some basic principles addressed in the literature that can be used to outline best practices. First, discharge planning should begin as soon as treatment planning commences. In this respect, discharge is dependant upon reaching a series of goals. This notion is identified in the ACT services standards (Table 5 ACT Discharge Standards).

Table 5 ACT Discharge Standards

- Criteria for discharge: reached established goals; successfully reached ability to function without support; moves outside geographic area; refuses service despite teams intensive and persistent efforts
- Discharge documentation should include: reasons for discharge, status at discharge, evaluation summary of progress; plan of follow-up; client involvement

Second, research suggests that the information identified in the risk assessment, including information from past care, as well as risk measurements, are communicated in an appropriate and timely fashion, with the opportunity for the receiving professionals to discuss with the discharging services, if necessary (Ignelzi et al., 2007). Third, in consideration of the second point – ideally information that a particular service requires for referral should also be the type of information that is addressed and measured upon discharge. This level of information would allow for outcome and evaluation measurement.

6.11. Best Practices Summary

The following (Table 6 Best Practices Summary) summarizes best practices for persons on probation order requiring mental health treatment. The summary is broken down into the individual components of the model of care.

Table 6 Best Practices Summary

Assessment
<ul style="list-style-type: none"> • Collaborative (lead by Probation Officer as they are responsible for client) • Shared Risk Assessment: • Use of risk assessment tools were possible; using tools created for corrections clients; identify co-morbid psychiatric and substance use disorders; Assess both dynamic and static risk factors • Risk Need Responsivity with broad definition of risk, including suicide, violence and to re-offend: • Target high risk, assess all needs (criminogenic and non criminogenic), Responsivity principle – address learning style, incorporate professional discretion (where scores on risk assessment seem low), assess five concepts for violence/ dangerousness • Occur in person as soon as possible – minimally in 10 days • Always measure and address substance use as well as mental health
Treatment
<ul style="list-style-type: none"> • Consistent and responds to identified needs in assessment (including basic needs) • RNR model: both Mental Health risks and Risk to Re-offend are addressed <p>Programming:</p> <ul style="list-style-type: none"> • Improvements in multiple areas; Focus on engagement; Depending on population (ie age, gender etc.); Barriers to treatment should be addressed <p>Case Management:</p> <ul style="list-style-type: none"> • Assertive engagement/ therapeutic alliance; focus on barriers/ unobstructed access to services; individualized care; prevent recidivism; community based; mobile staff; weekend and after hours; high frequency contact (immediate help and ongoing monitoring and support); work with support network; recovery is philosophy; collaboration with appropriate services
Discharge
<ul style="list-style-type: none"> • Discharge planning should begin as soon as treatment planning commences. • Criteria for discharge: reached established goals, moved, or refused services (only after significant efforts to engage) • Continuity of care: all information is shared with receiving professionals ,communicated in an appropriate and timely fashion, with the opportunity to discuss with discharging services • Discharge documentation should include: reasons for discharge, status at discharge, evaluation summary of progress; plan of follow-up; client involvement

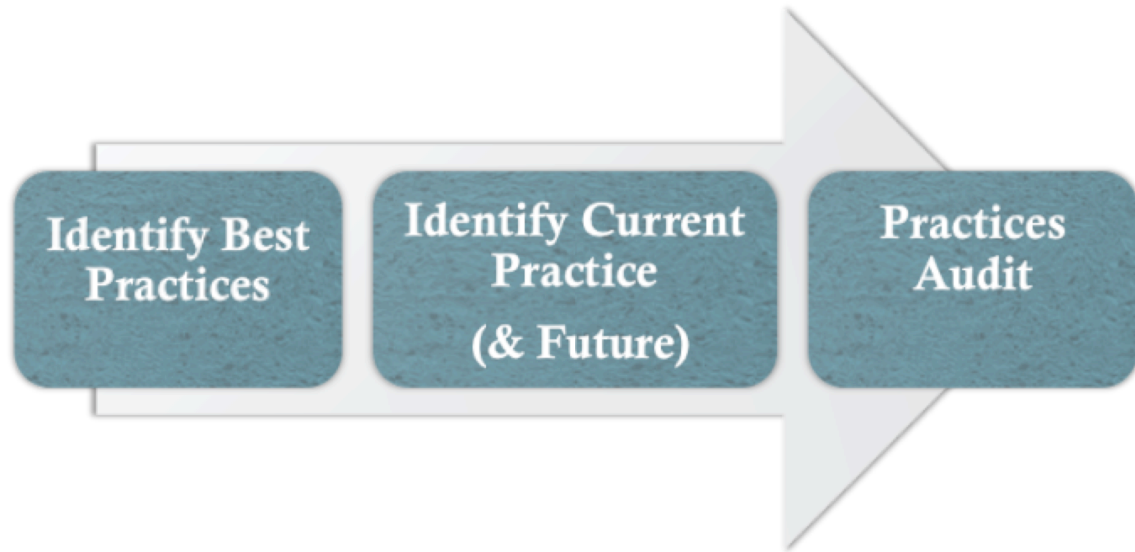
The next section will outline how these best practices are used to conduct a Practices Audit for persons on probation order requiring treatment through the BC Forensic Psychiatric Services Commission.

7. Methodology

7.1. Identifying Gaps in the Current Service

The project was designed as a review and evaluation of the current model of care within the British Columbia Forensic Psychiatric Services Commission (FPSC) for persons on Probation Order in the community requiring mental health treatment. Ensuring that persons requiring mental health treatment are attaining the optimal care they need guides the overall methodology. This particular study provides support for a larger project currently underway within the BC FPSC – reviewing the services offered to persons on probation order requiring mental health treatment. This project incorporates some of the data that was collected for the larger project with a specific focus on including materials that can help to conduct a thorough comparison of best practices identified in the literature and FPSC current practices. The larger project being conducted by FPSC similarly looks to understand the “current state” of services provided, and staff vision as to what services should and can be implemented in “future state” programming. This smaller research project will support the larger project by examining best practices in the literature and comparing with the results of the “current state” analysis. To thoroughly understand FPSC current practice, this project utilizes both qualitative and quantitative analysis of data collected. This methodology (Figure 1) allows for the incorporation of overarching trends with additional contextual themes, and resulting in a thorough understanding of the current model of care, and associated gaps between current care and optimal care.

Figure 1 – Methodology



7.1.1. Research Questions

1. What are best practices for mental health treatment for persons on probation order in the community?
2. What is the current model of care in place for persons referred to FPSC on Probation Order? (assessment process, treatment & case management, discharge process)
3. Within this model of care, what current gaps exist between services offered by FPSC and services requested and/or services needed as described in the available literature?

Best practices have been identified in section 6.11 to answer research question one. Research questions two and three will be addressed through the practices audit (described below).

7.1.2. Practice Audit

This project aims to assess the current model of care for persons on probation order requiring mental health treatment – namely assessment, treatment and discharge programming for this population. Thus, the project focuses specifically on system based activities that could be targeted for policy development for this select group of clients accessing services at Regional Forensic Clinics. *Practice Audit* methodology, whereby the study “determines the conformity of clinical practice with clinical practice guidelines” (Catts et al., 2010), is used to identify gaps in the overall model of care currently in place. This methodology requires the use of Clinical Practice Guidelines – of which none currently exist for this particular population. Thus, the initial best practices review has identified best practices for this particular population and presents a series of “guidelines” which can then be used to compare to the current model of care, and forms the backbone of the overall project.

The extent of the literature search for the best practices review was limited to system level best practices or minimum standards for this population of individuals, as this particular project is aiming to understand and address gaps in the overall model of care, in order to operate more effectively. The review consisted of a search of the Academic Search Premier database (all databases including PsychINFO, Medline, Criminal Justice Abstracts) for scholarly peer-reviewed articles, between 1990 and 2012, addressing mental health services for persons on probation order. Search terms included probation, mental health, offenders, mandated treatment and community orders. Articles addressing youth or juvenile services, and practices or services for corrections staff were removed unless they addressed general mental health services for the identified population. An additional internet search (refined to 2000 – 2012) for general mental health programming for persons on probation, high level policy documents, available national and international discussions regarding persons on probation order and mental health services, as well as national and international standards of care, was also conducted. Finally, references identified within articles that may be important were sought as well. From the initial search, articles were categorized based on the defined model of care identified above – assessment, treatment and discharge.

Secondary Data Collected

Secondary analysis involves the use of existing data collected for purpose of a previous study so that an alternative question can be pursued (Szabo and Strang 1997). As noted above, the current model of care is identified using data collected and analyzed as part of ongoing quality improvement initiative for the BC FPSC, including:

- Pre Forum Survey
- Referral Form and Progress Note Review
- Probation Treatment Client Forum Group Discussions

The participation of the author in the larger study enabled use of the data in the current project. Data from the Pre Forum Staff Survey and Referral and Progress Note Review was collected and analyzed as part of the author's Quality Analyst role with the BC FPSC. Further, the author, as Quality Analyst, was involved in the transcription of Forum group discussion data. Altogether, these data sources and associated analyses help to construct a thorough picture of the "current state" of service provision, including the assessment, treatment programming and discharge processes offered to clients referred on probation order to the FPSC. Additionally, the data offers potential options for "future state" programming by identifying strengths and weakness, or more specifically adherence or non-adherence to best practices, in the current service provision. Gaps between the services provided and what best practices are will be identified, and will help to provide information for a thorough evaluation of policy options.

The study methodology involves three steps. The first step involves a literature review from which best practice guidelines are introduced. Second, the data obtained from BC FPSC is analyzed for information regarding current practice that could be compared to these guidelines. This comparison between guidelines and current practice is presented and gaps in service are highlighted. The data collection also identifies strengths and weaknesses of the service that are not necessarily addressed in the best practice guidelines, but which may help to inform policy options. Finally, from the identified gaps in service, and strengths and weaknesses, policy options are developed and further evaluated against a series of criteria: health outcomes criteria – relevance, effectiveness and impact; implementation criteria – cost, political viability, administrative

ease, and authority. The policy analysis informs recommendations for future considerations for FPSC in regards to the services provided to persons on probation order requiring mental health services.

