

**THE COMMUNITY RE-ENTRY OF MENTALLY
DISORDERED OFFENDERS IN BRITISH COLUMBIA**

by

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Abstract

People with mental illness are overrepresented in British Columbia's jails. Mentally Disordered Offenders (MDOs) typically commit low-level crimes and receive short sentences that make them ineligible for parole. After incarceration, it is difficult for MDOs to find housing, employment, maintain good mental health and apply for benefits due to their mental illness, criminal record and, often, their addiction. Almost half of the MDOs released from jail fail to re-enter the community and consequently re-offend. In BC, there are too few transition services to help MDOs successfully re-enter the community. This study uses case studies from the United States to identify service delivery models that reduce the rate of recidivism among MDOs and interviews to find the gaps in mental health service delivery for MDOs in British Columbia. Recommendations include implementing a transition program, creating housing spaces for MDOs and establishing a mandate to service this complex, and often overlooked population.

Executive Summary

The prevalence of mental illness in Canadian federal and provincial prisons is 2 to 4 times higher than the general population. Upon release from incarceration, most mentally disordered offenders (MDOs) find community re-entry difficult. The “triple stigma” of mental illness, a criminal record and substance abuse prevents them from securing stable housing and seeking out mental health services. In addition, low educational attainment can also be a barrier to employment and re-integration. These inhibiting factors make community re-entry challenging for MDOs who do not receive support transitioning back into the community from jail.

Policy Problem

The policy problem central to this study is that there are too few transition programs to help mentally disordered offenders successfully re-enter the community after incarceration in British Columbia. This study defines an MDO as someone with a serious mental illness, such as schizophrenia, a mood disorder, an anxiety disorder or a concurrent substance abuse disorder. My research focuses on MDOs released on a warrant expiry or the date their sentence officially ends because most are ineligible for post-release services provided by the BC Forensic Psychiatric Services Commission. Although MDOs released on a warrant expiry are eligible for mental health services from the Regional Health Authorities, the Health Authorities do not provide forensic outreach to offenders and meta-analyses of clinical and assertive community case management show their programs do not reduce recidivism among MDOS. For the purposes of this study, a transition program is a service for people with a mental illness leaving jail and re-entering the community as parolees or offenders that have served their sentences.

Methodology and Results

The identification of a gap in transition services for MDOs released on a warrant expiry shaped the central hypothesis of this study: if an MDO participates in a transition program, they are more likely to be successful at re-entering the community. This study examines two case studies to determine the structural and operational elements essential to the success of a transition program for mentally disordered offenders as well as best practices. The two case studies are

from Washington State, The Mentally Ill Offenders Community Transition Program (MIO-CTP), and Tuolumne County, California, The Crime Abatement Rehabilitation/Recovery Enhancement Services (CARES), in the United States. Interviews with individuals from the Regional Health Authorities supplement the case studies' information.

The examination of the case studies shows that a transition program is an effective method to reduce recidivism among MDOs. On average, 13% of MDOs in the two transition programs re-offended compared to the recidivism rate of 41% of MDOs who do not receive services. The best practices derived from the case studies reveal that, with some modification, the components of a transition program are applicable to British Columbia. Discharge planning is the component that needs the most modification to make sure it addresses the target population of this study. The CARES program eligibility criterion requiring participants to be on probation is not applicable to BC because the population of MDOs in need of transition services often have sentences shorter than six months and hence, are ineligible for parole. As such, the eligibility criterion for BC should be set at a minimum sentence length of 60 days or the offender's third offence to ensure program staff can create a discharge plan without compromising the program's ability to include its target population. The case studies also provide valuable best practices to deal with housing shortages. For example, the CARES program creatively worked with landlords to secure housing for their clients. The remaining components of a transition program - case management and concurrent disorder counselling, need no modification.

The case studies also reveal an important component essential to a transition program's success not found in the literature review – inter-ministerial collaboration. The key to a transition program's success is the ability to get the mental health and justice systems to share information and expand their involvement in the treatment of MDOs outside their traditional mandates. The mental health system must be involved in the selection and discharge planning process before release and the justice system must be involved in the treatment of MDOs when they are in the community. This requires a high level of communication and collaboration between the two systems so they can align their goals and determine their different responsibilities.

Policy Alternatives

The two non-exclusive policy alternatives developed from the research are the Basic and Enhanced Transition programs. The goal of the Basic Transition program is to reduce recidivism among the participants by providing discharge planning, case management, concurrent disorder counselling and housing. The Enhanced Transition program incorporates all the aspects of the

Basic program and adds policies to enable participants to live independent and self-sufficient lives in the community by providing education, employment and life skills services. Both alternatives require collaboration between the Ministries of Health and Public Safety and Solicitor General to create policy guidelines on the operation and intended outcomes of a transition program. Evaluation and comparison of the two alternatives against the status quo is based on a set of objective criteria and measures for these criteria.

Policy Implications

The overall evaluation of the policy alternatives reveals a set of policy implications for the government of British Columbia.

- Collaboration between ministries and employing horizontal thinking is essential to create guidelines on how to serve mentally disordered offenders released on a warrant expiry via transition programs.
- The Ministries of Health and Public Safety and Solicitor General should lobby within government to reserve beds for mentally disordered offenders in new housing developments.
- Implement two pilot transition programs in Vancouver Island Health and Vancouver Coastal Health or Fraser Health for a period of 4 years.
- Implement the Basic and Enhanced transition programs simultaneously to ensure all the needs of mentally disordered offenders, from basic to social needs, are met.
- Measure the outcomes of the pilot transition programs using quantitative and qualitative indicators.

Dedication

*To my parents, Janis and Tony, for their encouragement, love
and insistence that I always look on the bright side of life.*

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Table of Contents

Approval	ii
Abstract	iii
Executive Summary	iv
Policy Problem.....	iv
Methodology and Results	iv
Policy Alternatives.....	v
Policy Implications	vi
Dedication	vii
Acknowledgements	viii
Table of Contents	ix
List of Figures	xi
List of Tables	xii
Glossary	xiii
1 Introduction	1
2 Background	3
2.1 The Policy Problem	3
2.2 The Prevalence of Mental Illness in BC Correctional Facilities	6
2.3 The Nature of MDOs Contact with the Criminal Justice System.....	6
2.4 Barriers to Community Re-entry	8
2.5 Evidence-Based Service Delivery for MDOs.....	11
2.6 Current Government Policy on MDOs in Canada.....	13
2.6.1 Federal Policy on MDOs.....	13
2.6.2 British Columbia’s Policy on MDOs	13
2.6.3 Other Provinces’ Policies on MDOs	14
2.7 Mental Health Services for MDOs in British Columbia	16
2.7.1 BC Forensic Psychiatric Services Commission.....	16
2.7.2 BC Mental Health Services	17
2.8 Conclusion.....	18
3 Methodology	20
3.1 Design.....	20
3.2 Criteria for Case Selection.....	20
3.3 Definition of Variables	22
3.4 Measurement of Variables.....	23
4 Case Studies	27

4.1	Introduction	27
4.2	The Mentally Ill Offenders Community Transition Program.....	28
4.3	Crime Abatement Rehabilitation/Recovery Enhancement Services	37
4.4	Best Practices Identified from Case Studies.....	42
4.5	Summary of Findings	45
5	Policy Alternatives	47
5.1	Introduction	47
5.2	Status Quo	48
5.2.1	BC Forensic Psychiatric Services Commission.....	48
5.2.2	BC Ministry of Health & The Regional Health Authorities.....	49
5.3	Transition Program.....	50
5.3.1	Phase 1: Basic Transition Program.....	50
5.3.2	Phase 2: Enhanced Transition Program.....	52
6	Criteria and Measurement.....	54
6.1	Recidivism.....	54
6.2	Cost Effectiveness	54
6.3	Political Feasibility and Public Acceptance	56
6.4	Administrative Ease.....	56
7	Evaluation of Policy Alternatives	57
7.1	Status Quo	58
7.2	Basic Transition Program.....	59
7.3	Enhanced Transition Program	62
8	Next Steps	64
9	Conclusion	67
Appendices		69
	Appendix A.....	70
	Appendix B.....	74
	Appendix C.....	75
Bibliography.....		76
	Works Cited	76
	Interviews.....	79
	Works Consulted.....	79
	Statutory Laws	80
	Websites Reviewed.....	80

List of Figures

Figure 1: The Continuum of Alternatives	47
Figure 2: Formula for Cost Effectiveness	55

List of Tables

Table 1: The Prevalence of Mental Illness in Male and Female Inmates in BC	6
Table 2: Crime rates for selected offences in Canadian cities.....	8
Table 3: Unemployment and Education in the General Prison Population	11
Table 4: The Effectiveness of ACT compared to Control Conditions	12
Table 5: Case Selection Matrix	21
Table 6: Definition of Variables.....	24
Table 7: Quantitative Measurement of Variables.....	25
Table 8: Qualitative Measurement of Variables.....	25
Table 9: MIO-CTP Hours of Discharge Planning Pilot Period	30
Table 10: Total Post Release Service Hours MIO-CTP Pilot Period	32
Table 11: Hours of Mental Health Counselling provided during MIO-CTP pilot period per participant	33
Table 12: Recidivism Rates of MIO-CTP during pilot period	35
Table 13: Recidivism Rates of MIO-CTP since 2003	36
Table 14: Best Practices of Transition Program Components.....	42
Table 15: Best Practices of Additional Transition Services	44
Table 16: Goals and Responsibilities of Selected Ministries	56
Table 17: Evaluation Matrix.....	57
Table 18: Selected BC Mental Health Non-Governmental Organizations.....	70
Table 19: John Howard Society Services in BC.....	72

Glossary¹

Conditional sentence	An offender serves a term of imprisonment in the community under specified conditions. Conditional sentences are more restrictive than probation, but less serious than custody. This type of sentence can only be imposed in cases where the term of imprisonment is less than two years.
Forensic	Pertaining to, or connected with, the legal system.
Mentally Disordered Offender	An offender with a serious mental illness, such as schizophrenia, a mood disorder, an anxiety disorder or a concurrent substance abuse disorder.
Parole	Parole is a program that allows offenders to serve the remainder of their sentence in the community under certain restrictions. Offenders are eligible to apply for parole after serving 1/3 of their sentence. In BC, the National Parole Board (NPB) only accepts applications for parole from offenders with a sentence of at least 6 months.
Probation	Probation is when an offender is given a suspended sentence or conditional discharge and released on conditions prescribed in a mandatory probation order, including reporting to a probation officer. In some cases, an offender is given probation in addition to a fine or sentence.
Recidivism	Repeated or habitual relapse into crime. An arrest for criminal behaviour after release from incarceration.
Remand	Non-sentenced custody or the court-ordered detention of a person while awaiting further court appearances.
Sentenced Custody	Detention of an offender convicted of a crime in a federal (2 years or more) or a provincial (less than 2 years) facility.
Warrant Expiry	A warrant expiry is the date a criminal sentence officially ends, as imposed by the courts at the time of sentencing. Offenders who reach warrant expiry after completing their entire sentence are no longer under the jurisdiction of BC Corrections. Offenders are usually released after serving 2/3 of their sentence.

¹ Statistics Canada June 2005, Public Safety 2005, National Parole Board 2007

1 Introduction

The over-representation of the mentally ill in Canadian federal and provincial prisons is indisputable. Numerous academic studies and literature reviews have shown that prevalence rates of mentally ill inmates are two to four times greater than the general population (Corrado et al., 2000, Brink et al., 2001, Welsh and Ogloff, 2003, Ogloff et al, 2004, Correctional Services of Canada, 2004). However, only recently has the disproportionately high incidence of mental disorders among offenders appeared on the public policy agenda. In 2004, the Correctional Service of Canada's (CSC) study entitled *A Health Care Needs Assessment* examined the mental health of people in federal prison by age, race, gender, sentence length and co-occurring substance abuse disorders. The CSC study echoed academic findings citing the prevalence of mental illness in federal prisons are two to four times greater than the general population. In response to the CSC's report, the Correctional Investigator of Canada included a section on mental health in his 2003 – 2004 annual report and called for action on a number of mental health issues including assessment, institutional treatment programs and ensuring the continuity of treatment on release. In May 2006, the Standing Committee on Social Affairs, Science and Technology released its study on mental health entitled *Out of the Shadows at Last*. The Committee's report supported the findings and recommendations of the CSC and the Correctional Investigator by stating mental health services in federal prisons are inadequate and mental health care must be ensured when offenders re-enter the community.

In BC, there are too few transition services to help offenders with a serious mental illness successfully re-enter the community. A coordinated, effective continuum of mental health care from correctional facilities to the community does not exist for the majority of offenders in BC and this may contribute to recidivism among offenders with mental illness. To establish the policy problem this study conducts a literature review that outlines the prevalence of mental illness in BC correctional facilities, the barriers offenders with mental illness face upon release, the evidence-based practices that aid community re-entry for MDOs and the status quo of mental health services available to offenders with a serious mental illness in BC. Case studies of transition programs are then used to explore their structural and operational components to determine best practices at aiding the successful community re-entry of offenders with a serious

mental illness. Finally, alternatives are presented and evaluated to determine if BC should adopt a transition program to address the public policy problem.

2 Background

2.1 The Policy Problem

The policy problem central to this study is that there are too few transition programs to help mentally disordered offenders (MDOs) successfully re-enter the community after incarceration in British Columbia. This policy problem also has broader implications. A direct consequence of unsuccessful community re-entry can be relapse into crime. Recidivism impacts society collectively through policing costs, remand time, court time, incarceration costs and feelings of public safety. As individuals, recidivism affects people monetarily and psychologically as the victims and perpetrators of crime. A lack of transition services to help MDOs re-enter the community also may contribute to increased rates of homelessness, continued substance abuse and poor mental health after incarceration ends. This, in turn, translates into costs to the health care system through the use of acute and emergency services and our social safety net through prolonged use of government benefits. The failure of mentally disordered offenders to re-integrate into the community after incarceration is not concentrated in the justice system, but reverberates throughout the whole system. For the purposes of this study, a transition program is a service for people with a mental disorder leaving jail and re-entering the community as parolees or offenders that have served their sentences (Spaite and Davis, 2005). This study defines an MDO as someone with a serious mental illness, such as schizophrenia, a mood disorder, an anxiety disorder or a concurrent substance abuse disorder.

Measuring the successful re-entry of an MDO into the community is complex. There are many possible measurements for successful re-entry into the community such as employment, hospital visits, maintaining sobriety, volunteerism, social integration and housing. Since this study examines the reports of transition programs from different jurisdictional areas, it cannot ensure consistency in the programs' reporting of qualitative data. For example, not all transition programs' are required to report on the participants' social integration or provide personal testimonials from the participants on the program's effectiveness. Most programs involved in measuring past offenders' success do report their recidivism. This study will use recidivism rates, a quantitative variable, as a proxy to measure an MDO's successful re-entry in the community. Recidivism measures only the arrest of an individual and provides no commentary on the

progress an individual may have made in making pro-social connections through participation in recreational activities or volunteerism, maintaining sobriety or employment. In using a quantitative instead of a qualitative dependent variable the nuisance and richness of the data is lost.

There is no publicly available government data and a dearth of academic studies on the recidivism rates of MDOs in Canada. However, Bonta, Law and Hanson (1998) conducted a meta analysis on the risk factors for recidivism among MDOs using 64 unique samples from Canada, the United States of America (USA) and the United Kingdom (UK). They found the mean, base recidivism rate among MDOs was 45.8% (Bonta, Law and Hanson, 1998). Lovell, Gagliardi and Peterson (2004) followed a cohort of MDOs in Washington State, USA for 39 months and found their recidivism rate to be 41%. The Mentally Ill Offender Grant Program in California reported in their 2002 annual legislative report that 44% of control-group members who did not receive services after incarceration re-offended. The three studies indicate that the recidivism rate among MDOs may vary from 41 – 46%. Due to the lack of an authoritative, Canadian government study of the recidivism rates of MDOs this study will use the most conservative rate of 41% as the base rate of recidivism (Lovell, Gagliardi and Peterson, 2004).

Diversion strategies are used to prevent people with mental illness from entering the correctional system. A diversion strategy is an intervention taken by the court, social workers or mental health providers to divert people with mental illness away from the criminal justice system in favour of community-based treatment (Spaite and Davis, 2005). Diversion strategies may be used pre-arrest, post-arrest, post-sentencing or post-release and include such services as prevention programs, crisis intervention, outreach, mental health courts, post-arrest services and transition programs (Spaite and Davis, 2005). Regardless of the point where the diversion occurs, the goal is the same – to use community-based treatment to help people with mental illness avoid contact with the justice system.

