Criminal Justice Diversion for Persons with Mental Disorders

A Review of Best Practices

Prepared for CMHA BC Division's Mental Health Diversion Project

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BC Division

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1 Introduction

1.1. Background

The Canadian Mental Health Association, BC Division has been provided funding from the Law Foundation of BC to create a guide to support the diversion of people with mental disorders out of the criminal justice system. The present best practice review has been created to serve as a background document to present at a Provincial mental health and justice advisory committee. Funding has been provided by BC Mental Health and Addiction Service, an agency of the Provincial Health Services Authority, to gather more input on a proposed diversion framework through a series of regional forums through BC.

1.2. Scope

The best practices described below apply to adults with mental disorders who are in conflict with the law and whose needs may be more appropriately met by mental health and social support services. This review has largely excluded issues relating specifically to adolescents and children.

For this review, the following broad definition of 'mental disorder' has been adopted: "a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with significantly increased risk of suffering, pain, disability, or an important loss of freedom" (American Psychiatric Association, 2000b).

1.3. Definition of 'Diversion'

The term "diversion" has been defined a number of ways in the literature and elsewhere. For the purposes of this document, the term "diversion" refers to:

> *The redirection of persons with mental disorders, who have committed an offence, away from the criminal justice system and towards mental health and social support services. Diversion for persons with mental disorders can occur at several points in the criminal justice process and is accomplished through a highly-coordinated and integrated effort between the mental health, social service, and criminal justice systems. The underlying philosophy of diversion is that the offending behaviour of many mentally disordered persons is more appropriately and effectively dealt with through the provision of treatment and support rather than through traditional criminal justice interventions*

The above definition was created by compiling the following elements of other versions of the definition:

- Offending behaviour results from the mental disorder and unmet service need. Diversion is based on the rationale that the offending behaviour can be primarily attributed to untreated, or ineffectively treated, mental disorder and the inadequacy or inaccessibility of existing mental health services. Therefore, access to and engagement in community-based treatment services is expected to reduce subsequent offending behaviour.

- *Treatment is more appropriate than criminal justice processing.* At the core of diversion is the idea that persons with mental disorders should be provided with opportunities for services and supports in the mental health system, rather than being processed and punished through the traditional criminal justice channels. The use of criminal justice interventions is perceived as an inappropriate, ineffective, and expensive manner for dealing with mental disorders; however, the principle of holding individuals accountable for their actions remains imperative.

- *Programs tailored for certain types of individuals.* Diversion is tailored for persons accused of crimes for whom voluntary mental health treatment and support services are a reasonable alternative to criminal justice sanctions. Accordingly, diversion programs primarily target persons with an identifiable mental disorder who have committed a minor, non-violent, chargeable offence. Typically, participation in the program is voluntary.

- *Multiple diversion points.* Diversion for persons with mental disorders can occur at several points in the criminal justice process, including: (a) **pre-arrest** (police-based diversion), (b) **post-arrest** (pre-trial diversion), (c) **post-sentence/plea** (jail- and court-based diversion) and (d) **post-incarceration** (jail-based programming and community re-entry diversion). Each of these points presents an opportunity to redirect persons with mental disorders towards treatment and support services, and to prevent initial involvement or further penetration into criminal justice system.

- *Coordination and integration of multiple systems.* All diversion programs are designed to improve the coordination and integration of existing mental health and social service programs with the criminal justice system to provide a seamless and continuous network of support capable of achieving the desired outcomes.

- *Achievement of desirable outcomes.* Diversion programs have a range of interrelated goals as they relate to persons with mental disorders, including: (a) preventing involvement in the criminal justice system, (b) decreasing incarceration, (c) linking and sustaining individuals in treatment and support systems, (d) reducing recidivism; (e) increasing treatment compliance, (f) reducing severity of symptoms, (g) improving quality of life, (h) reducing psychiatric hospitalization and (i) decreasing the costs of justice administration.

1.4. Trends and Needs

Research consistently demonstrates that criminal justice populations have a substantially higher prevalence rate of mental disorders compared with the general population. Internationally, research has revealed the following:

- 1 in 7 prisoners have psychotic illnesses or major depression—two to four times the rate of the general population (Fazel & Danesh, 2002)
- High rates of mental illness and substance have been reported in probation and parole populations (Lurigio et al., 2003)
- Persons with schizophrenia, compared to persons without mental illness, are almost 3 times more likely to have a criminal conviction are four times more likely to have a criminal conviction involving violence (Tiihonen, et al., 1997; Arseneault et al., 2000)
- The relationship between mental illness and crime/violence is exponentially strengthened if major mental illness co-occurs with substance abuse (Tiihonen, et al., 1997; Walsh et al., 2002; Angermeyer, 2007)
- 5–10% of violent offending in the community can be attributed to persons with mental illness (Walsh et al., 2002; Wallace et al., 2004; Fazel & Grann, 2006)

Similar trends in British Columbia and throughout Canada have been reported from:

- Prisoners in the Canadian provincial and federal corrections systems have a high lifetime prevalence of substance use disorder (76–87%), affective disorder (23–30%), anxiety disorder (15–18%), and schizophrenia (2%) (Bland et al., 1998; Brink et al., 2001)
- In metropolitan Vancouver, 15–20% of individuals admitted to pre-trial centres have a major mental disorder, 60–85% have a substance use disorder, and approximately 90% have other mental health problems (Roesch, 1995; Ogloff, 1996)

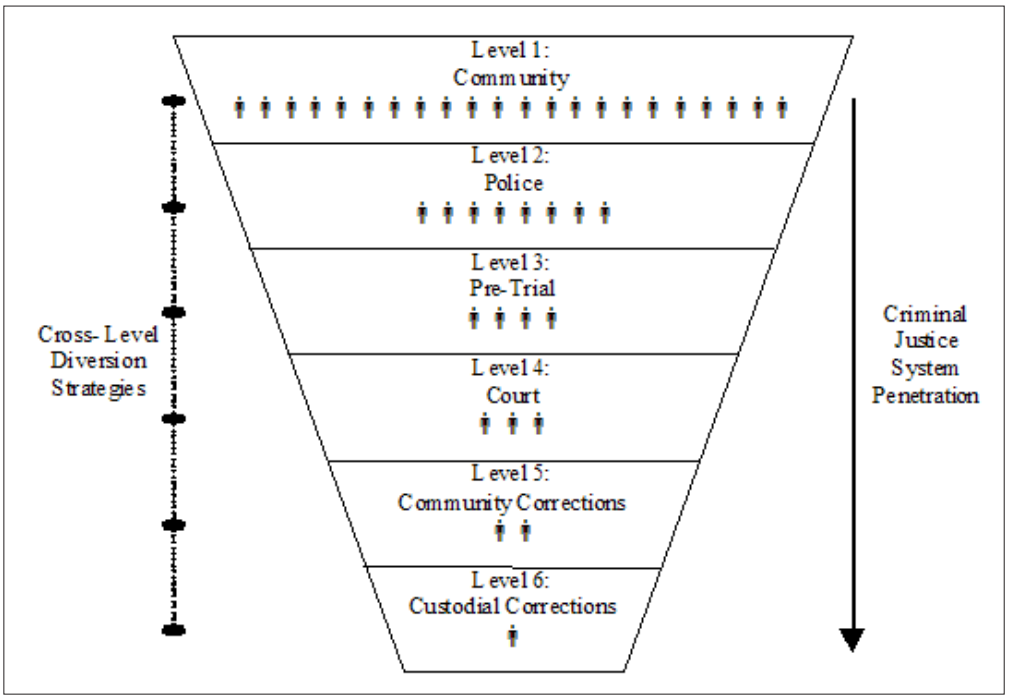
- Between 35–40 accused persons with symptoms of mental illness appear in the Vancouver Provincial Courts every day (BC Justice Review Task Force, 2005)
- Approximately, one-third of police incidents in the city of Vancouver are suspected to involve a person with mental illness (Wilson-Bates, 2008)
- Among people sentenced through Provincial courts in BC, over 30% have been medically diagnosed with a substance use disorder and an additional 26% were diagnosed with a mental disorder unrelated to substance abuse (Somers et al., 2008)

The reasons why individuals with mental disorders are over-represented in the criminal justice system is complex, but has generally been attributed to clinical risk factors, such as co-occurring addictions and treatment non-compliance, as well as social and systemic factors, such as improperly implemented deinstitutionalization policies, homelessness and poverty, community disorganization, poorly funded and fragmented community-based services, overly restrictive civil commitment criteria, and drug law reforms (see generally Lamb et al., 1999; Lurigio, 2000; Hiday, 2006; Silver et al., 1999).

1.5. Description of the Diversion Continuum

The criminal justice diversion continuum for individuals with mental disorders has been conceptualized in a number of ways in the literature. For the purposes of this review, the continuum has been divided into six levels that represent the multiple opportunities for diverting persons with mental disorders and preventing further penetration into the criminal justice system.

Figure 1
Conceptual Model of the Diversion Continuum



The above conceptual model draws from the Sequential Intercept Model created by Munetz & Griffin (2006) that reflects the flow of individuals through the criminal justice system as well as the filtering of individuals from the criminal justice system by using the multi-level diversion strategies discussed in this report.

2 A Review of Best Practicies Across the Diversion Continuum

2.1. Purpose

The purpose of this background paper is to provide a synthesis of current best practices in the criminal justice diversion of adults with mental disorders. The following descriptions of best practices are meant to influence and inform policy rather than dictate specifically what course of action should be taken.

2.2. Methods

A review of published literature was performed by entering relevant keywords into major databases, including NCBI PubMed, ISI Web of Science, Ovid, and Campbell Collaboration databases. Grey literature was retrieved by entering keywords into internet search engines (i.e., Google) and retrieving electronically published documents. The references of all identified articles and reports were hand-inspected for further relevant studies and reports. There were no methodological prerequisites for inclusion of studies and other literature in the review; however, as is noted throughout the literature, it should be mentioned that many aspects of criminal justice diversion have not yet been rigorously evaluated.

The best practice guidelines discussed below draw heavily on the information contained in the following two documents: Evidence-Based Practices in Diversion Programs for Persons with Serious Mental Illness who are in Conflict with the Law: Literature Review and Synthesis (Hartford et al., 2004) and Criminal Justice/Mental Health Consensus Project (Council of State Governments, 2002).

2.3. Definition of 'Best Practice'

This review considers a 'best practice' to be: an approach that is in keeping with the best possible available evidence and expert opinion about what works for diverting adults with mental disorders from the criminal justice system.