7.2. Data Description & Analysis

7.2.1. Pre Forum Staff Survey

In advance of the Probation Treatment Client Forum, an online survey was conducted with staff from all six of the Regional Clinic locations of the FPSC – Vancouver, Surrey, Kamloops, Prince George, Nanaimo, and Victoria. All FPSC Regional Clinic staff were invited to participate in the survey. The staff survey consisted of both closed and open ended questions to illustrate the current state of care in the Regional Clinics. Survey questions were created by a Probation Forum Steering Committee consisting of Directors and Managers from the Quality, Clinical and Research Departments of the FPSC, as well as the Quality Analyst and a Project Manager. The survey aimed to provide information on the current referral, treatment and discharge process, using feedback from frontline staff working with clients on Probation Order. The survey engaged staff in the process of describing the referral, treatment and discharge processes and to identify gaps in service.

The survey was created and distributed using a Canadian online survey server firm¹¹ through which an email with a link to the survey was distributed to staff. There were a total of seventeen questions. Questions consisted of a combination of multiple choice, multiple choice with an “other” open ended text response, likert type questions and finally open ended text response questions.

A total of 52 staff members responded to the survey out of a total population of 110 (response rate = 47%). The survey was open for two weeks. The majority of

¹¹ www.fluidsurveys.ca

respondents were nurses (44%), social workers (25%) and case managers (29%). Notably, people working in the fields of both psychiatry (8%) and psychology (6%) make up a small portion of the respondent population, however, this reflects the fact that these groups constitute a small portion of the actual total staff population. Respondents categorized as “Other” included administrative staff, managers and forensic liaison. All six regional clinics were represented in the survey; Surrey (31%), Vancouver (19%), Victoria (19%), Kamloops (12%), Nanaimo (12%) and Prince George (10%).

Analysis

Frequencies and percentages were calculated for each question. Open ended text responses were analyzed using thematic analysis to identify and report patterns and/or themes in the qualitative data (Braun and Clarke 2006). The six phases of thematic analysis include: familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. In this case, themes were identified regarding current gaps or potential changes to the current services, as they apply to assessment, treatment and discharge processes. The most common themes and the percentage of respondents who endorsed these themes were provided. For questions where respondents listed numerous answers, percentages were not calculated and responses were simply listed in rank order of number of times a particular answer was listed

Ultimately, descriptive data from the survey was compiled into a report used to help guide the format of the Probation Clinical Services Forum

7.2.2. Referral Form and Progress Note Review

In order to get a more complete understanding of the contents and quality of probation referral forms, all six regional clinics provided a number of their most recent probation referral forms and progress notes. Each Regional Clinic was asked to compile the case files for their most recent referrals dating back two months. Case files included referral forms, progress notes, court documentation, psychiatric assessments wherever necessary, and medication records where possible.

Analysis

Each of the files were reviewed for specific client demographic information including sex, age and diagnosis. Thematic analysis (Braun And Clarke, 2006) was used (see thematic analysis used in staff survey) to identify themes within the open ended *Reason for Requested Services* portion of the Referral Form. Probation conditions on the Probation Order were reviewed for type and number. Again, an additional analysis of the Probation Order was conducted using thematic analysis to identify types of services requested and who was identified to direct this service. Finally, progress notes were reviewed to identify the types of services FPSC Clinic staff provided to clients in the initial stage of referral and intake. This data was further reviewed for the evaluation portion of the study to provide evidence for current practice as it adheres to best practices, or does not adhere to best practices.

7.2.3. Probation Treatment Client Forum

The Probation Clinical Services Forum was designed to engage staff and elicit feedback on the various directions that FPSC can move in order to offer better services to clients on Probation Order. All staff (110) were invited to attend an 'in person' Forum located at BC Women's and Children's Hospital Chan Auditorium on November 24, 2011. In total, fifty-eight staff members (53%), including physicians, social workers and nurses attended from each of the FPSC Regional Clinics (Vancouver, Surrey, Kamloops, Victoria, Prince George, Nanaimo). The full day event consisted of a presentation of the findings from the online staff survey, the referral package review as well as data from the clinic databases, followed by open discussion groups on identified topics including: Intake and triage for high risk/high needs, moderate risks/needs, low risk/needs offenders; clinical services for mood disorders, personality disorders, impulse disorders, psychotic disorders and problem behaviours. Additionally, BC Corrections Probation Staff were invited to attend a session designed to outline the various strengths and weaknesses of the partnership with FPSC in regards to clients on Probation Order from the Corrections perspective. Each of these sessions was transcribed by support staff and themes identified to present a final report outlining general trends and findings.

Analysis

Analysis of the data from the Probation Forum consisted of identification of current practices that occur for each of the components of the model of care. In some cases the discussions that occurred at the Probation Forum addressed elements of service that staff felt were more relevant to the topic at hand. Themes that were listed in the final report were reviewed for evidence of adherence to, or non adherence to best practices from the forum and used in the evaluation portion of this study.

7.3. Ethics

Ethics approval for use of data collected and analyzed for ongoing quality improvement as part of the BC Forensic Psychiatric Services Commission Probation Clinical Services Review Project was obtained through the Simon Fraser University Department of Research Ethics. The data was made available by the Forensic Psychiatric Services Commission Research Ethics Committee as secondary data. Data was accessed by the Principle Investigator as a component of employment as a Quality Analyst with BC Mental Health and Addictions and as a support role in the FPSC Probation Clinical Services Review Project and subject to secondary analysis.

8. Moving Forward

8.1. Results: The Practices Audit and Identified Gaps

As stated above, the overall methodology for this project consists of a *Practice Audit* aiming to compare current practices, or in this case the “current state” against identified best practice guidelines. The guidelines were identified through the literature review of available academic and grey literature for persons on Probation Order in the community. Each of these guidelines was grouped under the appropriate category addressed in the defined model of care (assessment, treatment programming – including case management, and discharge).

BC FPSC current policies and procedures were reviewed. The data collected helps to fill out the contextual and additional staff practices that currently occur, that are not outlined through policy and procedure documentation. Wherever possible differences between the identified best practice guidelines and the current practices are highlighted. Additionally, results from the data also provide measures of evaluating policy options in the final portion of this project. The combination of best practices gaps in service in addition to staff highlights of current weaknesses, and recommendations for future services help to form the basis for potential policy options.

The following section incorporates results from the multiple data sources and analyses conducted, structured to reflect the identified components of the model of care – assessment, treatment and discharge. Each section will address the best practices identified in the literature review and the current practices and procedures of staff within the BC FPSC.

8.1.1.Assessment

According to the review of available evidence, best practices for the assessment of persons on probation requiring treatment include the need for an in-person, collaborative client-centred process, lead by the probation officer, based on an RNR model whereby a broad definition of risk is considered. Further, through examination of case management models for complex persons, assessments should occur in person as soon as possible (initial intake in 10 days for ICM), and should always address substance use.

The FPSC Probation or Bail Treatment Referral Protocol is as follows:

An individual may have as a condition of bail, probation order, or parole certificate that they attend a community clinic for treatment purposes. The assessment is conducted according to the following procedure:

1. Referral Process
 - a) the probation officer, bail supervisor or parole officer initiates the referral
2. Documents Required
 - a) Referral Form
 - b) Legal order (probation order, bail order, or parole certificate)
 - c) Police report
 - d) CPIC
 - e) In-service information
 - f) Collateral information
3. Case Assignment
 - a) The case is assigned through the intake process
4. The assessment is completed in accordance with the Intake Assessment Guidelines.
5. The treatment team maintains communication with the referral source on a need to know basis.

According to the FPSC Regional Clinics Client Flow Chart available with the current intake package, there are three steps to the referral process:

1. Referral Received
2. Referral reviewed by Duty Officer
3. Referral assigned to Psychiatrist & Case Manager

Current FPSC Intake Assessment Guidelines (for all FPSC clients) suggest that the intake assessment include: client history (personal, medical, mental health, criminal, supervision, alcohol and drug), current situation (daily living, supports, stressors, mental status, medications, attitude towards treatment), and a clinical summary, recommendations and intervention plan (key problems, risk factors, social supports, client goals and plans for short and long-term), in order to attain as much information about the referral as possible and to ultimately conduct an appropriate assessment of mental health treatment needs.

Referral Review Results

Fifty-eight referral forms were reviewed and the type of referral was identified, namely “referred due to Probation Condition” (71%), “Forensic Liaison and Probation Order” (7%), “Probation or Bail Condition” (5%), and “Bail Condition/ Probation Condition” (3%) or “Other” (10%) made up the referral types. The “Other” category included Forensic Liaison, Assessment of Risk, and Psychiatric Treatment. Four categories were identified for specific programming requests: alcohol and substance programming, anger management, sex offender programming, and specific assessments.

According to results only 72% of the probation referral packages reviewed have enough information in the notes to identify what kinds of services the FPSC Clinic staff should provide. In fact, the majority of the progress notes provided with the referral packages (74%) indicate that FPSC staff spent the initial periods (up to two months) setting up appointments for psychiatric assessment or sourcing out more background information. Activities identified that FPSC staff are involved with include intake, bridging – linking to other services, and probation officer case management support. Intake activities were defined as those related to information seeking, these include initial appointments to meet the client and probation officer and garner background information, psychiatric assessments, or risk assessments. Probation officer case management support activities refer to staff supporting the client, reporting on the activities of the client to the probation officer, or acting as the case manager for activities that fall outside of bridging and intake activities. Difficulties with intake include: client not attending appointments (cancelling, no-shows, and rescheduling), no contact (No fixed





address, not answering phone), not being cooperative at appointments, and lack of engagement/refusing service. Difficulties listed with bridging include refusal of referral by sourced services.

Staff Survey Results

Similar results were articulated by staff in the Staff Survey. According to survey respondents the current referral packages received by FPSC requires more information to provide a clearer picture of the client being referred, as well as, more information to triage clients to appropriate services. Staff reported that information about previous and current social supports and client history are often not included in the referral (despite being requested on the referral form). For information that should be included on the referral form, a request for specific services and more background information was indicated.

Notably, few respondents (33%) agreed that “the probation referral form usually provides enough information to allow for the appropriate triage of high-risk or high-need clients”. Moreover, the majority of respondents (82%) indicated that “specific services requested” should be included in the referral. Additionally, most respondents (70%) also felt that psychiatric history should also be included (Table 7 Additional Referral Information).

Table 7 Additional Referral Information

Response	Chart	Percentage	Count
Specific services requested		82%	41
Legal Order		64%	32
Psychiatric history		70%	35
Other, please specify:		40%	20
	Total Responses		50

The thematic analysis indicated that both Engagement Level: “client’s level of engagement”(respondent), Needs and Supports: “previous and current social supports should be clearly indicated” (respondent), as well as Risk Assessment Needs and

History of Violence and Suicide: “historical risk factors, especially violence with details and context” (respondent) should be included as background information.