This study examines the effectiveness of post-release diversion strategies, typically called transition programs, for two reasons. As previously mentioned, there are many points of contact one can make with a mentally ill person in the justice system and a corresponding number of strategies. This study chose to focus on post-release diversion strategies to narrow the scope of the study, provide focused analysis and policy alternatives. Second, this study identified a service gap in the post-diversion strategies that was more extensive than pre-arrest strategies. In BC, there are more services for people with mental illness at the entry point into the justice system than the exit point. For example, BC Psychiatric Services Commission is mandated to provide

court-ordered treatment for people with mental illness. Therefore, the BC Forensic Psychiatric Services Commission, an agency of the Provincial Health Authority, employs court liaison workers who work with the court to divert people with mental illness into their community based treatment programs by sentencing them to probation or a conditional sentence. Probation is a suspended sentence or conditional discharge where the convicted person is released on conditions prescribed in a mandatory probation order, including reporting to a probation officer (Statistics Canada, June 2005). An offender serves a conditional sentence in the community under specified conditions. Conditional sentences are more restrictive than probation, but less serious than custody. This sentence is only imposed in cases where the term of imprisonment is less than two years and is administered by the provinces and territories (Statistics Canada, June 2005). In Vancouver and Surrey, the Motivation, Power and Achievement Society (MPA), a non profit organization funded by Vancouver Coastal Health, Fraser Health and the Law Foundation of BC, provides advocacy for people with mental illness on remand and during trial and sentencing. The MPA also links people with mental illness to community-based program to ensure continuity of care (MPA, 2007). There is no over-arching diversion strategy in BC. As a result, service delivery for people with mental illness at the entry point in the justice system is uncoordinated, but there are still a number of services available whereas in post-release services there is a significant gap in services.

There is a significant service gap in post-release services for people with mental illness. BC Forensic Psychiatric Services Commission's mandate is to provide treatment to people only under court-order. Thus, MDOs released from jail on a Warrant Expiry Date (warrant expiry) or the date a criminal sentence officially ends as imposed by the courts at the time of sentencing, do not qualify for treatment. In 2004, only 4% of the sentenced offenders in BC were released to parole, indicating the majority were released on a warrant expiry (Statistics Canada, 2004). In addition, MDOs are more likely to commit low-level, non-violent crime and not qualify for parole (Ogloff et al. 2004). The Regional Health Authorities do not engage in outreach to MDOs while incarcerated and research has shown that assertive community treatment and clinical case management targeted at reducing hospitalization among people with mental illness does not reduce recidivism rates (see Section 2.5 for further discussion). For these reasons, I decided there was more of a need to address the problems in post-release services.

2.2 The Prevalence of Mental Illness in BC Correctional Facilities

Mental illness is over-represented in BC provincial jails compared to the general population. A literature review entitled *Mental Disorder, Substance Abuse and Criminal Justice Contact* by Ogloff, Davis and Somers (2004) found the rates of major mental illness, such as schizophrenia and depression, among provincial inmates in BC to be 3 to 5 times higher than in the general population. Brink et al. (2001) found similar results: the prevalence of major mental illness was 2 – 4 times higher among male inmates in BC than male community members in Edmonton. Female inmates in BC correctional facilities have slightly higher prevalence rates than men (Table 1). In addition to mental disorders, women also have alarmingly high rates of childhood and adult sexual and physical abuse, suicidal behaviour, poverty and low educational attainment, making them among the most marginalized groups in society (Nicholls et al., 2004). The CSC (2004) reported half of the federal inmates with substance use disorders also have a mental health disorder (termed a concurrent disorder), a statistic captured in Ogloff's (2004) statement: "substance abuse is the rule rather than the exception for mentally disordered offenders." For this reason, concurrent substance abuse disorders are considered in this analysis

Table 1: The Prevalence of Mental Illness in Male and Female Inmates in BC

Disorder	Male Inmates	Female Inmates
Schizophrenia	1.5%	4%
Anxiety	18.3%	24%
Mood	30.2%	20%
Substance Abuse	75.7%	67%

Source: Correctional Services of Canada, 2004

2.3 The Nature of MDOs Contact with the Criminal Justice System

Mentally disordered offenders typically commit low-level, non violent crimes such as drug and property crimes that have short sentences (Ogloff, et al., 2004). The median sentence

length in 2004 for BC offenders was 53 days (Statistics Canada, 2004). Parole is a program that allows offenders to serve the remainder of their sentence in the community under certain restrictions. Offenders are eligible to apply for parole after serving 1/3 of their sentence. However, in BC the National Parole Board (NPB) only accepts applications for parole from offenders with a sentence of at least 6 months (National Parole Board, 2007). In 2004, 398 offenders or 4% of sentenced offenders in BC were released on provincial parole meaning that the majority of offenders were released on a warrant expiry (Statistics Canada, 2004). When mentally disordered offenders are released with inadequate support services to transition into the community they are extremely vulnerable to “increased incidence of psychiatric symptoms, hospitalization, relapse to substance abuse, suicide, homelessness and re-arrest...[that] may lead some individuals to cycle through jails dozens or even hundreds of times (Osher, Steadman and Barr, 2003). A social worker with extensive experience working with MDOs in BC’s health care system confirms that due to inadequate mental health treatment and support services many mentally disordered offenders’ habitually cycle through the community back into the correctional system in BC (Interview A, 2007).

MDOs have a propensity to commit low level, non violent crime (Ogloff et al., 2004). Non-violent crimes usually have short sentences and consist of property and drug offences that are serious problems in the Lower Mainland. For example, in 2003 the sentence length for property crimes in BC ranged from 30 – 180 days (Statistics Canada, 2003). Despite a 7.5% decrease in the incidence of property crime in 2005, British Columbia had the second highest rate in Canada after the Northwest Territories (Statistics Canada, 2006). Vancouver, Abbotsford and Victoria ranked among Canadian cities with the highest incidences of robbery, break-ins and motor vehicle theft in 2005 (Table 1). Vancouver is notorious for its open drug scene in the Downtown East Side and Ogloff, Davis and Somers (2004) indicate that the high number of mentally disordered offenders involved in the criminal justice system is linked closely to their high rates of substance abuse. In 2005, British Columbia had the highest provincial rate of drug offences in Canada with a rate of 606.7 per 100,000, approximately 50% higher than Saskatchewan which had the second highest rate at 310.2% (Statistics Canada, 2005).

Table 2: Crime rates for selected offences in Canadian cities

	Homicide	Robbery	Break-ins	Motor vehicle theft	Total Criminal Code
Population of over 500,000	2005 rate per 100,000 population				
Vancouver	2.9	149	1192	990	11,226
Winnipeg	3.7	263	1070	1712	11,153
Edmonton	4.3	142	1025	1059	10,529
Montreal	1.3	147	892	649	7,328
Population between 100,000 and 500,000					
Saskatoon	3.7	248	1494	550	13,236
Regina	4.0	197	1740	1078	13,194
Abbotsford	2.5	106	1219	1514	12,886
Victoria	0.6	60	804	260	9,932

Source: Statistics Canada, *The Daily*, July 20 2006

2.4 Barriers to Community Re-entry

Most MDOs find community re-entry difficult. The “triple stigma” of mental illness, a criminal record and substance abuse prevents them from securing stable housing and seeking out mental health services. These factors plus, low educational attainment can also be a barrier to employment and re-integration. These inhibiting factors make community re-entry challenging for MDOs who do not receive support transitioning back into the community from jail.

Jones et al. (1984) defines stigma as a “mark” that sets a person apart and links the marked person to undesirable characteristic. Society typically rejects and isolates a person marked as undesirable (Jones, 1984). In the course of socialization, people understand what it

means to be identified as a mentally ill person, a drug addict or a criminal and have ideas that people generally reject such individuals as weak, dangerous, incompetent or untrustworthy (Link et al., 1997). Once a person is labeled as mentally ill, a drug addict or a criminal they have beliefs about how others will treat them and their expectations of rejection can erode confidence and impair social and occupational functioning (Link et al., 1997). In addition, they will also have real experiences of discrimination and rejection that will reinforce their negative beliefs. Stigma and expectations of stigma are real barriers that prevent MDOs from transitioning into the community and taking initiative in accessing mental health services.

MDOs that are homeless on release are more likely to re-offend than those with housing (Draine and Solomon, 1994). Draine and Solomon explain “mental illness, prior criminal arrest history, homelessness and substance abuse often create a pernicious network of risk factors for jail recidivism among mentally ill persons leaving jail.” The CSC (2004) reported 40% of aboriginal male inmates and 45% of aboriginal female inmates lived in “unstable housing”² before arrest and approximately 30% of non-aboriginal male and female inmates lived in unstable housing before arrest – compared to .2% of the general population in Canada. The CSC did not report what percentage of MDOs had unstable housing before arrest, but Hartwell’s (2005) study that included in-depth qualitative interviews with 20 MDOs in a Massachusetts prison found one-third expected to be homeless on release. These inmates described homelessness as isolating, unsatisfying and preferred some sort of supportive housing arrangements (Hartwell, 2005). One MDO stated “maybe things would have gone better that time (first release) if I was released to a halfway house instead of on my own” (Hartwell, 2005). However, the stigma surrounding an MDO makes securing housing individually or through social services difficult.

Stigma can be a barrier to an MDO’s community re-entry because it inhabits their ability to secure housing. Landlords are reluctant to rent to offenders with a mental illness or a concurrent disorder (Hartwell, 2004). Page’s (1977) study entitled *Effects of the Mental Illness Label in Attempts to Obtain Accommodation* found that landlords were less likely to indicate an apartment was available if a caller identified as a former mental hospital patient (23%) than if he or she was not so identified (83%). MDOs with concurrent disorders are also not preferred candidates for public housing because they are often not medically compliant and service providers consider them a difficult population to serve (Hartwell, 2004). A social worker with experience working with MDOs explains how the narrowly defined target populations and

² The CSC defined individual with unstable housing as homeless, living in substandard housing or paying 50% or more of their income on housing.

eligibility requirements of the Regional Health Authorities in BC causes fewer mental health services to be available to people with complicated needs, such as those with a criminal history and substance abuse (Interview A, 2007). According to this social worker, this situation “has a rebound effect because now you have more problems because you have less service...they are not going to mental health teams [because] that’s [a criminal history] a red flag” (Interview A, 2007). The narrow mandates of service providers combined with the stigmatization of MDOs are barriers to their successful community re-entry.

The stigma of mental illness and a distrust of health professionals prevent MDOs from initiating contact with mental health services. Howerton et al’s (2006) qualitative study exploring “the underlying motives and beliefs that guide help seeking” among male ex-inmates in the UK found that a chaotic childhood, distrust and fear of stigma are major barriers to accessing health services. Many interviewees’ negative experiences with health professionals shaped their distrust and the perception that doctors did not care or understand. One inmate described his experience with a correctional doctor after a suicide attempt: “the doctor says, oh, how are you feeling, you look all right to me and he sends me back to the wing...they don’t really understand what people are going through” (Howerton et al., 2006). A fear of diagnosis and the ensuing stigma of mental illness also prevented inmates from seeking mental health services. One inmate explained he avoided seeking mental health services because “you’re obviously a bit wrong if you’ve got a mental health problem, that’s how some people see it...” (Howerton et al., 2006). In a follow-up interview to the initial interview session, none of the 35 inmates interviewed had sought mental health services. The distrust of health care professionals and the stigma of a mental health diagnosis is a powerful factor that inhibits MDOs from seeking services.

Offenders are an under-educated population and literacy tests of Canadian inmates reveal 70% of inmates have below a grade 8 literacy level and 86% have below a grade 10 reading level (Table 4, CSC 2004). In addition, offenders may be legally barred from certain types of employment, from holding certain professional licenses or face discrimination when applying for jobs that require criminal background checks (Bruckner, 2006). The tendency for people with disabilities to have lower education and employment rates than the norm implies that MDOs probably have even lower rates than the general population of inmates. Finally, a concurrent disorder also compromises an MDO’s ability to professionally perform and retain employment if not treated. This multitude of factors makes it challenging for MDOs to re-integrate into the community through employment.

Table 3: Unemployment and Education in the General Prison Population

	Male		Female	
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal
Unemployed	60.3%	49.9%	72.2%	65.4%
No High School diploma	70%	57.5%	73.2%	54.4%

Source: Correctional Services of Canada, 2004

2.5 Evidence-Based Service Delivery for MDOs

When MDOs are released with no housing, treatment or financial resources they enter into a crisis situation – increasing the incidence of psychiatric symptoms, hospitalization, alcohol and drug use, suicide and recidivism (Osher, Steadman and Barr, 2003). Typically, case management is a method of delivering mental health services to people with mental disorders to prevent hospitalization, improve quality of life and client functioning (Bond et al., 2001). Through quantitative and qualitative research, academics have identified that case management focused on reducing hospitalization is not successful at reducing recidivism.

Initially, case management developed to help people with mental illness navigate the complex community-based mental health system that arose after deinstitutionalization. Case managers were clinic based, had a high number of cases and referred and coordinated community based services into an integrative treatment plan for the person with a mental illness (Mueser et al., 1998). Assertive Community Treatment (ACT) adapts standard case management to target people with mental illness who are high service users. ACT is characterized as being community based, having 24 hour coverage, providing outreach into the community and directly providing a variety of integrative clinical, rehabilitative and social services by a multi-disciplinary team in addition to co-ordinating services (Mueser et al., 1998). Countless academic studies on the effectiveness of ACT compared to clinic-based case management show that it significantly reduces hospitalization, increases quality of life and client functioning for high service users (Table 5). As a result, many governmental agencies and professional organizations consider ACT an “evidence-based” practice for high service users: including the BC Ministry of Health who published a best practices guideline for ACT in 2002 (Bond et al., 2001, Ministry of Health, 2002).

Table 4: The Effectiveness of ACT compared to Control Conditions

	Better	No Different	Worse
Psychiatric hospital use	74%	26%	0
Symptoms	44%	56%	0
Quality of lie	58%	42%	0

Source: Bond et al. 2001

Mueser et al’s (1998) article entitled *Models of Community Care for Severe Mental Illness: A Review of Research on Case Management* is an extensive review of studies on the effectiveness of ACT and reveals it does not reduce recidivism. Mueser et al. (1998) examines the results of 75 studies on the effectiveness of ACT on nine independent variables³, including time spent in jail and arrests. Of the 75 studies, 32 were controlled studies that compared the ACT model with standard case management: 70% of ACT programs had no effect on recidivism, 20% of ACT decreased recidivism and 10% increased recidivism among their clients (Mueser et al., 1998). The authors conclude it is unclear why ACT has a negligible effect on recidivism, but point to qualitative data that suggests clinical services “require significant modification to address the different needs of patients who are prone to engage in illegal behaviour” (Mueser et al., 1998).

Lamberti, Weisman and Faden’s (2004) study identified the Forensic Assertive Community Treatment model (FACT), a modified version of the Assertive Community Treatment (ACT), as an emerging model to treat people with mental illness who have contact with the law in the United States. Their investigation surveyed 16 programs with similar target populations, system coordination and service elements, three of which had published outcome data that reported a decrease in recidivism among participants. Lamberti et al. (2004) found the main component of FACT that distinguished it from ACT was the extent the goals of preventing arrest and incarceration determined program structure and function. ACT often serves people with a criminal history out of “necessity rather than design”, but FACT prioritizes the treatment of MDOs by requiring their clients to have a criminal history and using the justice system as their

³ The independent variables examined were: time in hospital, symptoms, social adjustment, housing stability, jail/arrests, substance abuse, medication compliance, quality of life, vocational functioning, patient satisfaction and relative satisfaction (Mueser 1998).

main source of referral (Lamberti et al., 2004). Furthermore, FACT integrates the justice system by involving correctional officials in programming. The surveys revealed the integration of the justice system is strategically important as it may prevent unnecessary incarceration (Lamberti et al., 2004). Half of the surveyed FACT programs reported the use of supervised residential housing that provides addiction services, instead of ACT's method of referral to existing community housing, to circumnavigate the reluctance of housing providers to accept a high-risk population. In addition to these distinctive characteristics, the majority of FACT programs provide case management and addictions counselling.

2.6 Current Government Policy on MDOs in Canada

2.6.1 Federal Policy on MDOs

In April 2006, the Correctional Service of Canada (CSC) received funding for five years from the Treasury Board to implement the Community Mental Health Initiative (CMI). The CMI's goal is to better prepare MDOs to successfully re-integrate into the community. To attain this goal the CMI plans to link up with existing service providers to orientate them to the needs and issues of MDOs, enhance discharge planning, transitional Mental Health services and community mental health specialists to support offenders in the community. The CMI also plans to address the regional and geographical challenges unique to each province through a steering committee composed of regional representatives. As of January 2007, the program is still in the planning and consultation stage (Correctional Services of Canada 2006).