2.4. Results

The results of the literature review are presented in the following seven sections: (1) strategies the apply across the diversion continuum, (2) community-based diversion, (3) police-based diversion, (4) pre-trial diversion, (5) court-based diversion, (6) community corrections diversion and (7) custodial corrections diversion.

2.4.1. Cross-Continuum Diversion Strategies

Eight key features that have emerged from the literature as being essential for creating a successful criminal justice diversion program (Steadman et al., 1995; Hartford et al., 2004; Council of State Governments, 2002). These elements apply across the entire criminal justice diversion continuum and are considered below.

a. Inter-Agency/Governmental Collaboration

Collaboration between at least two key stakeholders from the criminal justice and mental health systems is identified as the single most significant factor for the success of criminal justice diversion programs. Getting stakeholders to the table—which is often the greatest challenge—can be facilitated by ensuring that key leaders know the full benefits of collaboration. Involvement of social services agencies, housing agencies, mental health and addictions agencies, hospital/emergency room administrators, local corrections (institutional and community) agencies, law enforcement agencies, victim services, elected officials, mental health advocates, and persons with mental disorders

and their family members is recommended. Local and regional networks with representation across different sectors should be formed to examine and resolve barriers to services at the interface of the mental health and criminal justice systems. Often, the need for inter-agency/governmental collaborations is only realized, and transformational change achieved, after the enactment of legislation or sensational incidents/crimes involving individuals with mental disorders.

b. Service Integration, Streamlined Services, and 'Boundary Spanners'
A key to successful diversion programs is the integration of services that is encouraged through a liaison person, or 'boundary spanner,' with a mandate to effect strong leadership in coordinating agencies. A boundary spanner is a person who bridges several systems (i.e., mental health, addictions, criminal justice, social support) and can engage the right people in relevant agencies to exchange information, coordinate, and collaborate on effective integration.

c. Active Involvement and Regular Meetings among Key Personnel
Successful diversion programs begin with and sustained involvement of all relevant mental health, addictions, social support, and criminal justice agencies. Regular discussion of topics such as service coordination, information sharing, and establishing written Memoranda of Understanding (MOUs) is recommended.

d. Leadership and Accountability
Strong leadership is needed to network, coordinate, and provide direction to policy and program development—ideally using pooled funding for diversion strategies.

e. Early Identification and Formal Case-Finding Procedures
Procedures for identifying persons with mental disorders who are involved with the criminal justice system and in need of services are critical to the success of diversion programs. The mental health treatment needs of an individual should be screened as early as possible to determine their appropriateness for diversion.

f. Standardized Training, Cross-Training, and Increased Awareness
A core element of diversion programs is the training of police, court support workers, Judges, Crown and defence lawyers, probation and parole officers, and Justices of the Peace on issues relating to mental disorders and the availability of mental health and addiction services. Comprehensive basic training of all police officers on general issues relating the mental disorder as well as specialized training of a core group of police officers as first responders to mental health calls is recommended. Case managers should have knowledge and experience with mental health and criminal justice systems. Ensuring that lawyers and court staff are aware of pre-trial diversion options is key to the success of a diversion program. Continuing education and cross-training of the aforementioned professionals should be offered.

> "Ensuring that lawyers and court staff are aware of pre-trial diversion options is key to the success of a diversion program."

g. Enhanced Community Resources
Adequate resources—particularly active case management and appropriate housing—must exist in the community for any diversion program to be effective. The ability to help meet basic needs and access services is a necessity at each diversion point within the criminal justice process, as is further discussed in the following section.

2.4.2. Level 1: Community-Based Diversion

Introduction

An effective diversion model begins with the mental health and addiction service delivery system—before the behaviour of an individual with mental disorder is brought to the attention of the criminal justice system. Access to evidence-based practices is important for ensuring that people with mental disorders receive the appropriate treatment and support to help them address mental health and substance misuse problems. Appropriate action at the community level will help to reduce criminal justice interactions by providing individuals with mental disorders with the tools and services they require to achieve a better state of wellness within the community, reduce the occurrence of mental health crises, and have ready access to help and support when needed.

Best Practice Review

Five fundamental elements of an effectively organized mental health and addictions service system include: (1) providing a comprehensive and balanced continuum of services, (2) integrating services within and between systems, (3) matching services to individual need and allowing access to a full range of services,(4) promoting system inclusiveness to address health inequities and (5) measuring and monitoring system-level performance to make improvements. These elements are consistent with the World Health Organization's guiding principles for organizing mental health services (McDaid & Thornicroft, 2005) as well as several other systems-level principles and recommendations (see generally, U.S. Department of Health and Human Services, 1999; Health Canada, 2005; Hogan et al., 2003; Roberts & Ogborne, 1999).

An effective mental health and addictions system is one that provides access to a comprehensive and balanced continuum of services and supports. In a balanced care approach, a flexible range of services are primarily provided in community-based, local settings, that span the specialized and non-specialized sectors, and emphasize the following features (Thornicroft & Tansella, 2003):

- Care is provided close to home
- Services are mobile
- Interventions address both symptoms and disabilities
- Treatment and care is tailored to an individual's diagnosis and needs
- Interventions adhere to international conventions on human rights
- Services reflect the priorities of the service users and support personal empowerment
- Care is coordinated and services are linked among care providers and agencies.

The basic needs of persons with mental disorders are the same as anyone: safe and adequate housing; sufficient financial resources to meet reasonable food, clothing, transportation, hygiene and health needs; social interactions; and the opportunity to both participate in their own life planning and to contribute to society.

Above and beyond these basic needs, persons with mental disorders require access to a range of additional services and supports to maintain wellness in the community. Some of the essential services and supports that are offered in a best-practice, comprehensive and balanced mental health and addictions system include:

- **Early identification and intervention:** to detect and respond to early signs of mental disorders
- **Acute inpatient care:** to provide short-term, high-intensity, specialized interventions for persons in crisis who require immediate support or who are at risk of violence to self or others

- **Community-based alternative care models to inpatient care:** to offer access to services such as partial hospitalization, home treatment, and crisis houses
- **Case management/assertive community treatment:** to facilitate independent community living for people with mental disorders
- **Family support services:** to provide the families with support and to encourage their active involvement in the system
- **Self-help and other consumer-led initiatives:** to allow people with mental disorders and/or problematic substance use to share their experiences with each other in a mutually-supportive environment
- **Withdrawal management/ detoxification services:** to provide medical and psychosocial withdrawal management services to persons with problematic substance use issues in a supportive environment
- **Housing and residential facilities:** to provide a continuum of community-based housing options and residential facilities for persons with mental disorders
- **Supported education and supported employment programs:** to assist with the rehabilitation of persons with mental disorders
- **Aftercare services:** to sustain treatment gains and further develop community reintegration through the provision of addiction-relate support

> "The basic needs of persons with mental disorders are the same as anyone. Safe and adequate housing, clothing, transportation, health care; social interactions; and the opportunity to contribute to society."

Service needs vary from person to person and may include access to some or all of the above services and supports at any particular time.

A balanced and comprehensive mental health and addictions system should also seek to reduce inequities in health status among population groups and to remove systemic barriers that create disparities in access and utilization of mental health and addictions services (Kirby, 2006; U.S. Department of Health and Human Services, 1999). Overall, there is a need for flexibility and resourcefulness to find the approach that is most effective for each individual.

Specific to diversion, the Criminal Justice/ Mental Health Consensus Project (Council of State Governments, 2001) makes the following recommendations relating to the mental health system to avoid inappropriate criminal justice involvement of persons with mental disorders:

- Provide user-friendly entry to the mental health system for those who need service
- Expand the priority service definitions to include more people with mental disorders who have histories of criminal justice involvement
- Improve access to appropriate services by people with mental disorders who are at risk of criminal justice involvement or who have histories of criminal justice involvement and match services to those needs
- Draw funding for mental health services from a variety of public sources

The availability of these services and supports within the community will help reduce the number of people with mental disorders becoming engaged with the criminal justice system, but cannot prevent all engagement. An integrated and comprehensive response must also be developed within the criminal justice system to ensure that the most appropriate response is available for persons with mental disorders who engage in criminal behaviour.

2.4.3. Level 2: Police-Based Diversion

Case Study: A police officer returns countless times to a house or street corner in response to a call for assistance involving the same person with a history of mental illness; each time, the officer is unable to link the person to treatment.
—Council of State Governments, 2002

Introduction

Police agencies have become the first point of access to mental health services for many people with mental disorders, earning them the moniker "Psychiatrists in Blue." Most police agencies are called on regularly to intervene with persons exhibiting symptoms of mental disorders—from minor nuisance type offences (e.g., causing a disturbance) to more serious incidents involving threatened or actual violence. Indeed, the first few seconds of interaction between a police officer and a person with mental disorders can determine whether it will be a problematic or productive situation. In addition to the aforementioned strategies that apply across the diversion continuum (i.e., police training), many police agencies have developed specific strategies to improve interactions involving persons with mental disorders. While it has been suggested that such programs lead to better outcomes for persons with mental disorders, the police, and the public; some research suggests that formal pre-charge diversion programs at the police level is associated with increased criminal justice system penetration for persons with mental disorders (Nuffield, 1997). Therefore, the formal strategies recommended below should be designed and implemented in a manner that minimizes both net-widening and further criminalization of persons with mental disorders.

The majority of police-based diversion programs have been developed in the United States where all levels of government have supported alternatives to arrest for persons with mental disorders. The recommendations that follow are drawn primarily from substantial work done by the Criminal Justice/ Mental Health Consensus project (Council of State Governments, 2002), and supported by other research findings. A review of the literature on best practices in police-based diversion shows the following to be core elements for a successful program: (a) provide appropriate tools and training for dispatchers; (b) ensure appropriate on-scene response by police; and (c) establish a specialized crisis response site.

Best Practices

a. Appropriate Tools and Training for Dispatchers

Police dispatchers are responsible for receiving calls for service, gathering information about the situation, and communicating it to the patrol officer; therefore, the manner for which dispatch services handle calls involving individuals with mental disorders is important for how the police will eventually respond to the situation.

