

# A Framework for Diversion of Persons with a Mental Disorder in BC



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## Introduction

The purpose of this document is to provide a policy framework for diversion of individuals with mental health disorders in BC communities who find themselves involved with the criminal justice system. It provides a rationale for this discussion, a set of definitions, a description of the junctures where diversion is possible, and common issues in this field. The framework is described according to specific objectives for diversion, the kinds of different service providers that might provide diversion support and principles for service.

## Rationale

Currently there are a disproportionate number of people with mental disorders in the criminal justice and correctional systems. This is not only seen as an inappropriate consequence for illness related behaviour, but is also increasingly seen as a waste of valuable law enforcement and criminal justice system time, and of resources that may be more effectively spent on improving community mental health services.

## What is a Policy Framework?

A policy framework is a rationale and a set of principles that form the basis of making program and policy development for a particular population. It can be a visionary document written for a broad audience or it can be narrow and relate to specific government or specific agencies and their mandate.

A policy framework is used to develop and communicate a common understanding of the needs of and approaches to specific target populations. It provides direction, consistency and accountability.

## Key terms

This framework requires a shared understanding of the terms diversion, mental illness and mental disorder.

**Diversion:** Traditionally in the criminal justice context, diversion is defined as diverting persons from criminal prosecution. This definition limits the availability of diversion to those cases where criminal justice processing may be waived. These cases may be extremely limited by criminal justice policy—generally by type of offence, criminal record of the accused, and previous experience with diversion(s). In the context of mental health diversion, however, we have chosen to define diversion more broadly as **“an option to divert persons with mental disorder to appropriate treatment, supports, and services outside of or within the criminal and corrections systems in order to address the mental disorder contributing to the offending behaviour.”**

This broader definition includes a range of possibilities where pretrial diversion is not an option. These include diversion possibilities in the court system (e.g. Problem Solving Court models/processes), in community corrections through use of appropriate resources within the community (including community agencies, family, and community supports), in correctional institutions through the development and ‘diversion’ to appropriate facilities and resources, and through collaborative planning and transition from institutional and forensic services to community services and supports.

**Mental Illness:** The public mental health system defines service access on the basis of the presence of an axis I diagnosis. This would include such illnesses as schizophrenia, bipolar disorder, anxiety, depression and an eating disorder.

**Mental Disorder:** The criminal justice system uses the Criminal Code of Canada term “mental disorder.” The term “mentally disordered offender” (MDO) pertains to those people who have a mental disorder and/or substance use disorder (other than anti-social personality disorder), developmental disabilities (IQ below 70), low functioning (IQ above 70 with limited adaptive abilities), brain injury (organic or acquired) and Fetal Alcohol Effects or Fetal Alcohol Syndrome. It also includes seniors with behavioral and anger management issues.

When people with mental health issues come into contact with the law, they may be assessed for mental illness and treated in one or more of three service systems:

- ▶ Civil systems provided by the regular community mental health system
- ▶ Forensic psychiatric services
- ▶ Correctional services