2.6.2 British Columbia's Policy on MDOs

The BC government currently has no co-ordinated, overarching policy or strategy to address the needs of MDOs. However, the Ministry of Health Services, the Ministry of Children and Family Development, the Ministry of the Attorney General, the Ministry of Public Safety and Solicitor General and the Forensic Psychiatric Services Commission have formed a partnership to develop services and supports for persons with mental and/or substance use disorders. Their goal is to implement an evidence-based provincial program for people who are within or exiting the justice system and to reduce the risk of them re-entering. The Centre for Applied Research in Mental Health and Addictions (CARMHA) and Simon Fraser University provides research support to the Provincial Government to improve the efficiency and effectiveness of services for people at risk of entering the corrections system. CARMHA's research support includes the integration of anonymous service utilization data representing services that are known to play an

important role in the diversion of offenders and prevention of recidivism (i.e., health, income assistance, and correctional services). These data provide diverse opportunities to examine factors that place individuals at risk of entering (or re-entering) the corrections system, as well as patterns of service utilization that may effectively prevent recidivism. A preliminary report including the results of linked data analyses is forthcoming from CARMHA. The preliminary report was not released during this study's period of research.

2.6.3 Other Provinces' Policies on MDOs

Alberta and Ontario are the only two provinces, to this author's knowledge, that have formal, coordinated government diversion strategies in place. Alberta's Provincial Diversion Committee, co-chaired by the Alberta Mental Health Board and the Alberta Solicitor General, began to develop a Provincial Diversion framework in 2001. In 2001, Alberta's Provincial Diversion Framework Working Committee published a proposal outlining the target population, stakeholders, goals, objectives and expected outcomes of a provincial diversion strategy (Government of Alberta, 2001). This proposal recommended further consultation with stakeholders regarding "the detailed design of a phased in provincial diversion program" and the development of an Implementation Plan for the Provincial Program (Government of Alberta, 2001). Subsequent documents, such as the 2003 implementation plan, outlined the provincial standards on eligibility criteria, methods of community collaboration, information sharing, education and training and appropriate care, support and treatment. The government does not run programs, but funds community-based initiatives that adhere to the goals, guidelines and practices outlined in their implementation plan.

Started in 2001, the Calgary Diversion Project, described as "a community response to a community issue", diverts people with mental illness from entering the criminal justice system (Calgary Health Region, 2004). Its target population is people with mental illness who commit minor, low-risk offences. During the pilot period 71% of the 178 individuals who participated had their charges withdrawn and there was an 86% reduction in repeat offences (Calgary Health Region, 2004). In 2005, Alberta's Ministry of Health and Wellness provided 1.6 million to continue the Calgary Diversion Project and to initiate other diversion projects in Lethbridge and St. Paul (Alberta Mental Health Board, 2005). Currently there are no post-release services in Alberta.

Like Alberta, the Ontario government also takes a community-based approach to diversion services. Ontario published a diversion framework in February 2006 defining the target population, inter-ministerial responsibilities and the service functions of the three services offered in Ontario for people with mental illness in contact with the law – Pre-Charge Diversion Services, Court Support Services and Post Conviction Services (Government of Ontario, 2006). Pre-charge diversion services are available to an adult who appears to have mental health needs in contact with police, and would benefit from community or hospital-based mental health services as an alternative to incarceration (Government of Ontario, 2006). Court support services are for adults charged with a criminal offence and post-conviction services are for adults convicted of a criminal offence who would benefit from community or hospital-based mental health services as an alternative to incarceration (Government of Ontario, 2006). The Framework does not include transition or post-release services. The Framework states the goal in providing a framework is to ensure services are offered to the same standard across the province (Government of Ontario, 2006). The three types of services are independently run in various communities in Ontario, but adhere to the guidelines in the provincial diversion strategy and are funded by the Ontario government. The Ontario government is currently developing standards, performance outcomes and measures to monitor the provision of diversion/court support services and supports (Government of Ontario, 2006).

New Brunswick's Mental Health Court is an informal service for people with mental illness in contact with the law and worth mentioning because it is one of the few in Canada. Since 2000, Saint John, New Brunswick has had a Mental Health Court. The Mental Health Court works with people deemed fit to stand trial to divert them from jail to community-based treatment (New Brunswick Mental Health Court, 2003).

The two Canadian provinces that have diversion strategies in place, Alberta and Ontario, seem to favour a de-centralized or community-based administration of services. A de-centralized or community-based system consists of an overarching framework of guidelines published by the ministries, typically Justice and Health, that each health region uses as a guide to develop and administer their program. Alberta uses a community-based administration to "reflect the unique needs of Alberta's communities" and, in particular, aboriginal communities which are a primary concern (Government of Alberta, 2001). Similarly, Ontario's framework emphasizes the importance of addressing local need and integrating local services. A community-based program can be useful because cultural and personal needs may vary across geographical regions. The diversion frameworks of Alberta and Ontario do not include post-release transition services, so

they cannot be used as case studies. However, this study has included a case study with decentralized or community-based system of administration to reflect the Canadian trend of service delivery for MDOs.

2.7 Mental Health Services for MDOs in British Columbia

The lack of a formal diversion strategy in BC results in uncoordinated services for MDOs offered by governmental and non-governmental organizations. The BC Forensic Psychiatric Services Commission, an agency of the Provincial Health Authority, offers diversion and treatment services to a specific population of MDOs who are Not Criminally Responsible due to Mental Disorder (NCR-MD) or who are required to receive court-ordered treatment through parole or probation. However, the National Parole Board's policy of only accepting applications for parole from offenders with sentences of at least 6 months and MDOs tendency to commit low-level, non violent crime means the majority of MDOs are released on a warrant expiry are ineligible to receive services from BC Forensic. The Regional Health Authorities use clinical case management and ACT for adults with mental illness, but studies show that ACT is ineffective at reducing recidivism among MDOs. The majority of non-governmental agencies targeted at people with mental illness do not provide legal advocacy, forensic outreach or specific programming for MDOs (Appendix A). However, the non-governmental organizations that provide advocacy, outreach and programming for offenders have some specialized programming for MDOs (Appendix A). The following section outlines the current governmental services available to MDOs in an attempt to illustrate the nature of the service gap for MDOs.

2.7.1 BC Forensic Psychiatric Services Commission

The BC Forensic Psychiatric Services Commission (BC Forensics), an agency of the Provincial Health Authority, provides court-ordered services for mentally disordered adults in contact with the law (BCMHAS, 2007). BC Forensics' mandate is to serve a specific population of mentally disordered adults who are: (1) NCR-MD and sentenced to the Forensic Psychiatric Hospital to receive treatment, (2) referred for treatment while incarcerated at another correctional facility or (3) are court-ordered to receive mental health treatment as a condition of their probation, parole or conditional sentence. The services this population may receive include (BCMHAS, 2007):

- Mental status assessments for Pre-sentence Reports;

- Housing at Willingdon House for people determined to be NCR-MD after hospitalization
- Case management for MDOs who are court-ordered to receive treatment for their mental disorder
- Treatment for MDOs who are court-ordered to receive treatment for their mental disorder
 - Treatment provided by psychiatrists, psychologists, social workers, nurses and rehabilitation specialists
 - Treatment may include counselling, life skill training and employment services

The Forensic Psychiatric Hospital only treats people who are referred by the court as NCR-MD or are deemed a risk to themselves or others while incarcerated (BCMHAS, 2007). Not every person with a mental illness sentenced in BC completes their sentence at the Forensic Psychiatric Hospital because not every person with a mental illness is a risk to themselves or others. An MDO may be schizophrenic, but not disruptive or suicidal and be deemed “fit” to stand trial. If an MDO’s mental health deteriorates during their sentence in a general correctional facility they may be transferred to the Forensic Hospital until they are stabilized and then re-integrated into the general correctional population (Interview A, 2007). The provision of mental health services for MDOs who are only high risk means that many MDOs slip through the cracks until they re-offend.

BC Forensics also has two liaisons in the Lower Mainland who work with the courts to identify and divert people with mental illness from the correctional system to community-based treatment, usually through probation. The sentencing judge imposes probation conditions designed to regulate behaviour and enforce rehabilitation. In the case of a person with mental illness this usually consists of court-ordered treatment to manage their mental illness. Likewise, a parole board may grant an offender parole on the condition they seek psychiatric treatment. In a case of probation or parole, BC Forensics is mandated to administer court-ordered treatment for mental illness.

2.7.2 BC Mental Health Services

In 1997, the BC government adopted ACT as a best practice to deliver mental health services to individuals with serious and persistent mental illness who are intensive users of the

health care system. The goal of ACT in BC, as stated by the guidelines, is twofold. First, ACT aims to enable individuals with serious mental illness to live independent and self-sufficient lives in the community by receiving treatment in their own environment and appropriate to their needs. Second, ACT intends to reduce the need for hospitalization and decrease demand on emergency, acute care, forensic and transitional housing services. Each regional health authority employs some elements of ACT to deliver mental health services to high-risk client, but no region provides a complete ACT program. The ACT services differ across regions according to the population's need. Services may include outreach to the client in their community, direct service provision, 24-hour crisis response, low client – staff ratio and programming that addresses the client's vocational, education, social, recreational, housing and other personal needs. This may include the creation of an individualized service plan, group and individual therapy, advocacy for income assistance and housing, life skills and personal care education and service co-ordination. A minority of mental health clients receive ACT services. Finally, the Regional Health Authorities rarely provide outreach into correctional facilities to connect MDOs not already in the mental health system to services.

For the majority of adults with mental disorders who are not high service users, the Regional Health Authorities use traditional case management or clinical case management to deliver services. This type of mental health service delivery is office-based with limited outreach to the community and uses a broker method of referring clients to services, such as employment and counselling. The majority of mental health clients receive clinical case management.

2.8 Conclusion

This literature review outlines the factors that explain why the problem of too few transition services to aid the successful community re-entry of mentally disordered offenders is a pressing public policy issue. The prevalence of mental illness is higher in correctional facilities than the general population and the majority of MDOs commit are released on a warrant expiry. MDOs have difficulty re-entering the community due to stigma, homelessness, substance abuse, distrust of health professionals, low educational attainment and legal barriers to employment. Almost half of MDOs cannot overcome these barriers to community re-entry and consequently re-offend. The current level of services available to MDOs is inadequate because (1) the majority of MDOs are ineligible to receive transition services from BC Forensic and (2) the Regional Health Authorities provide inconsistent ACT services and do not provide outreach to MDOs in correctional facilities. In addition, ACT and clinical case management models targeted at

reducing hospitalization generally do not reduce recidivism. Thus, there is a service gap in treatment for the majority of MDOs after they are released from incarceration in British Columbia that may contribute to their cyclical movement through the health and justice systems.

3 Methodology

3.1 Design

The identification of a service gap for MDOs released on a warrant expiry shaped the central hypothesis of this study: if an MDO participates in a transition program, they are more likely to be successful at re-entering the community. Due to the specific focus of this hypothesis, this study faced two major challenges when determining its design. The first challenge was finding transition programs that served MDOs after incarceration or post-release. Many of the transition programs this study found diverted people before they entered a correctional facility and thus were ineligible. Of the transition programs that accepted MDOs after incarceration, many of them required participants to be eligible for parole or probation. Initially, this study wanted to include programs that only accepted MDOs with no parole or probation requirements, but had to drop this because of the dearth of programs with that criterion. The second challenge was the scarcity of reports or research on the effectiveness of post-release transition programs. The reports available often had different reporting requirements and measured different variables. As a result, a regression using a compiled quantitative data set was impossible. The richness provided by the qualitative data in the final and annual reports of the case studies and the similar themes influenced the use of qualitative independent variables. Interviews conducted with individuals in the Regional Health Authority augmented the research by providing a BC perspective on the policy alternatives derived from American case studies.

3.2 Criteria for Case Selection

The three criteria used to select the transition programs for this study were the length of operation, admission requirements and availability of data on recidivism. This study set the minimum length of time a transition program must be in operation at two years. This criterion facilitates primary document research, as most government-funded programs typically must produce at least an annual operating and financial report. It also allows the program to correct any “growing pains” and provide long-term statistics on recidivism. As the dependent variable of this study is recidivism, it is crucial the program has statistics on the recidivism rates of their participants. To fulfil the criterion “admission requirements”, participants must have a serious

mental illness and been incarcerated before admitted into the program. This ensured the programs in the case study were post-release transition programs that serve MDOs who have been incarcerated and not transition programs that divert people from entering the correctional system through probation. This ensures continuity of comparison.

Table 5: Case Selection Matrix

Program Name	Program Location	Admission Requirements	Year Program Initiated	Data on Recidivism
Alberta's Provincial Diversion Program	Calgary & Edmonton, Canada	- Must be arrested - Must have a serious mental illness	2004	No
Butte County Forensic Resource Team	Butte County, California, USA	- Must be arrested - Must have a serious mental illness	2004	?
Crime Abatement Rehabilitation/Recovery Enhancement Services	Tuolumne County, California, USA	- Must be incarcerated - Must have a serious mental illness	2001	Yes
Maryland Community Criminal Justice Treatment Program	Operates in 18 of the 24 jurisdictions in Maryland	- Must be incarcerated or arrested - Must have a serious mental illness	1998	?
Massachusetts Forensic Transition Program for Mentally Ill Offenders	Boston, Massachusetts, USA	- Must be incarcerated - Must have a serious mental illness	1998	Yes, but only track each cohort for 6 months
Mentally Ill Offender Community Transition Program	King County, Washington, USA	- Must be incarcerated - Must have a serious mental illness	1998	Yes
Ontario Diversion Framework	Various cities in Ontario, Canada	- Must be arrested or incarcerated - Must have a serious mental illness	2006	No

This study's criteria of data on recidivism rates and admission requirements limited the selection pool of the cases, as illustrated in Table 5. In Canada, no programs, to this author's knowledge, fulfilled all of the criteria. Much of the academic research on transition programs occurs in the United States and, as a result, there is a greater diversity of transition programs and most are required to report the recidivism rates of their participants. In addition, the Mentally Ill Offenders Community Transition Program (MIO-CTP) and the Crime Abatement Rehabilitation/Recovery Enhancement Service (CARES) program were chosen as case studies because (1) the co-ordinators of the program were co-operative and supportive of this project by agreeing to provide archived reports; (2) their reports contained useful data and (3) the Mentally Ill Offenders Crime Reduction Grant Program (MIOCRG) that funds CARES has a similar decentralized or community-based system of administration to the diversion programs in Canada.

3.3 Definition of Variables

This study defines a transition program as a service for mentally ill people leaving jail and prison and re-entering the community as parolees or offenders that have served their sentences (Spaite and Davis, 2005). Transition programs focus on reducing recidivism among their participants and typically offer four basic services to achieve this goal: discharge planning, counselling, housing and case management (Spaite and Davis, 2005, Lamberti et al., 2004, Hartwell, 2004). A proxy, recidivism, will represent the dependent variable "successful community re-entry". I use a quantitative proxy to measure the dependent variable instead of a qualitative proxy because it is a variable that can represent "successful community re-entry" and typically diversion strategies reports contain this number. Recidivism percentages also facilitate the calculation of cost effectiveness. There are other possible qualitative measurements for successful re-entry into the community, such as social integration, but not all transition programs' are required to report on the participants' social integration or provide personal testimonials on the program's effectiveness from the offenders. It is important to note recidivism measures only the arrest of an individual and provides no commentary on the progress an individual may have made in making pro-social connections through participation in recreational activities or volunteerism, maintaining sobriety or employment. As a result, in using a quantitative instead of a qualitative dependent variable the nuisance and richness of the data is lost.

The four major components of a transition program, discharge planning, case management, housing and counselling, will act as proxies for the independent variable "transition

program”. These measurements are not totally independent and there may be some co-linearity between the independent variable. However, due to the lack of data available on transition programs, a regression is impossible and the measurement will be largely qualitative with quantitative measures added when available. Please see Table 6 for the definition of the components of a transition program.

3.4 Measurement of Variables

Data for transition programs is mainly qualitative; however, quantitative data will be included when available. I use quantitative and qualitative measures to capture the different types of data (Tables 7 and 8). Most data sources are publicly available government documents. Information not available via these sources comes from interviews with the directors of the transition programs.

Table 6: Definition of Variables

<i>Dependent Variable</i>	<i>Definition</i>
Recidivism	A participant in a transition program is arrested and/or convicted of a crime.
<i>Independent Variable</i>	<i>Definition</i>
Transition Program	A service for mentally ill people when they re-enter the community after parole or release from jail or prison at the end of their sentence. Transition programs consists of, at least, discharge planning, case management, housing and substance abuse counselling.
<i>Components of a Transition Program</i>	<i>Definition</i>
Discharge Planning	Prior to release, a case manager reviews all of the MDOs' available health and correctional records, consults with the MDO about their needs on release and creates a plan outlining the MDOs' needs to successfully re-enter the community.
Case Manager	A person who assists the participant re-enter the community.
Housing	A shelter that reasonably protects its resident from the elements and intruders, has running water, a bathroom, kitchen and heat.
Psychiatric Counselling	A rehabilitation program that focuses on mental health disorders.
Addictions Counselling	A rehabilitation program that focuses on drug and alcohol addictions.