Probation Forum Results

Forum group discussions highlighted criteria for triage as mental illness (including severity), risk (suicide, violence), needs (community, supports, treatment etc.), and history of forensic service. Prioritization would occur for risk and needs. Notably, staff stated that an incomplete referral should be sent back, if the Probation Officers resist changes to the model of care. Again, standard communication with Probation staff was indicated as a solution to challenges.

Overall Findings – Assessment

The current assessment procedure for FPSC Regional Clinics does not always include in-person collaboration with Probation Staff or with the referred offender. As noted in the data, with the current system, the information that should be provided as outlined in the referral packages (reason for referral, psychiatric history, legal order; police report; CPIC; In-service information; Collateral information), is not being provided. Without enough information, and as noted in the staff survey, FPSC staff are unable to do a risk assessment based on the RNR model. Staff working with FPSC have a heightened level of skill for working with this population – as identified in the Probation Forum, that provides them with the professional discretion they need to assess a referral appropriately, but this is still dependant on receiving enough information. Table 8 Audit of Best Practices – Assessment, outlines the finding for the audit of best practices for the assessment process.

Table 8 Audit of Best Practices – Assessment

Identified Best Practices	Current Practice	Identified Gap
<p>Collaborative (lead by Probation Officer as they are responsible for client)</p>	<p>Referral form and additional information is submitted to FPSC. Referral form requires: legal order; police report; CPIC; In-service information; Collateral information The Assessment protocol for FPSC states “treatment team maintains communication with the referral source on a need to know basis”.</p>	<p>No clear collaboration REQUIRED by FPSC – although this does occur in some cases.</p>
<p>Risk Assessment: Shared risk assessment. Use tools where possible. Identify co-morbid psychiatric and substance use disorders. Assess both dynamic and static risk factors</p>	<p>FPSC utilizes the START as part of their assessment process. When appropriate information is provided both co-morbid psychiatric and substance use disorders, as well as static risk factors are reviewed</p>	<p>Probation Officers do not share their risk assessment with FPSC. Substance Use/ Abuse may be identified but this is not a clear focus or <i>requirement</i> of the assessment The START does not identify static risk factors – static factors are addressed, by staff, when an appropriate level of information is provided.</p>
<p>RNR with a broad definition of risk, including suicide, violence and to re-offend: Target High Risk. Assess all needs. Responsivity Principle – address learning style. Incorporate Professional discretion. Assess five concepts for Violence/ Dangerousness</p>	<p>RNR principle is incorporated into assessment: High Risk is targeted for Assertive Case Management Bulk of assessment is based on Professional Discretion – notably FPSC staff identify a high skill level with this population</p>	<p>Responsivity Principle: unclear whether learning style or motivation identified. Assessment of Violence/ Dangerous is addressed in START but not for static risk factors – unless completed by professional based on profession discretion</p>
<p>Occur in person as soon as possible – minimally in 10 days</p>	<p>There is no minimum standard for an assessment time frame</p>	<p>In some cases the assessment or initial appointment does not occur for up to 2 months</p>

8.1.2. Treatment

With regards to treatment, three main concepts were identified in the best practice review, notably treatment should:

1. Respond to identified needs in the assessment.
2. Be complex with multiple outcome goals
3. Include case management that targets a higher need population.

The BCMHAS, Forensic Psychiatric Services Commission information guide states that regional programs provide: court-related psychiatric and psychological assessments, mental health assessment and treatment, and community case management. According to FPSC policy (CCR-727) an Integrated Treatment Plan (ITP) is created, based on and developed from the START in addition to a review of the file and collateral information, and represents the formal plan of interdisciplinary care for patients and clients receiving treatment. The ITP is to be completed no later than three months after a client attends their first appointment. The ITP is completed in collaboration with other team members. The ITP identifies needs and associated therapeutic interventions as appropriate. Action items and due dates for completion are identified for each intervention. The ITP is also designed to be completed with participation from the patient.

Additionally, according to FPSC's *Clinical Case Management of Persons Subject to Court Orders* document, the goals of clinical case management is to assist the client to reside successfully in the community without undue risk to the members of the public or self. The case management process will assess and monitor the "client's mental state and ability to function in the community, while ensuring that clients have access to available services necessary to maintain their mental health and meet their individual community living needs"(1); monitor "compliance with prescribed treatments and interventions" (2) and will notified Probation if appointments are missed. Frequency of clinical contact is directly related the risk/needs level of client – as the level of risk decreases frequency of contact also decreases. Intensive Case Management for high risk clients includes weekly visits with case manager and home visits where appropriate. Minimally, clients must be seen by their case manager no less than once a month, and by a psychiatrist no less than once every three months. Client's family are involved as a support, and regular communication with Probation Officer is considered important.

Referral Review

Results from the Probation Referral Package review, relevant to treatment, indicate that clients referred are primarily male (90%) and are most often referred due to a Probation Condition (71%). Reasons for requested services include: needs for psychiatric or psychological counselling, specific service requests (e.g. risk assessment, sex offender treatment etc.), re-referral or transfer, and alcohol or substance use issues. For conditions that indicated specific mental health needs – as opposed to general counselling or services – four themes emerged: substance use treatment, anger management, sex offender programming and request for specific assessment.

Staff Survey

Identified additional services most often recommended for clients, by respondents, include Community Addictions Services (94%) followed by community mental health (76%) and primary care provider (75%). Additional services identified in the open-ended questions that staff most often recommended were housing, counselling services, specific community programs: native friendship centre, Ask Wellness, primary care providers, disability application, and vocation rehabilitation.

Services identified by staff that FPSC currently provides includes case management for mental health and addiction issues for persons on probation, psychiatric treatment for Axis I disorders and bridging clients to secondary mental health and addiction services. Crisis support was indicated by 37% of respondents as a service that FPSC *should* provide, where comparatively, only 29% of respondents indicated that this was a service that is already being provided.

Thematic analysis of open ended questions revealed themes regarding the distinct abilities of FPSC staff that separates them from other mental health services, namely: knowledge of forensic psychiatric issues, risk assessment and management, and assertive community treatment. Respondents also indicated particular themes affecting their ability to provide treatment, including a lack of shared care across services providers – “the limited information sharing” (respondent), lack of housing – “housing is an ongoing problem for these clients and the case managers who are trying to help them” (respondent), a lack of engagement and limited clinic based services: “ongoing

legal problem, going in and out of custody, no fluid process and lack of engagement”(respondent).

Probation Forum

Group discussions during the Probation Forum indicated that the clinic staff expressed a strong relationship with local stakeholders. As well, in some clinics there is an RCMP MH Liaison person that helps to coordinate activities across the Clinic and the RCMP. For all types of disorders discussed, assessment and case management were indicated as required for service provision. Roles and responsibilities for probation officers, was also suggested as a requirement for persons with high risks or high needs. Further, alcohol and substance use treatment services, anger management treatment services, and outreach or assertive case management were identified as recommendations for future programming.

Overall Findings – Treatment

FPSC currently provides psychiatric assessment and treatment, individual counselling and treatment monitoring for persons on probation. According to FPSC policies and results noted above, FPSC services are client-centred and individualized. An integrated treatment plan (ITP), based on risks and needs is used to coordinate treatment and ensure that staff is responding appropriately. However, as stated above, if the information provided during the assessment procedure is lacking, then the management of treatment is only as good as the assessment. Thus, for treatment then, the first gap is that treatment planning may not be based on all available information and hence may not be responding to client needs in the best way possible.

Best Practices for this complex population require case management that includes an assertive engagement process and services provided in the community. According to the BCMHAS, FPSC document – *Clinical Case Management of Persons Subject to Court Order*, clinical case management includes the principle “to work with clients in the community” (2), however, staff home visits are to be conducted “where appropriate” and while frequency of visits are based on high risks/ needs, if these are not appropriately identified as per an assessment, than the appropriate level of frequency will not occur.

Finally, while not necessarily a gap between best practices and current practices, it must be noted that there is a lack of available housing and substance use treatment services. Housing was continually identified as an important component of this complex group of offenders and should be considered through care. Similarly, substance use is an identified issue with this complex group and treatment should consider providing, or ensuring substance use services as a parallel component to treating mental health issues. While results of the review indicate that bridging to community mental health and addiction services is provided, this is not explicitly required or stated as a focus in procedural guidelines or policies.

Ultimately, FPSC adheres to the majority of guidelines in this category (see Table 9 Best Practices Audit – Treatment). Services are individualized to the client, there is coordination and continuity of care amongst associated groups and services, and case managers are skilled and knowledgeable about other services.

Table 9 Best Practices Audit – Treatment

Identified Best Practices	Current Practice	Identified Gap
Consistent and responds to identified needs in assessment (including basic needs)	Practice is consistent and aims to respond to identified needs in the assessment, including basic needs	Lack of appropriate information provided in assessment may hamper the response to needs
RNR model: both Mental Health risks and Risk to Re-offend are addressed	RNR model is incorporated	No gaps
Programming: Improvements in multiple areas. Engagement focus Depending on population (ie age, gender etc.). Barriers to treatment should be considered and addressed	Case Management and Individual assessment and treatment. Barriers to treatment are considered per client.	While engagement is a focus, the referral review indicated that engagement at the assessment level may be hampered by not incorporating home visits, or assertive assessments.
Case Management: Assertive engagement/ therapeutic alliance. Focus on barriers/ unobstructed access to services. Individualized care. Prevent recidivism. Community based. Mobile staff. Weekend and after hours. High frequency contact. Work with support network. Recovery is philosophy. Collaboration with appropriate services	Assertive Case Management for high-risk clients. Barriers to treatment discussed on an individual basis, but are not outlined as a requirement of ITP planning. Collaboration with community services and support networks are a key focus of FPSC	Unclear whether high frequency contact occurs. Unclear whether staff is mobile. Unclear whether services are offered on the weekend or after hours. Recovery as a principle is not identified in the procedural guidelines, policies, or program information pamphlets.

8.1.3. Discharge

Best practice guidelines for discharge are minimal. Generally discharge should:

- Commence at beginning of assessment
- Be based on reaching established goals; or
- Be based on refusal of service despite teams intensive and persistent efforts

As well, discharge procedures should include communication with referring agency with an update of status and follow-up plan (continuity of care and clear discharge documentation).

The BC Mental Health and Addictions, Forensic Psychiatric Services Commission – Clinical Case Management of Persons Subject to Court Orders: Definitions, Principles and Guidelines states:

Discharge planning begins on admission. As per the discharge policy, when appropriate a discharge summary is completed by the treatment team. The report is forwarded to the receiving community resource. A closing letter is forwarded to the referral source indicated the reason the file is closed (4)

These guidelines are in accordance with best practices identified in the literature.