The following recommendations are intended to assist dispatchers gather information, handle the situation, and appropriately dispatch calls involving persons with mental disorders (Council of State Governments, 2002):

- Ensure that dispatchers receive training specific to handling calls relating to incidents involving persons with mental disorder
- Provide dispatchers with a list of questions that help determine whether mental disorder is relevant to the call for servic
- Provide dispatchers with tools that determine whether the situation involves violence or weapon
- Provide dispatchers with a flowchart to facilitate the dispatch of calls involving persons with mental disorders to the appropriate designated personnel
- Ensure that radio communication between dispatchers and police is done using appropriate language, including describing the persons' actual behaviour rather than using labels (i.e., presumed diagnosis)

- Develop specific guidelines on how to record information in the dispatch database about calls in which mental disorder is suspected to be a factor—including coding of locations of repeat calls

b. On-Scene Assessment, Response, and Disposition
Police officers should be trained in procedures to recognize incidents in which mental disorder may be a factor. In particular, the following procedures are identified as being important for police when attending to an incident (Council of State Governments, 2002).

Police must stabilize the scene using deescalating techniques or trauma-informed responses appropriate for people with mental disorders. Techniques that are considered appropriate to respond to people with mental disorders include, but are not limited to, the following: remaining calm and avoiding over-reacting, understanding that a rational discussion may not take place, speaking simply and briefly, and acknowledging the reality of the delusional or hallucinatory experiences for the individual.

> "It is important for police to be able to recognize behaviours, actions, and speech that are indicative of mental disorder."

It is important for police to be able to recognize behaviours, actions, and speech that are indicative of mental disorder, including bizarre mannerisms, incoherent communication, disorientation, delusions/hallucinations, hyperactivity, and slow responses—to name a few. Rather than being treated as conclusive proof of mental disorder, the recognition of these signs and symptoms should act to modify the police officer's on-scene response to an individual, such as asking questions related to mental disorder, obtaining collateral information from friends/relatives, and if applicable assisting with access to needed prescribed medication. This also includes making a determination as to whether the person might meet the criteria to be apprehended under Section 28 of the BC Mental Health Act (i.e., apparently suffering from mental disorder, acting in a manner likely to endanger their own safety of that of others) and transported to a physician for examination. Voluntary assessment and treatment should be encouraged, but officers must also be aware of and prepared to resort to involuntary apprehension procedures. A Police Triage Guide has been developed by the BC Association of Chiefs of Police to assist with making this determination and is available online (BCACP, 2007). Since substance misuse is associated with elevated risks for violence for persons with mental disorders, officers should be observant of signs that would indicate that alcohol and/or drug misuse is a factor.

It is recommended that the response of police be guided by their assessment of the seriousness of the crime that has allegedly been committed by a person with a mental disorder. More specifically, officers should consider alternative responses (i.e., referring to mental health services) in lieu of arresting an individual who has come to the attention of police because of minor criminal behaviour (i.e., nuisance-type acts) stemming from their mental disorder. Of course, this can only be done if clear guidelines are developed to assist and support officers in making appropriate disposition decisions.

If appropriate, on-site responders should have access to personnel who have mental health training and/or expertise. Such on-site expertise might be provided by police officers with extensive training in mental health issues, or by mental health professionals who co-respond with police officers. Specially trained mental health professionals should be available

to respond to scenes involving barricaded or suicidal individuals with mental disorders. Three police response models for persons with mental disorders are discussed at the end of this section. A key ingredient of the on-site police response models for people with mental disorders is that the mental health "expert" has a good understanding of the availability of local community resources.

Another on-scene response best practice for police is to establish written protocol to enable officers to implement appropriate responses based on the nature of the incident, the behaviour of the individual, and availability of resources (Council of State Governments, 2002). The following are recommended elements of the written protocol for police (Council of State Governments, 2002):

- Institute a flowchart that matches hypothetical situations involving persons with mental disorders with disposition options
- Formalize agreements between law enforcement and mental health partners participating in the protocols
- Provide information to victims with mental disorders and their families to help prevent re-victimization and increase understanding of criminal justice procedures
- Create restraint policies to ensure that individuals with mental disorders are transported to appropriate facilities with the least restrictive restraint as possible
- Where neither arrest nor mental health assessment is warranted, the officer should try to connect the individual with family, friends, peer support groups, crisis center, advocacy services, and/or engage a mental health provider as necessary. This can be done through formalize partnerships with community agencies (e.g., CMHA)
- Ensure accurate documentation of police contacts with people whose mental disorders seemed to have been a factor in an inciden
- Address barriers for information sharing between different sectors (i.e., health, police, and mental health) and develop procedures or memoranda of understanding to share information in an appropriate manner—perhaps on a case by case basis. These protocols should be reviewed during cross-training sessions to ensure the content and reasons for them are understood by all personnel
- Persons with mental disorders who are involved with mental health agencies should be given the opportunity to provide advance consent to release certain information to law enforcement agencies if an incident occurs (i.e., medication information). Advanced consent can be the most efficient way to ensure that relevant information is available to assist officers in making an appropriate response
- Modify police performance evaluations to recognize and reward an officer's success at collaborating with, and making referrals to, community partners, at successfully resolving situations, and reducing the need for use of force

c. Specialized Crisis Response Site

A specialized crisis response site has been recognized as a core element of many police-based diversion programs (Steadman et al., 2001). These sites are designed to alleviate the problems associated with police transporting an individual in psychiatric crisis to traditional emergency services (i.e., hospital emergency rooms). The key features of a specialized crisis response site include: a centralized site (i.e., single point of entry, accessible 24 hours a day by police, co-location of mental health and substance abuse services); police-friendly policies and procedures (i.e., no refusal police for all police referrals, streamlined processes to minimize police officer wait time); an established legal foundation to accept and detain individuals; innovative and intensive cross-training of law enforcement, mental health, and health personnel; and services that go beyond assessment and evaluation (i.e., linking individuals to mental health and community services).

d. Examples of Police-based Diversion Models
Following their review of the literature, Hartford et al. (2004) describe three distinct models for police diversion:

1. **The Crisis Intervention Team (CIT) model.** This program is staffed by officers with 40 hours of special training in mental health issues. In situations with persons with mental disorders, staffed officers have a chance to defuse the situation before it escalates. In Canada, the CIT model has been adapted for use by police departments in Vancouver, Camrose, Chatham, and Calgary. The Lower Mainland Division of the RCMP has developed a CIT program model that provides integrated training to police officers, ambulance paramedics, dispatchers, emergency room personnel and other community first responders, and works to develop community level interdisciplinary liaison teams to increase collaboration and problem solving.

2. **The Psychiatric Emergency Response Team (PERT) model.** This program pairs licensed mental health professional with police officers, both of whom respond to situations involving persons with mental disorders. The mental health professionals and the police officers receive 80 hours of training over a four week period. In Canada, the PERT model has been adapted for use by a police department in Hamilton.

3. **The Crisis Mobile Team (CMT) model.** This program is comprised of behavioural health experts who help police officers at the scene decide a course of action in incidents involving mentally ill offenders. Case managers may refer the person to an appropriate outpatient facility. In Canada, the CMT model has been adapted by police departments in London, New Westminster, Gatineau, and Halifax.

The CIT model, combined with having a mental health facility with a 'no refusal policy' for police cases, appears to be most effective at diverting persons with mental disorders away from the criminal justice system (i.e., fewer arrests) and towards mental health services (Steadman et al., 2000).

4.4. Level 3: Pre-Trial Diversion

Case Study: Month after month, a prosecutor charges the same person with committing a different public nuisance crime, and, each time, the defendant with mental illness pleads guilty to time served.
—Council of State Governments, 2002

Introduction

The literature indicates that in communities with poorly developed treatment systems and lack police-based diversion strategies, prototypical candidates for pre-trial diversion have committed a non-violent, minor offence as a result of symptomatic mental illness (Munetz & Griffin, 2006). Pre-trial diversion, also known as post-arrest diversion, takes place during the period between an individual's arrest and their appearance at court. During this period, the Crown prosecutor may direct an evaluation to remove mentally disordered persons from the prosecution process and divert them to treatment or other specialized diversion programs for a defined period. Pre-trial diversion should preferably take place as early as possible, such as at the charge approval or bail hearing stages. In the former case, charge approval is suspended until completion of the period of diversion. In the latter case, prosecution of the charge(s) is suspended pending completion of some form of diversion. In either case, Crown counsel does not proceed with the charges for individuals who successfully complete the diversion process.

Throughout the discussion of best practices for pre-trial diversion, it is important to be mindful of the issues raised by Nuffield (1997) based on observations of pre-trial diversion programs, including:

- Diverting offenders who would not have significantly penetrated the justice system
- Whether diversion staff should be most closely affiliated with the Crown or defence, and whether prosecutors should screen cases at an early stage
- The degree to which information is presented to defendants being offered diversion regarding the true nature of their prospects if they proceed to court
- The degree to which diversion programs are evidence-based or effective

A review of the literature on best practices for pre-trial diversion shows the following to be core elements for a successful program: (a) development of integrated teams for program planning and implementation, (b) establishing early identification and formal case finding procedures, (c) ensuring wide-spread knowledge of diversion alternatives, and (d) implementing clear and appropriate procedures, protocols, and conditions to support the pre-trial diversion program.

Best-Practices

a. Integrated Team

Development of a pre-trial diversion program (including the framework, funding and staffing) should be done by an integrated planning team that includes judiciary, Crown and defence counsel, mental health service administrators, community service providers, jail administrators, and social services. Team members must be committed, long-term, and willing to champion the program—working at a high level of cooperation to promote effective collaboration and linkages between systems. These team members must be leaders within their sector with good communication skills, an understanding of system components and informal networks, and work to develop broad based institutional support for the program. An integrated coordinating group with service providers from the same key sectors should meet on a regular basis to discuss day-to-day aspects of the pre-trial diversion program.

b. Early Identification and Formal Case Finding Procedures

Identification of persons with possible mental disorders should occur at the earliest opportunity through police information or

routine initial screening for mental illness and co-occurring substance misuse at time of jail intake. Further mental health screening should be conducted within 48 hours when mental disorder is suspected, with follow-up evaluation as necessary. Defendants who are awaiting trial in custody and are identified as having a mental disorder should be considered for crisis intervention, short-term treatment (including, continued use of psychiatric medication prescribed prior to admission to jail), and discharge planning.

It is important for defence/duty counsel to be appointed early in the process, potentially before charges are laid, in order to identify the mental health status of their client and assess their potential for pre-trial diversion. Defence counsel should have sufficient training to identify mental health issues of their clients and should consider reviewing multiple information sources as soon as possible after appointment, such as interviews with clients, family members and friends, and reviewing police reports and other pre-trial information (Council of State Governments, 2002). It is suggested that, at minimum, diversion program staff check daily rosters of jail and remand inmates to find clients, interview them, recommend diversion if appropriate, and link them to mental health treatment and support (Hartford et al., 2004). Sufficient opportunities must also be available to Crown counsel early in the process to consider alternatives to prosecution.