Table 7: Quantitative Measurement of Variables

Dependent Variable	Method of Measuring Dependent Variable
Recidivism	<ul style="list-style-type: none"> ○ Percent change in recidivism rates among mentally disordered offenders compared to control group
Independent Variables	Method of Measuring Independent Variables
Discharge Planning	<ul style="list-style-type: none"> ○ The total number of hours an offender participates in discharge planning
Case Management	<ul style="list-style-type: none"> ○ The total number of hours of life skill training the participant receives ○ The total number of hours of assistance provided to re-register for government benefits ○ The total number of hours of assistance provided organizing / accompanying participants to appointments, meetings and/or recreation events
Counselling	
<i>Substance Abuse</i>	<ul style="list-style-type: none"> ○ The number of hours per week a participant receive ○ The type of addictions counselling available to the participant
<i>Mental Health</i>	<ul style="list-style-type: none"> ○ The number of hours per week a participant receives ○ The types of psychiatric counselling available to the participant

Table 8: Qualitative Measurement of Variables

Independent Variables	Method of Measuring Independent Variables
Discharge Planning	<ul style="list-style-type: none"> ○ Describe the selection process of participants ○ Describe the composition of the selection process committee ○ Describe the services provided by the discharge planners pre release
Case Management	<ul style="list-style-type: none"> ○ Describe the services provided by the case manager ○ Describe how the services provided by the case manager change as the participant progresses through the program
Housing	<ul style="list-style-type: none"> ○ Establish if the participant received housing or not ○ Describe any housing subsidy and who provides it ○ Describe the type of housing provided to the participant (ex. structured, semi-structured, shared or independent)
Counselling	
<i>Substance Abuse</i>	<ul style="list-style-type: none"> ○ Describe the type of substance abuse counselling offered ○ Describe the type of professional that offers substance abuse counselling ○ Describe the transition program's substance abuse counselling requirements (ex. Mandatory or voluntary participation)
<i>Mental Health</i>	<ul style="list-style-type: none"> ○ Describe the type of mental health counselling offered ○ Describe the type of professional that offers substance abuse counselling ○ Describe the transition program's mental health counselling requirements (ex. Mandatory or voluntary participation)

4 Case Studies

4.1 Introduction

The following section examines two case studies to determine the structural and operational elements essential to the success of a transition program for mentally disordered offenders as well as best practices. The two case studies selected are from Washington State, The Mentally Ill Offenders Community Transition Program, and Tuolumne County, California, The Crime Abatement Rehabilitation/Recovery Enhancement Services, in the United States. The annual and final reports of both programs are the source of all the qualitative data (Tuolumne County, 2004, California Board of Corrections, 2002 & 2005, Washington State Department of Corrections, 2001, 2002, 2005 & 2006, Department of Social and Health Services Correspondence, 2003). The reports were reviewed and summarized to provide the information in the following sections. To address any differences between the justice systems in Canada and the United States the beginning of this section will briefly define some key terms and outline the different jurisdictional responsibilities of state and county in the American correctional system. At the end of this section, a summary will provide an analysis of the cases' strengths, weaknesses and applicability to Canada.

Background on the United States Correctional System

California and Washington, the two states examined in this study, classify crimes as felonies or misdemeanours. States loosely define these crimes - a felony is a serious crime and a misdemeanour is a less serious crime than a felony that can be punished by less than a year in jail (California Courts, 2007 and Washington Courts, 2006). The sentence of a felony can vary from months to years depending on the crime.

Counties are responsible for housing people convicted of a crime with a sentence of a year or less in jail and supervising people on probation. Judges may place a defendant on probation instead of making them serve their sentence in a correctional facility. However, the judge may also sentence a person to jail time and retain the ability to bring the defendant out of the correctional facility and place him or her on probation (Bachtelle, 2007). States are

responsible for housing people convicted of a crime with a sentence of a year plus a day or more in prison and supervising people on parole.

The following two transition programs meet this study's criteria. The Mentally Ill Offenders Community Transition Program (MIO-CTP) is a state-run program: it accepts people whose sentence has expired or are on parole. The majority of the MIO-CTP participants' sentence has expired, so their participation is voluntary. The average time a participant in the MIO-CTP spent incarcerated was 25 months. If a MIO-CTP participant is on parole, their participation in the program becomes one of the provisions of their parole. The CARES program is a county-run program, so the program can only accept people on a warrant expiry or probation. The CARES program only accepts people eligible for felony probation, as opposed to a person on misdemeanour probation or a warrant expiry. The average time a participant in the CARES program spent incarcerated was 166 days. Participation in the CARES program is a condition of probation, so non-compliance with any aspect of the CARES program is a probation violation.

4.2 The Mentally Ill Offenders Community Transition Program

Background

In 1998, the Mentally Ill Offender Community Transition Program (MIO-CTP) began in King County, Washington to help mentally ill offenders re-enter the community. The Washington legislature passed RCW 71.24.460 which recognized a lack of counselling, housing and financial support to recently released mentally ill offenders often led to a psychiatric relapse and recidivism. This lack of support, in turn, increased the state's health and correctional costs, threatened public safety and decreased the offender's quality of life (RCW 71.24.460). To address this public policy problem, RCW 71.24.460 authorized funds for a 5 year pilot program, the MIO-CTP, to provide mentally ill offenders with counselling, housing and case management once released.

Washington's financial management office used the recidivism rate of enrollees to determine the MIO-CTP's success. To qualify for funding after the pilot period ended the recidivism rate of the enrollees could not exceed 15%.⁴ In a letter to Senator Joseph Zarelli, the Chair of the Senate Ways and Means Committee overseeing the pilot project, the three

⁴ According to Lois Thadel at the Community Integration Assistance Program of the Mental Health Division in Washington State the 15% target is "embedded in nearly mythological lore". It was an accounting decision that split the difference between data from California's Forensic Conditional Release Program that suggested recidivism rates of MDOs with treatment was 11% to 18%.

departments coordinating the MIO-CTO, the Department of Social and Health Services, the Department of Corrections and the King County Department of Community and Human Services, reported a recidivism rate among enrollees of 14.3%. As a result, Washington State continued funding the MIO-CTP and it is in its ninth year of operation and has an annual budget of \$500,000.

Discharge Planning

The annual reports of the MIO-CTP consistently identify discharge planning as the key component in the program. Discharge planning provides continuity of care for the MDO after incarceration by immediately providing housing, medical appointments and minimizing the delay in their receipt of government benefits. However, before discharge planning begins there is a selection process. The Department of Corrections (DOC) evaluates all mentally ill offenders against the program selection criteria and refers a group of possible candidates to the selection committee. The selection committee consists of representatives from the DOC, the Department of Community and Health Services, and the Department of Social and Health Services - the three departments that co-administer the program. For each candidate the DOC compiles a referral packet for the selection committee that includes the legal history of the offender's crimes, mental health assessments and any other medical information. The DOC transfers the candidates to four launch sites where the selection committee members interview the candidates to determine their interest and suitability. Once the selection committee makes their decisions, and the candidate accepts, the discharge planning process begins.

Discharge planning starts three months before release and consists of several components. The goal of discharge planning is to provide the MDO with a seamless transition back into the community. To achieve this, a "multi-system" team composed of a mental health provider, a DOC Community Corrections Officer, a prison-based DOC staff member and an addictions counsellor develops an individualized treatment plan for each offender. This multi-system team takes into consideration the MDO's mental illness, medication needs, substance abuse, parole requirement (if any) and housing needs when developing the individualized treatment plan. The development of an individualized treatment plan is also a collaborative effort with the MDO. In 2002, MDOs received, on average, 36 hours of discharge planning (Table 9). Discharge planning also provides an opportunity for the multi-system team to develop trust and a therapeutic relationship with the offender.

Table 9: MIO-CTP Hours of Discharge Planning Pilot Period

Year	Total Pre Release Hours	Pre Release Hours Per Person
2003	Not available	Not available
2002 N = 13	470	36.1
2001 N = 14	489	34.9
2000 N = 11	163	14.8
1999 N= 26	308	11.8

Source: Washington State Department of Corrections 2002

The multi-system team also organizes the administrative details of community re-entry such as applying or re-applying for government benefits and co-ordinating housing. Initial appointments with psychiatrists and substance abuse counsellors, who are part of the MDO's team, coincide with the first week or day of release. The team's preparation for release relieves the stress offenders usually face on release and allows them to focus on rehabilitation.

Case Management

Case managers oversee the implementation of the released MDO's (now referred to as the participant) treatment plan by co-ordinating services, providing services and monitoring participation. A participant's case managers provide them with support in many ways - from helping the participant settle into their housing and orientating them to the program to reminding them of their counselling appointments and helping the participant develop their transition plan. The intensity of case management depends on the participant's needs and abilities outlined in their treatment plan. However, every participant's first week is similar.

A participant's first week in the community is a vulnerable time as relapses into crime and substance abuse are common. To mitigate the chances of relapse, the MIO-CTP requests the

participants to remain at their home during the first week unless accompanied by their case manager. On the day of release, the case manager meets the participant at the correctional facility and takes them to their housing where they meet the housing manager and receive an orientation. The case manager then takes the participant shopping for clothing, toiletries, bedding, cookware, groceries and cleaning supplies. The participant usually has an appointment with the Department of Social and Health Services for an interview that completes their application for financial benefits. The rest of the week consists of some administrative tasks, such as meeting the MIO-CTP program staff, obtaining legal identification, and attending appointments with their mental health and substance abuse counsellors. In the first week, the case manager works closely with the participant to ensure they know where to go and what is expected of them. For example, the case manager accompanies the participant to their counselling appointments to ensure they know where to go and how to get there on public transit.

Throughout the participant's time in the MIO-CTP the case manager's main role is to help the participant achieve the goals outlined in their treatment and transition plans. This role takes a variety of forms. For example, a case manager will teach skills, such as cooking, shopping, personal hygiene and banking, to encourage the participant's independence if their history prevented them from developing daily life skills. As the participant reaches their goals in their treatment plan, their case manager will help them develop a transition plan. A transition plan includes goals targeted at helping the participant achieve independent living. A transition plan may include: a mapped strategy for achieving greater self determination, reduction of dependence on formal systems, living in a less structured housing environment, engagement in educational, and employment activities and increased self monitoring of medications. A case manager will support these transition goals by, for example, helping them find employment or re-training programs. Until graduation from the program, the participant receives approximately 4.5 hours of services a week and the case manager conducts at least two home visits per month to help them achieve their treatment and transition goals (See Table 10).

Table 10: Total Post Release Service Hours MIO-CTP Pilot Period

Year	Total Post Release Service Hours	Post Release Service Hours per person
2002* N = 23	5486	238.5
2001 N = 18	4829	268.3
2000 N = 13	4011	308.5
1999 N = 26	3668	141.1

* Formal reporting suspended from 2003 – 2005 due to uncertain funding

Source: Washington State Department of Corrections 2002

Housing

The MIO-CTP arranges the participant’s housing before they are released. The MIO-CTP contracts an organization that specializes in housing former offenders to arrange the housing and participants may qualify for a housing subsidy of up to \$6,600 per year. Initially participants stay at a transition house that provides onsite house management, resident monitoring and clinical services. The participant can move into a less structured living situation once their case manager decides they have adequately adapted to their routine and their mental health is stable. However, independent living may not be achievable for some participants due to a lack of life skills, unstable mental health or substance abuse. In this case, there is a structured housing option that provides meals and other supports for daily living, so the participant can focus on achieving stability.

Initially the program struggled to obtain housing for participants with particular profiles/criminal justice histories such as sex offenders, fire starters and felons. The barriers to housing for these types of offenders include: eligibility criteria – a housing option may not accept felons or participants with behaviour that makes communal living unsafe, participants pose a liability to landlords and communities, and the lack of affordable housing stock. The housing situation improved towards the end of the program’s pilot period after finding an appropriate facility, although sex offenders were still ineligible and more likely to be homeless.

Counselling

The MIO-CTP requires participants to engage in structured programming that includes mandatory mental health treatment and substance abuse counselling if an addiction exists. The program requires participation in a minimum of five group sessions of per week. Mental health and substance abuse professionals and a community corrections officer lead these group sessions. Weekly meetings between the persons providing counselling increases communication and coordination of each participant's treatment plan.

Participation in one group and one individual mental health session per week is mandatory. The focus of the treatment is individually determined, but generally includes relapse prevention, medication compliance and strategies to maintain a good quality of life.

Table 11: Hours of Mental Health Counselling provided during MIO-CTP pilot period per participant

Counselling Service	1999 N = 26	2000 N = 13	2001 N = 18	2002 N = 23
Individual Mental Health	63	170	104	99
Group Mental Health	21	42	39	57
Total hours per person per year	84	212	143	156
Total hours per person per week	1.6	4	2.8	3

Source: Washington State Department of Corrections 2002

The MIO-CTP offers a specialized treatment program to address concurrent disorders, common among participants. The MIO-CTP has two staff members trained in the integrative treatment of con-current disorders. Integrative treatment is onsite and consists of motivation enhancement, preventative intervention and trigger identification. Participants with a substance abuse problem are also encouraged to seek counselling for addiction outside the program through secular programs, such as Alcoholics Anonymous and Narcotics Anonymous, faith based programs or culture based programs.

The MIO-CTP 2006 annual report emphasized the importance of having a Community Corrections Officer (CCO) in the program. The report highlighted how a CCO allows for collaboration between treatment and the community corrections system when a participant is on parole. This collaboration helps maintain some continuity in care for the participant if they violate their parole because the CCO can make recommendations in disciplinary hearings that include input for the participant's multi-system team. The CCO's power to conduct random room searches and urine analysis can help the program staff pre-empt incarceration and address relapse quickly.

Recidivism

In a letter to Joseph Zarelli, the chair of the Senate Ways and Means Committee that oversaw the MIO-CTP pilot, the MIO-CTP reported a 14.3% recidivism rate of participants in the mature program. The rate of recidivism is the percentage of program participants with at least two years in the community post release convicted of a felony or had committed a new felony within the first two years, excluding the first year cohort. The recidivism rate of 14.3% in the final report does not include the recidivism rate of 43% from the first year cohort. The MIO-CTP 1999 annual report identified the high rate of substance abuse among participants and a lack of a drug treatment strategy as the reasons behind the high rate of recidivism in the first year. Recidivism rates dropped in to 9% in the second year with the implementation of a drug treatment strategy (Table 12). However, the decision to exclude the recidivism rate of the first year cohort may have been influenced by the legislative requirement to keep recidivism under 15% to qualify for funding after the pilot period ended. When compared to Lovell, Gagliardi and Peterson 2004 findings that the recidivism rate among MDOs are 41% it appears that participation in the MIO-CTP reduced the likelihood of recidivism.

Table 12: Recidivism Rates of MIO-CTP during pilot period

Year	Recidivism Rate of MIO-CTP cohort
2002 ⁵	0.0%
2001	7.1%
2000	9.1%
1999 ⁶	42.3%

Source: Washington State Department of Corrections 2002

In the three years since the pilot program ended in 2003 recidivism rates among participants in the MIO-CTP have risen (Table 13). The MIO-CTP conducted a focus group with staff members from the three departments in June 2006 to investigate this trend. The focus group revealed five programming problems that may have contributed to this rise in recidivism among participants: lack of program development and review, the termination of the selection process, uncertain funding, the removal of the Corrections Officer from program team and lack of housing for sex offenders.

The focus group attributed the lack of program development and review to the loss of institutional knowledge among the staff. Program development and review proved crucial in the first year of the program when MIO-CTP staff decided to implement an integrative drug treatment program to address the influx of participants with co-occurring mental health and substance abuse disorders.

Funding for the MIO-CTP was uncertain from 2003 - 2005. In 2003 when the pilot program ended, referrals and enrolments were suspended for six months while the state legislature reviewed the program. Once funding was reinstated staff terminated the selection process because enrolment was low and the selection process was lengthy and delayed enrolment. The decision to end the selection process coupled with the proliferation of voluntary programs post release offered by the Department of Corrections decreased the pool of participants ideally suited for the program.

⁵ This data represents less than 12 months in the community

⁶ The results of the 1st year cohort are not representative of the MIO-CTP's current programming and not including in subsequent analyses

A structural change in the Department of Corrections resulted in the replacement of the Community Corrections Officer (CCO) with Risk Management Specialists (RMS) in 2005 and disrupted the coordination and treatment process. The focus group determined this change had a negative impact on the quality of the program's treatment and thus the stability of the participants' mental health. The MIO-CTP uses a housing complex, Berkley House, that has video monitoring of activity to ensure treatment compliance. However, sex offenders are not allowed at Berkley House due to its close proximity to a school, so participants with a history of sex offences are housed at alternative housing facilities with limited monitoring system. Lack of monitoring at these alternative housing facilities hinders the case manager's ability to pre-empt relapses among participants. This in turn resulted in more substance use violations and evictions that led to homelessness and compromised the participants ability to succeed in the MIO-CTP.

