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## VISITING EXPERTS' PAPERS

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### CORRECTIONAL SERVICES FOR THE MENTALLY DISORDERED OFFENDER: A CHALLENGE THAT MERITS AN INTEGRATED RESPONSE

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*"Ashley Smith was a fourteen-year-old placed in a youth facility for one month in 2003 after throwing crabapples at the mailman. Smith was placed in solitary confinement after disruptive behavior on her first day. Her initial one-month sentence would last almost four years, almost entirely in isolation. Often violent and unpredictable, Smith exhibited many attempts at choking herself into unconsciousness; guards responding were often attacked by Smith, sometimes with weapons she had manufactured and concealed. The frequent 'use of force' reports required to document responses became a source of concern for facility officials. Eventually, Corrections Canada administrators instructed guards and supervisors not to respond to the self-strangling attempts by Smith, "...to ignore her, even if she was choking herself". Officials kept transferring her to other facilities, preventing the implementation of a Canadian law requiring mandatory review of prisoners kept in isolation for more than sixty days.*

*While at Grand Valley Institution for Women in Kitchener, Ontario, on 16 October 2007, Smith requested transfer to a psychiatric facility; she was placed on a formal suicide watch on 18 October. In the early hours of 19 October, Smith was videotaped placing a ligature around her neck, an act of self-harm she had committed many times before. Guards did not enter her cell to intervene; they stood outside her cell and watched while 45 minutes passed before she was examined and pronounced dead.*

*Three guards and a supervisor at the Grand Valley Institution for Women were charged with criminal negligence causing death in relation to Smith's suicide; the warden and deputy warden were fired. The criminal charges were later dropped.*

*A coroner's jury returned a verdict of homicide in the Ashley Smith case in December of 2013 after more than a year of testimony and over 12,000 pages of evidence. The verdict supported the conclusion that the actions of others indeed contributed to her death but stopped short of a finding of criminal or civil liability. The jury additionally provided 104 recommendations to the presiding coroner, most of which were intended to suggest ways in which the Canadian Correctional System could better serve female inmates and inmates suffering from mental illness. The jury specifically recommended that indefinite solitary confinement should be banned."<sup>1</sup>*

#### I. INTRODUCTION

The tragic death of Ashley Smith did not occur in an under-developed or under-resourced correctional system. The federal correctional system in Canada is considered to be one of the finest in the world. That one young woman could immobilize such a system so entirely into in-action and inhumanity in the face of genuine human misery is shocking. The Ashley Smith story received unprecedented media attention and certainly raised community awareness and calls for action for the treatment of offenders with mental health problems in Canada. Our Correctional Investigator declared that this was a preventable death and the Correctional Service of Canada has since taken significant steps in elaborating its Mental Health Strategy across the system, both in prisons and for aftercare after

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<sup>1</sup> Adapted from <[http://en.wikipedia.org/wiki/Ashley\\_Smith\\_inquest](http://en.wikipedia.org/wiki/Ashley_Smith_inquest)>.

release. But every day all over the world similar tragedies play out in our prisons and correctional facilities. It is now common in correctional discourse to refer to prisons as the 'new asylums'. Despite all of our attempts to humanize correctional environments, prisons continue to be primarily 'schools of crime' for young, tough men who can find their place in the 'school-yard hierarchy' and are somehow able to endure the pains of imprisonment and cope with their circumstances. But for those offenders who are a little different and don't fit in, those who are mentally ill, those who are intellectually or physically disabled, the elderly and the physically ill, the weak, vulnerable and the emotionally disturbed, then prison becomes a nightmare.

Correctional staff can sometimes use (or more accurately abuse) the miss-fits in our prisons as fodder for their entertainment. I remember one of my own incidents of indoctrination into the prison culture as a young psychologist. I was called upon to visit the segregation cells to intervene with an offender who was apparently threatening to slash his wrists with a razor. As I approached his cell and caught the foul smell (he had smeared his body and cell walls with his feces), I noticed that two officers at the other end of the unit were having quite a laugh at my expense. The mentally ill in prisons become the butt of jokes. But much more often, these miss-fits in our prisons irritate and annoy, and quite easily frustrate and anger, both correctional staff, and their fellow offenders. In the absence of clear policy, early and sensitive assessment of needs and ongoing monitoring, appropriate staff training, and the availability of a range of programmatic alternatives, correctional practice will tend to resort to traditional punitive measures such as the removal of privileges and the overuse of segregation as a means of managing the challenging behaviors of mentally disordered and other special needs offenders.

The changing demographics and characteristics of offender populations, with a much higher incidence of a variety of mental disturbance, cognitive deficits, addictions, proneness to violence, poor education and chronic unemployment, and both community and familial alienation, are posing serious challenges to modern corrections. It can be overwhelming to outline all of the issues that deserve more determined and focused attention. However, in this paper the focus will be on outlining some possible solutions or responses rather than simply cataloguing the problems. Following a general introduction in Part I of the paper to help us understand and contextualize the issue, especially as it pertains to the origins and prevalence of the problem of the mentally ill for correctional services, Part II of the paper will then attempt to sketch out what it would look like in the ideal in corrections if we had:

1. Appropriate and encompassing, evidence-informed policies or strategies for dealing with mentally disordered and other special needs offenders;
2. A range of programmatic alternatives, before imprisonment as diversionary measures, during incarceration and after release into the community, aimed to both support these offenders and reduce the likelihood of further exacerbating their mental or physical distress, effectively managing their conditions and minimizing harm to themselves or others;
3. A systematized approach for assessing needs, monitoring behavior and evaluating impact of our interventions; and finally;
4. Training and skills development of staff members both to sensitize them to the unique needs and characteristics of these offenders and equip them to better respond.