> "Many communities lack sufficient capacity to develop specialty courts with dedicated judges, staff, and counsel."

c. Knowledge of Diversion Alternatives

In addition to being knowledgeable about mental health issues, professional staff members that are involved in pre-trial processes (e.g., Crown counsel, Defense/Duty counsel, pre-trial centre staff) must be made aware of the available alternatives to criminal justice processing and incarceration. Defense counsel should be able to identify alternatives to incarceration in appropriate cases for their clients with mental disorders. As well, defense counsel should be familiar with relevant case law and legislation, and should be aware of the mental health resources in their local community. This includes knowing the availability of programs/services for the client, program/service admission criteria and requirements, length of stay of programs/services, confidentiality rules imposed by the program, and costs for programs/services. Strategies that have been used to improve knowledge of diversion alternatives include (Council of State Governments, 2002):

- Establishing resource centers—usually for Defense counsel—to provide information regarding alternatives to incarceration for people with mental disorders
- Developing materials and training programs that cover recent holdings that might affect clients with a mental disorders
- Making resources available to family members and friends of people with mental disorders to help them navigate the criminal justice system
- Collaboration between professionals involved in pre-trial processes and staff in the mental heath system.

One element of pre-trial diversion may include consultation with the victim regarding the decision to divert; therefore, it is imperative that individuals who have been victimized by a defendant with a mental disorder receive education about potential diversion programs.

Echoing the section on best practices for community-based diversion, the pre-trial diversion literature emphasizes that Crown and defence counsel will be reluctant to apply for, or consider, diversion alternatives if the required mental health treatment services,

programs, or supports do not exist or are difficult to access for the individual.

d. Procedures, Protocols, and Conditions
Crown counsel should develop specific policies for the diversion of persons whose offence is linked to their mental disorder. It is suggested that the policy should not necessarily screen out individuals on the basis of criminal history or a current offence of domestic abuse. The diversion process must achieve a definitive and speedy direct link to appropriate treatment services and supports. Therefore, clearly defined treatment protocols and service guidelines should serve to expedite access to care and/or services for diverted individuals. The guidelines on compliance and termination must be clearly written in a plan which is explained to and understood by the individual, and signed by the individual and the diversion worker.

The literature also suggests a few strategies to assist defendants with mental disorders in complying with conditions of pre-trial diversion (Council of State Governments, 2002). These include ensuring that co-occurring substance misuse is identified, tailoring pre-trial diversion conditions to individual need, ensuring that conditions are the least restrictive and least onerous options available for the individual, and developing guidelines on compliance and termination policies that recognize the needs and capabilities of people with mental disorders. Prior to terminating diversion for non-compliance, is should be ensured than non-compliance was voluntary and wilful rather than a symptom of the mental disorder or a result of unintended difficulties with the treatment plan. Where diversion is terminated or the individual withdraws, the case should be returned to court without prejudice.

2.4.5. Level 4: Court-Based Diversion

"I used to give probation terms and wait for them to violate probation, and then we would file a petition and they would come back to court. Now I set review dates so they have come back in and prove to me that they have done something."
—Judge's comment on adopting problem-solving approach (Farole, 2005)

Introduction

Court-based diversion strategies target adults with mental disorders who have not been diverted from the criminal justice system at the community, police, or pre-trial levels. This section will discuss the contributions that can be made by the courts (i.e., judges) in the criminal justice diversion of persons with mental disorders. Unlike the strategies discussed in the previous section on pre-trial diversion, this section discusses diversion strategies that are the result of judicial exercise of discretion, rather than prosecutorial discretion.

Court-based diversion best practices can be divided into traditional court practices and speciality mental health court practices. Most of the literature on court-based diversion is focused specifically on mental health courts, in which judges and lawyers work with other officers of the court, psychiatrists, mental health workers and case managers, other service providers, and defendants to fashion treatment alternatives for persons with mental disorders. In Canada, mental health courts are in operation in Toronto and Saint John. It should be noted that mental health courts are heterogeneous with substantial variability between locations in the practices and procedures that are used to deal with individuals with mental disorders (Hartford et al., 2004). Many communities lack sufficient capacity to develop specialty courts with dedicated judges, staff, and counsel. Locations that do not developed speciality courts, either because of lack of capacity or other reasons, should still consider integrating problem-solving processes into traditional courtroom practices. There are several ways in which the process can be implemented on a more limited basis, such as postponement of sentencing pending a referral to treatment and administration of alternative sanctions for prison-bound offenders.

The literature on court-based diversion best practices indicates the following to be core elements for a successful program: (a) informed program planning and administration, (b) timely identification and linkage to services, (c) clear understanding and informed choice of defendants, (d) mental health docket in traditional courts, (e) integrating problem-solving practices into traditional courts and (f) alternative sentencing planning strategies (Nuffield, 1997; Council of State Governments, 2002; Hartford et al., 2004; Farole et al., 2005).

Best Practices

a. Informed Program Planning and Administration

In planning a court diversion program, there should be cross-sector representation including judges (as leaders/drivers of design and administration), police, Crown and defence counsel, court administrators, pre-trial staff, corrections, mental health service providers, substance use treatment providers, housing and other service providers, mental health advocates, victim services, consumers, and family members. The diversity of this committee should necessarily reflect the complexity of the issues that are faced by defendants with mental disorders.

During the planning stages, it is important to identify and clearly document the following program elements: eligibility criteria; monitoring mechanisms; realizable goals; information sharing protocols; and agency leaders/policy makers to serve on an advisory committee. The target group for the court diversion program should be well defined, should not overlap with other problem-solving courts (drug court, community court), and

should focus on criminal behaviour that is related to mental disorder. Regarding the advisory committee, their role is to address ongoing issues of policy implementation and practice; facilitate ongoing training and education; monitor program successes and failures; monitor adherence to the mission; coordinate with relevant activities and initiatives across the criminal justice, mental health, addiction, and social support systems; suggest revisions to policies and procedures when appropriate; and advocate for support.

b. Timely Identification and Linkage to Services
The sooner that participants are identified and linked to services, the sooner they will return to the community and reduce the burden on the court and correction systems.

The literature recommends the following for court diversion programs:

- Accept requests for diversion from a number of sources, including police, jail and pre-trial services, service providers, Crown and defence counsel, family members, court staff, and advocates or supporters
- Advertise eligibility criteria and educate potential referral sources to promote accurate referrals. It is suggested that one or two primary referral sources are selected to be especially well-versed in procedures and criteria
- Ensure the facilitation of release of mental health information (i.e., observations of the arresting officer, pre-trial information, mental health reports if the defendant's competency has been called into question) where appropriate for use in a dispositional alternative
- Ensure that service capacity exists for the timely completion of mental health pre-sentence reports (i.e., complete assessments conducted by a mental health clinician) where there are indications that the offender may have a mental disorder
- Ensure speedy review of referrals by Crown counsel, defence counsel and a clinician
- Expand sentencing options that are available in rural areas to provide appropriate services for people with mental disorders
- If an individual's competency or cognitive capacity may be an issue, expedite the assessment and determination. In particular to minor offences, the time to determine competency or capacity (i.e., fitness to stand trial) should not be greater than the potential sentence

c. Client Understanding and Informed Choice
Defendants must fully understand program requirements and potential outcomes before agreeing to participate. The following practices are identified as key for ensuring that defendants make informed choices regarding diversion:

- Defence counsel must be provided to individuals in order to assure informed consent to all decisions about program involvement
- Terms of participation must be put in writing for review by the defendant and their counsel
- Concerns about an individual's competency or cognitive capacity must be addressed in a timely manner whenever they arise
- Consequences for non-compliance must be clearly communicated and contained in the written contract, detailing what action could be taken in response to the individual's failure to comply with conditions
- Where plea agreements are offered, the potential effects of criminal conviction should be clearly explained—especially for minor, non-violent offences. Potential effects of a guilty plea include limitations on housing and employment options, travel, and access to some treatment programs
- Participants should be informed whether they have the option to withdraw and return to traditional court process at any time without impact on their case

d. Mental Health Docket in Traditional Courts
The court docket in a traditional courtroom can be dedicated for a period of time (e.g.,

one afternoon per week or biweekly) to defendants for whom mental disorder is, or may be, a factor in the offence which brings them before the court. The same principles outlined above would apply to this model. No special courtroom is necessarily required as it is the interaction within the court which makes it distinctive.

> "Probationers and parolees with mental disorders have trouble complying with their conditions and are, therefore, at increased risk for technical violations, new arrests/charges, and new sentences including incarceration."

e. Integrating Problem-Solving Practices into Traditional Courts

As is articulated by Farole et al. (2005), there is no practical reason that the problem-solving practices used successfully by specialized courts cannot be integrated into traditional courtrooms. The main challenge lies in changing both traditional judicial decision-making philosophy and the adversarial, non-inclusive nature of the criminal justice system. Other challenges lie in the lack of information about resources in the community and lack of court time to adequately address the complex needs of each defendant. Some recommendations, drawn from the experience of judges in problem-solving courts, to overcome these barriers include (Farole et al. 2005):

- Judicial leaders must understand, support, and promote the use of problem-solving practices throughout the court system. These leaders should encourage bench judges to practice these methods when appropriate and to volunteer for specialized court assignments
- New judicial orientation and judicial college curricula should include a mandatory module on problem-solving philosophy
- Judges from problem-solving courts should make regular presentations to other sitting judges to promote problem-solving practices and to provide updates about outcomes of specialty courts. All judges should also observe problem-solving courts in action—either by sitting in on the court or shadowing a judge from that court. Finally judges who have an interest should be encouraged to volunteer for assignments in specialty courts
- Similar training should be encouraged and implemented for Crown and defence counsel to encourage understanding and use of these practices on a regular basis. Court staff, including clerks and sheriffs, would also benefit from education in this area
- Problem-solving practices that have been identified for integration into traditional court practices include (Farole et al. 2005):
  - Being proactive, such as asking questions, reaching out to service providers, finding solutions to create more individualized, and sometimes unconventional, court orders
  - Direct engagement with defendants for the purpose of developing an individualized and appropriate court order
  - Judges being aware of the services and treatment currently available in their local community
  - Requiring the defendant to report back to court to discuss progress with court mandates
  - Using other mechanisms as sanctions for non-compliance including increased frequency of court appearances and lectures, and investigating the cause of any problem with compliance with the client and service providers to determine the most appropriate response
  - Adopting a team-based, non-adversarial approach. This is contingent on the willingness of Crown and defence counsel to work as a team with each other and with the judge to craft a plan that will most effectively assist

the defendant without compromising their interests

For cases in which clients agree to participate in a judicially monitored diversion program, the duration of participation should not be longer than the maximum period of incarceration or probation that a defendant could have received if found guilty in a traditional court process. Duration should also vary depending on the defendant's progress in the diversion program. Conditions of supervision should be the least restrictive necessary, especially for those charged with minor offences to avoid the likelihood of violations leading to potential increase in criminal justice system involvement. And, program completion should result in a positive legal outcome: Pre-plea outcomes may include reduction or dismissal of charges, while post-plea outcomes should include early termination of supervision, vacated pleas, and reduced or eliminated fines.

f. Alternative Sentencing Planning Strategies

When appropriate, alternative correctional strategies should be considered for 'prison bound' convicted offenders. Such alternative strategies include (but are not limited to) intensive surveillance (i.e., electronic monitoring), enrolment in treatment, educational or vocational programs, restitution, and community service (Nuffield, 1997). Such strategies should be individually tailored to each offender—being mindful of the nature of serious mental disorders in that relapse is a normal part of recovery. There is some evidence to suggest that alternative sentence planning for adult offenders with mental disorders holds some promise for diverting offenders from prison and into intensive community interventions (Nuffield, 1997).