Table 13: Recidivism Rates of MIO-CTP since 2003

Year	Recidivism Rate of MIO-CTP cohort
2006	34.7%
2005	23.8%
2004	13.9%

Source: Washington State Department of Corrections 2005, 2006

Administration

A review of the available annual reports⁷ revealed 3 main areas where the MIO-CTP developed best practices in program administration:

1. Inter-departmental communication

- Institutional knowledge among staff members enabled them to work across systems and access and co-ordinate services easily
- Achieved by staff learning other departments' goals, regulatory requirements and procedures through participation on various inter-departmental committees, inter-departmental meetings

2. Program development

⁷ Annual reports from 2001, 2002, 2005 and 2006 are available. Annual reports from 1999 and 2000 have been archived and are not available. Annual reports were not required by the legislature in 2003 and 2004.

- Introduce and improve services and protocols to respond to the needs of the participants and ensure the program meets its goal of reducing recidivism
- Achieved through frequent program review and development
- Examples of service development: introduction of concurrent disorder counselling after first year recidivism rates 42%, employment training, improved participant access to government benefits, introduction of art therapy and a women's group
- Example of protocol development: stream lining program administration through introduction of the Multi-System Care plan for the discharge component and development of a wait list

3. Staff Development

- To support inter-departmental communication needed to ensure institutional knowledge is not lost
- Achieved by formal bi-weekly staff meetings to discuss issues or problems concerning service delivery for the participants and training two staff members as chemical dependency counselors – an upgrade from their certificate status.

Additional Services

MIO-CTP introduced employment services to their participants in the last two years of the pilot program, a service not identified by this study as a component of a transition program to measure the dependent variable. A staff member specializing in vocational services runs employment groups that teaches participants skills and motivates them to gain employment, volunteer work or pursue education. Participants have worked in construction, administration, coffeehouses and restaurants as well as completed their GED, dietician programs and musical studies.

4.3 Crime Abatement Rehabilitation/Recovery Enhancement Services

Background

In 1998, the California State Sheriffs Association and Mental Health Association of California sponsored legislation, SB 1485, to create the Mentally Ill Offenders Crime Reduction

Grant program (California Board of Corrections, 2002). The MIOCRG program awards grants to counties to support “the implementation and assessment of multi-agency demonstration projects designed to curb recidivism among mentally disordered offenders” (California Board of Corrections, 2002). To be eligible for a MIOCRG grant counties must submit a proposal illustrating need and provide a comprehensive plan. All grant recipients must track five criminal justice outcomes, number of bookings, number of convictions, jail days, Global Assessment of Functioning (GAF) scores and hospital inpatient days, to help MIOCRG determine the success of their program. The California legislation allocated \$32 million for 2001 – 2004 grant period.

MIOCRG awarded Tuolumne County \$520,266 to implement a pilot program, the Crime Abatement Rehabilitation/Recovery Enhancement Services (CARES), from July 2001 – June 2004 to address the county’s large mentally ill offender population, uncoordinated forensic mental health service system and jail overcrowding. In 2000, mentally ill offenders comprised approximately 30% of Tuolumne’s jail population and two-thirds of the inmates had re-offended three or more times indicating a severe problem of recidivism among mentally ill offenders in Tuolumne. The Sheriff’s Department, the Probation Department and the Mental Health Department administer the program. The CARES program managed twenty-three participants over the three-year pilot period. Three participants in the CARES program re-offended during the pilot period, for a recidivism rate of 13%. Two participants had outstanding warrants for crimes committed before the program that resulted in their arrest during their participation. The MIOCRG program renewed funding to CARES in 2006.

As mentioned in the methodology section of this study, transition programs reports consist mainly of qualitative data. The CARES program did not collect quantitative data on the components of the program like the MIO-CTP, but did collect qualitative data. Quantitative data on the recidivism rates of the CARES cohort is available. Therefore, this case study can only fulfil the methods for measurement for the independent variables in Table 8 and for the dependent variable in Table 7.

Discharge Planning

The selection process is the first step in discharge planning. The CARES eligibility criteria are: the participant must be booked into jail, eligible for felony probation and a resident in the county for a year and a half. The average number of days in jail a participant served before release into the CARES program was 166 days. CARES’ requirement of felony probation makes participation in the program a condition of their probation, meaning non-compliance with any aspect of the program is a violation and could result in jail time. The requirement of felony

probation gave the staff tools to make a difficult and high-risk population to comply with treatment. A trade-off was that this requirement disqualified misdemeanants from the program and resulted in too few felons who met the enrolment criteria, resulting in only 23 participants when the program was capable of managing 30. The jail classification officer, a CARES staff member who works in the jail, identifies and assesses the incarcerated people who met the basic eligibility requirements. After the jail classification officer screens the candidates and gathers their pertinent information, such as medical history, residency and medications, at least two CARES staff members meet with the candidate to assess their suitability. CARES staff discusses the program with the candidate and finds out their mental health, housing, employment and financial needs. If CARES accepts the candidate into the program they must sign a consent form agreeing to: actively participate in all individual and group sessions, abstain from alcohol and drugs 24 hours before any individual or group session, comply with the probation terms and participate in intensive case management. If the candidate accepts these terms, they enter into the program and begin to receive services.

Once accepted, the MDO begins the discharge planning process. The external and internal case managers, in consultation with the MDO create a treatment plan outlining the needs of the MDO, so services can be co-ordinated before their release. Discharge planning typically addresses “medication, housing, finances, education, transportation, completion of legal obligations, medical and dental care, psychiatric and psychological need, counselling, family and relationship issues” and any other need identified by the team. Each treatment plan is individualized, so the services provided vary. However, each participant, at minimum, receives mental health counselling, probation surveillance, and housing, vocational and medical assistance.

Case Management

CARES offers case management while the MDO is in jail and after incarceration. Throughout the MDO’s incarceration, they receive “stabilizing services” from the internal CARES case manager. The Tuolumne County Jail offers no mental health treatment, so the internal case manager provides MDOs accepted into the program with mental health and substance abuse counselling, medical and psychiatric care, and symptom and life management. The internal case manager works with the external case manager to create a continuum of care for the MDO and ease their transition into the community.

After incarceration, the external case manager takes over from the internal case manager and begins to oversee the MDO’s, now referred to as the participant, treatment and progress in the

program. For the first two weeks, the external case manager meets bi-weekly with the participant and assists them in applying for government benefits, obtaining identification and securing stable housing. The external case manager accompanies the participant to all their medical and social service appointments as needed as well as helps the participant to buy clothing, groceries and household items. After the first two weeks, the external case manager meets weekly with the participant for the duration of their time in the program. The external case manager runs internal sessions with participants on mental health, con-current disorders, symptom management and life management as well as connects participants to external services in the community. If necessary, the case manager arranges for medication support services that include ordering prescriptions, medication delivery and monitoring medication compliance. Finally, the external case manager helps the participant develop and meet the short-term and long-term goals outlined in their treatment plan.

Housing

The CARES program works with local agencies to provide safe housing where sobriety is mandatory for the participants. External case managers assist participants in finding a suitable shelter, securing leases, paying rents, purchasing and repairing household items, developing relationships with landlords and improving housekeeping skills. Participants do not receive a subsidy, but the program does provide each participant with first and last month's rent. House visits occur at least twice a month to monitor participants' situations.

The multiple responsibilities of the program administrators prevented them from developing robust community housing options. Tuolumne is a small, rural county with a population of 60,000 and no public housing facilities. Housing resources remained scarce throughout the program. As a result, CARES staff utilized shelters and transition homes immediately after incarceration until they could arrange more stable permanent housing. The small community in Tuolumne allowed CARES staff to also make personal connections with landlords to get them to provide housing. The CARES final report identified that landlords responded well to the fact that participants were on probation and in the CARES program as they could call a probation officer or a CARES case manager if there were any problems.

Counselling

Participation in counselling is mandatory in the CARES program. CARES team members offer individual mental health counselling to participants that may involve their families if possible and appropriate. CARES team members also provide education related to the

participant's mental disorder, proper use of medication and side effects. If a participant has a concurrent disorder, the CARES team members also supply integrative treatment to address the participant's mental health and substance abuse disorder holistically. CARES team members also refer participants to external substance abuse counselling, such as a dual diagnosis group, Alcoholics Anonymous or Narcotics Anonymous.

Recidivism

During the three years of the CARES program's pilot period there were 23 participants, 15 females and 8 males. Three participants re-offended and two participants were arrested on existing warrants for crimes committed before their entry into the program. The participants arrested on warrants for crimes committed prior to entry into the program are not calculated in the recidivism rate because the crime was not committed while in the CARES program. The total recidivism rate for the CARES cohort over 3 years was 13%.

Administration

The CARES' Final Program Report identified one area of best practices in administration of the program:

1. Inter-agency cooperation

- The CARES' staff knowledge on each agency's limitations and abilities allowed them to better collaborate in the best interest of the client
- Achieved by: team building – inter-agency commitment to share information and collaborate through the planning process, staff training and “learning by doing” through interactions with members of other agencies

Additional Services

The CARES program provides additional services to their participants than identified by this study as a component of a transition program. The CARES team provides education services assisting participants in completing their GED. They also conduct evaluations on their interests and skills to develop an individualized education plan. The CARES program collaborated with the Amador-Tuolumne Community Action Agency to teach life skills such as fiscal management, personal hygiene, accessing support and services and time management in weekly group sessions. Topics for these group sessions included grocery shopping and cooking, purchase and care of clothes, use of transportation and help with social and family relationships. The CARES team

also provided sexual health education and reproductive counselling. Finally, the CARES program offered vocational assistance. Vocational assistance included work-readiness training, resume writing, skills acquisition and job search techniques. To enhance the participants' skill-set, team members organized volunteer and vocational opportunities, educated employers, and acted as job coaches.

4.4 Best Practices Identified from Case Studies

Table 14 summarizes the best practices of the transition components derived from the two transition programs, their weaknesses, strengths and applicability to British Columbia. Table 15 summarizes the best practices of the additional components found in the two transition programs.

Table 14: Best Practices of Transition Program Components

Best Practice	Weaknesses	Strengths	Applicability to British Columbia
Discharge Planning			
<p>Eligibility Criteria</p> <ul style="list-style-type: none"> ○ Evaluates candidates against a specific set of criteria that describes the target population 	<ul style="list-style-type: none"> ○ CARES criterion of probation would exclude MDOs released on a warrant expiry & cause a BC program to miss the target population 	<ul style="list-style-type: none"> ○ Effective way to target the MDO population, give staff enough time to complete discharge planning and screen for suitable candidates 	<p>Applicable</p> <ul style="list-style-type: none"> ○ Parole or probation should not be an eligibility criterion ○ Should set a minimum sentence length of 60 days to give staff enough time to complete discharge planning or third offence to target repeat offenders
<p>Selection Process</p> <ul style="list-style-type: none"> ○ Correctional Staff refer candidates to transition program staff. ○ Transition program staff reviews candidates' medical and criminal records and interview them 	<ul style="list-style-type: none"> ○ MIO-CTP's practice of transferring MDOs to a launch site for interviews ○ In BC, MDOs sentences are too short and the time to transfer an inmate is too long for the MIO-CTP selection process to be feasible 	<ul style="list-style-type: none"> ○ BC jails already have classification officers who can identify possible candidates 	<p>Applicable</p> <ul style="list-style-type: none"> ○ A centralized, province wide program might not be feasible ○ Concentration of jails in Vancouver / Fraser Valley allows staff to travel to evaluate candidates

Best Practice	Weaknesses	Strengths	Applicability to British Columbia
<p>Discharge Planning</p> <ul style="list-style-type: none"> ○ Identify participants' needs in terms of housing, counselling, financial assistance and health care 	<ul style="list-style-type: none"> ○ None 	<ul style="list-style-type: none"> ○ Allows the case manager to organize services for release date ○ Provides a continuum of care and structure for the participant ○ Minimizes delay in receipt of benefits, housing and services 	<p>Applicable</p>
<p>Case Management</p> <ul style="list-style-type: none"> ○ Co-ordinates external services, monitors participation, provides crisis support / services and manages treatment plan 	<ul style="list-style-type: none"> ○ None 	<ul style="list-style-type: none"> ○ MIO-CTP shared caseload allows for specialization ○ A proven method to successfully deliver mental health services 	<p>Applicable</p> <ul style="list-style-type: none"> ○ Regional Health Authorities already provide case management, so there exists institutional knowledge of implementation
<p>Counselling</p> <ul style="list-style-type: none"> ○ Individual and group mental health and concurrent disorder counselling offered by program staff ○ External substance abuse support groups encouraged 	<ul style="list-style-type: none"> ○ None 	<ul style="list-style-type: none"> ○ Participants gain skills to stop addiction and manage their mental health 	<p>Applicable</p>
<p>Housing</p> <ul style="list-style-type: none"> ○ Provide housing for participants or assistance securing housing ○ Provide some financial support towards housing 	<ul style="list-style-type: none"> ○ Financial assistance increases total cost of program 	<ul style="list-style-type: none"> ○ Financial assistance increases stable housing options 	<p>Applicable</p> <ul style="list-style-type: none"> ○ Lack of affordable public housing in BC for MDOs might make it difficult for staff to find appropriate housing

Table 15: Best Practices of Additional Transition Services

Best Practice	Weaknesses	Strengths	Applicability to British Columbia
<p>Administration</p> <ul style="list-style-type: none"> ○ Mechanisms, such as regular meetings, to ensure effective collaboration between the departments involved in program ○ Staff development, such as understanding procedures of other departments, to ease service delivery ○ Bi-annual program development to ensure program is meeting mandate and needs of the participants 	<ul style="list-style-type: none"> ○ Co-ordinating of meetings between departments is time intensive 	<ul style="list-style-type: none"> ○ All departments' actions are co-ordinated and services delivery is efficient 	<p>Applicable</p> <ul style="list-style-type: none"> ○ Must be a clear mandate that outlines roles and responsibilities and system of decision making to avoid deadlock and conflict
<p>Vocational Support</p> <ul style="list-style-type: none"> ○ Teach participants how to job search, write a resume and act in an interview ○ Co-ordinate volunteer positions & work training programs so participants can gain marketable skills 	<ul style="list-style-type: none"> ○ None 	<ul style="list-style-type: none"> ○ Increase chances of employment which would decrease reliance on public system 	<p>Applicable</p>
<p>Education Services</p> <ul style="list-style-type: none"> ○ Co-ordinate opportunities for participants to complete their GED and pursue higher education ○ Develop an education plan 	<ul style="list-style-type: none"> ○ None 	<ul style="list-style-type: none"> ○ Participants gain skills that help them become more independent 	<p>Applicable</p>

Best Practice	Weaknesses	Strengths	Applicability to British Columbia
Life Skills <ul style="list-style-type: none"> ○ Educate participants on daily life skills including: hygiene, cooking, shopping, fiscal management and transportation use 	<ul style="list-style-type: none"> ○ None 	<ul style="list-style-type: none"> ○ Participants gain skills that help them become more independent 	Applicable

4.5 Summary of Findings

The case studies show that a transition program is an effective method to reduce recidivism among MDOs. On average, 13% of MDOs in the two transition programs re-offended compared to the recidivism rate of 41% of MDOs who do not receive services (Lovell, Gagliardi and Peterson, 2004). The best practices derived from the case studies reveal that, with some modification, the components of a transition program are applicable to British Columbia. Discharge planning is the component that needs the most modification to make sure it addresses the target population of this study. The CARES program eligibility criterion requiring participants to be on probation is not applicable to BC because the population of MDOs in need of transition services are released on a warrant expiry. As such, the eligibility criteria for BC should be set at a minimum sentence length of 60 days or the offender's third offence to ensure staff can create a discharge plan without compromising the program's ability to include its target population. The case studies also provide valuable best practices to deal with housing shortages, especially the CARES program that creatively worked with landlords to develop their own housing stock. The remaining components, case management and concurrent disorder counselling, need no modification.

The finding that both transition services provided employment, education and life skills services introduces components of a transition program not included in the original scope of this study because the literature on FACT did not cite them as essential to community re-entry. However, there is literature claiming employment reduces recidivism (Buck 2000; Seiter & Kaldela, 2003). Brucker (2006) supports the transition programs' decision to provide employment services to participants stating, "Participation in the labour force has the potential to boost self-esteem" and "is an important measure of the success of offender re-entry." Furthermore, an interview (Interview B 2007) with an occupational therapist at one of the

Regional Health Authorities outlined how important education, employment and recreational services can be to a person with mental disorders. The case studies' inclusion of employment and education services warrants their consideration in any proposed policy alternative.