## **II. HISTORICAL CONTEXT, PREVALENCE, AND THE MENTAL ILLNESS-OFFENDING RELATIONSHIP**

### **A. Deinstitutionalization of the Mentally Ill**

The 'deinstitutionalization' movement began in America in the mid-1950s. *Deinstitutionalization* refers to the policy of moving severely mentally ill people out of large institutions, ideally in order to reintegrate them back into communities with appropriate psychiatric aftercare. Although undoubtedly fueled in large measure as a rather straightforward cost-effective practice for reducing public expenditures, there were other well-meaning aspects to this movement. After the Second World War, psychodynamic and psychoanalytic psychiatry emerged in importance with its emphasis on the influ-

ence of life experiences and social factors. Similarly, advances in pharmacology led to the widespread introduction of chlorpromazine, commonly known as Thorazine, arguably one of the most well-known psychotropic medications and the first significantly effective antipsychotic medication. These breakthroughs, together with the introduction of other social and psychological therapies held out the promise of a more normal existence outside institutions for persons with mental illnesses. It was believed this could prevent chronicity and the dependency effects of institutionalization (Grob, 1991). A Mental Health Commission under President Jimmy Carter in 1978 summarized the new, progressive approach as having:

“...the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services.”

The deinstitutionalization movement began to spread quickly worldwide. Other than prohibition, the magnitude of deinstitutionalization of the severely mentally ill perhaps qualifies it as one of the largest social experiments in American history. In 1955, census estimates indicate there were 558,239 severely mentally ill patients in the nation's public psychiatric hospitals. By 1994, this number had been reduced to 71,619, a decrease in institutionalization of the mentally ill of 87% at a time when the nation's total population increased by close to 60% (from 164 million to 260 million) (Torrey, 1997).

However, the promised approach of 'community-based' care and treatment for persons with serious mental illnesses was never created and it is generally acknowledged that the deinstitutionalization movement led to a decentralized and uncoordinated mental health system that was not providing integrated and comprehensive services to those with the greatest needs, namely, persons with severe and persistent mental illnesses.

In the years following the beginning of the deinstitutionalization movement, despite its well intentioned aims, some serious unintended consequences emerged, and for many mentally ill persons, unemployment, poverty, homelessness and community rejection and stereotyping, simply compounded their suffering and added to their loss of dignity. Another major consequence that is now generally accepted and deplored is that our prisons and jails have become the 'new asylums' for the mentally ill — surrogate mental hospitals for the severely mentally ill when there is no other apparent alternative to manage their behavior. This is commonly referred to as the phenomenon of 'criminalization of mental disorder'. It has become perhaps one of the most prevalent and intractable challenges facing correctional services worldwide.

## **B. From Prisons to Asylums and Back to Prisons**

It is quite interesting to point out that the situation we are facing today, with so many mentally ill individuals locked up in our prisons and jails, often without receiving appropriate treatment and under conditions that exacerbate their illness, is exactly the situation we faced in the early 1800s, before the advent of modern psychiatry and before the invention of the psychiatric institution, or mental health hospital.

Beginning in the mid-1800s, early reformers who visited prisons and jails in America were aghast with the conditions in those institutions of punishment. Dorothea Dix, for example, one of the most prominent of these early reformers, reported the following to the legislature in the State of Massachusetts:

*“I come to present the strong claims of suffering humanity. I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, and the outcast. I come as the advocate of helpless, forgotten, insane and idiotic men and women...of beings wretched in our prisons...I proceed, Gentleman, briefly to call your attention to the state of Insane Persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens: Chained, naked, beaten with rods, and lashed into obedience!” (taken from Torrey, 1997)*

In the 1800s the mentally ill were being picked off the streets and confined in prisons and jails in large numbers for minor and nuisance offences such as theft or disorderly conduct. In an interesting

precursor of history, it was just as it is today. But curiously, and in considerable contrast to today, the situation of the confined mentally ill in the 1800s spurred government officials into action. The abhorrent conditions that were documented by a number of early reformers served as at least one impetus for a wave of construction of what were, for the time, more modern, sanitary and humane 'insane asylums'. The reform efforts of the day were remarkably successful in advocating for the confined mentally ill. Gradually though quite steadily, mentally ill individuals were moved out of prisons and jails and placed in public psychiatric hospitals. By 1880, there were 75 public psychiatric hospitals in the United States for the total population of 50 million people. A census of 'insane persons' was carried out that year which was perhaps one of the most comprehensive ever carried out. It included letters to all physicians asking them to enumerate all 'insane persons' in their communities, a question about 'insanity' on the census form that went to every household, and a canvassing of all hospitals, jails, and public almshouses. A total of 91,959 'insane persons' were identified, of which 41,083 (44.7%) were living at home, and 40,942 (44.5%) were in hospitals and asylums for the insane. The remainder (9,302) was in public housing of one kind or another and only 397 (or a small 0.7%) were in jails.

### C. The Scope of the Problem Today

*"Deinstitutionalization doesn't work. We just switched places. Instead of being in hospitals the people are in jail. The whole system is topsy-turvy and the last person served is the mentally ill person."* Jail official, Ohio

There is no doubt that the number of mentally ill in American prisons and jails today is dramatically higher than the rather small 0.7% documented in the 1880 census. Headlines began to appear routinely in the early 1990s to highlight the extent of the problem. For example, in New York, the estimated population of 10,000 mentally ill inmates in the state's prisons was noted as surpassing that of the state's psychiatric hospitals.<sup>2</sup> In Seattle it was remarked that 'quite unintentionally, the jail has become King County's largest institution for the mentally ill.'<sup>3</sup> And the Los Angeles County Jail, where approximately 3,300 of the 21,000 inmates 'require mental health services on a daily basis', was referred to as the 'the largest mental institution in the country'.<sup>4</sup>