2.4.6. Level 5: Community Corrections Diversion

Case Study: A parole officer already struggling with an overwhelming caseload is assigned an individual with mental illness released from prison; the officer receives only limited support from the community-based mental health program. The parolee is rearrested and returned to prison when he commits a new crime—urinating on a street corner and making lewd gestures to frightened people passing—displaying in public the symptoms of his untreated mental illness.
—Council of State Governments, 2002

Introduction

As an alternative to incarceration—and an integral element of most jail diversion programs—the community corrections system has a significant role to play in the diversion of individuals with mental disorders. On account of the high prevalence of mental disorders amongst probationers and parolees, the community corrections system has been referred to as a de facto community mental health system (Lurigio, 1996). However, unlike the mental health system, traditional probation and parole departments often lack the resources and specialized training needed to identify and appropriately deal with the needs of individuals with mental disorders (Lurigio et al., 2003).

In Canada, the community corrections system generally consists of persons convicted of a criminal offence who are serving sentences in the community, either because: (a) a judge has ordered a community sentence (i.e., conditional sentence, probation), or (b) a parole board has granted release from a correctional institution. In both cases, the individual is supervised in the community and must abide by the conditions of their release. Persons sentenced to community supervision, such as probation, fall within the mandate the BC Corrections Branch, Ministry of Public Safety and Solicitor General, and are supervised by probation officers. The BC Corrections Branch is also responsible for the supervision of persons on alternative measures and bail. Persons who are released from incarceration fall within the mandate of the Correctional Service of Canada and are supervised by parole officers.

In addition to the core elements that are essential across the criminal justice diversion continuum (i.e., staff training, systems integration and collaboration), the literature draws attention to several best-practice strategies for community corrections diversion, including: (a) mental health screening; (b) probation/parole revocation prevention; (c) intensive and specialized case management; and (d) specialized caseloads. Collectively, these strategies aim to identify persons with mental health needs, link them to appropriate services, and prevent further offending and/or incarceration.

Best Practices

a. Screening

Effective screening is a necessary first step in properly addressing the mental health and addiction needs in the criminal justice system (Lurigio & Swartz, 2006). Many individuals serving sentences in the community (i.e., probation, parole) have unidentified mental health or substance abuse needs. In fact, few probationers and parolees with mental disorders are identified prior to sentencing and are mandated to participate in treatment (Veysey, 2006). This is particularly true if the individuals' mental health or substance abuse issues were not an explicit part of their offence, or were not exhibited prior to sentencing or, in case of parolees, during incarceration (Lurigio, 2000; Lurigio et al., 2003).

Upon intake, the mental health and substance abuse service needs of probationers and parolees should be routinely evaluated by trained staff members using a standardized screening instrument (Lurigio & Swartz, 2006). The screening should cover issues such as symptoms of mental disorders, psychiatric

treatment history, presence of mental retardation or developmental disabilities, history of suicide attempts and current suicidal ideations, and history of violence (Lurigio, 1996). Several screening instruments, such as the Referral Decision Scale (Teplin & Swartz, 1989), can be used by trained lay persons with criminal justice populations; however, few instruments have been validated in community corrections populations. The results of the screen should be used to ascertain the need for a subsequent referral to a mental health professional for a more comprehensive follow-up evaluation (Lurigio, 1996).

b. Managing Treatment Conditions and Technical Violations

The participation of probationers or parolees in treatment services may be mandated by the Court or parole board, or it may be initiated by a probation or parole officer with the understanding that failure to comply may result in revocation. In either case, the responsibility of choosing the most appropriate intervention and monitoring compliance may be left to the discretion of the probation and parole officer. Research has shown that probationers and parolees with mental disorders have trouble complying with their conditions and are, therefore, at increased risk for technical violations, new arrests/charges, and new sentences including incarceration (Skeem et al., 2006). Probation and parole officers should be prepared to use non-traditional methods for managing the conditions of mentally disordered probationers/parolees and dealing with their technical violations.

In order to break the criminal justice cycle that can be produced by these technical violations, several jurisdictions have established specific strategies for dealing with probationers and parolees in a manner that recognizes their mental health needs while simultaneously holds them accountable for their actions. These revocation prevention strategies generally employ one of more of the following practices (Council of State Governments, 2002; Lurigio, 2000):

- Establishing incentives for probationers/parolees with mental disorders to comply with conditions, such as reducing the frequency of reporting after a period of compliance
- Employing a graduated scheme of responses before employing the most serious response (i.e., revocation of probation/parole)
- Consulting with treatment service providers before taking action on a violation related to treatment or failure to undergo a mental health evaluation. For example, in response to a technical violation, probation and parole officers can refer mentally disordered probationers/parolees with non-violent offences to more intensive treatment and services in lieu of a court hearing and more punishment
- Responding to minor technical violations early to obviate the need for revocation and prevent more serious violations
- Establishing agreements and written guidelines with service providers regarding the support that they will provide and the actions that will be taken for failure to participate in treatment or if other problems arise
- Enlisting the assistance of mental health providers to help probationers/parolees better understand the consequences of their behaviour in terms of sanctions. For example, a joint meeting between the officer, the service provider, and the probationer/parolee to identify barriers to compliance and to make changes in the treatment plan or probation rules as necessary

These strategies emphasize the use of non-custodial alternatives when dealing with technical violations for probationers or parolees who have not committed a new criminal offence and are not a public safety risk. For cases that require removing a probationer or parolee from the community,

the goal should be to minimize their length of incarceration, as is done in the Parole Restoration Project, operated by the Center for Alternative Sentencing and Employment Services (CASES) in New York City (Council of State Governments, 2002). Under this program, technical parole violators with special needs (i.e., mental illness, substance abuse) are linked with case management, mental health and social services in order to return them to the community in an expeditious manner.

> "Jails and prisons represent an opportunity to identify, engage, and treat offenders with mental disorders."

c. Intensive and Specialized Case Management

Intensive case management is identified as a critical feature of any diversion program that targets offenders with mental health and/or substance abuse needs (Loveland & Boyle, 2007; Godley et al., 2000). The most promising case management model is assertive community treatment (ACT), which combines a team-based and outreach approach to case management. The key elements of assertive community treatment are: a low staff-to-consumer ratio (usually 1:10), multi-disciplinary teams who share responsibility of client, services that are tailored to the needs of the clients, full-time coverage, and assertive outreach primarily delivered in the community. There is ample evidence to support assertive community treatment as a best practice, particularly for individuals with serious mental disorders who have the highest service needs (i.e., an extensive history of hospitalizations or poor engagement with community-based services) (Vanderplasschen et al., 2007; Burns et al., 2007; Meuser et al., 2003; Dumont et al., 2002; Ontario, 2005).

Several jurisdictions have developed specialized "forensic" ACT teams (FACT) that shift the focus from preventing hospitalization to preventing arrest and incarceration for persons with mental disorders (Morrissey et al., 2007). In practice, the FACT model often deviates from high-fidelity ACT models, such as not providing 24/7 availability or employment specialists, and adds new elements, such as including probation, parole, or police officers to the treatment team (Morrissey et al., 2007). FACT is distinct in that it requires all clients to have criminal justice histories, accepts the majority of referrals from criminal justice agencies, and incorporates supervised residential treatment for high-risk clients particularly those with co-occurring substance use disorders (Morrissey et al., 2007). As a less costly, yet effective, alternative to the FACT model, the forensic intensive case management (FICM) model has similar features to FACT (i.e., assertive, in-vivo, and time-unlimited services), but does not have individual caseloads, self-contained teams, or 24/7 capacity. FICM programs that are effective at reducing rates of arrest and incarceration tend to integrate substance abuse treatment within their program, and emphasize jail diversion and coordination of mental health and criminal justice systems (Loveland & Boyle, 2007). Research suggests that specialized programs that are used in criminal justice settings (i.e., FACT or FICM) need to incorporate modules that explicitly focus on reduction of criminal behaviour and recidivism (Morrissey et al., 2007).

d. Specialized Caseloads

A growing body of literature suggests that the 'specialized mental health caseload' model is a promising practice for managing probationers and parolees with a mental disorders (Skeem & Louden, 2006; Lurigio, 2001). The 'specialized mental health caseload' model includes the following core elements (Skeem & Louden, 2006):

- Officers exclusively supervise persons with mental disorders
- Officers have a reduced caseloads

(approximately one-third the size of traditional caseloads
- Officers receive sustained training in relevant issues
- Officers intervene directly with probationers or parolees and actively coordinate with external service providers;
- Officers work as teams with treatment providers, attend treatment team meetings, and advocate to secure such appropriate treatment and social services
- Officers are likely to address treatment non-compliance by talking with the probationer or parolee to identify any obstacles to compliance, resolve these problems, and agree on a compliance plan, rather than merely remind probationers or parolees of the rules or threaten them with incarceration

The specialized caseload model can also serve as a transitional approach for persons who require short-term intensive assistance, such as mentally disordered persons released from jail or prison, until they are ready to be moved to a standard probation caseload (Lurigio, 1996). The Cook County (Chicago) Adult Probation Department's Mental Health Unit (MHU) is an example of a best-practice specialized caseload model (Council of State Governments, 2002). The MHU is staffed by probation officers with mental health training and the program provides clinical assessments, intensive supervision, and service linkage to probationers with metal disorders.