## What We Know About Persons with Mental Disorders and their Interaction with the Criminal Justice System

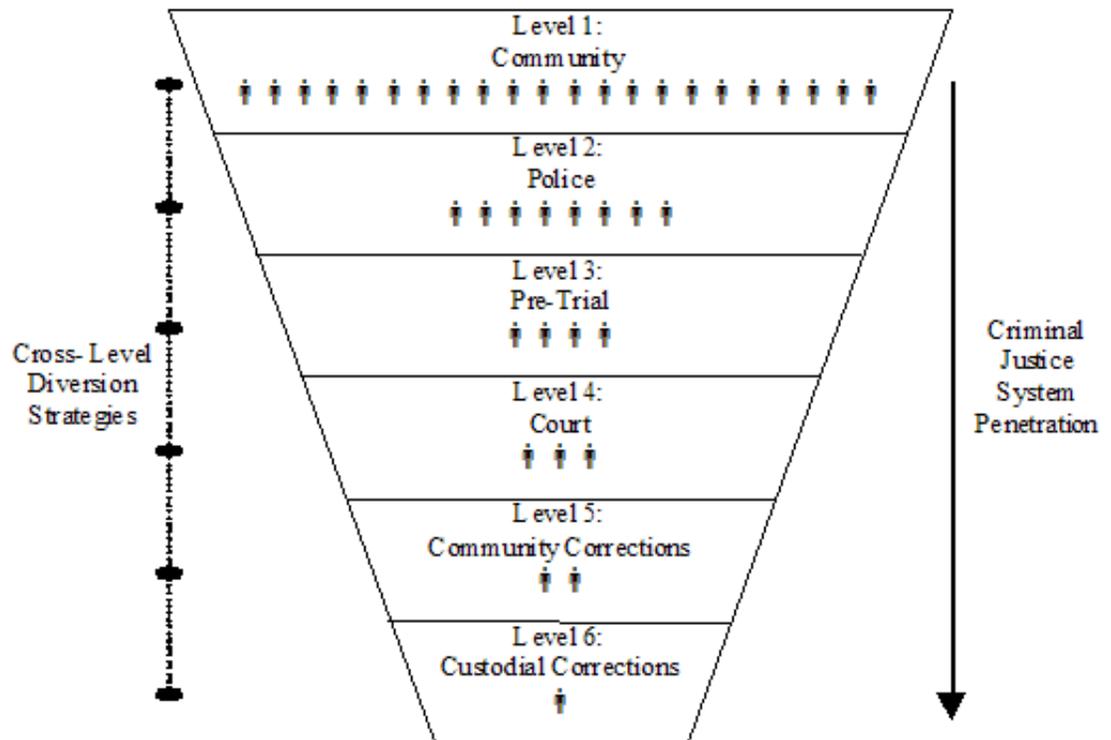
A series of reports were reviewed in the development of this initiative. Summarizing their findings, we can discern the following:

- ▶ **For the individual with a mental health problem and or his or her family, coming to terms with the possibility of a disorder and seeking and accessing care is a challenge.** Research on a cohort of BC individuals, found that from the time of first onset it took three years on average for people with schizophrenia, and schizoaffective disorder to access treatment. From the time of acute onset it took on average one year to access care. From the time for first onset it took between seven and eight years for people with mood disorders to access care. From the time of acute onset it took six months to access care.<sup>i</sup>
- ▶ **A majority of individuals accessed mental health care via crisis intervention.** In BC research conducted by the Canadian Mental Health Association, 60% of the sample accessed mental health treatment directly from the hospital, through the emergency ward, under emergency or crisis-driven situations. And 30% of the sample was brought to hospital by the police.<sup>ii</sup>
- ▶ **Since the closure of long stay psychiatric institutions there has been an increase in the number of people with mental disorders in contact with the police, in conflict with the law, and in jails.** The increase in the number of mentally ill people in the criminal justice system may be as much a product of the increase in the use of substances by people with mental illnesses as it is due to the deinstitutionalization of mentally ill patients.<sup>iii</sup>
- ▶ **The police are increasingly called upon to engage with and manage mentally disordered individuals on a daily basis.** The report *Lost in Transition*, recently released by the Vancouver Police Department, provides a snapshot of the situation encountered by police departments across North America. The report states that 31%—and in some areas of the city almost 50% of police incidents involved a person believed to be suffering the effects of a mental illness.<sup>iv</sup>
- ▶ **There are more individuals with a mental disorder in the criminal justice system in BC than one would expect by chance:** In 1999/2000, there were 52,000 individuals (43,859 adults and 8,234 youth) involved with the provincial corrections system. Almost 15,000 (29%) of the total cohort were classified as mentally disordered offenders. The prevalence rate is nearly twice the rate for the general British Columbia population.<sup>v</sup>
- ▶ **The combination of a mental disorder and substance use (concurrent disorders) is particularly hazardous, resulting in significantly higher health and human service costs, as well as greater involvement with corrections.** A recent BC report found that health and social service costs for those with concurrent disorders were over nine times higher than those with no psychiatric diagnosis.<sup>vi</sup>