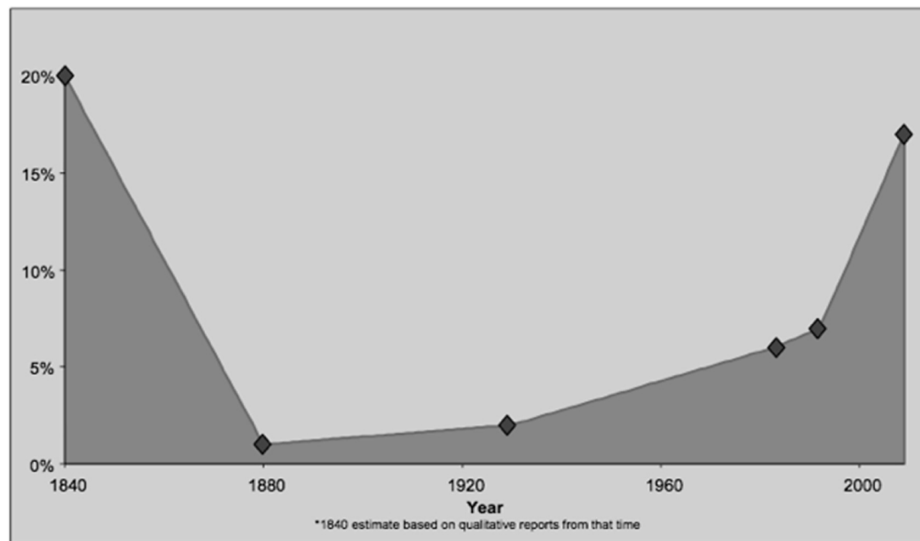
A comprehensive survey by the *Treatment Advocacy Centre* in 2010 estimated that there were perhaps close to three times more mentally ill confined in prisons and jails in America than in psychiatric hospitals (Torrey et al., 2010). In 2014, another survey adjusted the estimate to *ten times* the number of individuals with serious mental illness in state prisons and county jails compared to the nation's remaining mental hospitals (Torrey et al., 2014). It was noted as well that in 44 states in America, the largest institution housing people with severe psychiatric disease is now a prison or jail and not a mental hospital. Figure 1 below shows the historical increase in concentration of the mentally ill in prisons and jails in America in graphic detail.

<sup>2</sup>Foderaro, L. (1994, Oct. 6). For mentally ill inmates, punishment is treatment. *New York Times*, p. A1.

<sup>3</sup>Keene, L. (1993, July 6). A helping hand keeps mentally ill out of jail. *Seattle Times*, pp. A1, A7.

<sup>4</sup>Grinfeld, M. J. (1993, July). Report focuses on jailed mentally ill. *Psychiatric Times*. pp. 1-3.

**Figure 1**  
**Percentage of Jail and Prison Inmates With Serious Mental Illness**



The criminalization of the mentally ill may not be as dramatic in other nations, but it is nonetheless widely recognized as significant (Salize & Dresing, 2005; Knight & Stephens, 2009). However, estimating the scope of the problem of the mentally ill within the criminal justice system more precisely is difficult to do, both because of the issue of diagnostic unreliability and because the population is quite inconsistently defined from study to study (Cohen & Eastman, 2000). Sometimes researchers restrict the definition of mental disorder only to major psychotic and manic-depressive or serious depressive illness. At other times, studies include developmental disabilities (IQ below 70), low functioning (IQ above 70 with limited adaptive abilities), brain injury (organic or acquired), fetal alcohol effects/syndrome, other less serious disorders (e.g., anxiety, post-traumatic stress), and quite often, serious substance abuse disorder. Of course when the latter is included, the prevalence rates rise significantly.

Researchers have also tried to highlight the problem by focusing on different points in the criminal justice process, or by looking at the issue from different perspectives. For example, we can look simply at prevalence rates within jail or prison populations, to capture the scope of the problem as an end result, or we can look at the issue in terms of the experience of the mentally ill individual and ask the question of what the likelihood of incarceration might be for that individual over the course of their life. In one study, for example, a telephone survey was carried out of 1,401 randomly selected members of the National Alliance for the Mentally Ill, an American advocacy and support group composed mostly of family members of persons with schizophrenia and manic-depressive illness. It was found that 40 percent of the mentally ill in this group had been arrested and incarcerated at some time in their lives (Steinwachs et al., 1992).

But regardless of definitional issues or where we look to get a sense of the problem, it is indisputably recognized that the mentally ill routinely 'slip through the cracks' in health and social support systems and are at considerably high risk for contact with the criminal justice system. This occurs at every point in the process; disproportionate numbers of mentally ill come into contact with the police, are arrested, end up in police cells or on remand, appear in court, and are convicted and imprisoned (Ogloff, 2004).

Beginning in the 1980s, a number of methodologically sound studies using stringent criteria to define mental disorder began to document substantial prevalence rates among prisoner populations. After conducting interviews with 3,332 prison inmates in New York State in the late 1980s, Henry Steadman and his colleagues reported that at least 8% of them had "very substantial psychiatric and functional disabilities that clearly would warrant some type of mental health service" (Steadman et al., 1987). In looking at a number of these early prevalence studies, one reviewer (Jemelka et al., 1989) concluded that it could be safely estimated that at least 10 to 15% of prisoners have a major thought or mood

disorder and “need the services usually associated with severe or chronic mental illness.” Steadman and his colleagues (Steadman et al., 2009) published another methodologically sound survey of mental illness among jail inmates in 2009. A total of 822 inmates in five jails (three in New York and two in Maryland) were assessed using a structured diagnostic interview to determine the existence of serious mental illness during the previous month. Serious mental illness was defined as including schizophrenia, schizophrenia spectrum disorder, schizoaffective disorder, bipolar disorder, brief psychotic disorder, delusional disorder, and psychotic disorder not otherwise specified. A total of 16.6 percent of the prisoners met stringent criteria for a psychotic disorder, more than double what was found ten years earlier, with the rate among women (31.0%) being much higher than that among men (14.5%).

Mullen, Holmquist, and Ogloff (2003) conducted an extensive review of existing Australian epidemiological data to arrive at a reliable composite prevalence estimate. They concluded “that the prevalence of major mental illness among male prisoners is significantly greater than in the general population in the community” (p. 2). They noted that 13.5% (1 out of 7) of male prisoners, and 20% (1 out of 5) of female prisoners, had reported having prior psychiatric admissions, figures that are clearly much higher than the general population.