2.4.7. Level 6: Custodial Corrections Diversion

> *Case Study: Jail and prison administrators watch their systems swell with these individuals, who spin through the revolving door of the institution. Corrections officials' job is to keep these inmates alive, even if that means isolating them in administrative segregation with no outside contact for weeks on end. When the release date comes around, freedom for many prisoners is only temporary, unless they are among the few for whom reentry has meant planning and linkage with community supports.*
> *—Council of State Governments, 2002 Introduction*

A comprehensive criminal justice diversion scheme reaches for persons with mental disorders even after they have been sentenced to incarceration in jail or prison. While not usually considered diversion in the traditional-sense, custodial corrections diversion strategies aim to provide mentally disordered offenders with access to necessary services and supports in an effort to attend to their needs and to prevent further involvement with the criminal justice system. In this sense, custodial corrections diversion can be thought of as a recidivism-prevention strategy.

In Canada, the term jail refers to a provincial correctional centre for individuals who are remanded into custody (i.e., awaiting trial) or sentenced to a term of incarceration for two years less a day; whereas, the term prison refers to a federal correctional centre for individuals who are sentence to a term of incarceration for two years or more. While the two terms are used interchangeably in this document, it is recognized that custodial corrections diversion best-practice strategies will need to vary according to the length of incarceration, type of setting, and type population (American Psychiatric Association, 2000).

Jails and prisons represent an opportunity to identify, engage, and treat offenders with mental disorders. Moreover, the provision of mental health and addiction services can reduce the harmful effects of incarceration. While there is no single "best" way of organizing services, a best-practices custodial corrections diversion strategy includes the following core services: (1) screening, assessment, and evaluation (2) mental health and addictions treatment and (3) community re-entry (Council of State Governments, 2002; American Association for Correctional Psychology, 2000; American Psychiatric Association, 2000; Anno, 2000).

Best Practices

a. Screening, Assessment, and Evaluation Services
Immediately upon arrival to jail or prison, all inmates should be screened by a qualified professional for mental health and substance use disorders (US Department of Justice, 2004; American Psychiatric Association, 2000; American Association for Correctional Psychology, 1999; Council of State Governments, 2002; Ogloff et al., 2007). The purpose of this screening is to determine the inmates' risk for violence and suicide, and whether they are acutely or seriously mentally ill and require immediate evaluation by a mental health professional (American Psychiatric Association, 2000; Anno, 2000). Within 14 days of arrival at the jail or prison, more comprehensive screening should be performed with all inmates by a health care professional. This includes a medical screening, behavioural observation, mental health and substance abuse history, treatment motivation and readiness, mental retardation and other developmental disabilities, and an assessment of suicide potential (US Department of Justice, 2004; American Psychiatric Association, 2000).

Because of the high rates of co-occurring substance-use disorders among jail detainees, the detection of either a substance-use disorder or a mental illness should trigger an evaluation for co-occurring conditions (Osher et al., 2003). Screening inmates for suicide and motivation/readiness for treatment is also

recommended (U.S. Department of Justice, 2004). Procedures should be in place for those who are not identified as having mental health needs during the screening process, but may subsequently require mental health care, including emergency services. Promising screening tools that have been development for the purposes of identifying offenders with mental disorders include the Referral Decision Scale (Teplin & Swartz, 1989), the Brief Jail Mental Health Screen (Steadman et al., 2005), and the Jail Screening Assessment Tool (Nicholls et al., 2005).

Those who are identified as being in need of treatment and support should receive a targeted assessment or evaluation so that they can be assigned to appropriate services. The American Psychiatric Association (2000) recommends that a brief assessment be completed within 72 hours of screening positive for mental health and/or substance abuse problems. A comprehensive mental health evaluation is then required for diagnostic formulation and development of a treatment plan.

> "Clinical expertise and familiarity with community-based mental health resources inform release decisions and determination of conditions of release."

b. Mental Health and Addictions Services

Upon admission to the facilities, inmates should receive a written communication explaining the availability, and how to access, mental health and substance abuse services. The mental health and addictions services provided to inmates should be—at least—equivalent to the level of services available to persons in the community (World Health Organization, 2007b; American Psychiatric Association, 2000). The core elements of comprehensive mental health and addictions treatment in jails and prisons include (American Association for Correctional Psychology, 1999; American Psychiatric Association, 2000; Council of State Governments, 2002; World Health Organization, 2007):

- Inpatient resources in jail or in an external hospital
- Seven-day-a-week mental health coverage, including 24-hour nursing coverage areas in which people with acute or emergent psychiatric problems are housed
- A written treatment plan for each inmate who is receiving ongoing mental health services
- Full range of psychotropic medication prescribed and monitored by a psychiatrist with capacity to administer them in an emergency setting
- Crisis intervention to provide short-term emergency care for inmates who are an immediate danger to themselves or others;
- Special observation, seclusion, or restraint capability
- Supportive and informative verbal interventions
- Trained custodial staff in the recognition of mental health and substance use problems
- Comprehensive continuum of suicide prevention services
- Programs that provide productive, out-of cell activity and necessary psychosocial and living skills
- Longer-term care to provide structured treatment and rehabilitative services that consist of pharmacotherapy, life skills training, employment readiness interventions, and recreational activities
- Services for special populations with mental illness and addictions, such as mentally ill sex offenders, inmates with co-occurring mental illness and substance abuse disorders, inmates with HIV, women inmates, the geriatric population, and inmates with mental retardation or developmental disabilities

- Segregated facilities to provide care of the most severely and chronically mentally disordered inmates
- Individualized care plans and managers to track the progress of inmates with mental disorders to ensure that current treatment and services needs are being met
- Integrated substance abuse treatment and services

Programs that have been identified as being particularly effective in reducing recidivism for inmates with mental disorders, include specialized cognitive behavioural therapy, therapeutic community programs, correctional industries programs, and basic adult education programs (Aos et al., 2006; Morrissey et al., 2007; Mitchell et al., 2006; Lipsey et al., 2007; Lurigio, 2000).

c. Community Re-Entry Services

Upon release for jail or prison, inmates with mental disorders enter the community with numerous needs. Following release from jail or prison, individuals have an elevated risk for suicide, relapse to substance abuse, homelessness, and a host of other negative outcomes (Daniel, 2007; Barr, 2003). Too often, inmates with mental disorders are unprepared for community re-entry, are released without a discharge plan, and are not engaged with community services (Daniel, 2007; Lurigio, 2001).

Providing community re-entry services to inmates with mental disorders is essential. Community re-entry services prepare inmates for release during their incarceration and ensure the continuity of services following release to the community (American Association for Correctional Psychology, 1999; American Psychiatric Association, 2000). The Criminal Justice/Mental Health Consensus project makes the following recommendations concerning community re-entry of inmates with mental disorders (Council of State Governments, 2002):

- *Ensure that clinical expertise and familiarity with community-based mental health resources inform release decisions and determination of conditions of release.*
  This includes ensuring that: (a) release decisions address issues unique to inmates with mental disorders; (b) special conditions of release are realistic, relevant and research-based to address the risks and needs of parolees with mental disorders; and (c) the releasing authority identifies and obtains access to community-based programs and resources adequate to support the treatment and successful community reintegration of parolees with mental disorders.

- *Facilitate collaboration among corrections, community corrections, and mental health officials to effect the safe and seamless transition of people with mental disorders from prison to the community.*
  This includes ensuring that: (a) transition planners in each institution are identified and charged with coordinating the case management process, (b) involvement of all relevant agents and individual who all assist in carrying out the transition plan, (c) the transition from secure housing to the community progresses in a gradual sequence of planned steps, (d) assignment to an appropriate community-based provider, (e) the transition plan integrates housing support services and provides releasees with mental disorders an arrangement for safe housing, (f) arrangements are made for at least a week's supply of important medications, (g) inmates receive public benefits immediately upon release, (h) close monitoring of inmates in the days approaching release and modify the discharge plan when appropriate, (i) provide enhanced discharge planning to ensure continued case management for inmates with mental disorders who will complete their sentence in prison.

Two promising models for community re-entry for mentally disordered inmates include Critical Time Intervention (CTI) and the APIC Model. CTI is a nine-month, three-stage intervention that uses specialized workers to strengthen an individual's long-term ties to formal and informal relationships in the community and to provide individualized support and advocacy during the critical time of transition (Draine & Herman, 2007). The core elements of CTI are small caseloads, active community outreach, individualized case management plans, psychosocial skill building and motivational coaching. The APIC Model is a comprehensive re-entry strategy that has the following core components: (a) assessing the clinical and social needs, and public safety risks of the inmate (b) planning for the treatment and services required to address the inmate's needs (c) identifying required community and correctional programs responsible for post-release services and (d) coordinating the transition plan to ensure implementation and avoid gaps in care (Osher et al., 2002; 2003).

3 Key Findings

In summary, the literature review has identified the following best practices—organized according to conceptual model of the diversion continuum (Figure 1)—for diverting persons with mental disorders from the criminal justice system:

A. Cross-Continuum Strategies

- Inter-agency/governmental collaboration amongst a diverse set of stakeholders;
- Service integration, streamlines services, and boundary spanners
- Active involvement and regular meetings among key personnel
- Strong and accountable leadership
- Early identification and formal case-finding procedures
- Standardized training, cross-training, and increased awareness relating to mental disorders, mental health services, and diversion practices
- Ensuring enhanced community resources.

B. Community-Based Diversion

- Providing a comprehensive and balanced continuum of services
- Integrating services within and between systems
- Matching services to individual need and allowing access to a full range of services (particularly for those at risk of criminal justice involvement of with criminal justice histories)
- Promoting system inclusiveness to address health inequities (including people with mental disorders who have histories of criminal justice involvement
- Measuring and monitoring system-level performance to make improvements;
- Providing user-friendly entry to the mental health system for those who need services
- Drawing funding for mental health services from a variety of public sources

C. Police-Based Diversion

- Ensuring appropriate tools and training for dispatchers
- Using appropriate on-scene assessment, response, and disposition by police for people with mental disorders
- Establishing a specialized crisis response site

D. Pre-Trial Diversion

- Using an integrative planning team to develop the program/strategyEstablishing early identification and formal case finding procedures
- Ensuring wide-spread knowledge of diversion alternatives amongst criminal justice professionals
- Developing specific procedures, protocols, and conditions for the diversion of persons whose offence is linked to their mental disorder.