Staff Survey

According to the staff survey the top two improvements that could be made to the current discharge process include: establishing a clear criteria for discharge (67%); and setting clear timelines and limits for treatment (29%). Respondents indicate that clients are often discharged because the client re-offends or is referred to a more appropriate resource. Discharge planning is indicated by over half (57%) of respondents to begin at the point of starting treatment, followed by “90 days before termination of the Probation Order”(27%), and when treatment is to conclude (25%).

Thematic analysis indicates that improvements respondents would make to the service if possible include: the need to develop relationships with community services

and primary care, and making a discharge based on client needs: “having appropriate available resources to meet the identified needs of clients” (respondent).

Probation Forum

Staff expressed the need for discharge planning to commence prior to admission and that this should be based on communication with Probation Officer and determination of risk. Discharge planning should involve the client and stakeholders early in the process. Information required for discharge includes everything required for treatment. Discharge should include close liaison with Probation Officer.

Identified Gaps

There are no obvious gaps with the current discharge process of FPSC Regional Clinics for persons on probation order requiring treatment. Currently, according to the staff survey, the majority of staff begin discharge planning when treatment begins, as per best practice. While not indicated in the best practices review, potential gaps identified by staff, include a clear discharge criteria and better relationships with external services. As with treatment and case management, a proper assessment may be necessary to conduct a proper discharge.

Table 10 Audit of Best Practices – Discharge

Identified Best Practices	Current Practice	Identified Gap
Discharge planning should begin as soon as treatment planning commences.	Discharge planning begins at commencement of service	Discharge planning may not begin at beginning of service because assessment process is limited
Criteria for discharge: reached established goals, moved, or refused services (only after significant efforts to engage)	Criteria for discharge is not outlined in the FPSC Discharging Patients/ Clients Policy	There is no clear criteria for discharge
Continuity of Care: all appropriate information is shared with receiving professionals is communicated in an appropriate and timely fashion, with the opportunity for the receiving professionals to discuss with the discharging services, if necessary	Discharge plan is developed by treatment team with client and involves linkage to community resources where necessary with appropriate follow up.	No significant gaps. Could improve relationships with external services
Discharge documentation should include: reasons for discharge, status at discharge, evaluation summary of progress; plan of follow-up; client involvement	Anticipated discharge date; Reason for discharge; Where referred and contacts made; Acceptance from referral source; Legal status at discharge; progress note and discharge summary.	No gaps

All in all, there are a number of gaps identified in the Assessment, Treatment and Case Management, and Discharge processes occurring with FPSC. The next section of this project will focus on identifying and evaluating options that will help to close any gaps currently highlighted.

9. Policy Criteria

The overall goal of this analysis is to assess the current model of care and provide recommendations outlining necessary changes to optimize mental health treatment for persons on probation in British Columbia. In this case, the model of care is broken into three sections: Assessment, Treatment, and Discharge. Policy options are provided in response to highlighted gaps in the model of care, identified through the research phase of this project and evaluated here against a series of criteria.

Rodriguez-Garcia (2000) proposes five criteria that should be applied to the evaluation of health policy alternatives: Relevance, Progress, Efficiency, Effectiveness and Impact. Three of this criteria are applicable to the current problem at hand, namely:

1. Relevance: does the intervention contribute to the health needs of the target population?
2. Effectiveness: to what degree does this particular intervention attain its objectives? And;
3. Impact: what is the effect of the activity on overall health and related social and economic conditions of the broader public?

For this particular project, the fourth criteria, progress (how do actual results compare with projected or scheduled results?), is not applicable. The fifth criteria, efficiency (what are the results in relation to resource expenditure of the intervention) is incorporated here, by addressing costs as a separate criteria, in addition to the above measure of effectiveness, but is not highlighted as an evaluation criteria. Impact is also broken into two components: number of offenders affected and public safety. Additionally, a measure of social justice is added and incorporates social justice concepts of human rights and equality (see Table 11 Health Outcomes Criteria).

Criteria selected for evaluating each policy option as it applies to implementation (Table 12 Implementation Criteria), includes: Costs, Capacity, Political Viability, Administrative Authority, and Administrative Commitment. Each of these criteria is defined and provided an appropriate measure and source of data. Evaluating policy

options takes on two main foci then – Health Outcomes, and Implementation. Each of these criteria will be discussed in detail below.

Table 11 Health Outcomes Criteria

Criterion	Definition	Measure
Relevance	Does the intervention affect the health needs of the target population?	Yes/No
Effectiveness	Fidelity: extent to which the policy option adheres to best practices	Score out of 36
Impact	Number of offenders affected ><= current # of referrals (1405)	Rank out of 4 (1 = highest impact; 4 = lowest impact)
	Public safety: overall health and related social and economic effects on the broader public	
Social Justice	Human rights: best possible mental health care	Yes/No
	Equality: equal access and equal treatment	Low, Moderate, High

Table 12 Implementation Criteria

Criterion	Definition	Measure
Costs	Tangible financial costs: estimated cost of additional resources and changes	\$\$/ new referral (additional cost/referral)
Political Viability	Acceptability – whether the policy option is acceptable to actors in the policy process	Low/ Moderate/ High
	Responsiveness – does the policy option respond to the needs of FPSC?	Responsive/ Not Responsive
Administrative Ease	Additional staff requirements?	# of new staff
	Staff Commitment – the extent to which staff will accept the proposed changes to the model of care.	High = 1; Moderate = 2; Low = 3
	Additional staff training?	Yes = 1/ No = 0
	Is there required coordination amongst agencies?	Yes = 1/ No = 0
Authority	Does FPSC have the authority to implement the option?	Yes/ No

9.1. Relevance

In a report commissioned by the Nova Scotia provincial government it was noted that individuals whose actions result from their illness, and not ill intent, need access to programs that improve their mental health and, in turn, reduce risks to public safety (Nova Scotia, 2011). FPSC has a mandate to treat persons with mental health issues in conflict with the law, and more specifically under court order. To address *relevance* a discussion will be provided as to whether the policy option is relevant to improve the Mental Health needs of the target population – with the idea that this will subsequently improve re-offending. For each option a simple yes or no will be provided.

9.2. Effectiveness

One criterion identified for use in health intervention evaluations applicable for this particular project is effectiveness (GWUCGH, 2000). As discussed in the literature review, at the intersection between probation and mental health services there are two underlying goals – reduce recidivism and improve mental health. In the context of the model of care, the assessment, treatment and discharge processes must be considered.

Effectiveness, here, is measured by examining fidelity to proposed best practices. Best practices were identified for this particular population, keeping in mind the goal to both improve mental health and risk to re-offend. Fidelity can be defined as methods to assess adherence to the standards of a program model (Moncher & Prinz, 1991; Walts, 1993). Fidelity to program models is used extensively in mental health (Randall, Wakefield & Richards, 2012), and more recently used in justice programming (Mabry et al., 2003). Further, as noted in Mabry and colleagues (2003), recognition of existing best practice materials is essential to quality improvement.

Research measuring fidelity to Assertive Community Treatment (ACT) standards gives a score to each of the identified components of the ACT standards (Van vugt et al., 2011). In this case, to measure fidelity to best practices for persons on probation order requiring mental health treatment, a score out of 3 (no fidelity = 0, low = 1, moderate = 2, high fidelity = 3) is given to each of the identified best practices as they apply to each

component of the model of care. Therefore, because each component of the model of care has four identified areas of best practice, the scoring ranges from zero through thirty-six (max score of 3 for each area).

9.3. Impact

Impact is addressed by asking: what is the effect of the activity on overall health and related social and economic conditions of the broader public? In this case there are two parameters to consider – the extent to which the policy option affects the population it is trying help, and the long term impact the policy option will have on the broader community and society. The first parameter is measured simply by addressing the relative number of persons that will be affected by the policy compared to current levels (greater than, less than or equal to).

The second component is a measure of public safety. Public safety as a concept is not necessarily focussed specifically on crime data (Graves, 2011) but encompasses different government services, including police, fire departments, hospitals and non-government organizations, fire service etc, and includes activities such as protection from car accidents, or fires. Public safety here refers to the need to improve the health of offenders (including improving harm to self and improving mental health), and protecting the public from harm inflicted by these offenders in the form of criminal activity. To measure public safety the extent to which the option decreases utilization of public services (health care, social services) is considered, as well as decreasing involvement with the criminal justice system. In this respect, with high risk offenders having more risk factors, and thus an increased likelihood to harm self or others, utilization rates should increase across public services depending on the level of offender risk. This forms the basis of the impact measure for public safety. Additionally, necessary externalities will be discussed.

An externality is defined as a “phenomenon or effect to which the marker assigns no value, positive or negative, but which has a societal cost or benefit (Patton & Sawicki, 1993) . For each policy option, where applicable, a qualitative measure of the intangible costs and benefits – that cannot be quantified – are discussed. A valuation of this

externality is provided and discussed as part of the impact criteria of public safety. Impact is ranked across all policy options provided in relation to one another – the policy option given a rank of one has the greatest impact.

9.4. Social Justice

Social Justice as a principle generally refers to a society that is based on the principles of equality and solidarity, understanding the values of human rights and the dignity of every being (Zajda, Majhanovich & Rust, 2006). As noted by the World Health Organization (2005), “In addition to the obvious suffering due to mental disorders, there exists a hidden burden of stigma and discrimination faced by those with mental disorders” (page1). Livingston (2009) points to numerous human rights declarations, covenants and treaties which outline the need to respect human rights of individuals involved with corrections systems. Notably, the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Office of the United Nations High Commissioner for Human Rights, 1991), states that criminal offenders should receive the best available mental health care. Equality can be defined as equal access to equal treatment, and simple assess whether or not all members of the population at hand have equal access to the same treatment (O’Brien, 2011). Measuring social justice here as a criterion incorporates a discussion assessing whether the offender is receiving the *best* possible mental health care, and whether all offenders are receiving the same care.

9.5. Costs

As with any health care provision, costs must be considered when evaluating potential changes and policy options. According to the FPSC annual report (2010) roughly 1405 (out of 3555) offenders on probation are referred to FPSC each year (keeping in mind that this number is increasing). This makes up roughly forty percent (39.5%) of all referrals to FPSC. The annual operating budget of FPSC is \$54, 950, 412. Thus, the calculated annual operating cost of probation referrals is \$21 980 165 (\$54 950 412 x .40), totalling approximately \$15 645 per referral for treatment services.