- ▶ **When care systems rely on self report the data is rarely accurate with regards to the prevalence of substance use disorders.** Researchers examining new clients to the Surrey Pre-Trial centre reported a prevalence of 60.9% of admissions with substance use issues. Alcohol disorders were the most prevalent (24%), followed by cannabis (16.5%) and cocaine (10.2%). Poly drug use disorders were relatively common (15%). Particularly concerning in this study was the fact that only 8% (of the entire sample) had formal diagnoses of co-morbidity noted in their clinical files.<sup>vii</sup>
- ▶ **Compared to the general population, Aboriginal people are over-represented in the corrections population and exhibit disproportionately high rates of concurrent disorders.**<sup>viii</sup> Aboriginals represent 18% of the federal prison population although they account for just 3% of the general Canadian population. The best estimate of the overall incarceration rate for Aboriginal People in Canada is 1,024 per 100,000 adults. Using the same methodology, the comparable incarceration rate for non-Aboriginal persons is 117 per 100,000 adults. There continue to be fundamental differences between the concept of justice among Aboriginal communities and in the mainstream justice system, which may contribute to the problem. As well, only a fraction of Aboriginal offenders have access to culturally appropriate programs; many more Aboriginal offenders are sent into the mainstream system, often triggering negative consequences.<sup>ix</sup>
- ▶ **Gender Matters:** In many courts, over 80% of female offenders had received a psychiatric diagnosis, which is up to 30% higher than the corresponding percentage among males. Considerably higher levels of health and human services utilization by females combined with high rates of substance use disorders, mental disorders, and concurrent disorders suggests that court liaison activities might warrant a focus on the specific needs of women within the corrections population.<sup>x</sup>
- ▶ **Adults in the corrections system were more likely (1.2–1.9 times) to have been diagnosed in the previous year with a mental illness than the general population.** Rates of substance use in the adult corrections cohort were 11–13 times greater than the general population rates. As noted in the literature review, substance use problems appear to be endemic among prisoners.<sup>xi</sup>
- ▶ **The number of mentally ill inmates within the Canadian federal prison system is significant, and this number appears to be increasing over time.** Recent research investigated the changing profile of the federal inmate population over the years 1997–2002. For men, there was a significant increase in the number having a past mental health diagnosis (10%–15%), having a current diagnosis (7%–10%), and being prescribed medication (9%–16%). They also report a significant increase in the proportion of men admitted with a maximum security recommendation. For female inmates there was a significant increase in the number with a past diagnosis (20%–23%), but no significant increases in current diagnoses (13%–16%) or the percent for which medication was prescribed (32%–34%).<sup>xii</sup>

## Key Juncture Points

A system of diversion system includes the possibility for diversion at a number of key juncture points. The following model is from the American Consensus Project.<sup>xiii</sup> The notion implicit in this diagram is that diversion is possible at any point in the continuum of community mental health and correctional mental health services and that in an ideally functioning system individuals with a mental illness would receive their care and support in the community system.



### 1. Best Clinical and Community Practices (Community)

Provide a comprehensive and balanced continuum of services which is integrated across systems. The continuum must be tailored to individual needs, inclusive, and accessible.

### 2. First Response (Police/Crisis Response)

Ensure that dispatchers have the necessary training and tools, police have access to appropriate on-scene assessment, response techniques, and disposition alternatives, including a specialized crisis response site.

### 3. Pre Trial (Crown Counsel)

An integrative planning team is necessary to develop a program/strategy which includes early identification and formal case-finding procedures and protocols, policies, criteria and procedures for the diversion of persons whose offence is linked to their mental disorder. The program/strategy should be widely advertised among criminal justice professionals.

### 4. Post Charge (Court)

Planning and administration of a program/strategy must be cross-sectoral and informed. Timely identification of and linkage to services is required. Programs/strategies may include

a mental health court, mental health docket, and/or integrated problem solving practices in traditional courts with alternative sentencing planning strategies. Defence counsel must be fully informed and available to ensure that defendants are able to make an informed choice.

## 5. Community Corrections/Transition to Community

Effective and routine screening procedures should be implemented, and options for non-conventional (flexible) management of treatment conditions and technical violations should be available. Intensive and specialized case management (either through specialized caseloads within the corrections service or with a contracted external agency) should be available.

## 6. Custodial/Transition to Community

Routine and evidence-based screening, assessment and evaluation services should be implemented at intake and as required, mental health and addictions and concurrent disorder services should be available, and community transition services and protocols should be collaboratively established.