Reviewing results from 49 worldwide studies of mental illness among incarcerated individuals (19,011 prisoners), Fazel and Danesh (2002) reported an overall prevalence rate of 4% for psychotic illnesses. Considering that the estimated lifetime prevalence rate for the general population is about 1% (American Psychiatric Association, 1994, 2000), the prevalence for schizophrenia among prisoners is clearly considerably higher.

Fazel and Danesh (2002) also analyzed 31 studies examining major depression within incarcerated populations (10,529 prisoners). Because of differences in diagnostic criteria, there was considerable variation between studies, with reported rates of depression as low as 5% and as high as 14% in some individual studies. Nonetheless, the prevalence of major depression in the general population is estimated to be 5-9% for females and 2-3% for males (American Psychiatric Association, 2000). The meta-analytic results of Fazel and Danesh (2002) are 2-3 times higher, in the same range as the four times higher for psychotic illness.

Several consistent findings worth noting are the higher prevalence of mental illness for both female offenders and prisoners held in remand. The Fazel and Danesh (2002) review, for example, found higher rates of depression among females (12%) than males (10%), a finding that has been confirmed in a number of other studies (Brinded et al., 2001). Prins (1995) reviewed numerous studies and concluded that one third of the population of British prisoners required psychiatric treatment, but that this number would be higher among those on remand. Similarly, in a New Zealand study (Brinded et al., 2001), it was found that male remand offenders had higher rates than the male sentenced offenders for all categories of mental disorder that were studied. Parsons, Walker, and Grubin (2001) investigated mental illness among 382 female remand prisoners in the United Kingdom. They found that a very high 59% had at least one *current* mental disorder (*excluding* substance use disorders), including 11% with psychotic disorders.

One large-scale and well-conducted survey by the Correctional Service of Canada (1990), using a quite reliable interview schedule (the D.I.S.), involved a random sampling of more than 2000 male offenders sentenced federally across Canada. It was found that there was a lifetime prevalence of 10.4% for psychotic disorders, 29.8% for depressive disorders, and 55% for anxiety disorders. Co-occurring antisocial personality, drug, and alcohol problems were present in close to 40% of federal prisoners.

More recent Canadian research (Boe et al., 2003) looked at the changing profile of the federal inmate population over the years 1997-2002. Over just a few years, there was a significant increase in the number of male offenders who were admitted with a past mental health diagnosis (10% to 15%), a current diagnosis (7% to 10%), or being prescribed medication (9% to 16%). The rates were considerably higher for female offenders, although not showing the same level of increase over the years (for past diagnosis from 20% to 23%, for current diagnoses from 13% to 16%, and for the percent for which medication was prescribed from 32% to 34%).

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In the US in 2006, the federal Bureau of Justice Statistics (BJS) reported on the findings of perhaps the single largest survey ever conducted of mental health problems among state, federal and local jail and prison populations throughout the US. Some of the major findings are shown in Table 1.

**Table 1**  
**Recent History and Symptoms of Mental Health Problem Among US Prisoners\***

Category of Mental Health Problem	State Prisons	Federal Prisons	Local Jails	Corrections Canada 2000
<b>Recent history of mental health problems<sup>a</sup></b>	56.2%	44.8%	64.2%	
<b>Symptoms of mental health disorder<sup>b</sup></b>	49.2%	39.8%	60.5%	
<b>Major Depressive Disorder</b>	23.5% 15.4%	16.0%	29.7% 23.9%	29.8% 10.4%
<b>Psychotic Disorder</b>		10.2%		

<sup>a</sup> In the year before arrest or since admission.

<sup>b</sup> In the 12 months prior to the interview.

\*Data from James D.J. and Glaze L.E. (2006). *Mental Health Problems of Prison and Jail Inmates*. Bureau of Justice Statistics Special Report. US Department of Justice: NCJ 213600.

Interestingly, the BJS survey differentiated between recent histories of mental health problems versus actual symptoms of various mental disorders. With both types of definition, the findings showed quite substantial prevalence rates.<sup>5</sup> The figures of prevalence for major depression (16 to 30%) and psychotic disorders (10 to 24%) were in the same range as was found in the Corrections Canada survey. This BJS survey also confirmed the trends noted in other research of higher rates of mental health disturbance among remand versus sentenced prisoners, and higher rates among females versus males (for example, within State prisons, 73% of females reporting mental health problems versus 55% for males). Moreover, the typical pattern of high co-occurring substance abuse was also highlighted. Over 50% of prisoners with mental health problems were found to have a co-occurring substance abuse disorder, a prevalence that was much higher than what was identified among prisoners without mental health problems. As a rather unique aspect of this survey, the backgrounds of mentally ill offenders were also examined. Quite strikingly, it was found that compared to the non-mentally ill, the mentally ill population demonstrated both much higher rates of homelessness prior to incarceration, and much more early experience of physical or sexual abuse.

So in summarizing an answer to the question, how many people with severe mental illnesses are in jails and prisons on any given day? Numerous studies of prevalence rates have been carried out over the years that vary in definition of mental illness and the kinds of populations that are sampled. However, it is generally agreed that in the extreme, if mental illness is defined to include only schizophrenia, manic-depressive illness, and severe depression, then 40% or more of all jail and prison inmates appear to meet these diagnostic criteria, a figure in the range of at least *four times* that found in the general population.<sup>6</sup> The figures are higher for females than for males and tend to be higher for offenders held on remand versus sentenced. Finally, if we add substance abuse disorder to the mix, then more than half of these offenders also have co-occurring substance abuse disorders.

<sup>5</sup> A recent history of mental health problems included a clinical diagnosis or treatment by a mental health professional. Symptoms of a mental disorder were based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

<sup>6</sup> An estimated 11% of the U.S. population age 18 or older met criteria for these mental health disorders, based on data in the National Epidemiologic Survey on Alcohol and Related Conditions, 2001-2002 (NESARC), U.S. Department of Health and Human Services, National Institute of Health, National Institute on Alcohol Abuse and Alcoholism, Bethesda, Maryland.