In addition to this current cost for probation clients, a series of three additional cost types are considered for each policy option, including:

- *One-time fixed costs* (equipment, training, etc.)
- *Operations and maintenance costs* (ongoing costs of the alternative, staffing etc.)
- *More or less clients*

For this analysis, each of these additional costs are considered and when identified, are added to the overall costs as greater than the status quo (>\$15 645). If these costs are identified as no longer being present or less than the current situation (such as less staffing), these are subtracted from the current cost and listed as (<\$15645). For each policy option a rating of greater than, less than or equal to the current cost is identified (>, <, =). This cost measure albeit simple, should provide a basic assessment of tangible costs, as FPSC funding is provided annually as global funding.

9.6. Political Viability

Political Viability can be defined as the extent to which there may be opposition to the policy option (Patton & Sawicki,1993). Political viability for this project is defined through two particular types of viability, namely, acceptability and responsiveness.

Acceptability is whether a policy is acceptable to the actors in the political process, in this case, the client, the public, politicians, applicable policy makers, and the staff at FPSC, and associated organizations (BC Community Corrections, Community Mental Health). Responsiveness refers to the perception of whether the policy option meets an original need set out in the problem. To measure whether the option is acceptable a series of three questions are considered:

- Is the proposed alternative acceptable to policy makers, policy targets, the general public, voters, etc.?
- How visible is the policy option to the public?
- To what extent is the public protected from harm?

For responsiveness, one question will be asked:

- Are high risk to re-offend individuals receiving treatment (according to best practices)?

In this case, the responses are purely qualitative and a general assessment of how politically feasible each policy option is will be provided. A general measure of low, medium or high will be provided for each answer. Responsiveness is either Responsive or Not Responsive.

9.7. Ease of Implementation

The criteria entitled ease of implementation, is defined as the ability of FPSC to implement the policy option. Ease of Implementation is given a quantitative score based on a series of four categories: additional staff requirements, staff commitment, additional staff training, and required coordination amongst other organizations. In this case the higher the score the harder the policy will be to implement, thus the lower the score the more administrative ease.

Additional staff requirements, simply means whether or not the policy option requires the hiring of staff in addition to staff that is already in place. Staff requirement is rated as a simple yes or no (yes = 1, no = 0). Staff commitment is defined as the extent to which staff will accept the proposed changes to the model of care. Staff commitment is based on information provided in the staff survey and forum, and considers whether the option was a recommendation provided by staff. Commitment is ranked using high acceptance, moderate acceptance, or low acceptance. If an option was provided in the survey and forum then it is given a ranking of high acceptance and a score of (=1). For moderate acceptance (= 2) the option was recommended in one of the survey and forum. A low acceptance rating (= 3) if the option was not provided by staff at any time.

Additional staff training simply refers to whether or not there is additional training that staff will be required to take – rated as either yes or no (yes = 1, no = 0). The category, required coordination amongst other organizations addresses whether or not the proposed policy option requires contact, coordination and programming considerations with organizations outside FPSC (BC Corrections, Substance Misuse Programs etc.). Again, required coordination is given either a yes or no (yes = 1, no = 0)

9.8. Authority

Authority is defined as the extent to which FPS has the ability to implement the option in terms of legal authority, staff authority, and policy authority (ability to change policies). Authority is measured by identifying all the additional authority areas required for the policy option and whether FPSC currently has the ability to control changes that would occur as a result of the policy option.

Each policy option is first evaluated to assess whether or not the proposed actions are within the legislated mandate of the Forensic Psychiatric Services Commission – legal authority. Second, each option is assessed for whether FPSC has the authority to change the behaviour of staff. For example, if the proposed policy option requires changes in behaviours of organizations external to FPSC, then FPSC does not have staff authority. Finally, each option is assessed for its requirement to change policies under the authority of FPSC. In this case, if policies are required to be implemented in other organizations or policies outside of FPSC require changing than FPSC does not have policy authority. Authority is given a simple measure of yes or no. For any of the categories of authority, if FPSC does not have authority than the overall rating is also No. A rating of Yes to Authority is given if the proposed options meets all of the authority categories.

10. Policy Options and Evaluation

- Option 1: Maintain Status Quo
- Option 2: Collaborative Assessment
- Option 3: Focus on High Risk
- Option 4: Assertive Community Treatment (ACT)

10.1. The Need to Address Substance Use

Due to the well known effect substance use may have on both criminal behaviour and mental health, there is an overwhelming need to address substance use issues as a component of treatment for this population of offender. This notion is evidenced via comments throughout the literature review and the research portion of this project (Staff Survey, Referral Review, Probation Forum). Moreover, as originally stated in the best practices review when assessing for mental health issues, substance use issues should always be addressed as well. For this reason, the need to address substance use is embedded within the policy options provided here, rather than as a separate option. Substance use treatment must be an integral component of the assessment, treatment and discharge processes, and for this evaluation is considered as a component of mental health care and as a risk factor, and will be discussed throughout where necessary, within each option.

10.2. Option 1: Maintain Status Quo

In response to the increasing demands on FPSC Regional Clinic resources for services to persons on probation order requiring mental health treatment, one policy option would be to maintain the status quo and change nothing. The status quo would mean that referrals are accepted via fax and assessment made through the information provided by probation officers and through interviews with clients. The original problem of not knowing whether FPSC is providing the treatment needed by clients, has been discussed throughout this review, and in some cases, FPSC is responding appropriately. However, there are some significant glaring deficiencies in service, namely little collaboration with BC Corrections staff, not enough information provided to FPSC to assess appropriately, and required improvements in assessment, treatment and discharge guidelines. With this option, FPSC staff could request additional information with which to make a better assessment, but the general behaviours within the organization would not change. Below (Table 13 Health Outcomes Criteria – Status Quo & Table 14 Implementation Criteria – Status Quo) is a breakdown of an evaluation of this policy options, followed by a brief explanation:

Table 13 Health Outcomes Criteria – Status Quo

Criterion	Definition	Measure
Relevance	Does the intervention affect the health needs of the target population?	No
Effectiveness	Fidelity: extent to which the policy option adheres to best practices	21 / 36
Impact	What is the effect of the activity on overall health and related social and economic effects on the broader public:?	No Change (4)
Social Justice	Human Rights – best possible mental health care	Low / High
	Equality – equal access to equal care	

Table 14 Implementation Criteria – Status Quo

Criterion	Definition	Measure
Costs	Tangible Financial Costs: Estimated cost of additional resources and changes	\$15 645 / referral
Political Viability	Acceptability – whether the policy option is acceptable to actors in the policy process	Low Acceptability
	Responsiveness – Does the policy option respond to the needs of FPSC	Not Responsive
Administrative Ease	Additional Staff Requirements?	0
	Staff Commitment: The extent to which staff will accept the proposed changes to the model of care.	Low = 3
	Additional Staff Training?	0
	Is there required coordination amongst agencies	No = 0
Authority	Does FPS has the authority to implement the option	Yes

Relevance

As discussed, relevance addresses whether the policy option contributes to the health needs of the target population. In this case, in the research portion of this project needs were identified, and substantive gaps identified. While this policy option does contribute to the health needs of the target population as it provides needed services, without an improvement in the assessment, under this option, client needs are not necessarily addressed. With this option, FPSC, cannot respond to the MH needs of the population if it does not know what they are. This option is not relevant.

Effectiveness

Through careful consideration of the best practices, and identified discrepancy (See Appendix A Fidelity Score) a fidelity score of 20 (out of possible 36) was given. Major discrepancies occurred throughout the assessment, with only two categories within the discharge phase of treatment achieving a high fidelity score.

Impact

If the status quo is maintained current levels of services utilization, and safety will remain the same. Overall this option has no impact on health and socio-economic development from current levels.

Social Justice

If the Status Quo is maintained, offenders will not have access to the best care possible and thus ranks low on the human rights measure. However, this option ranks high on equality as all offenders have equal access to equal treatment.

Costs

There are no additional costs to this policy option. Costs remains \$15 645 / referral. However, it must be noted that referrals are increasing and resources will be increasingly stretched. FPSC will not be able to maintain the same service and cost per referral at this current level if the number of referrals continues to increase. Essentially the global funding will be divided up amongst a greater number of referrals and while this will seem more cost effective per referral, this also suggests that clients will receive poorer service.

Political Viability

This policy option is not politically viable. According to the five questions addressed to measure acceptability and responsiveness, this option will not be acceptable in the future, albeit might be acceptable currently; and is not responsive to the needs of high risk to re-offend clients.

- Is the proposed alternative acceptable to policy makers, policy targets, the general public, voters, etc.?

If clients are not receiving the services they need and public safety is affected, this option will not be acceptable to the broader public, politicians and provincial policy makers as needs and a lack of response become more visible in the community through increased service utilization in health and social services, and increased contact by clients with the criminal justice system (re-offending)

Moreover, FPSC has recognized the need to review their service, and thus maintaining the status quo will likely not be acceptable to the leadership and management of FPSC. Further, FPSC staff, like other health care professionals, strive to provide best practices and this option will not be in line with staff values.

- How visible is the policy option to the public?

While not visible at the outset, a lack of access to services, may result in increases in service utilization outside of FPSC, including health, social and criminal justice services and thus the increased usage may be visible to the public.

- To what extent is the public protected from harm?

With increasing referral rates, if clients and probation officers are no longer able to access services due to limited resources, both the client and the public may not be protected from harm. If client risks and needs go unnoticed, then staff cannot respond appropriately, and thus these risks and needs are not responded to a leave the client and the community at risk of harm.

- Are high risk to re-offend individuals receiving treatment (according to best practices)?

In some cases, yes, high risk to re-offend individuals are receiving treatment – but not in all cases, as they may go unnoticed, and thus this option is responsive to a limited degree.

Administrative Ease

Additional staff requirements, simply means whether or not the policy option requires the hiring of staff in addition to staff that is already in place. There are no additional staff requirements for this option (= 0)

At no time in any of the research components of this project did staff report that the current state is optimal. In many cases, strengths were identified – such as specialized skills by staff for working with clientele, but there were a number of identified issues.

This option received a score of low (3) for staff commitment because it was not indicated as an option.. There is no additional staff training required for this option (0). There is no additional required coordination for this option (No)

Authority

FPSC has full authority to decide to choose to maintain the status quo as no legislation or policies are required to be changed or implemented with this options in either FPSC, or through other organizations.