E. Court-Based Diversion

- Informed planning and administration of program/strategy with cross-sector representation
- Timely identification and linkage to services
- Ensuring that defendants understand the program requirements and make an informed choice
- Establishing mental health dockets in traditional courts
- Integrating problem-solving practices into traditional courts
- Using alternative sentencing planning strategies

F. Community Corrections Diversion

- Implementing effective and routine screening and assessment procedures
- Using non-conventional management of treatment conditions and technical violations

- Providing intensive and specialized case management
- Establishing specialized caseloads.

G. Custodial Corrections Diversion

- Providing routine and evidence-based screening, assessment, and evaluation services
- Providing mental health and addictions services
- Providing community re-entry services.

References

Alberta's Provincial Diversion Framework Working Committee. (2001). Reducing the criminalization of individuals with mental illness. Retrieved January 3, 2008 from www.amhb.ab.ca/Publications/reports/businessPlans/Documents/ABProvDiv-ReducingCrime.pdf

American Association for Correctional Psychology. (2000). Standards for psychology services in jails, prisons, correctional facilities, and agencies. *Criminal Justice and Behavior,* 27, 433–494.

American Psychiatric Association. (2000). Psychiatric Services in Jails and Prisons. 2nd Edition. Washington, DC: Author.

American Psychiatric Association. (2000b). Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC.

Angermeyer, M.C. (2000). Schizophrenia and violence. *Acta Psychiatrica Scandinavica,* 102, 63–67.

Anno, B.J. (2000). National Correctional Health Standards. In Ashford, J.B., Sales, B.D., and Reid, W.H. (Eds.). Treating Adult and Juvenile Offenders with Special Needs (pp. 81–96). Washington, DC: American Psychological Association.

Aos, S., Miller, M., & Drake, E. (2006). Evidence-Based Adult Corrections Programs: What Works and What Does Not. Olympia: Washington State Institute for Public Policy. Retrieved January 3, 2007 from: www.wsipp.wa.gov/rptfiles/06-01-1201.pdf

Appelbaum, K.L., Hickey, J.M., & Packer, I. (2001). The role of correctional officers in multidisciplinary mental health care in prisons. Psychiatric Services, 52 (10), 1343–1347.

Arseneault, L., Moffitt, T.E., Caspi, A., Taylor, P.J., & Silva, P.A. (2000). Mental disorders and violence in a total birth cohort—Results from the Dunedin study. *Archives of General Psychiatry,* 57(10), 979–986.

Barr, H. (2003). Transinstitutionalization in the courts: Brad H. v. City of New York, and the fight for discharge planning for people with psychiatric disabilities leaving Rikers Island. *Crime & Delinquency,* 49 (1), 97–123.

BC Association of Chiefs of Police [BCACP]. (2007). Police Triage Guide: Indications of Mental Disorder & Endangered Safety. www.jibc.bc.ca/police/main/PIIMIC/PIIMIC_PoliceTriag%20Guide.pdf

Bland, R.C., Newman, S.C., Thompson, A.H., & Dyck, R.J. (1998). Psychiatric disorders in the population and in prisoners. *International Journal of Law and Psychiatry,* 21 (3), 273–279.

Boccaccini, M.T., Christy, A., Poythress, N., & Kershaw, D. Rediversion in two postbooking jail diversion programs in Florida. *Psychiatric Services,* 56(7), 835–839.

Brink, J., Dohery, D., & Boer, A. (2001). Mental disorder in federal offenders: a Canadian prevalence study. *International Journal of Law and Psychiatry,* 24(4), 339–356.

BC Justice Review Task Force. (2005). Beyond the revolving door: a new response to chronic offenders. Report of the Street Crime Working Group. Retrieved January 3, 2008 from: www.bcjusticereview.org/working_groups/street_crime/scwg_report_09_29_05.pdf

British Columbia. (2004). Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction. British Columbia: Ministry of Health Services. Retrieved October 1, 2007 from www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

Broner, N., Lattimore, P.K., Cowell, A.J., & Schlenger, W.E. (2004). Effects of diversion on adults with co-occurring mental illness and substance use: outcomes from a national multi-site study. *Behavioral Science and the Law, 22,* 519–541.

Bureau of Justice Assistance. The Council of State Governments Justice Center. (2007). Improving Responses to People with Mental Illnesses—The Essential Elements of a Mental Health Court. Retrieved February 1, 2008 from consensusproject.org/mhpc/

Burns, T., Catty, J., Dash, M., Roberts, C., Lockwood, A., & Marshall, M. (2007). Use of intensive case management to reduce time in hospital in people with severe mental illness: *Systematic review and meta-regression. British Medical Journal,* 335, 1–7.

Canadian Mental Health Association, BC Division. (2003). Study in Blue and Grey: Police Interventions with People with Mental Illness. www.cmha.bc.ca/files/policereport.pdf

Canadian Psychiatric Association. (2005). Clinical practice guidelines: Treatment of schizophrenia. *Canadian Journal of Psychiatry,* 50 (Suppl. 1), 1S–56S.

Chandler, R.K., Peters, R.H., Field, G., & Juliano-Bult, D. (2004). Challenges in implementing evidence-based treatment practices for co-occurring disorders in the criminal justice system. *Behavioral Science and the Law,* 22, 431–448.

Clark, J. (2004). Non-Specialty First Appearance Court Models for Diverting Persons with Mental Illness: Alternatives to Mental Health Courts. Delmar, NY: Technical Assistance and Policy Analysis Center for Jail Diversion. gainscenter.samhsa.gov/pdfs/jail_diversion/pre_trial_nocover.pdf

Council of State Governments. (2002). Criminal Justice/Mental Health Consensus Project. Council of State Governments. Retrieved January 3, 2008 from consensusproject.org/downloads/Entire_report.pdf

Daniel, A.E. (2007). Care of the mentally ill in prisons: Challenges and solutions. J*ournal of the American Academy of Psychiatric and Law,* 35, 406–410.

Draine, J. & Herman, D.B. (2007). Critical time intervention for reentry from prison for persons with mental illness. *Psychiatric Services,* 58 (12), 1577–581.

Draine, J., & Solomon, P. (1999). Describing and evaluating jail diversion services for persons with serious mental illness. *Psychiatric Services,* 50, 56–61.

Dumont, R., Miller, D., Bailey, G., Brooks, R., Higenbottam, J., et al. (2002). B.C.'s Mental Health Reform Best Practices for Assertive Community Treatment. British Columbia: Ministry of Health and Ministry Responsibility for Seniors. Retrieved October 1, 2007 from www.health.gov.bc.ca/mhd/pdf/bp_assertive_community_treatment.pdf

Farole, D.J., Puffett, N., Rempel, M., & Byrne, F. (2005). Applying the problem-solving model outside of problem-solving courts. *Judicature,* 89(1), 40–42.

Farole, D.J., Puffett, N., Rempel, M., & Byrne, F. (2005). Applying problem-solving principles in mainstream courts: lessons for state courts. *Justice System Journal,* 26(1). findarticles.com/p/articles/mi_qa4043/is_200501/ai_n13638871/pg_1

Fazel, S. & Danesh, J. (2002) Serious mental disorders in 23 000 prisoners: a systematic review of 62 surveys. *The Lancet,* 359(9306), 545–550.

Fazel, S., & Grann, M. (2006). The population impact of severe mental illness on violent crime. *American Journal of Psychiatry,* 163, 1397–1403.

Fisler, C. (2005) Building trust and managing risk: a look at a felony mental health court. *Psychology, Public Policy and the Law,* 11(4), 587–604.

Godley, S.H., Finch, M., Dougan, L., McDonnell, M., McDermeit, M., & Carey, A. (2000). Case management for dually diagnosed individuals involved in the criminal justice system. *Journal of Substance Abuse Treatment,* 18, 137–148.

Griffin, P.A., Steadman, H.J., & Petrila J.D. (2002). T*he use of criminal charges and sanctions in mental health courts. Psychiatric Services,* 53, 1285–1289.

Grudzinskas, J.D., Clayfield, J.C., Roy-Bujnowski, K., Fisher, W.H., & Richardson, M.H. (2005). Integrating the criminal justice system into mental health service delivery: The Worcester diversion experience. *Behavioral Sciences and the Law,* 23, 277–293.

Hartford, K., Davies, S., Dobson, C., Dukeman, C., Furhman, B., Hanbidge, J., et al. (2004). Evidence-based practices in diversion programs for persons with serious mental illness who are in conflict with the law: literature review and synthesis. Prepared for Ontario Mental Health Foundation and Ontario Ministry of Health and Long-Term Care.

Hartford, K., Carey, R.,& Mendonca, J. (2006). Pre-arrest diversion of people with mental illness: literature review and international survey. *Behavioral Science and the Law,* 24, 845–856.

Health Canada. (2005). National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada. Ottawa, Ontario. Retrieved October 1, 2007 from www.nationalframework-cadrenational.ca/uploads/files/HOME/NatFRA1steditionEN.pdf

Henderson, S. (2003) Mental Illness and the Criminal Justice System. Unpublished. www.mhcc.org.au/projects/Criminal_Justice/contents.html

Hiday, V.A. (2006). Putting community risk in perspective: A look at correlations, causes and controls. *International Journal of Law and Psychiatry,* 29, 316–331.

Hogan, M.F., Adams, J., Arredondo, R., Carlile, P., Curie, C.G., Fisher, D.B. et al. (2003). Achieving the Promise: Transforming Mental Health Care in America. Final Report for the President's New Freedom Commission on Mental Health. Retrieved October 1, 2007, from www.mentalhealthcommission.gov/reports/reports.htm

Kirby, M.J.L, & Keon, W.J. (2006). Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Ottawa, Ontario: Standing Senate Committee on Social Affairs, Science and Technology. Retrieved October 1, 2007 from www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm

Lamb, H.R., Weinberger, L.E., & Gross, B.H. (1999). Community treatment of severely mentally ill offenders under the jurisdiction of the criminal justice system: A review. *Psychiatric Services,* 50, 907–913.

Lamberti, J.S., Weisman, R.L., Schwarzkopf, S.B., Price, N., Ashton, R.M., & Trompeter, J. (2001). The mentally ill in jails and prisons: Towards an integrated model of prevention. *Psychiatric Quarterly,* 72 (1), 63–77.

Lipsey, M.W., Landenberger, N.A., & Wilson, S.J. (2007). Effect of cognitive-behavioral programs for criminal offenders. Campbell Collaboration. Retrieved January 4, 2008 from www.campbellcollaboration.org/doc-pdf/lipsey_CBT_finalreview.pdf

Loveland, D. & Boyle, M. (2007). Intensive case management as a jail diversion program for people with a serious mental illness: A review of the literature. *International Journal of Offender Therapy and Comparative Criminology,* 51 (2), 130–150.