#### **D. Mental Illness and Offending: A Complex Relationship**

To what extent mental illness is predictive of offending is still very much debated. We know, for example, that individuals suffering from psychotic illness are at higher risk for violent offending than the general population. This is exacerbated when there is co-occurring substance abuse and/or evidence of certain kinds of delusions (Mullen, 1997; 2001; Robert et al., 2014; Wallace et al., 2004).<sup>7</sup> However, when we look at offenders with mental illness versus those with not, then research has shown that offenders with mental illness are actually at lower risk of re-offending (e.g., Porporino & Motiuk, 1995; Quinsey et al., 1998).

In a major Canadian meta-analytic review of 64 studies examining the relationship between mental illness and offending (Bonta et al., 1998), the authors concluded that: “the major predictors of recidivism were the same for mentally disordered offenders as for non-disordered offenders” (p. 123). Particular criminal history factors (e.g., juvenile delinquency) were predictive of offending for both groups. Moreover, some of the best ‘dynamic’ predictors (i.e., criminogenic needs) for both general and violent recidivism were quite similar for both mentally ill and non-mentally ill offenders (e.g., poor living arrangements, antisocial personality, substance abuse, relationship instability and employment problems).<sup>8</sup>

It has been suggested that for some mentally disordered offenders (sometimes referred to as being both ‘bad’ and ‘mad’), there are perhaps two separate trajectories or pathways operating simultaneously. The criminal trajectory begins in early adolescence with the emergence of disruptive and delinquent behavior, and then the mental illness trajectory follows in the early to late 20s as the genetic predisposition towards psychotic illness flares up in psychotic episodes (Wallace et al., 2004). This obviously argues for the treatment of both aspects of risk for mentally ill offenders—managing their illness as well as addressing the more usual risk factors for offending (e.g., substance abuse; unemployment; criminal attitudes).

In managing mentally ill offenders so as to avoid further contact with the criminal justice system, it is also clear that particular dynamic risk factors should be considered. For example, it has been demonstrated that maintaining psychiatric treatment after release can substantially reduce violent recidivism among offenders with schizophrenia (Robert et al., 2014). One of the most popular risk assessment tools used with mentally disordered offenders (The HCR-20 by Webster et al., 1997) describes five situational factors which should be addressed to avoid re-offending: *a lack of feasible plans, exposure to destabilizers, lack of personal support, non-compliance with remediation attempts, and stress*. These contextual factors that can put mentally ill offenders at higher risk for re-offending are clearly crucial for the design of correctional services for the mentally ill that are preventive and protective in nature (as will be discussed later in the paper).

However, preventing the re-offending of the mentally ill is not the only concern that should preoccupy correctional services. At the front end, there is a major issue to contend with in terms of diverting the mentally ill from contact with the criminal justice system in the first instance.

In contrast to the typical media portrayal of mentally ill serial killers committing heinous crimes, the reality is that most mentally ill individuals never commit crime, or at least never commit any serious crime. What we know quite clearly is that most severely mentally ill people we imprison are there because they have been charged with a variety of rather minor offences. One American study (Valdiserri et al., 1986) reported that compared with the non-mentally ill, mentally ill jail inmates were “four times more likely to have been incarcerated for less serious charges such as disorderly conduct and threats”. They were also 3 times more likely to have been charged with disorderly conduct, 5 times more likely to have been charged with trespassing, and 10 times more likely to have been charged with harassment. Another American study tracked a sample of seriously mentally ill individuals discharged

<sup>7</sup>Examples are persecutory delusions or delusions that ‘command violence’ against others and/or that provoke fear.

<sup>8</sup>In the now predominant ‘rehabilitation theory’ in the field, often referred to as the Risk-Need-Responsivity paradigm (RNR) (Andrews and Bonta, 2003), an important distinction is made between ‘static’ risk factors that are unchangeable (e.g., background and criminal history factors), and ‘dynamic’ risk factors often referred to as criminogenic needs. These latter dynamic factors can be altered and should be the focus of our correctional services and intervention attempts.



from a psychiatric hospital in Ohio (Belcher, 1988). After six months, 32% had been arrested and imprisoned, typically for exhibiting bizarre behavior such as walking in the community without clothes and talking to themselves. They mostly failed to take their prescribed medications and frequently abused alcohol or drugs. Significantly, all of these former patients also became homeless during the 6-month follow-up period. The most common charges brought against the mentally ill who end up in jail are lewd and lascivious behavior (such as urinating on a street corner), defrauding a store owner (eating a meal, then not paying for it), disorderly conduct, panhandling, criminal damage to property, loitering or petty theft. These are clearly offences that are mostly expressive of mental illness rather than indicators of any intractable criminality.

Though there is some relationship between mental illness and offending, it is neither straightforward nor inevitable. How we typically manage the mentally ill offender also seems to strengthen the relationship rather than weaken it. From what we know about which mentally ill individuals we imprison and why, the risk factors for offending among the mentally ill, and the treatment and support needs of these individuals, it is clear that an integrated criminal justice and social service response is called for. The remainder of this paper will outline what this could like in the ideal.

### **III. RESPONDING TO THE CHALLENGE OF MENTALLY ILL OFFENDERS IN CORRECTIONS**

#### **A. Challenges and Concerns for Correctional Services**

Jails and prisons all over the world are inadequately resourced to deal with the mentally ill offender.

- Assessment is typically the result of informal observation of unusual behavior rather than the application of diagnostic tools for early detection of symptomology or mental health background.
- Staff members are poorly trained to deal with the mentally ill offender, especially line prison officers who have to contend daily with the pressures and difficulties of managing these individuals.
- Psychiatric care is difficult to access, both because forensically trained psychiatrists are few and far between<sup>9</sup>, and the few that are available would rather work within psychiatric hospitals (where they are typically in charge) rather than correctional settings (where they typically are not).
- Specialized mental health correctional facilities, where there can be an appropriate balance of correctional supervision and professional mental health intervention, are the exception.
- And programs designed and developed specifically to intervene with mentally disordered offenders are rare; with those that have been evaluated for effectiveness being even rarer.