10.3. Option Two: Collaborative Assessment with Probation Officer

According to the practices audit conducted above a significant deficiency in the FPSC service provision is a collaborative assessment process with appropriate risk assessments (to re-offend, violence, suicide, criminogenic), and enough information to inform treatment.

Currently, admissions are accepted on the basis of information provided in a referral form. A common theme identified throughout the analysis of data was the lack of information provided with the referral form from BC Community Corrections. With this proposed policy option an admission would only be accepted after a thorough in person interview that includes adherence to RNR principles, includes appropriate risk assessments and discussion regarding the type of services required (as well as goals for discharge). Thus, this policy option results in a triage process in collaboration with the Probation Officer. Specifically, admission to FPSC regional clinics for mental health services, for persons on probation order would not be accepted until this intake process is completed with participation from both the probation officer and the patient. While FPSC cannot control the participation of the Probation Officer, they can currently decide whether or not a referral is accepted, and can decide to only accept referrals once this process is completed.

This policy option could occur in two stages – the referral form submission and the collaborative assessment. The referral form submission could remain similar to the process that is currently in place, with perhaps the requirement of information regarding the status of risk for this individual and a measure of the extent of needs. Unless the appropriate information is provided, referrals will not even be considered for admission to FPSC services.

The second stage would be the collaborative assessment process. The collaboration would occur in person, and would be led by the Probation Officer – as they are ultimately responsible for the client. This assessment may entail the use of the START in addition to a measure of static risk factors (including violence risk factors) and

additional background information. If the probation officer has completed an assessment tool, this could be included. Ultimately, both the FPSC staff member and the probation officer would conduct the assessment, from which a treatment plan could be constructed.

The involvement of the probation officer throughout the process will also help to initially engage the client. This thorough assessment with probation officer involvement will allow for a clearer picture of the needs and risks of the patient being referred. This will also improve the course contact with the referred patient ensuring that they appear for their initial assessment, and are involved with decisions about their care. Notably, this option may have some difficulty with interagency collaboration without regard to leadership (Glasby & Dickenson, 2008), valuing the ‘other’ organization (Casey, 2008) and variations in organizational functioning (McCloskey et al., 2009).

The evaluation of this option is discussed below (Table 15 Health Outcomes Criteria – Collaborative Assessment & Table 16 Implementation Criteria – Collaborative Assessment):

Table 15 Health Outcomes Criteria – Collaborative Assessment

Criterion	Definition	Measure
Relevance	Does the intervention contribute to the health needs of the target population?	Yes
Effectiveness	Fidelity: extent to which the policy option adheres to best practices	29 / 36
Impact	What is the effect of the activity on overall health and related social and economic effects on the broader public?	Affects all referrals (1405 +) & broad impact across service utilization. (3)
Social Justice	Human Rights – Access to Best Care	Moderate
	Equality – Equal Access to Equal Care	High

Table 16 Implementation Criteria – Collaborative Assessment

Criterion	Definition	Measure
Costs	Tangible Financial Costs: Estimated cost of additional resources and changes	\$15 645 / referral
Political Viability	Acceptability	High Acceptability
	Responsiveness	Yes
Administrative Ease	Additional Staff Requirements?	No = 0
	Staff Commitment: The extent to which staff will accept the proposed changes to the model of care.	High = 1
	Additional Staff Training?	Yes = 1
	Is there required coordination amongst agencies	Yes = 1
Authority	Does FPS has the authority to implement the option	No

Relevance

As discussed, relevance addresses whether the policy option affects the health needs of the target population. In this case a better assessment would affect the treatment of clients, through improved recognition of risks and needs, and thus improve the health needs of the target population. This policy option is relevant (yes).

Effectiveness

In this case the fidelity score to best practices is rated as a 31 (See Appendix A Table 23 Fidelity Scores). By Improving the assessment process through collaboration with Probation Officers, six of the identified gaps between best practices and the current service may be addressed, including a collaborative assessment, shared risk assessment, improved definition of risk, expedited assessments, responds to needs, need for better engagement.

Impact

This policy option has the potential for a large impact. The option of improving the assessment process would affect all clients referred on probation order for required mental health treatment in a positive way – as treatment would likely improve.

Ultimately, if this option improves the treatment and health outcomes of all clients referred to FPSC, then the societal impact will also be large. As stated previously, clients on probation requiring mental health treatment are complex, have high needs, and access services more than others – thus by improving treatment, FPSC would reduce the utilization of other health services and likely reducing broader health costs. The improvement in health may also result in improvements in accessing basic needs such as housing and employment resulting in less reliance on social services. Finally, the reduction in risk to self and to others, in addition to the likely reductions in recidivism will also have an impact and improvement on public safety overall. As a fault, this option does not require intensive treatment, and while treatment should still respond to the identified risks, it may not do so with the intensity so required for high risk clients, thus the broader impact to the public will be slightly dampened.

Social Justice

This option is an improvement on the status quo, but does not adhere to all of the identified best practices, and thus ranks moderate. In terms of equal access to equal treatment, this option ranks high as all referrals have access to the same care.

Costs

There are no additional fixed costs, or operations and maintenance costs to this option. Currently, both Probation Staff and FPSC staff are conducting assessments to the best of their ability, this option would simply combine efforts, albeit time would be required to design a new procedure for collaborative assessments. All in all, the cost for this option remains equivalent to the status quo at \$15 645 per referral.

Political Viability

Acceptability

- Is the proposed alternative acceptable to policy makers, policy targets, the general public, voters, etc.?

The proposed alternative, would be acceptable to policy makers, clients, the general public and voters, because it is aiming to provide service according to best practice. There may be some resistance from BC Corrections staff as the behaviour of Probation Officers would have to change, and clients would not necessarily be admitted to services just because they have a probation order – as more information would be required. This option is in line with the values of FPSC. Notably, most behaviours will not change and will only be enhanced with this option – thus by providing better service, staff will be agreeable, while not requiring any major overhaul of procedures and policies.

- How visible is the policy option to the public?

This option will not be visible to the public as this will occur in-house between Community Corrections and FPSC. The broader public benefits may also not be attributed to this activity.

- To what extent is the public protected from harm?

The public is protected from harm, albeit, FPSC will still be required to respond to low risk and high risk individuals in the same way, and services may be stretched. Furthermore, this does not alleviate the issue that FPSC is not providing services recommended by staff, or that clients may need additional services such as housing or substance abuse treatment.

Responsiveness

- Are high risk to re-offend individuals receiving treatment (according to best practices)?

Currently FPSC is providing treatment services according to best practices outlined in their integrated treatment plan and the internal assessments conducted upon the offender. However, as noted in the staff survey and referral review, information provided to FPSC is not sufficient to make an appropriate and timely assessment. Thus, due to insufficient information, FPSC may not be currently providing adequate treatment for high risk to re-offend individuals. If the assessment procedure was improved by including the Probation Officer in the assessment process than services would be improved and would adhere to best practices, and high risk to re-offend individuals will receive treatment.

Administrative Ease

There are no additional staff requirements for this option as the switch to collaborative assessments can occur with current staff (0). This option was recommended in each of the research portions of this project, the staff survey and staff forum, and for this reason staff commitment ranks high (high = 1).

While there may be no additional staff required for this policy option, there may be some additional training for the new collaborative assessment, and for creating new protocols. In this case there is additional staff training required (yes = 1). Further there is required coordination amongst other organization as Probation Officers will have to change the way they refer patients, and should lead the assessment process in addition to providing more information.

Authority

FPSC has the authority to change their referral process. This option does not limit who can be referred as all clients under court order may still be treated through FPSC. FPSC does not have the authority to change procedures of Community Corrections, and does not have the authority to change the behaviour of community corrections staff or its policies, thus FPSC does not have authority for this option

10.4. Option Three: Assess and only Treat High Risk

For persons on probation order requiring mental health treatment, as discussed previously, high risk refers to a high risk to re-offend, or a high risk to harm self or others. The policy options of focussing services on high risk individuals requires first a thorough assessment of risk – including all factors addressed in the literature review, namely use of a validated tool that assess psychiatric risks as well as risks to re-offend, dynamic and static risk factors, risk factors associated with violence, and the recognition of additional criminogenic factors that may increase both criminal behaviour as well as poor mental health. Further, the assessment of substance use issues would be highlighted here – as staff could identify and focus on all needs with greater intensity.

As discussed, persons on probation order requiring mental health treatment make up a complex group of individuals who often attempt to access health services more so than other populations, while also lacking in various social supports and basic needs (Keene, Janacek & Howell, 2003; Frounfelker et al., 2010). This group of individuals may also lack the learned abilities and social skills to advocate appropriately for help when it is needed (Owens, Rogers & Whitesell, 2011).

Community Mental Health services currently have Assertive Community Treatment (ACT) programs that could provide services for individuals who have more severe mental illness and who may require more intensive supports in the community. These individuals may have a low risk to re-offend or harm oneself or others, and would not necessarily require the specialized skills of Forensic Psychiatric staff. With ACT teams already in place in the community, FPSC could step in to focus specifically on persons that are identified as high risk – ensuring that this group receives the specialized attention that is needed.

With this policy option FPSC would shift the service focus. Not all probation referrals would be accepted. Following a thorough assessment process, whereby all risks are identified, FPSC staff would make a decision as to whether the individual is a *high risk* referral and accept only those clients that fall under this identification. Following the identification of high risk, these clients would be afforded the intensive

services based on their risks and could be implemented and the appropriate treatment and monitoring of the individual provided.

Ultimately, the Risk Need Responsivity (RNR) principle would also need to be addressed in this option. Identification of risks, as stated is crucial, and a focus on needs would mitigate risks. This option would require a focus on the responsivity of referred individuals as well (learning style, motivational stage etc.), abilities of the individual, substance use issues and respond in a more appropriate way. In this case, the RNR principle would be a highlighted area, as FPSC identify their ability to work with forensic clients and the RNR principle is a best practice in forensic settings with this population.