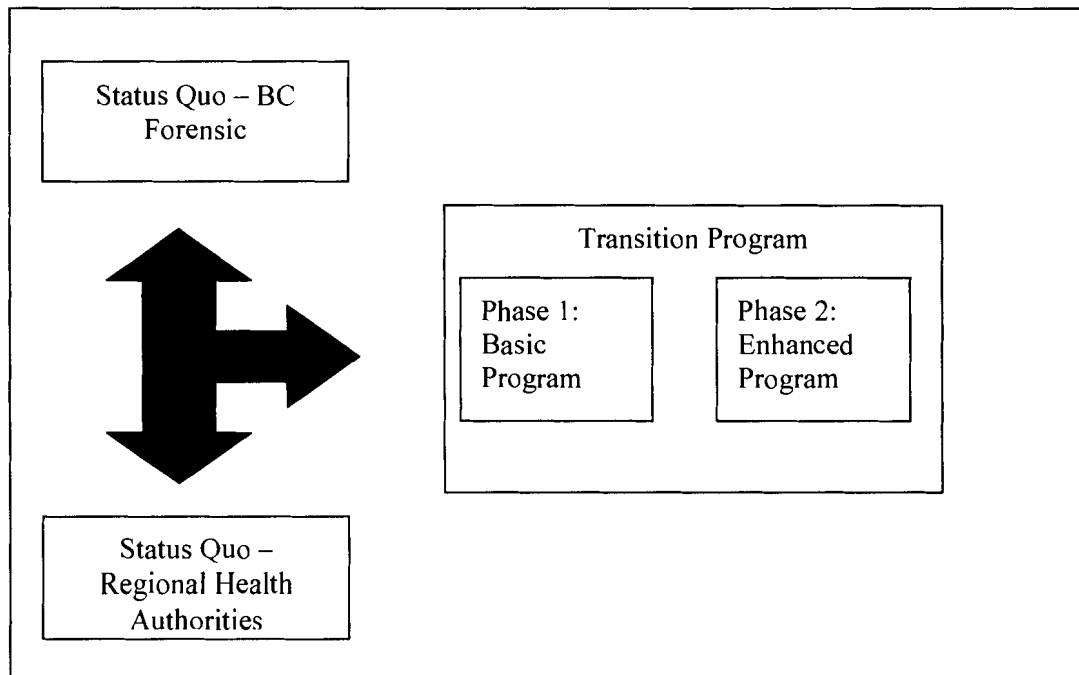
The additional findings also reveal an important component essential to a transition program's success not found in the literature review – inter-ministerial organization. The case studies show the key to a transition program's success is the ability to get the mental health and justice systems to expand their involvement in the treatment of MDOs outside their traditional mandates. The mental health system must be involved in the selection and discharge planning process before release and the justice system must be involved in the treatment of MDOs when they are in the community. This requires a high level of communication and collaboration between the two systems so they can align their goals and determine their different responsibilities.

5 Policy Alternatives

5.1 Introduction

This section presents alternatives, derived from the case studies, to address the lack of transition services in BC to aid the community re-entry of MDOs. The alternatives are situated among the status quo of services available to MDOs through BC Forensic and the Regional Health Authorities (Figure 2). The alternative of a Transition Program is divided into two separate phases. The first phase, termed the Basic program, focuses on reducing recidivism in the short run by providing “core services” of discharge planning, case management, counselling and housing. The second phase, the Enhanced program, includes the components of the Basic program and builds on them by offering services such as vocational training and education services targeted at increasing the participants’ independence and decreasing their reliance on government benefits.

Figure 1: The Continuum of Alternatives



5.2 Status Quo

5.2.1 BC Forensic Psychiatric Services Commission

Goals:

- To serve clients court-ordered to receive treatment

Target Population:

- People with mental illness who, as a probation or parole requirement, are court-ordered to seek treatment
- People found Not Criminally Responsible due to Mental Disorder (NCR-MD)

Policy Mechanisms:

- Psychiatric assessment to determine if a person is NCR-MD
- Hospitalization of people determined to be NCR-MD where they receive psychiatric treatment and rehabilitation services
- Housing at Willingdon House for people determined to be NCR-MD after hospitalization
- Case management for MDOs who are court-ordered to receive treatment for their mental disorder
- Treatment for MDOs who are court-ordered to receive treatment for their mental disorder
 - Treatment provided by psychiatrists, psychologists, social workers, nurses and rehabilitation specialists
 - Treatment may include counselling, life skill training and employment services

Actors:

- BC Forensic Psychiatric Services
- BC Justice System

Timeline:

- Currently available

5.2.2 BC Ministry of Health & The Regional Health Authorities

Goals:

- *Assertive Community Treatment:* to enable individuals with serious mental illness to live independent and self-sufficient lives in the community by receiving treatment in their own environment and appropriate to their needs
- *Clinical Case Management:* to enable individuals with mental illness to live independent and self-sufficient lives in the community by referring clients to treatment services in a clinical setting
- *Both service delivery models:* To reduce the need for hospitalization and decrease demand on emergency, acute care, forensic and transitional housing services

Target Population:

- *Assertive Community Treatment:* individuals with serious and persistent mental illness and accompanying functional disabilities who are intensive users of the health care system
- *Clinical Case Management:* individuals with serious mental illness who are not intensive users of the health care system

Policy Mechanisms:

Broad

- Guidelines: Ministry of Health published a document on Assertive Community Treatment (ACT) that outlines the benchmarks, program structure, goals, objectives and outcomes from which each Health Authority must base their program design; Each Regional Health Authority has their own guidelines to mental health services to aid referral for clinical case managers
- Regional Health Authorities: each Health Authority provides some aspects of ACT and clinical case management; each Health Authority adapts the Ministry's guideline to the specific needs and resources of their region

Specific⁸

- Specialized services to address the client’s vocational, education, social, recreational, housing and other personal needs
- Enhancement of services and community supports
- Advocacy for clients

Actors:

- Ministry of Health
- Regional Health Authorities: Fraser Health Authority, Vancouver Coastal Health Authority, Northern Health Authority, Vancouver Island Health Authority, Interior Health Authority

Timeline:

- Currently Available

5.3 Transition Program

Overarching Goal:

- To reduce recidivism among participants and enable them to live independent and self-sufficient lives in the community

5.3.1 Phase 1: Basic Transition Program

Goal:

- To reduce recidivism among participants

Target Population:

- Mentally Disordered Offenders released from incarceration on a warrant expiry.

Policy Mechanisms:

Broad

⁸ Each Regional Health Authority differs in the specific services offered to mentally ill adults. These examples come from Fraser Health.

- Ministry of Health, Public Safety and Solicitor General, Employment and Income Assistance and BC Forensic Psychiatric Services collaborate to create guidelines on the operation and intended outcomes of a transition program
- Implement a pilot transition program in Vancouver Island Health Authority and either Vancouver Coastal or Fraser Health Authority
- Transition staff receive specialized training

Specific

- Discharge planning while the participant is incarcerated: requires co-ordination with Correction officials to identify eligible candidates and a selection committee to interview candidates, Correction staff and transition staff collaborate to establish the process of evaluation
- Eligibility criteria: participant must be incarcerated for a minimum of 60 days or for their third offence to ensure staff have enough time to discharge plan without making the target population ineligible
- Housing for participants after incarceration if available and the participant requires supported public housing
- Assistance securing housing for participants if supported public housing is not available or if participant is able to live independently
- Case management to co-ordinate, organize and provide services/treatment
- Counselling for mental health and concurrent disorders: individual and group therapy

Actors:

- Ministry of Health, Public Safety and Solicitor General and Employment and Income Assistance
- Regional Health Authorities
- BC Forensic Psychiatric Services

Measures of Successful Implementation:

- The recidivism rates of participants are lower than the control group over the pilot period

- The majority of participants obtain / maintain sobriety over the pilot period: this may be measured by incidences of relapse via self-reporting and observation by transition staff
- The majority of participants maintain stable mental health over the pilot period: this may be measured by medication compliance, incidences of relapse and self-reported improvement
- The majority of participants secure / maintain stable housing over the pilot period
- Semi-structured interviews or focus groups with the participants to discover their conceptions of successful community re-entry, personal accomplishments and level of satisfaction with the program
- Semi-structured interviews or focus groups with the staff to discover the effectiveness of programming and their conceptions of participants' success

Timeline

- Pilot program runs for 4 years

5.3.2 Phase 2: Enhanced Transition Program

Goal:

- To enable participants to live independent and self-sufficient lives in the community

Target Population:

- Mentally Disordered Offenders released from incarceration on a warrant expiry

Policy Mechanisms:

- Same broad and specific mechanisms as the Basic Transition Program
- Vocational services: such as resumé composition, interview techniques, coordinated volunteer opportunities & job search
- Education services: such as assistance coordinating/applying for General Equivalency Degree, college and/or trade classes

- Life skills: such as help shopping, cooking, cleaning, managing finances and transportation

Actors:

- Same actors as the Basic Transition Program

Measures for Successful Implementation:

- A decrease in the number of participants on government support (Disability and Welfare) over the pilot period
- An increase in the number of participants working part and full time over the pilot period
- An increase in the education level of participants over the pilot period
- An increase in the level of independent functioning of the participants over the pilot period
- Semi-structured interviews or focus groups with participants to discover their conceptions of success in education, employment and life-skills

Timeline:

- An occupational therapist in one of the Regional Health Authorities recommended the enhanced and basic transition program be implemented together to provide a holistic approach to community re-entry (Interview B, 2007). However, if political will weak or financing limited the enhanced program may be introduced after a period of time.

6 Criteria and Measurement

This section defines the criteria used to measure each policy alternative. The measurement of each policy alternative using objective criteria facilitates fair comparison and evaluation. Two of the four criteria are the most important – “recidivism” and “cost effectiveness”. A low recidivism rate is essential to the program’s success. A decrease in recidivism indicates a reduction in crime and avoidance of jail time. It indirectly indicates an improvement in the quality of life of the person with a mental illness both of which are the main goals of a transition program. When examining social policy and introducing the possibility of providing more services to a population it is crucial to examine the cost effectiveness of the alternative to ensure the alternative is not going to overburden the system.

Each criterion will be measured using dollars, percentages or “poor, fair and good”. Recidivism will be measured using percentages. Dollars will measure cost effectiveness. “Poor, fair and good” will measure political feasibility, public acceptance and administrative ease. A “poor” rating is defined as the alternative did not meet the criterion. If an alternative receives a rating of “fair”, it means the alternative did meet the criterion, but there was some uncertainty on the alternative’s strength. Finally, if an alternative receives a rating of “good” it means the alternative did meet the criterion and there was no uncertainty on the alternative’s strength.

6.1 Recidivism

The literature review of this study established that the goal of a transition program is to aid MDOs in successful community re-entry, for which recidivism is a proxy. Therefore, it is crucial that the transition program decreases recidivism for it to be an effective method to address the policy problem. This study defines a decrease recidivism as a total recidivism rate below 41%, which is the rate of recidivism Lovell, Gagliardi and Peterson (2004) established, of MDOs who receive no services upon release.

6.2 Cost Effectiveness

This criterion measures the cost effectiveness of the transition program by comparing the costs per 100 MDOs who do not receive services, or the status quo, to the cost per 100 MDOs

who participate in a transition program (Figure 2). The cost effectiveness of each alternative will be determined using back-of-the-envelope calculations based on the average yearly cost of running a transition program. This is based on the budget of the two case studies, the average number of participants in 2003 of both transition programs and yearly incarceration costs in BC for men. The figures will come from the budgets of the case studies and represent the yearly cost of the alternative based solely on incarceration and transition program costs. This estimation does not include personal costs such as probability of employment and quality of life or other social costs such as policing, court time, remand time, health care or reduction in crime rate. As such, this criterion will not represent the full savings a transition program might provide to ministries working with MDOs because incarceration is only one of the many services used by an MDO. To understand the full scope of a transition program's cost effectiveness these personal and social costs should be included. However, this is beyond the capabilities of this study, but should be available in summer 2007 once CARMHA has completed their analysis of inter-ministry service utilization data. When this data becomes available, cost effectiveness should be re-evaluated.

Figure 2: Formula for Cost Effectiveness

1. Formula for Total Cost of Status Quo:

$$(MDOs \text{ who re-offend}) (Jail \text{ cost per year}) = TC$$

2. Formula for Total Cost of a Transition Program:

2a.

$$\frac{\text{Cost of transition program per year}}{\text{Average number of participants per year}} = \text{Average cost per participant per year (ACP)}$$

2b.

$$(MDOs \text{ who re-offend})(ACP + Jail \text{ cost per year}) + (MDOs \text{ who do not re-offend})(ACP) = TC$$

6.3 Political Feasibility and Public Acceptance

This criterion measures two types of acceptance needed to implement a new program – political and public. First, the criterion will determine whether the ministry of Health and Public Safety and Solicitor General would support this initiative based on their documented goals and responsibilities on the provision of mental health services (Table 16). The goals of the Ministry of Health and the Regional Health Authorities align because the Ministry of Health sets province-wide goals, standards and performance agreements for health service delivery by the health authorities. This criterion also measures the public acceptance of the alternative based on Jimenez’s (2005) study of “not in my backyard” or NIMBY attitudes of Lower Mainland residents towards Special Needs Residential Facilities (SNRF) and disability community groups mandates. SNRFs provide care, supervision, counselling, information, referral, advocacy, or health care services for people with problems related to physical or mental disabilities, psychiatry, drug or alcohol addictions, legal custody, emergency or crises.

Table 16: Goals and Responsibilities of Selected Ministries

Ministry	Goals
Health Mental Health and Addictions	<ul style="list-style-type: none"> ▪ to better support people with severe mental illness ▪ to enable them to live successfully in the community ▪ to improve their level of independence and quality of life
Public Safety and Solicitor General	<ul style="list-style-type: none"> ▪ protect citizens and communities from crime ▪ enhance public safety ▪ safeguard the public interest through regulatory programs

Sources: Ministry of Public Safety and Solicitor General 2007 & Ministry of Health 2005

6.4 Administrative Ease

This criterion measures if the policy alternative is complex in design, implementation and administration. Elite interviews and government documents will be used to determine the alternative’s administrative ease.

7 Evaluation of Policy Alternatives

Table 17: Evaluation Matrix

Criteria	Status Quo	Transition Program	
	BC Forensics Services Commission and BC Mental Health Services	Phase 1: Basic Transition Program	Phase 2: Enhanced Transition Program
Decreases Recidivism	- Rate of recidivism for MDOs without services: 41%	Rate of recidivism in the MIO-CTP and CARES programs: 13 – 24%	GOOD At least same results as Basic Program
Cost Effectiveness	2 million	2 – 2.6 million	FAIR Depending on the services offered costs will be higher
Administrative Ease	GOOD No change necessary	FAIR - BC lacks public housing for MDOs - Inter-ministry collaboration complex	FAIR - Same as Basic program - More services increases complexity
Public Acceptance	FAIR - Public pressure to address the problems in the Downtown Eastside increasing	FAIR - Public likely to be “NIMBY” about housing for MDOs - Disability groups likely to support	FAIR - Same as Basic Transition program
Political Feasibility	FAIR - Does not align with government’s goals and responsibilities	FAIR - Aligns with departments goals	FAIR Same as Basic Transition Program

7.1 Status Quo

The status quo does not effectively reduce the rate of recidivism among MDOs. This criterion reveals the main problem with the status quo is a service gap for the majority of the MDO population. The recidivism rate for MDOs who do not receive mental health services upon release is 41% (Lovell, Gagliardi and Peterson, 2004). BC Forensics provides transition services to the MDOs population court-ordered to receive treatment on probation or parole. However, the majority of the MDO population are released on a warrant expiry and are ineligible to receive services from BC Forensic. This population is eligible for mental health services administered by the Regional Health Authorities, but studies show that they are ineffective at reducing recidivism. Academic studies reveal ACT and clinical case management, the current method of mental health service delivery used by the Regional Health Authorities, have no effect on the recidivism rates of 70% of clients, decreases recidivism rates of 20% of clients and increases recidivism among 10% of clients (Mueser et al., 1998, Bond et al., 2001, Lamberti et al., 2004). MDOs need specific services targeted at reducing recidivism and the majority do not receive these services under the status quo.

The status quo is also not cost effective compared to the Basic Transition program alternative. Per hundred people, the cost of the status quo, a 41% recidivism rate among MDOs, is the same as the cost of a basic transition program that has a recidivism rate of 13% - 2 million dollars (Appendix C). The cost effectiveness criterion is an extremely conservative estimate and does not include personal and social costs, so the cost effectiveness of the status quo is likely much lower than estimated. This criterion is a powerful result because it indicates the status quo is not an effective use of resources and the basic transition program is a viable, cost effective alternative. However, cost effectiveness of the transition program alternative may decrease if the cost of building additional housing is included.