The National Sheriffs Association in the US, responsible for oversight in the administration of jails across the country, succinctly outlined some of the key challenges as follows (Torrey et al., 2010):

- Mentally ill offenders are referred to as 'frequent flyers' to highlight the fact that they are regular and repeat offenders, often being arrested and imprisoned dozens of times.
- Mentally ill inmates cost more to manage.
- Mentally ill inmates tend to remain in jail or prisons longer than the non-mentally ill, often because they find it difficult to understand and follow jail and prison rules and are charged much more frequently for infractions.
- Mentally ill inmates are often major management problems and end up in administrative segregation in large numbers.
- Mentally ill inmates are at much higher risk for committing suicide.
- Mentally ill inmates are more often abused, both by fellow inmates and staff.

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<sup>9</sup>Forensics is not a popular specialization within psychiatry and the few forensic psychiatrists who are trained tend to work in forensic psychiatric settings where they focus mostly on assessing individuals for the courts for competence to stand trial. There are variations across jurisdictions around the world, but most acknowledge some variant of a 'not guilty by reason of insanity' plea which then leads to indefinite civil commitment rather than sentencing and imprisonment in a correctional institution.

Of course some correctional jurisdictions have few if any resources at all for managing the mentally ill offender (Agomoh, 2013). But even some fairly advanced correctional agencies point to the limitations in programs and services available for these offenders. Illustrative of this are the findings from a 2004 survey by the Province of British Columbia in Canada of the service and program needs for mentally disordered offenders (Oglaff et al., 2004b). The survey included all Canadian Provinces and Territories, as well as specific international jurisdictions that were similar in population and culture to British Columbia (i.e., New Zealand, Scotland, Victoria (Australia), and Maryland, USA). Some of the findings are shown in Table 2 below, listed in order of how frequently each concern was mentioned.

Additional resources were seen as especially critical in order to improve the ‘continuum of care’ for mentally ill offenders. This included both more and easier access to secure forensic psychiatric beds to treat acutely disordered offenders, more programs for individuals with co-occurring mental health and substance abuse, sustainable funding for diversion initiatives, and funding to ensure aftercare upon return to the community. The enhancement of community-based services was seen as particularly urgent, especially community-based residential support and programs to support social reintegration of offenders into the community. This of course is consistent with findings that suggest that re-entry programs for mentally ill offenders need to emphasize both basic sustainable economic and material support for these individuals as well as their specific treatment needs (Wilson, 2013).

**TABLE 2: MOST URGENT MDO SERVICE/PROGRAM NEEDS<sup>10</sup>**  
**Area of Need Identified**

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

Clearly, even well-developed correctional jurisdictions are able to identify a range of service gaps. But what is encouraging is that they are also able to describe some of their ‘best practice’. The State of Victoria in Australia, for example, has established the Victorian Institute of Forensic Mental Health, also known as Forensicare, governed by a council that reports to the Minister of Health and includes representatives from the Attorney General, Corrections Victoria, and the Minister of Health. It is noteworthy that the State has developed a well recognized and multi-faceted forensic mental health service that includes court liaison workers (nurses and psychologists) in magistrate courts to assist in diverting mentally ill offenders, formal intake assessments of all offenders entering jails, a range of psychiatric services in prisons and jails, an acute assessment unit for mentally disordered offenders in the state remand jail, a secure forensic hospital, a range of community-based forensic mental health services, and close coordination with regional and local mental health services. As part of a broader provincial ‘mental health plan’, the Province of Alberta in Canada has focused on creating a comprehensive diversion framework for mentally ill offenders (Alberta Health Service, 2001). In the US, the state of Maryland operates an excellent jail-based diversion program that provides social work and psychiatric services to help identify candidates for diversion to mental health treatment in the community. And various Canadian and US jurisdictions have introduced both mental health courts, to divert mentally ill from the criminal justice system in the first instance, and comprehensive re-entry

<sup>10</sup> Adapted from Oglaff et al. (2004).

programs to support mentally ill offenders released from prisons. Common to many of these 'best practice' examples is the establishment of formal links between law enforcement, the judiciary, forensic and correctional services and other non-governmental and governmental services and agencies responsible for community mental health, social services, employment, housing and family services, . . . etc. It is this focus on the development of an *integrated and collaborative* service delivery model that creates correctional policies and strategies for managing the mentally ill offender that are ultimately effective (Osher et al., 2012).

#### **B. Innovative Policies and Strategic Direction for Dealing With Mentally Disordered Offenders**

What focus and underlying principles should underpin an effective, well integrated approach for dealing with the issue of the mentally ill in corrections?

The American National Sheriffs Association (2010) highlighted a few broad areas as practical and sensible options:

- Greater use of 'Mental Health Courts' where offenders are essentially given a choice between either following a treatment plan in the community (including the taking of medication) or going to jail (Lamb & Wienberger, 2008; Moore & Hiday, 2006).
- A greater emphasis on assisted outpatient treatment (AOT) for the mentally ill released from hospitals, jails, or prisons, where there is a court ordered requirement to continue taking medication as a condition for living in the community. A number of studies have demonstrated that even this rather straightforward change in practice can substantially reduce the likelihood of re-arrest, alcohol or drug abuse, as well as homelessness, risk of suicide, and episodes of violent behavior among individuals with serious mental illnesses (Phelan et al. 2010; Swartz et al., 2009).
- Change in government funding systems so that departments of mental health pay the local corrections departments for the treatment costs of all seriously mentally ill inmates.
- A reform of mental health treatment laws so that treatment interventions can be made based on 'need for treatment' criteria rather than dangerousness. Typically, it is the dangerousness standard that necessitates law enforcement involvement. But mentally ill individuals should be able to access treatment before they become dangerous or commit a crime, and not after.