## Framework Objectives

The objective of developing a framework for diversion is to build consensus about the best possible service system for people with mental disorders in order to maintain public health and public order and to support individuals to live with optimal health in the least restrictive environment, there are several specific objectives:

- ▶ Through increasing skill in recognizing and responding to mental health crises, individuals with a mental disorder who are in a crisis will be effectively diverted by the police and other first responders into the mental health system rather than the criminal justice system.
- ▶ When people with a mental disorder are involved in the criminal justice and corrections systems, they will continue to receive appropriate mental health, social and support services.
- ▶ When either forensic conditions or criminal conditions support community re-entry, a gradual and supported transition to the community mental health system will be facilitated through collaboration between the forensic/correctional and community mental health systems.
- ▶ With the development of an approach and capacity development, appropriate monitoring systems can be put into place to demonstrate that individuals with mental illness are being treated in the most appropriate treatment systems.

## Target Population

The target population is people with a mental disorder who have been, are, or are at risk of coming into contact with the criminal justice system whose mental health needs have not been adequately met in the community. This will include people who have been in previous years excluded from treatment in the community mental health system such as people with brain injury, fetal alcohol spectrum disorder and concurrent disorders.

## Principles of Practice

In discussing principles of practice the question is really what are the most important values to enshrine in principles of how we work with this group of people? The list developed through the series of fora is indicative of the commitment of participants to good, inclusive and effective service. The elements can be separated into three categories: how we treat the client, how we provide service, and systemic responsibilities.

Client Relations	Service System Principles	System Principles
<ul style="list-style-type: none"> <li>▶ Dignity</li> <li>▶ Respect</li> <li>▶ Persistence</li> <li>▶ Patience</li> <li>▶ Cause no further harm.</li> <li>▶ Work with the possibility of a trauma history</li> <li>▶ Engage client and ensure client understands needs and responsibilities</li> <li>▶ Provide as much responsibility as the client can manage</li> <li>▶ Work towards good money management</li> </ul>	<ul style="list-style-type: none"> <li>▶ Achieve timeliness of response in a crisis</li> <li>▶ Provide for continuity of care across providers and agencies.</li> <li>▶ Create meaningful engagement with no arbitrary end date for services</li> <li>▶ Make sure that that client's interests and needs are paramount</li> <li>▶ Make sure approach is recovery/strength focussed</li> <li>▶ Celebrate successes and don't personalize failures</li> </ul>	<ul style="list-style-type: none"> <li>▶ Work to identify and eliminate policy barriers</li> <li>▶ Create community that is welcoming</li> <li>▶ Create buy in from agencies for collaboration</li> <li>▶ Inclusive:               <ul style="list-style-type: none"> <li>a) Broaden definitions beyond Axis I</li> <li>b) Work to increase communication across federal/provincial responsibilities</li> </ul> </li> <li>▶ Resolve privacy legislations issues to improve Information sharing and record integration.</li> <li>▶ Pool resources when possible.</li> <li>▶ Provide cross-training and education</li> </ul>

## Service Providers

Effective diversion requires the collaboration of qualified individuals and targeted services from the criminal justice and mental health, social and support systems:

- ▶ Those involved in responding to a mental health crisis in the community. This includes police, dispatch staff, emergency mental health professionals, service providers, families, friends and community members.
- ▶ Those involved in the identification of individuals who are considered suitable for diversion may be from the criminal justice system and/or from the mental health system. This includes forensic, court, probation, court and jail staff as well as correctional staff. These individuals should be trained by qualified representatives from both the criminal justice and mental health systems.
- ▶ Providers of the continuum of mental health services are suitably qualified and trained professionals to provide assessment, treatment, rehabilitation and follow-up services.
- ▶ Providers of services for individuals with co-occurring mental illness and substance abuse problems are qualified and trained professionals in addictions and mental illness. This includes clinicians as well as detox and transitional housing facilities.
- ▶ Providers of social support services are qualified to assist with finances, housing, and activities of daily living. Specifically, this would include non profit supported housing providers, staff working with Ministry of Employment and Income Assistance and BC Housing funded outreach providers.

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