In the short run, maintaining the status quo is administratively easy and has few political consequences. However, in the long run there may be political consequences to inaction. An interview with a social worker with 15 years experience in the justice system states he has seen few changes in mental health policy and minimal consequences for the government (Interview A, 2007). However, the abundance of poverty, mental illness, crime, drug addiction and homelessness in the Downtown Eastside is increasingly gaining more media attention. In 2004,

the Genie award-winning documentary *FIX: The Story of an Addicted City* followed the campaign to establish Canada's first safe injection site in Vancouver and exposed Vancouver's thriving drug scene (National Film Board of Canada, 2006). Media coverage of the Robert Pickton murder trial has shone a spotlight on the problem of drug abuse, violence and prostitution among women in the downtown eastside (CTV 2007, CBC 2007). As the 2010 Olympics approach, public pressure to address the social problems in the Downtown Eastside may increase. Inaction on this public policy problem has few political consequences in the short run, but may turn into a significant criticism and political issue in the long run.

In addition, the expressed roles and responsibilities of the Ministry of Health, Public Safety and Solicitor General are not met under the status quo. The Ministry of Health's three main goals regarding mental health and addictions are to better support people with severe mental illness, to enable them to live successfully in the community and to improve their level of independence and quality of life. Under the status quo, there is little support for the majority of MDOs upon release as almost half of them re-offend which compromises their independence and quality of life. In regards to MDOs, the Ministry of Public Safety and Solicitor General is not protecting citizens and communities from crime. The Ministry of Public Safety and Solicitor General's failure to ensure continuity in mental health care for the majority of MDOs after incarceration may contribute to more crime. The failure of the Ministry of Health and Public Safety and Solicitor General to fulfil their mandate regarding MDOs could be fodder for any political or public criticism on inaction.

7.2 Basic Transition Program

Compared to the status quo, the Basic Transition Program successfully reduces recidivism at a lower cost than the status quo. The evidence from the case studies show that by offering core services such as discharge planning, housing, concurrent disorder counselling and case management the recidivism rates among people with mental illness after incarceration ranges from 13% - 23%. At a 13% recidivism rate, the Basic Transition Program is as cost effective as the status quo based on incarceration costs alone. If further personal and social costs were included, the cost effectiveness of this alternative would significantly increase. At the high end of the recidivism range, 23%, the cost effectiveness is \$600,000 more than the status quo. In addition, the budgets of the case studies used to calculate the cost effectiveness of the Basic Program include education and employment services. I could not separate these costs because the employees' time providing services were not itemized – for example, CARES employees who

provide education and employment services provide counselling and case management. Since the Basic Transition Program does not include education and employment services the cost effectiveness of this alternative may be even higher than estimated. These two key criteria show that the Basic Transition program is a strong alternative to the status quo.

This alternative is not easy to administer because of the lack of available public housing in BC and the complexity of inter-ministerial collaboration. Residential, supervised housing is a crucial component to a transition program because MDOs are extremely vulnerable to recidivism in the first two weeks after incarceration and have difficulty securing housing due to the stigma surrounding their criminal record and mental health (Hartwell, 2005, Link, 1997, Page, 1977). Currently, there are 2,190 housing spaces for the mentally ill in British Columbia and a 750 person formal wait list: a 3 to 4 year wait list (Morrow et al., 2006, Interview B, 2007). The Canadian Centre for Policy Alternatives estimates the need for housing to be much higher because the wait list does not reflect people who are homeless, under-housed and not on the wait list (Morrow et al., 2006). When housing becomes available, the Regional Health Authorities' mental health teams often allot it to clients they perceive as the most likely to succeed at independent living, a demographic that rarely includes mentally disordered offenders (Morrow et al., 2006, Interview A, 2007). A social worker in one of the Regional Health Authorities explains how this approach causes fewer services to be available to a person with mental disorders who develop more problems, such as substance abuse and a criminal history (Interview A, 2007). A lack of public housing may compromise the Basic Transition program's ability to achieve the reduction in recidivism found in the case studies.

The lack of public housing for MDOs is a challenge, but does not prevent the implementation of the pilot transition programs. Studies show that stigma causes landlords to discriminate against people with mental illness as potential tenants and causes the public to resist people with mental illness as neighbours in housing developments (Page, 1977, Draine and Solomon, 1994, Link et al., 1997, Hartwell, 2004, Jimenez, 2005). However, the CARES program in rural Tuolumne County had no public housing infrastructure and arranged housing through personal contacts. This involved face-to-face meetings between the landlord and case manager to explain the program, its goals and essentially de-stigmatize the participant. CARES' final report states that landlords were more receptive to housing MDOs who were in the CARES program because if they had any problems they could call the case manager. In Regional Health Authorities that have smaller communities, this type of community liaising might create more housing options. This creative community liaising may work in urban areas too. The 2007 BC

Budget committed to build new housing developments and this could relieve the housing shortage in the Lower Mainland.

The case studies revealed that a transition program is complex to administer because MDOs pass through multiple ministries' jurisdictions. Both transition programs provide excellent examples of best practices to overcome the problems associated with inter-ministerial collaboration. However, the complexity of a transition program does not diminish with the presence of the best practices alone; great deal of organization, collaboration and communication is required from the ministries involved to ensure success.

The political feasibility of this alternative is good. This issue has already received attention on the provincial government's policy agenda with three key ministries mentioning their participation on an inter-ministerial committee in their service plans. This inter-ministerial committee hired CARMHA at SFU to link service-use data from Health, MEIA and Public Safety and the Solicitor General that will guide the creation of an evidence-based strategy to address mental illness, criminal justice and substance use. In addition, BC's 2007 budget focuses on improving access to public housing that is needed to implement the housing component of the transition program. These policy commitments indicate there is a policy window on this issue and an opportunity to make some change.

The implementation of the transition program should not garner any significant criticism from the public because it is a more cost effective method to reduce recidivism among MDOs than the status quo. However, the lack of public housing available to MDOs might require the development of new housing. The public often holds "not in my backyard" (NIMBY) attitudes to the development of housing for people with mental illness (Jimenez, 2005). Jimenez's analysis found that NIMBY attitudes are not as overwhelming as the media depicts, but they are still a prevalent source of opposition. The public often oppose housing for people with mental illness because of a fear of personal safety, property devaluation and neighbourhood degradation. Based on Jimenez's findings, the public is likely to oppose housing for MDOs because of the stigma surrounding their criminal history and mental illness. To overcome opposition, Jimenez recommends a targeted education campaign and careful selection of a development site in a new community where residents are less likely to hold NIMBY attitudes. Disability community groups are likely to be supportive of any government programming that would aid the population they serve and could be a strong ally in public education on mental illness.

The stereotypes of people with mental illness are pervasive in society and the media. A study conducted on 184 prime-time television programs over a two-week period found 3% of

characters committed violent crime and 30% were characters with mental illness (Meier, 2006). In 2000, a telephone interview of 1,022 adults conducted by the US National Mental Health Association half of the respondents categorized mentally ill characters portrayed in the media as drug addicts, alcoholics and criminals (Meier, 2006). In reality, the crime rate among people with mental illness is less than 4%, the same as the general population (Meier, 2006). While targeted education may convince people to support housing developments for MDOs this study does not suggest that it will result in the complete de-stigmatization of people with a mental illness and criminal record in society. However, the development of housing for people with mental illness and a criminal record is an important first step as it may result in interaction between people with and without a mental illness and a criminal record and erode some long-standing stereotypes.

7.3 Enhanced Transition Program

The Enhanced Transition program is an alternative derived from the additional findings in the case studies. Employment and education services are the additional program features of the Enhanced Transition program. The CARES program provided employment and education services throughout their pilot program and the MIO-CTP provided employment and education services in the last two years of their pilot program. The recidivism rate of both programs' pilot period was 13%, so, at the very least, additional programming did not negatively affect the recidivism rate. The case studies did not keep statistics or describe how employment and education services contributed to decreasing recidivism among participants, so it cannot be determined if there was a positive affect on recidivism. However, an occupational therapist from one of the Regional Health Authorities explained that education, employment and life skills services are as essential to success as the "core services" offered in the basic program alternative (Interview B, 2007). She asserts for an offender to avoid re-offending they must make new habits, social connections and do something meaningful with their lives (Interview B, 2007). As such, this study recommends the simultaneous implementation of the enhanced and basic programs to address MDOs needs holistically. However, the enhanced program may be phased in if it is not politically feasible or the administration would be too complex so that it would compromise the success of the basic program.

Both transition programs included education and employment services in their budgets and these budgets were used to calculate the cost effectiveness of the Basic Transition Program as there was no way to separate the cost of education and employment services. Therefore, the cost effectiveness of an Enhanced Transition program with education and employment services may

be similar to the Basic Transition program. However, depending on the type and extent of education and employment services offered the cost could increase, so I gave it a rating of fair.

The administrative ease, political feasibility and public acceptance of an Enhanced Transition Program face the same challenges as the Basic Transition Program, discussed in the previous section.

8 Next Steps

This study uncovered a service gap for mentally disordered offenders – there are too few services to aid mentally disordered offenders in successfully re-entering the community. Without services, MDOs are more likely to re-offend because they find it difficult to overcome the barriers they face on release from a correctional facility alone. The case studies reveal two key factors to successful community re-entry of MDOs: inter-ministerial collaboration and transition services. Transition programs are administratively complex because MDOs pass through two ministries' jurisdictions. To ensure some continuity of care and a structured environment for MDOs the Ministry of Health and Public Safety and Solicitor General must step out of their traditional silos of influence and collaborate to serve this complex, and often overlooked, population. Successful programs use horizontal thinking: mental health workers must liaise with offenders inside correctional facilities and correctional staff must participate in the treatment of MDOs in the community. Ministries must also share information with other programs that treat similar populations run by the Regional Health Authorities to avoid duplication. To achieve the level of integration needed for a transition program to be successful the initiative, mandate and resources must come from the provincial government. The Ministries of Health and Public Safety and Solicitor General need to collaborate to establish guidelines on how to ensure MDOs released on a warrant expiry receive mental health care during incarceration and after release into the community.

In addition, these two ministries have to use their influence to reserve beds in new housing developments. The government must allocate spaces specifically for MDOs in new housing developments for a transition program to succeed. Mentally disordered offenders do not easily fit into one category. They are likely to have a substance abuse problem in addition to their mental health disorder and criminal history – which means they are an extremely complex group that need specialized services. If housing for the mentally ill is increased overall this complex group will continue to be pushed to the back of the line because they are viewed as a population least likely to succeed.

Based on the criteria and evaluation, the Basic Transition program is clearly the most cost effective method to help MDOs re-enter the community. However, occupational therapists in the

Regional Health Authorities strongly advise the concurrent implementation of the Basic and Enhanced Transition programs to meet all the MDOs' needs, not just the basic ones (Interview B, 2007). Therefore, this study recommends the implementation of a Basic and an Enhanced pilot transition program in the Vancouver Island Health Authority and either the Vancouver Coastal Health or the Fraser Health Authority.

This study recommends pilot programs in only two of the five Regional Health Authorities for three reasons. First, the initial cost of a transition program is significant: the budgets of the case studies range from \$200,000 - \$500,000. To put a transition program in five health authorities would be expensive and a high initial investment may be a barrier to implementation. However, a transition program in more than one health authority is recommended due to the difficulty in transferring inmates within BC and to ensure equitable access to services.

A centralized transition program, like the MIO-CTP, that transfers MDO candidates from correctional facilities across the province to be interviewed and participate in the program is not feasible in BC. Correctional facilities cannot guarantee a bed would be available to transfer an inmate on short notice (Interview A, 2007). Since the target population typically has short sentences, there would be limited time to wait for a bed to open in a correctional facility, interview the candidate, select them and begin to discharge plan. It makes more logistical sense to have the transition staff located in an area close to correctional facilities so they can travel to interview candidates and discharge plan. Finally, the requirement that a person complete a program in a centralized location, such as the Lower Mainland, might separate some MDOs from their family and community. Out of all the provincial correctional facilities 40% are located outside the Lower Mainland, 34% on Vancouver Island and 6% in Prince George. Therefore, it makes sense for transition programs to be started in the two regional health authorities with the largest concentration of inmates. Expansion of the program can occur if the pilot programs are successful.

There is a dearth of evidence-based research on the effectiveness of transition programs on recidivism. Therefore, it is important that the government measure the quantitative and qualitative outcomes of any pilot transition program. To be effective, a control group must be employed. As mentioned in Section 5, certain outcomes should be measured over the pilot period. The Basic Transition Program should measure: (1) the reduction in recidivism rates, (2) sobriety / relapse rates, (3) stable mental health / relapse rates and (4) secure housing / homelessness. The Enhanced Transition Program should measure: (1) the number of participants

on government support / employed; (2) the level of education; and (3) the level of independent functioning. The collection of qualitative data, through semi-structured interviews or focus groups, is also important when working with such a complex population because quantitative data does not always capture the whole situation. Qualitative data ensures the personal experiences, opinions and accomplishments of staff and offenders are recorded. Data collection may add more stress and complexity to the administration of the transition program, which could result in inaccurate reporting. To avoid any problems, this study recommends providing in-house administrative assistance on data collection for the staff. Accurate data collection is crucial to measure the outcomes, determine the program's success and contribute to expanding the body of research on services for MDOs.

9 Conclusion

One just needs to walk around the Downtown Eastside in Vancouver to know the area is noticeably concentrated with people who have some serious problems, such as addiction, mental illness and criminality. Without a doubt, this is their personal struggle, but these personal problems translate into real financial and social costs. Mental illness is not just a personal struggle; it is a public policy problem. Without intervention, the MDO population generally re-offends at a rate of 41%. Cycling through the justice system uses a tremendous amount of public resources, in the form of policing, remand, court time and incarceration, and threatens public safety – in 2004, the Lower Mainland had the second highest rate of property crime and the highest rate of drug offences in Canada. This problem also has larger, indirect implications: the homelessness and addiction that characterizes the MDO population and is concentrated in the Downtown Eastside may adversely affect BC's reputation as a tourist destination, a 9.4 billion dollar industry in 2004, and overshadow the 2010 Olympics.

This study has shown that when mentally disordered offenders receive transition services the recidivism rate can drop to as low as 13%. However, this study has its limitations. The lack of suitable case studies, due to this study's focus on post-release services, resulted in the use of only two case studies. This may raise questions about the extent these results can be generalized, but a lack of existing data should not prevent research and policy development in this field. In fact, the lack of evidence-based research on transition services in Canada indicates a need for leadership, research and innovation on this issue.

Post-release services are just a part of the larger problem of mental illness in the criminal justice system. To create robust policy for people with mental illness in the justice system additional research is needed on prevention and post arrest services. In an April 2007 meeting, Dr. Julian Somers described a study by the Centre for Applied Research in Mental Health and Addictions examining patterns of service utilization among people with mental illness who are in contact with the justice system. Preliminary results suggest that substance abuse is significantly correlated with service utilization across a variety of domains, including corrections, health, and income assistance. If confirmed, Dr. Somers said that these results may indicate that substance use, rather than mental disorders in general, may warrant particular focus in future research on the

prevention of recidivism to the corrections system. My study hopes to contribute to the larger goal of creating an effective diversion strategy in British Columbia for people with mental illness in contact with the justice system.