Lurigio, A.J. (Ed.) (1996). Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and Codisorders. Seattle, WA: National Coalition for Mental and Substance Abuse Health Care in the Justice System.

Lurigio, A.J. (2000). Persons with serious mental illness in the criminal justice system: Background, prevalence, and principles of care. *Criminal Justice Policy Review,* 11(4), 312–328.

Lurigio, A.J. (2000). Drug treatment availability and effectiveness: Studies of the general and criminal justice populations. *Criminal Justice and Behavior,* 27 (4), 495–528.

Lurigio, A.J. (2001). Effective services for parolees with mental illness. *Crime & Delinquency,* 47(3), 446–461.

Lurigio, A.J., Cho, Y.I., Swartz, J.A., Johnson, T.P., Graf, I., & Pickup, L. (2003). Standardized assessment of substance-related, other psychiatric, and comorbid disorders among probationers. *International Journal of Offender Therapy and Comparative Criminology,* 47(6), 630–652.

Lurigio, A.J., & Swartz, J.A. (2006). Mental illness in correctional populations: the use of standardized screening tools for further evaluation or treatment. *Federal Probation,* 70(2), 29–35.

McDaid, D. & Thornicroft, G. (2005). Mental health II: Balancing Institutional and Community-based Care. European Observatory on Health Systems and Policies. World Health Organization. Retrieved October 1, 2007 from www.euro.who.int/document/e85488.pdf

Meuser, K.T., Torrey, W.C., Lynde, D., Singer, P., & Drake, R.E. (2003). Implementing evidence-based practices for people with severe mental illness. *Behavior Modification,* 27(3), 387–411.

Mitchell, O., Wilson, D.B., & MacKenzie, D.L. (2006). The effectiveness of incarceration-based drug treatment on criminal behavior. Campbell Collaboration—Criminal Justice Review.

Morrissey, J., Meyer, P., & Cuddeback, G. (2007). Extending assertive community treatment to criminal justice settings: origins, current evidence, and future directions. *Community Mental Health Journal,* 43 (5), 527–544.

Munetz, M.R., & Griffin, P.A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services,* 57(4), 544–549.

Nicholls, T.L., Roesch, R., Olley, M., Ogloff, J., & Hemphill, J. (2005). Jail Screening Assessment

Tool (JSAT): Guidelines for Mental Health Screening in Jails. Burnaby, BC: Mental Health, Law, and Policy Institute, Simon Fraser University.

Nuffield, J. (1997). Diversion Programs for Adults (User Report No. 1997-05). Ottawa: Solicitor General Canada. Retrieved February 15, 2008 from ww2.ps-sp.gc.ca/publications/corrections/199801a_e.asp

Ogloff, J.R.P., Davis, M.R., Rivers, G., & Ross, S. (2007). The identification of mental disorders in the criminal justice system. *Trends and Issues in Crime and Criminal Justice,* 334. Retrieved January 20, 2008 from www.aic.gov.au/publications/tandi2/tandi334.html

Ogloff, J.R.P. (1996). The Surrey Pretrial Mental Health Program: Community Component Evaluation. British Columbia Forensic Psychiatric Services Commission.

Ontario. (2005). Ontario Program Standards for ACT Teams. 2nd ed. Ontario: Ministry of Health and Long-term Care. Retrieved October 1, 2007 from www.health.gov.on.ca/english/public/pub/ministry_reports/mentalhealth/act_standards.pdf

Ontario. (2004). Best Practices in Four Cities in Southwestern Ontario: The Interface between People with Mental Illness and the Criminal Justice System. Prepared for the Mental Health Foundation and Ontario Ministry of Health and Long-term Care Retrieved June 2007 from www.pmhl.ca/en/procedures.html

Osher, F., Steadman, H.J., & Barr, H. (2003). A best practice approach to community reentry from jails for inmates with co-occurring disorders: The APIC Model. *Crime & Delinquency,* 49 (1), 79–96.

Osher, F., Steadman, H.J., & Barr, H. (2002). A best practice approach to community re-entry from jails for inmates with co-occurring disorders: The APIC Model. The National GAINS Center. Retrieved January 3, 2008 from gainscenter.samhsa.gov/pdfs/reentry/apic.pdf

Roberts, G., & Ogborne, A. (1999). Best Practices: Substance Abuse Treatment and Rehabilitation. Health Canada. Retrieved October 1, 2007, from www.hc-sc.gc.ca/hppb/alcohol-otherdrugs

Roesch, R., (1995). Mental health interventions in jails. In G. Davies, S. Lloyd-Bostock, M. McMurran, & C. Wilson (Eds.), Psychology, Law, and Criminal Justice (pp. 520–531). New York: Walter de Gruyter.

Seltzer, T. (2005). Mental health courts: a misguided attempt to address the criminal justice system's unfair treatment of people with mental illness. *Psychology, Public Policy and the Law,* 11(4), 570–586.

Shafer, M.S., Arthur, B., & Franczak, M.J. (2004). An analysis of post-booking jail diversion programming for persons with co-occurring disorders. Behavioral Science and the Law, 22, 771–785.

Silver, E., Mulvey, E.P., & Monahan, J. (1999). Assessing violence risk among discharged psychiatric patients: toward an ecological approach. *Law and Human Behavior,* 23(2), 237–255.

Skeem, J.L. & Louden, J.E. (2006). Toward evidence-based practice for probationers and parolees mandated to mental health treatment. *Psychiatric Services,* 57 (3), 333–342.

Slate, R.N., Feldman, R., Roskes, E., & Baerga, M. (2004). Training federal probation officers as mental health specialists. *Federal Probation,* 68 (3), 9–15.

Somers, J.M., Carter, L., & Russo, J. (2008). Corrections, Health and Human Services: Evidence-Based Planning and Evaluation. Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University.
www.carmha.ca/publications/resources/pub_chhr/Corrections_Health_HumanServices_EBPE.pdf

Steadman, H.J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behavioral Science and the Law,* 23, 163–170.

Steadman, H.J., Scott, J.E., Osher, F., Agnese, T.K., & Robbins, P.C. (2005). Validation of the Brief Jail Mental Health Screen. *Psychiatric Services,* 56, 816–822.

Steadman, H.J., Stainbrook, K.A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A specialized crisis response site as a core element of police-based diversion programs. *Psychiatric Services,* 52 (2), 219–222.

Steadman, H.J., Deane, M.W., Borum, R., & Morrissey, J.P. (2000). Comparing outcomes of major modes of police responses to mental health emergencies. *Psychiatric Services,* 52, 645–649.

Steadman, H.J., Deane, M.W., Morrissey, J.P., Westcott, M.L., Salasin, S., & Shapiro, S. (1999). A SAMHSA Research Initiative Assessing the Effectiveness of Jail Diversion Programs for Mentally Ill Persons. *Psychiatric Services,* 50(12), 1620–1623.

Steadman, H.J., Morris, S.M., & Dennis, D.L. (1995). The diversion of mentally ill persons from jails to community-based services: A profile of programs. *American Journal of Public Health,* 85(12), 1630–1635.

Strauss, G., Glenn, M., Reddi, P., Afaq, I., Podolskaya, A., Rybakova, T., et al. (2005). Psychiatric disposition of patients brought in by crisis intervention team police officers. *Community Mental Health Journal,* 41(2), 223–228.

Teplin, L.A., & Swartz, J. (1989). Screening for severe mental disorder in jails: The development of the Referral Decision Scale. *Law and Human Behavior,* 13, 1–18.

Thornicroft, G. & Tansella, M. (2003). What Are the Arguments for Community-based Mental Health Care? Copenhagen, WHO Regional Office for Europe. Retrieved October 1, 2007 from www.euro.who.int/document/E82976.pdf

Tiihonen, J., Isohanni, M., Rasanen, P., Koiranen, M., & Moring, J. (1997). Specific major mental disorders and criminality: A 26-year prospective study of the 1966 Northern Finland birth cohort. *American Journal of Psychiatry,* 154(6), 840–845.

U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General—Executive Summary. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health

Services, National Institutes of Health, National Institute of Mental Health. Retrieved October, 1, 2007 from www.surgeongeneral.gov/library/mentalhealth/summary.html

U.S. Department of Justice. (2004). Effective Prison Mental Health Services: Guidelines to Expand and Improve Treatment. Washington, DC. Retrieved January 10, 2008 from www.nicic.org/pubs/2004/018604.pdf

U.S. Department of Justice. (2000). Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health: Mental Health Courts. Washington, DC: Office of Justice Programs. Retrieved January 3, 2008 from: www.ncjrs.gov/html/bja/mentalhealth/contents.html

US Department of Justice. (1990). Jail Diversion for the Mentally Ill: Breaking Through the Barriers. The National Coalition for the Mentally III in the Criminal Justice System. Retrieved June 2007 from www.nicic.org/pubs/1990/008754.pdf

Vanderplasschen, W., Wolf, J., Rapp, R.C., & Broekaert, E. (2007). Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs,* 39(1), 81–95.

Veysey, B.M. (1996). Effective strategies for providing mental health services to probationers with mental illness. In A.J. Lurigio (Ed.), Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and Codisorders. Seattle, WA: National Coalition for Mental and Substance Abuse Health Care in the Justice System.

Wallace, C., Mullen, P.E., & Burgess, P. (2004). Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders. American *Journal of Psychiatry,* 161(4), 716–727.

Walsh, E., A., Buchanan, A., & Fahy, T. (2002). Violence and schizophrenia: examining the evidence. British *Journal of Psychiatry,* 180, 490–495.

Watson, A.C., & Angell, B. (2007). Applying procedural justice theory to law enforcement's response to persons with mental illness. *Psychiatric Services,* 58, 787–793.

Wilson-Bates, F. (2008, January). Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources. Report for the Vancouver Police Board and Chief Constable Jim Chu.

Wolff, N., & Pogorzelski, W. (2005) Measuring the effectiveness of mental health courts: challenges and recommendations. *Psychology, Public Policy and the Law,* 11(4), 539–569.

World Health Organization. (2007). Preventing Suicide in Jails and Prisons. Retrieved January 3, 2006 from www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf

World Health Organization. (2007b). Mental Health and Prisons. Retrieved January 8, 2008 from www.who.int/mental_health/policy/development/MH&PrisonsFactsheet.pdf

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