Table 17 Health Outcomes Criteria - High Risk Focus

Criterion	Definition	Measure
Relevance	Does the intervention contribute to the health needs of the target population?	No (only high risk)
Effectiveness	Fidelity: extent to which the policy option adheres to best practices	28 / 36
Impact	What is the effect of the activity on overall health and related social and economic effects on the broader public:?	Affect less than current number (<1405) but has greater impact on high risk group. (2)
Social Justice	Human Rights – Access to Best Care	Moderate
	Equality – Equal Access to Equal Care	Low

Table 18 Implementation Criteria – High Risk Focus

Criterion	Definition	Measure
Costs	Tangible Financial Costs: Estimated cost of additional resources and changes	= \$15645/ referral
Political Viability	Acceptability	Low
	Responsiveness	Yes
Administrative Ease	Additional Staff Requirements?	No = 0
	Staff Commitment: The extent to which staff will accept the proposed changes to the model of care.	High = 1
	Additional Staff Training?	Yes = 1
	Is there required coordination amongst agencies	Yes = 1
Authority	The extent to which FPS has the authority to implement the option	No

Relevance

As discussed, relevance addresses whether the policy option affects the health needs of the target population. For this policy options, only those persons identified as high risk would receive treatment through FPSC. A shift in focus to high risk services would allow for skilled forensic staff to utilize their abilities on high risk persons thus offering specialized services not available elsewhere. In this case, the option is only relevant for high risk clients, low risk clients may attain care from Community Mental Health services but this is not guaranteed. Without all of the target population being affected relevance is a No.

Effectiveness

The fidelity score for this option would be 28 (See Appendix A Table 23 Fidelity Score). The shift towards high risk offenders, does not alleviate the need to conduct a more thorough assessment with cooperation from Community Corrections. In fact, the assessment process would become crucial component of this option, to ensure that individuals are assessed appropriately. The assessment process would need to

highlight all factors that attribute to high risk, and a full assessment could not be attained without proper information. Thus, while probation officers may not need to be involved or collaborate in the assessment, an appropriate amount of information would be required to make an accurate assessment and persons should not be accepted if this information is not provided. As such, while not necessarily a collaborative one, a shared risk assessment is necessary. The RNR principle would remain important to this option, as well. There is no identified time frame for the assessment, although this options does allow for an appropriate response to needs, and programming and case management would be improved. Ultimately, discharge planning would not necessarily improve from the status quo.

Impact

Additional costs for this option would be incurred by other systems, such as Community Mental Health. Community Mental Health will need to take on low risk offenders in the community. However, ACT teams already in place through Community Mental Health should be able to offer appropriate treatment to this complex group of clients. Further, while this option results in less clients for FPSC, being able to focus on high risk clients – clients at a higher risk to re-offend or harm self or others – may provide a broader social benefit in the form of a safer community and less drain on additional services because the individuals at greatest risk to the community are more likely to get the treatment to mitigate risks.

Social Justice

For this option, persons would have access to better care than the status quo, but arguably not access to the *best* care as this does not adhere to all of the best practices identified in the research portion of this project. Further, this option ranks low on equality as not all clients have access to this care, particularly persons identified as low risk.

Costs

Overall costs will likely be reduced due to the decreased number of referrals. Community Mental Health will need to take on low risk offenders in the community. As

well, FPSC staff would have to be far more mobile and available to clients, resulting in additional variable costs such as gas mileage and after hours time. The Cost for this option would remain relatively equal to the current cost, with less clients overall, but clients with greater needs. (=\$15 645)

Political Viability

Acceptability

- Is the proposed alternative acceptable to policy makers, policy targets, the general public, voters, etc.?

Again, this policy option may protect the public from high risk offenders, however, low risk offenders will be shifted to an already burdened Community Mental Health Service. The inability for any offender to access needed mental health treatment will not be acceptable to the public.

- How visible is the policy option to the public?

This policy option will be visible to the community as there will likely be considerable response from Community Mental Health and the media both because the burden is shifted and because low risk offenders will be under the treatment of the community – something that the public may not currently be aware of.

- To what extent is the public protected from harm?

This option should result in greater protection to the public as higher risk individuals should receive more appropriate case management.

Responsiveness

- Are high risk to re-offend individuals receiving treatment (according to best practices)?

Yes. This option will allow FPSC to adhere to best practices for the high risk offender. Keeping in mind that this policy option require an appropriate risk assessment. Overall acceptability for this options would be low, while responsiveness is given a yes.

Administrative Ease

There are no additional staff requirements (0). This policy option can be provided by the staff currently in place. This option was recommended in each of the research portions of this project, the staff survey and staff forum, and for this reason staff commitment ranks high (high = 1). There will be no additional training for this option (0), as the staff survey and probation forum indicated that staff felt they had additional skills with which to work with this specialized clientele

There would be additional coordination (yes) required with Community Corrections to ensure that an appropriate amount of information is provided to do a thorough assessment of risk. There would need to be coordination with Community Mental Health as well to ensure that low risks clients are not turned away because they are not considered to be voluntary. As well, this option will require additional coordination with various services in the community to provide more intense treatment – such as coordinating with substance use treatment services and self-help groups.

Authority

FPSC does not have the authority to decide whether or not to treat only high risk individuals. According to the Forensic Psychiatry Act, FPSC is required to treat persons under court order. Moreover, if FPSC decides not to treat these offenders, and the likelihood that they will not attend Community Mental Health, both because they will be turned away, and because they are less likely to volunteer for treatment, these offenders may not receive any treatment. However, even though FPSC does not have the authority to change their mandate under the Forensic Psychiatric Services Act, there is no legislation preventing Community Mental Health services from treating clients on probation. Thus, with agreements through Community Mental Health, Probation Officers can refer their clients to Community MH offices if they are low risk, and refer only high risk clients to FPSC.

10.5. Option Four: Assertive Case Management Model

As stated above, the Canadian Mental Health Association defines Assertive Community Treatment (ACT) as a “client- centered, recovery-oriented mental health service intended to facilitate psychosocial rehabilitation for persons who have the most serious mental illness and have not benefited from traditional programs (GWUCGH, 2000). Forensic Assertive Community Treatment, is similar to ACT, but also addresses the need to prevent recidivism. This model requires staff to provide more intensive, high frequency services, in the community (not the office). For this policy option, FPSC staff would need to change the way some services are offered, would need to increase the frequency of contact with clients and engage clients more assertively (increased efforts and techniques). This management model would also require adherence to the minimum standards highlighted previously (See Table 2 ACT Standards Summary).

Table 19 Health Outcomes Criteria – ACT Case Management

Criterion	Definition	Measure
Relevance	Does the intervention affect the health needs of the target population?	Yes
Effectiveness	Fidelity: extent to which the policy option improves adherence to best practices	34/ 36
Impact	What is the effect of the activity on overall health and related social and economic effects on the broader public?	Affect current number (1405) with greater impact on all groups (1)
Social Justice	Human Rights – access to best care	High
	Equality – equal access to equal care	High

Table 20 Implementation Criteria – ACT Case Management

Criterion	Definition	Measure
Costs	Tangible Financial Costs: Estimated cost of additional resources and changes	>\$15 645 / referral
Political Viability	Acceptability	High
	Responsiveness	Yes
Administrative Ease	Additional Staff Requirements?	Yes = 1
	Staff Commitment: The extent to which staff will accept the proposed changes to the model of care.	Low = 3
	Additional Staff Training?	Yes = 1
	Is there required coordination amongst agencies	Yes = 1
Authority	The extent to which FPSC has the authority to implement the option	Yes

Relevance

Assertive Community Treatment has proved effective in treating persons with more difficult cases of mental illness (Morrissey, Meyer & Cuddeback, 2007). This model would provide more intensive services to a complex group of clients and would likely contribute to the overall health of the population at hand, while also reducing more risks compared to current levels, and resulting in improved community safety. Yes this option is relevant.

Effectiveness

The fidelity score for this option is 32 out of 36. This model would not require collaboration with Probation Officers during the assessment phase, nor would it require a shared risk assessment. The assessment phase of the treatment would remain similar to the status quo. The RNR model would be implemented in this model, as it is now, with respect to providing more response to needs and individualized client abilities. The assessment and discharge would be conducted according to minimum time standards.

The model would allow for response to identified need in assessment. For programming there would be improvement in multiple areas, and case management would be more intense. Further discharge would change significantly and adhere to identified standards – improved continuity of care, discharge planning commencing at start of treatment, and discharge based on specific criteria, with appropriate documentation.

Impact

This options would have an impact on all clients referred to FPSC, as this model would apply across all risk levels. Overall, this model would likely have the greatest impact within the community, if the assessment reveals all of the appropriate risks for persons on probation order requiring mental health treatment, and the care provided adheres to the ACT standards, the entire population will likely have a reduction in risks – improving safety to client and community, as well as reducing utilization rates of other services (1).

Social Justice

Compared to other options provided, the Act model ranks highest on fidelity to best practices, and would be available to all clients, and thus ranks high on the human rights measure of Social Justice. According to the Social Justice measure of equality all offenders referred to FPSC will have access to this care. This option ranks high in both categories

Costs

This model would likely increase costs to FPSC both in terms of increased time commitments of staff, resulting in the need to hire additional staff in order to meet needs. Assertive case management also requires more outreach to clients in the community and the mileage and additional time will cost money. Therefore, with the addition of new staff and variable costs, the overall cost per referral to FPSC would be greater than the current amount (>\$15 645).

Political Viability

Acceptability

- *Is the proposed alternative acceptable to policy makers, policy targets, the general public, voters, etc.?*

Yes. This option would be highly acceptable to policy makers, and the general public as FPSC would be protecting the public from harm by providing better care, would look better in the public eye for implementing an intense service and would look to be responding to the increased needs of mental health persons in the community (Brown 1999)

- *How visible is the policy option to the public?*

This option would not be visible to the public directly, but should enhance service, thus reducing harm and indirectly have benefits to the public.

- *To what extent is the public protected from harm?*

Protection of the public from harm would be substantial as all offenders at FPSC would be treated with Assertive Case Management

Responsiveness

- *Are high risk to re-offend individuals receiving treatment (according to best practices)?*

Yes. This model of case management would allow the FPSC staff to adhere to best practices, as this model is based on best practices for more complex clients, such as probationers requiring treatment.

Administrative Ease

There are additional staff requirements for this option as the switch to ACT would require more time allotted to staff per referral, and thus result in the need for more staff (Yes = 1). This option was not recommended in each of the research portions of this project; the staff survey and staff forum, and for this reason staff commitment ranks low (low = 3). There may also be some additional training as to what assertive community treatment entails or both new staff, as well as current staff (yes = 1). There is required

coordination amongst other organization as probation officers will have to change the way they refer patients, providing more information. Additionally, FPSC staff will need to coordinate with local services, as per ACT standards, to ensure that clients are receiving the treatment they need.

Authority

Yes. FPSC does have the authority to implement this model. This model would not require changes to the overall mandate or legislation and does not require staff from other agencies to change their behaviour or organizations to change policies and procedures.