Appendices

Appendix A

Table 18: Selected BC Mental Health Non-Governmental Organizations

Service / NGO	Housing	Employ & Retraining	Help Applying for Benefits	Consumer Education	Leisure & Social	Support Groups	Case Mgmt	Addictions Counselling	Legal Aid	Forensic Outreach
Motivation, Power and Achievement	X		X		X				X	X
Mood Disorders Association						X				
Fraser Valley Brain Injury	X					X	X			
Anxiety Disorders Association				X						
Schizophrenia Society				X						
CMHA 100 Mile House	X	X			X					
CMHA Burnaby		X		X	X		X			
CMHA Cowichan		X					X			

Service / NGO	Housing	Employ & Retraining	Help Applying for Benefits	Consumer Education	Leisure & Social	Support Groups	Case Mgmt	Addictions Counselling	Legal Aid	Forensic Outreach
CMHA Delta						X				
CMHA Kamloops		X		X	X					
CMHA Kelowna	X				X					
CMHA Kootneys	X	X				X				
CMHA Naniamo		X			X		X			
CMHA North/West Vancouver		X	X			X	X			
CMHA Penticton				X	X		X			
CMHA Port Alberni	X	X				X	X			
CMHA Richmond	X	X		X	X		X			
CMHA Salmon Arm	X	X		X	X					
CMHA Simon Fraser	X	X		X			X			

Service / NGO	Housing	Employ & Retraining	Help Applying for Benefits	Consumer Education	Leisure & Social	Support Groups	Case Mgmt	Addictions Counselling	Legal Aid	Forensic Outreach
CMHA Vernon	X	X			X	X				
CMHA Victoria	X	X		X	X					
CMHA White Rock				X	X					
CMHA Williams Lake	X	X			X					

Sources: Motivation, Power and Achievement, Mood Disorders Association of BC, Fraser Valley Brain Injury Association, Anxiety Disorder Association, BC Schizophrenia Society and Canadian Mental Health Association all online

Table 19: John Howard Society Services in BC

Service / John Howard Branch	Mental Health	Housing	Employ & Retraining	Help Applying for Benefits	Consumer Education	Leisure & Social	Support Groups	Case Mgmt	Addiction Counselling	Legal Aid	Forensic Outreach
Fraser Valley			X				X				X
Lower Mainland	X	X	X	X			X		X		X
Victoria	X	X	X			X	X				X
Nanaimo	X	X	X				X		X		

Service / John Howard Branch	Mental Health	Housing	Employ & Retraining	Help Applying for Benefits	Consumer Education	Leisure & Social	Support Groups	Case Mgmt	Addiction Counselling	Legal Aid	Forensic Outreach
N. Island	X						X				
Kootenays		X	X				X		X	X	
Okanagan	X						X	X	X		
Thompson	X	X	X				X	X			
Northern		X					X	X			X

Source: John Howard Society online

Appendix B

INTERVIEW QUESTIONS

The general focus of the questions is: (1) your perception of transition and mental health services for MDOs in BC, and (2) insights into the feasibility and efficiency of different policy alternatives.

Area 1: Importance of the policy problem/study; insights into BC's mental health services for Mentally Disordered Offenders (MDOs)

1. What is your perception of BC's mental health services for Mentally Disordered Offenders released on a warrant expiry?
2. Is it important that BC implement diversion strategies, such as transition services?
3. What is your perception of the availability of housing for MDOs?

Area 2: Insights into Policy Alternatives

4. In terms of recidivism from a public policy perspective, what do you think are the best options to facilitate MDOs successful community re-entry in BC?
5. In your view, would the government consider implementing a transition program?
6. In your estimation, would the public be supportive of a transition program? What past experiences do you draw on to reach that opinion?
7. What is your opinion of the status quo?
8. What is your opinion of the basic transition program alternative?
9. What is your opinion of the enhanced transition program alternative?
10. Are there any other ways to facilitate MDOs successful community re-entry in BC?
11. Are there any other aspects of this policy study you would like to see?

Appendix C

Calculations for Cost Effectiveness

1. Status quo

$$(\$134.69^9 \times 365 \text{ days})(40) = 2.02 \text{ million (2m)}$$

2a) Average Cost of Transition Program

$$\$500,00 \text{ (MIO-CTP)} + \$173,422 \text{ (CARES)} = \underline{673,422} = \$336,711$$

2

2b) Cost per participant

$$\underline{\$336,711} = \$14,029.63$$

24

2c) Cost Effectiveness for recidivism at 13%

$$(13)(\$14,029.63 + \$49,161.85) + (87)(\$14,029.63) = 2.04 \text{ (2m)}$$

2d) Cost Effectiveness for recidivism at 24%

$$(24)(\$14,029.63 + \$49,161.85) + (76)(\$14,029.63) = 2.58 \text{ (2.6m)}$$

⁹ Statistic Canada 2004, Table 251-0007, Adult correctional services daily operating expenditures for British Columbia per person

Bibliography

Works Cited

- Bond, G., Drake, R. & Mueser K. (2001). Assertive Community Treatment for People with Severe Mental Illness: Critical Ingredients and Impact on Patients. *Disease Management and Health Outcomes*, 9 (3), 141-159.
- Bonta, J., Hanson, K. & Law, M. (1998). The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis. *Psychological Bulletin*, 123 (2), 123-142.
- Brink, J., Doherty, D. & Boer, A. (2001). Mental disorder in federal offenders: A Canadian prevalence study. *International Journal of Law and Psychiatry*, 24, 339-356.
- Bruckner, D. (2006). Re-entry to Recovery: A Promising Return-to-Work Approach for Certain Offenders with Mental Illness. *Criminal Justice Policy Review*, 17 (3), 302-313.
- Buck, M. (2000). Getting back to work: Employment programs for ex-offenders. Retrieved, March 2007, from, http://ppv.org/ppv/publications/assets/94_publication.pdf.
- California Board of Corrections (2002). Mentally Ill Offenders Crime Reduction Grant Program: Annual Legislative Report. Sacramento, California.
- California Board of Corrections (2005). Mentally Ill Offender Crime Reduction Grant Program: Overview of Statewide Evaluation Findings. Sacramento, California.
- CBC (2007). The missing women of Vancouver. Retrieved, February 2007, from, <http://www.cbc.ca/news/background/pickton/history.html>
- Calgary Health Region (2004). Press Release: Calgary Diversion Project celebrates 3 years of success. Retrieved, April 2007, from, http://www.calgaryhealthregion.ca/publicaffairs/news/pdf/2004/2004-09-28_calgary_diversion_project.pdf
- Corrado, R., Cohen, I., Hart, S. & Roesch, R. (2000). Comparative Examination of the Prevalence of Mental Disorders Among Jailed Inmates in Canada and the United States. *International Journal of Law and Psychiatry*, 23 (5-6), 633-647.
- Correctional Investigator of Canada (2005). Annual Report of the Correctional Investigator of Canada 2004-2005. Retrieved, November 2006, from, http://www.oci-bec.gc.ca/reports/pdf/AR200405_e.pdf
- Correctional Services of Canada (2006). Volunteers on the Inside. Let's Talk: CSC Priorities for 2006 – 2007 and Beyond. 30 (4). Retrieved, December 2006, from, http://www.csc-scc.gc.ca/text/pblct/letstalk/2005/30-4/pdf/letstalk_30-4_e.pdf
- Correctional Services of Canada (2004). A Health Care Needs Assessment of Federal Inmates in Canada. *Canadian Journal of Public Health*, 95, S1 – S62.

- CTV (2007). 26 Women at heart of case had complex lives. Retrieved, February 2007, from, http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070117/missing_overview_070117/20070119/
- Department of Social and Health Services, Washington State. Correspondence December 16, 2003. Retrieved, December 2006, from, <http://www1.dshs.wa.gov/pdf/EA/GovRel/Leg1203/MIOCTPO.pdf>
- Draine, S. & Solomon, J. (1994). Jail Recidivism and the intensity of case management services among homeless persons with mental illness leaving jail. *The Journal of Psychiatry & Law*, 22, 245-261.
- Government of Alberta (2001). Reducing the Criminalization of Individuals with Mental Illness. Retrieved, January 2006, from, <http://www.amhb.ab.ca/publications/pdfs/ABProvDiv-ReducingCrime.pdf>
- Government of Alberta (2003). Implementing the Provincial Diversion Program in Alberta Communities: Guidelines and Standards. Retrieved, January 2007, from, <http://www.amhb.ab.ca/publications/pdfs/ABProvDiv-PhaseI.pdf>
- Government of Ontario (2006). A Program Framework for: Mental Health Diversion / Court Support Services. Retrieved, January 2007, from, http://www.health.gov.on.ca/english/public/pub/ministry_reports/mentalhealth/framework.pdf
- Hartwell, S. (2004). Triple Stigma: Persons with Mental Illness and Substance Abuse Problems in the Criminal Justice System. *Criminal Justice Policy Review*, 15 (1), 84-99.
- Hartwell, S. (2005). The Organizational Response to Community Re-entry. *Research in Social Problems and Public Policy*, 12, 197-217.
- Howerton, A., Byng, R., Campbell, J., Hess, D., Owens, C. & Aitken, P. (2007). Understanding help seeking behaviour among male offenders: qualitative interview study. *British Medical Journal*, 334 (303), 1-7.
- Jimenez, L. (2005). From NIMBY to YIMBY: Understanding Community Opposition to Special Needs Residential Facilities in Vancouver. Retrieved, March 2007, from, http://www.sfu.ca/mpp/pdf_news/Capstone/Liza%20Jimenez%20capstone.pdf
- Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D. & Scott, R. (1984). *Social Stigma: The Psychology of Marked Relationships*. New York: Freeman.
- Lamberti, J., Weisman, R. & Faden, D. (2004). Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness. *Psychiatric Services*, 55 (11), 1285 – 1293.
- Link, B., Struening, E., Rahav, M., Phelan, J. & Nuttbrock, L. (1997). On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with Dual Diagnoses of Mental Illness and Substance Abuse. *Journal of Health and Social Behaviour*, 38 (June) 177-190.
- Lovell, D., Gagliardi, G., Peterson, P. & Jemelka R. (2004). Forecasting Recidivism in Mentally Ill Offenders Released from Prison. *Law and Human Behaviour*, 28 (2), 133-155.
- Meier, K. (2006). An Enduring Stereotype: Criminalization of Mental Illness in the Media. *Visions*, 2 (8), 7-8.

- Ministry of Health (2002). Assertive Community Treatment: Best Practices. Retrieved, February 2007, from, http://www.healthservices.gov.bc.ca/mhd/pdf/bp_assertive_community_treatment.pdf
- Ministry of Health (2005). Best Practices in Mental Health and Addictions. Retrieved, January 2007, from, <http://www.healthservices.gov.bc.ca/mhd/best.html>
- Ministry of Public Safety Canada (2005). Warrant Expiry Date. Retrieved, April 2007, from, <http://www.publicsafety.gc.ca/prg/cor/tls/wed-en.asp>
- Ministry of Public Safety and Solicitor General (2005). Service Plan Update. Retrieved, January 2007, from, http://www.bcbudget.gov.bc.ca/2005_Sept_Update/sp/pssg/Goals,Objectives,StrategiesandResults.htm
- Morrow, M., Frischmuth, S. & Johnson, A. (2006). Community-Based Mental Health Services in BC. *Canadian Centre for Policy Alternatives*. Retrieved, March 2007, from, http://www.sfu.ca/economicsecurityproject/docs/community_mental_health_services.pdf
- Mueser, K., Bond, G., Drake, R. & Resnick, S. (1998). Models of Community Care for Severe Mental Illness: A Review of Research on Case Management. *Schizophrenia Bulletin*, 24 (1), 37-74.
- National Film Board of Canada (2006). FIX: The Story of An Addicted City. Retrieved, February 2007, from, <http://www.onf.ca/trouverunfilm/fichefilm.php?lg=en&id=51263&v=h>
- National Parole Board (2007). Parole Applications for Provincial/Territorial Offenders. Retrieved, March 2007, from, http://www.npb-cnlc.gc.ca/infocntr/Parole_Applications/parole_app_e.htm#whatisparole
- Nicholls, T., Lee, Z., Corrado, R. and Ogloff, J. (2004). Women Inmates Mental Health Needs: Evidence of the Validity of the Jail Screening Assessment Tool (JSAT). *International Journal of Forensic Mental Health*, 3 (2), 167-184.
- Ogloff, J., Davis, M. & Somers, J. (2004). *Mental Disorder, Substance Use and Criminal Justice Contact: A Systematic Review of the Scholarly Literature*. Victoria: Ministry of Health Services.
- Osher, F., Steadman, H. & Barr, H. (2003). A Best Practice Approach to Community Reentry From Jails for Inmates with Co-occurring Disorders: The APIC Model. *Crime and Delinquency*, 49 (1), 79-96.
- Page, S. (1977). Effects of the Mental Illness Label in Attempts to Obtain Accommodation. *Canadian Journal of Behavioral Science*, 9, 85-90.
- Seiter, R. & Kadela, K. (2003). Prisoner re-entry: What works, what does not, and what is promising. *Crime & Delinquency*, 49 (1), 360-388.
- Spaite, P. & Davis, M. (2005). The Mentally Ill and the Criminal Justice System: A Review of Programs. Ohio: National Alliance on Mental Illness. Retrieved, December 2006, from, http://www.namiohio.org/REVIEW_PROGRAMS.pdf
- Standing Committee on Social Affairs, Science and Technology (2006). Out of the Shadows at Last. Retrieved, October 2006, from, <http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm>
- Statistics Canada (2006). The Daily – July 20, 2006. Retrieved, November 2006, from, <http://news.gc.ca/cfmx/view/en/index.jsp?articleid=228629>

- Statistics Canada (2005). Crimes by offences, by province and territory. Retrieved, November 2006, from, <http://www40.statcan.ca/l01/cst01/Legal04a.htm>
- Statistics Canada (June 2005). Returning to Correctional Service after release: A profile of Aboriginal and non-Aboriginal adults involved in Saskatchewan Corrections from 1999/00 to 2003/04. Retrieved, March 2007, from <http://www.statcan.ca/english/freepub/85-002-XIE/0020585-002-XIE.pdf>
- Statistics Canada (2004). Adult correctional services, admissions to provincial, territorial and federal programs (British Columbia). Retrieved, November 2006, from, <http://www40.statcan.ca/l01/cst01/legal301.htm>
- Tuolumne County Sheriff's Department (2004). Crime Abatement and Rehabilitation/Recovery Enhancement Services: Final Program Report. Turlock: California.
- Washington State Department of Corrections (2001). Mentally Ill Offender Community Transition Program: Annual Report to the Legislature. Retrieved, December 2006, from, <http://www.metrokc.gov/dchs/mhd/reports/mio/MIO-CTPreport.pdf>
- Washington State Department of Corrections (2002). Mentally Ill Offender Community Transition Program: Annual Report to the Legislature. Retrieved, December 2006, from, <http://www1.dshs.wa.gov/pdf/EA/GovRel/Leg1202/MIOCTP.pdf>
- Washington State Department of Corrections (2005). Mentally Ill Offender Community Transition Program: Annual Report to the Legislature. Retrieved, December 2006, from, www1.dshs.wa.gov/word/hrsa/mh/MIO_CTP.doc
- Washington State Department of Corrections (2006). Mentally Ill Offender Community Transition Program: Annual Report to the Legislature. Olympia: Washington.
- Welsh, A. & Ogloff, J. (2003). The Development of a Canadian Prison Based Program for Offenders with Mental Illnesses. *International Journal of Forensic Mental Health*, 2 (1), 59-71.

Interviews

Interview A, 2007

Interview B, 2007

Works Consulted

- Haimowitz, S. (2004). Slowing the Revolving Door: Community Reentry of Offenders with Mental Illness. *Psychiatric Services*, 55 (4), 373 – 375.
- Hartwell, S., Jalbert, S. & Orr, K. (2006). Persons with Mental Illness Post Prison Release. *Law Enforcement Executive Forum*, 6 (4), 175 – 185.
- Hartwell, S. (2005). The organizational response to persons with mental illness involved with the criminal justice system. *Research in Social Problems and Public Policy*, 12, 197-217.
- Hartwell, S. (2003). Short-Term Outcomes for Offenders with Mental Illness Released from Incarceration. *International Journal of Offenders Therapy and Comparative Criminology*, 47 (2), 145-158.

- Hartwell, S. (2001). Female mentally ill offenders and their community reintegration needs. *International Journal of Law and Psychiatry*, 24, 1-11.
- Hartwell, S., Friedman, D. & Orr, K. (2001). From Correctional Custody to Community. *New England Journal of Public Policy*, 73-81.
- Solomon, P., Draine, J. & Meyerson, A. (1994). Jail recidivism and receipt of community mental health. *Hospital and Community Psychiatry*, 45 (8), 793-797.

Statutory Laws

- RCW 71.24.460 Mentally ill offenders, Report to legislature, Contingent termination of program. Retrieved, December 2006, from, <http://apps.leg.wa.gov/RCW/default.aspx?cite=71.24.460>

Websites Reviewed

- Anxiety Disorders Association of BC online at <http://anxietybc.com/site/>
- BC Mental Health and Addiction Services online at www.bcmhas.ca/ForensicService/ServicesPrograms.htm
- BC Schizophrenia Society online at <http://www.bcscs.org/>
- California Courts online at <http://www.courtinfo.ca.gov/selfhelp/glossary.htm#F>
- Canadian Mental Health Association online at <http://www.cmha.ca/bins/index.asp>
- Fraser Valley Brain Injury Association online at <http://www.fvbia.org/>
- John Howard Society of Canada online at <http://www.johnhoward.ca/>
- Mood Disorders Society of Canada online at <http://www.mooddorderscanada.ca/>
- Motivation, Power and Achievement Society online at <http://www.mpa-society.org/>
- New Brunswick Mental Health Court online at <http://www.mentalhealthcourt-sj.com/home.html>
- Washington State Courts online at http://www.courts.wa.gov/newsinfo/resources/index.cfm?fa=newsinfo_jury.termguide&altMenu=Term