A good example of a significant change in policy direction is the comprehensive *Mental Health Strategy* recently adopted by Corrections Canada, developed in collaboration with the Mental Health Commission of Canada and provincial/territorial correctional jurisdictions across the country (Correctional Service of Canada, 2009). The strategy appropriately highlights the fact that:

"Individuals with mental health problems and/or mental illnesses often have previous points of contact with multiple systems, including provincial/territorial and federal correctional jurisdictions, health care institutions, and social services. All systems have a shared mandate to provide an integrated approach of active client engagement, stability, successful community integration, and overall harm reduction in ways that are sensitive to diverse individual and group needs. Integrated efforts with the "common client" will result in fewer justice system contacts and increase public safety." (p. 7)

As guiding principles, the strategy adopts the following:

- Individuals with mental health problems and/or mental illnesses should be provided access to services irrespective of race, national or ethnic origin, color, religion, age, sex, sexual orientation, marital status, family status and disability (Canadian Human Rights Act, 1977, c.33, s.11);
- Mental health services should be client-centered, holistic, culturally sensitive, gender-appropriate, comprehensive, and sustainable;
- Mental health care should be consistent with community standards;
- The role and needs of families in promoting well-being and providing care should be recog-

- nized and supported;
- Prevention, de-escalation of behaviors associated with mental health problems and/or mental illnesses, interventions, and other mental health activities/services are critical to minimizing and managing the manifestations of mental health symptoms and promoting optimal mental well-being;
- Promotion of mental health recovery is a grounding philosophy underpinning the continuum of care;
- Meaningful use of time, including participation in programming for individuals with mental health problems and/or mental illnesses, is critical to their becoming contributing and productive members of the community;
- In addition to their involvement in correctional systems, individuals with mental health problems and/or mental illnesses experience a compounded stigma that creates barriers in their ability to obtain services, and also influences the types of treatment and supports received, reintegration into the community and their general recovery; and finally,
- Mechanisms should be established to ensure ongoing evaluation of the effectiveness of mental health services throughout the continuum of care.

The Corrections Canada strategy details the need for action and the expected results in seven key areas: Mental Health Promotion; Screening and Assessment; Treatment, Services and Support; Suicide and Self-Injury Prevention and Management; Transitional Services and Support; Staff Education, Training and Support; and Community Supports and Partnerships.

Beginning in 2007, Corrections Canada enhanced resources significantly in two major ways. First, an *Institutional Mental Health Initiative* (IMHI) focused on enhancement of institution-based services for the mentally ill. This included:

- Development of a computerized Mental Health Intake Screening System to identify offenders who could be experiencing significant psychological distress at intake. Follow-through assessments then try to develop a more precise picture of an offender's mental health needs, which is in turn incorporated into the offender's overall correctional plan;
- Primary Multi-Disciplinary Mental Health Care teams in institutions work to provide offenders with access to comprehensive mental health care, and focus as well on mental health promotion, mental illness prevention, and early intervention, treatment and support (e.g., suicide prevention);
- Design of a mental-health training package delivered to all correctional staff to increase staff awareness of mental health issues and enhance their skills in working with these offenders;
- Development of intermediate care units for male offenders with mental health issues in institutions;
- Consistency in standards at Corrections Canada's Regional Treatment Centers.

Approximately 125 new positions were created to fulfill the staffing complement for the IMHI including nurses, psychologists, social workers, and behavioral counselors.

Secondly, a comprehensive *Community Mental Health Initiative* (CMHI) was introduced to ensure effective discharge planning for mentally ill offenders and appropriate, supportive community supervision. Approximately 50 new positions were created across Canada as a part of this CMHI, including:

- Clinical Social Workers as 'discharge planners';
- Community Mental Health Specialists to work directly with offenders with mental health disorders at selected parole sites. These professionals also participate in multidisciplinary teams, provide training for front-line staff and develop partnerships with local agencies;

- Coordinators to manage the initiative in each region, and to help new staff work with existing community-based services to enhance mental health support for offenders in the community.

The CMHI also provides funding to local agencies and organizations, for example, for personal support workers for some offenders and to address the unique needs of mentally disordered Aboriginal and women offenders.

Corrections Canada is in the early phase of implementation of this rather ambitious strategy. However, some key indicators of success are currently being monitored that are intended to help adjust the strategy over time for greater impact. It will hopefully not remain as comprehensive only on paper.

Another impressive, comprehensive and well-integrated Policy Framework for dealing with the mentally ill within criminal justice was developed by the State of Victoria in Australia, as previously mentioned (Thomas, 2010). The document *'Diversion and support of offenders with a mental illness: Guidelines for best practice'* is required reading for any correctional jurisdiction wishing to embark on a similar course. Not only is there a thoughtful presentation of some key principles for managing this issue at the systemic level, in partnerships with other stakeholders, but the evidence-base in support of these principles is reviewed, how policy and program development should proceed is outlined, including for special groups such as female offenders, young offenders and offenders from culturally diverse backgrounds, and finally, a set of 'best practice' examples, both from Australia and internationally, is outlined and discussed.

The Victoria Justice strategic framework takes as its point of departure the fact that there is a logical sequence of interventions that should take place in order to reduce the chance that people with a mental illness will penetrate deeper into the criminal justice system. This concept is nicely captured in the *Sequential Intercept Model* developed by Munetz and Griffen (2006) (see Figure 2 below). It describes a series of possible interception points that are critical for a truly integrated response for managing the mentally ill within the criminal justice system.

Worthy to review in some detail is both this *Sequential Intercept Model* (see Figure 2 below) as well as the principles underpinning the Victoria Justice strategy (as shown in Table 3).