10.6.Evaluation Matrix

Table 21 Policy Analysis Summary – Health Outcomes

Criterion		Status Quo 6.1	Collaborative Assessment	High Risk Focus	ACT Case Management
Relevance		No	Yes	No	Yes
Effectiveness		21	29	28	34
Impact		No change #4	Affects all (1405) & broad moderate impact across services and public #3	Affect less than current (<1405), and high impact on high risk group across services #2	Affect all (1405) and high impact across services (highest fidelity score) #1
Social Justice	Human Rights	Low	Moderate	Moderate	High
	Equality	High	High	Low	High

Table 22 Policy Analysis Summary – Implementation

Criterion		Status Quo	Collaborative Assessment	High Risk Focus	ACT Case Management
Costs	\$\$	=\$15645	= \$15645	=\$15645	>\$15645
Political Viability	Acceptability	Low	High	Low	High
	Responsive	No	Yes	Yes	Yes
Admin Ease	Staff Requirements	0	0	0	1
	Staff Commitment	3	1	1	3
	Additional Staff Training	0	1	1	1
	Required Coordination	0	1	1	1
Authority	Yes/ No	Yes	No	No	Yes

11. Recommendations

1. Collaborative Assessment
2. ACT Case Management once barriers addressed

Implementing an ACT case management model with a focus on reoffending (FACT) would have the greatest affect on overall health outcomes – on all measures. Notably, this model ranks highest on fidelity to best practices, while also having the greatest impact overall – all referrals will be provided with intense treatment that responds to all needs, and responds the best to the social justice criterion as well. Additionally, FPSC has the authority to implement this model immediately.

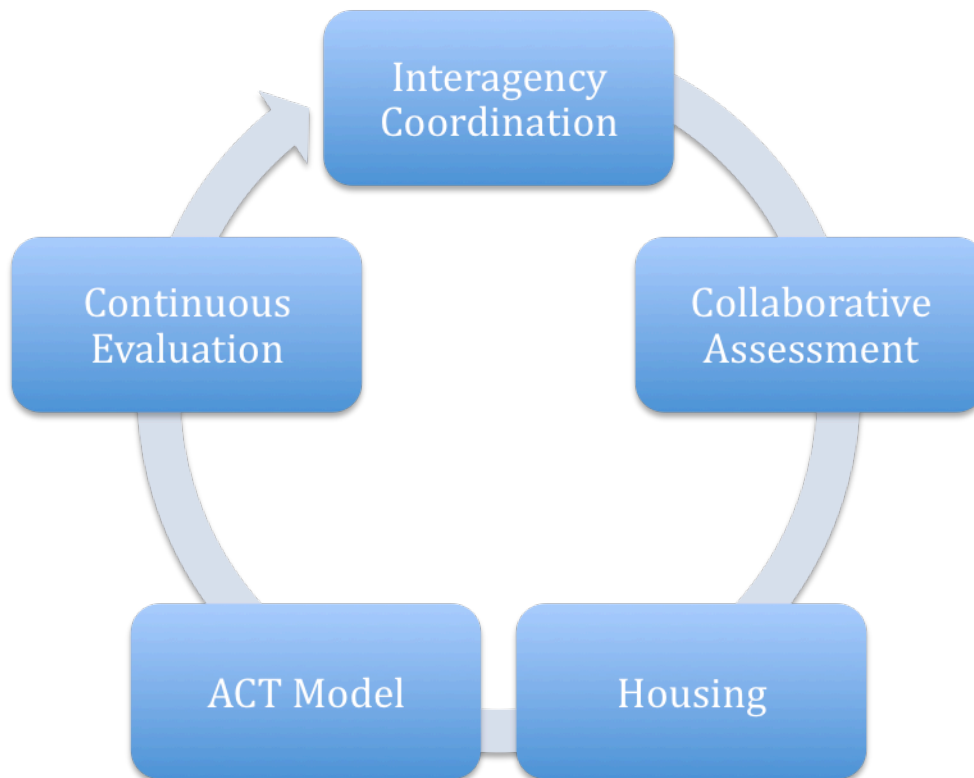
However, as with any case management models, it is only as good as the original assessment, thus to make the ACT (or FACT) model appropriate it would also have to have an improvement in the assessment process. The ACT model is also the most expensive, and most difficult to implement according to the policy analysis. Moreover, research indicates that implementing an ACT model can also be hampered by the need to address housing deficiencies (Neumiller, 2009; Drake & Mueser 2000) inter-organizational issues (Ackerson, Barry & Karroll, 2005), and clinical barriers (Drake & Muser, 2000).

Alternatively, the collaborative assessment option is not within the authority of FPSC to implement directly. However, the collaborative assessment would not require additional staff and would not cost more than the current model. Therefore, in order to capitalize on the fidelity score of the collaborative model, it is recommended that both the Collaborative Assessment as well as the ACT model are implemented – albeit phased in over time, in a coordinated manner.

11.1. Implementation Strategy

Implementing the Collaborative Assessment process in addition to an ACT model would require extensive coordination outside FPSC as well as within FPSC. The following (Figure 2) outlines the strategy to implement the recommendations discussed above.

Figure 2 Implementation Cycle



Prior to introduction of a Collaborative Assessment process, the need to coordinate with BC Community Corrections is essential. Keeping in mind that this model hinges on the Probation Officer leading and being fully involved with the assessment. Ultimately, this assessment may be used to refer clients towards community mental health as well, but at this initial stage building the relationship, changing behaviours and procedural guidelines remains the priority.

Once agreement is made regarding the improved and cooperative relationship between BC Community Corrections and FPSC, the collaborative assessment can begin

to inform treatment services offered through FPSC. Prior to the ACT model being implemented, addressing housing difficulties would take priority. Maintaining fidelity to a particular model of care, is only necessary and possible if barriers are addressed. Housing was continually identified as a primary issue to providing services to offenders.

If both the collaborative assessment and housing are addressed, then FPSC can look towards introducing Assertive Community Treatment (ACT). This model would require additional staff, funding and staff education, but arguably provides the best treatment for this population of offender. Following the implementation of the ACT model it would be important to introduce continuous evaluation – of both fidelity to ACT as well as health outcomes. From this FPSC and BC Community Corrections could move forward to reduce the overall treatment needs, and risks of persons on probation order requiring mental health treatment in British Columbia.

11.2. Limitations

There were two main limitations of this research project – the lack of perspective from the offender, and the lack of research. Attempting to evaluate any health service without available research is both difficult and uncertain. Although, evaluation is ultimately a beneficial endeavour without an appropriate level of research, there are issues of validity and precision in terms of best practices. Further, the lack of perspective from the offender population leaves a large hole in the attempt to be comprehensive, and to offer best practice.

11.3. Future Studies

There is a dearth of research and information regarding the treatment needs and best practices for the identified population discussed throughout this research project. As stated, there are no identifiable standards of practice for working with offenders on probation requiring mental health treatment, despite the identified need. Future research should aim to understand this population better, and understand the types of services that work best for improving the health, and ultimately the offending of this population.

There is also a need for cost-benefit and cost effectiveness research in regards to inter-agency collaboration. Global funding does not take into account the reduced costs associated with reductions in service utilization across various organizations. This research may help to maintain services, that are more effective in terms of health, such as the ACT model, that on the surface seem more expensive, yet the cost savings by other organizations suggest more cost efficiency on a broader level.

11.4. Changing Course

By introducing the collaborative model, the entire model of care becomes more effective, as do all services offered to persons on probation with FPSC. Assertive Community Treatment adheres to best practices with the utmost fidelity in this evaluation and likely offers the best model with which to attain the best outcomes. However, there are numerous barriers to implementing the ACT model and these must be addressed prior to the implementation of ACT. Housing remains a common need identified by staff throughout the evaluation, and represents a key component to moving forward on the introduction of an ACT model.

All in all, the Forensic Psychiatric Services Commission has taken it upon themselves to better the services offered and ultimately improve the outcomes for clients referred. This project is just one small piece in a larger project and FPSC should be commended for their ability to reflect and move forward.

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Appendices

Appendix A

Table 23 Fidelity Scores

Best Practices	Status Quo = 21	Collaboration = 29	High Risk = 28	ACT = 34
Collab. Assess	1: some collaboration but not required	3: would require collaboration	2: no collaboration required – treatment similar to status quo with better assessment and identification of risk	2: no collaboration required – treatment similar to status quo with better assessment and identification of risk
Shared Risk Assessment:	2: tool to address psychiatric risks and risk to re-offend, assesses both dynamic and static, substance use is not necessarily addressed	3: uses tools, improved assessment process and identification of risks and needs, collaborative improves the shared risk assessment overall	2: uses tool, and results in more cooperation with assessment	2: uses tool, and results in more cooperation with assessment
Assessment: RNR with broad def of risk	2: RNR principle, except responsivity principle not clear. Assess of violence not in relation to static risk factors.	2: RNR principle is addressed, except responsivity principle is not clear. Improved assessment overall	3: RNR principle is addressed, including responsivity principles; improved assessment; targets high risk	3: principle is addressed, including responsivity principles; improved assessment; responds more appropriately to high risk.
10 days	1	1	1	3: occurs in person, in accordance with ACT standards

Cons. & resp. needs	2: needs are not addressed if they are not identified at outset.	3: improved assessment would result in better response to needs	3: improved assessment would result in better response to needs	3: improved assessment would result in better response to needs
Treat/ Case Man. RNR	3: both Mental Health risks and Risk to Re-offend are addressed	3: both Mental Health risks and Risk to Re-offend are addressed	3: both Mental Health risks and Risk to Re-offend are addressed	3: both Mental Health risks and Risk to Re-offend are addressed
Prog.	1	2: Improved assessment and focus on engagement	2: improved assessment, closer focus on individual needs not focussed on engagement	3: Improved assessment, improved focus on individual needs and focus on engagement
Assert. Case Manag	1: cannot have appropriate case manage. without appropriate assess.	2: improved assessment: no assertive engagement; no recovery philosophy does respond to needs more appropriately	2: improved assessment; does not include recovery as a philosophy, or require assertive engagement.	3: Adheres to all standards

Table 23 Cont.

Disch Plan	2: discharge planning might not be achievable without appropriate assess.	3: improved assessment would improve discharge planning	3: improved assessment would improve discharge planning	3: adheres to all discharge standards
Disch Criteria	1: discharge planning depends on attaining goals – not achievable without appropriate assess; no engage	1: not a focus	1: not a focus	3: adheres to all standards
Disch docCont of Care	3	3	3	3
Disch doc	2 provided but not consistent or outlined	3 ; based on assessment & current methods	3: based on assessment & current methods	3