**Figure 2**  
**The Sequential Intercept Model For Managing Mentally Ill Offenders**

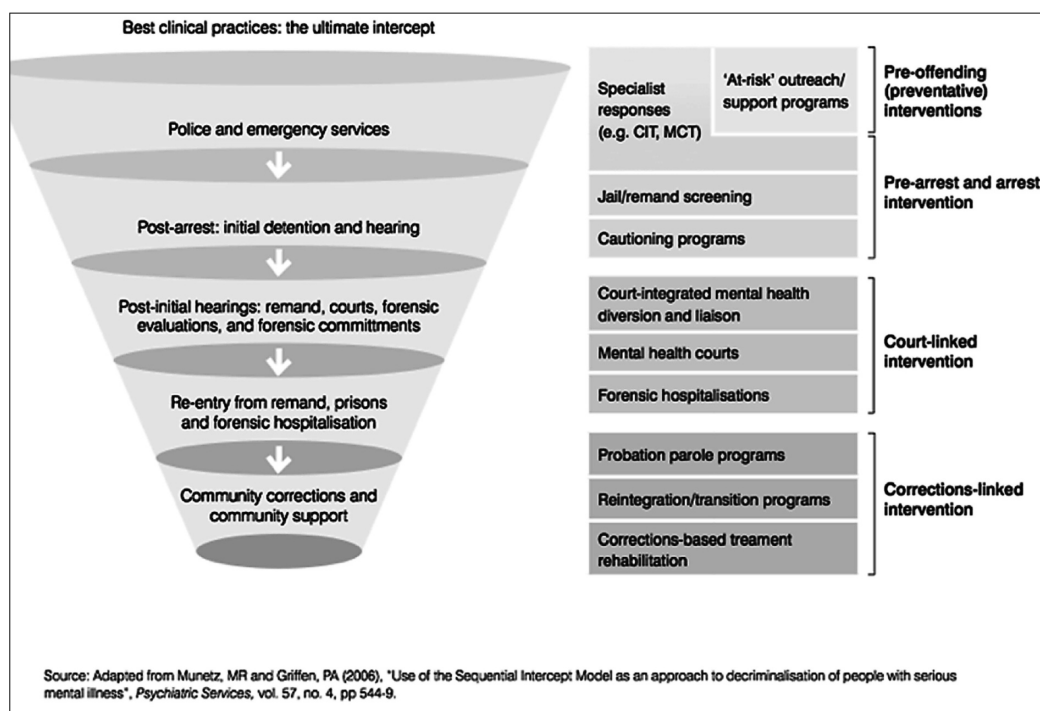


Table 3

Victoria Justice Framework For Managing the Mentally Ill Within Criminal Justice

## PRINCIPLES THAT UNDERPIN BEST-PRACTICE DIVERSION AND SUPPORT FOR MENTALLY ILL OFFENDERS

### **Collaboration, communication and coordination are essential**

Complex programs involving multiple stakeholders should seek to deliver a 'single system' experience wherever possible, requiring program goals and activities to be coordinated, process duplication to be minimized, and timely and appropriate information sharing.

### **Community safety is not compromised**

Research indicates that well-designed diversion and support programs do not increase risk to the community. Addressing mental health and related problems that are linked to offending is more likely to reduce recidivism than usual criminal justice sanctions.

### **Accountability for criminal behavior is retained**

Mental illness may sometimes reduce moral culpability but not legal responsibility. Participation in diversion from mainstream criminal justice processes is commonly linked to alternatives to imprisonment that meet community expectations for accountability. The rights and interests of victims must be acknowledged.

### **Human and legal rights are protected**

Diversion and support programs should seek to enhance and support the exercise of the human rights of people with mental illness. They should also ensure that legal rights are not infringed by the diversion and support process.

### **Consumer and family or carer participation ensures policy and service development are better targeted, more effective and sustainable**

People with mental illness (consumers) and family and friends who care for them (carers) provide vital insights into policy and program design that cannot be provided by other stakeholders.

### **Mental illness and associated issues are identified, assessed and treated as early as possible**

Screening and assessment should seek to identify mental illness and associated problems (especially substance use) as early as possible.

Early identification, assessment and treatment

increases prospects for recovery and prevention of escalating problem behaviors.

### **Programs deliver culturally safe, holistic services tailored to individuals**

Mental illness is experienced differently by different people, and is often associated with many complex and interacting problems. Programs should be needs-based, and provide or broker well-coordinated, integrated and culturally safe services. This often means working with individuals within the context of their family and community.

### **Quality and integrity of health interventions are maintained**

The quality of services and supports provided to people through diversion programs should be equivalent to services available in the general community. Health interventions should be provided and managed by health services and retain a focus on achieving health and wellbeing related outcomes for individuals and families.

### **A recovery orientation is essential**

Recovery is a personal process of changing one's attitudes, values, feelings, goals, skills and roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life beyond the effects of mental illness. The model is consistent with the "good lives" model of offender rehabilitation.

### **Programs balance fidelity to the evidence base with environmental constraints and innovation**

The evidence for diversion and support programs is growing, but incomplete. Fidelity to the existing evidence base should be balanced by the desirability of local flexibility, innovation and evaluation. Resource limitations, including workforce, infrastructure, funding and other constraints also necessitate innovation.<sup>1</sup>

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<sup>1</sup> Adapted from "Diversion and Support of Offenders With A Mental Illness: Guidelines for Best Practice" (2010). National Justice Chief Executive Officers' Group and the Victorian Government Department of Justice.

### C. Programmatic Interventions and Services for Dealing with the Mentally Disordered Offender

Mentally disordered offenders are both 'mentally ill' and prone to 'criminal offending' at some level of severity. As we have seen, often the offending is of a minor nature, fueled and exacerbated by the symptoms of mental illness. But clearly as well, serious violence is also possible. Many mental illnesses are chronic or relapsing conditions where acute phases or relapses may trigger offending behavior. What is clear is that regardless of level of risk for offending, treatment for the mentally ill offender should balance both a focus on the 'mental illness' and on the 'criminal propensity'. Criminal justice and mental health outcomes can be significantly affected if there is a judicious and mutually supportive convergence of interventions and services that can address both dynamic criminological risk factors as well as appropriate management of the mental illness. One recent meta-analytic review of 26 program evaluations that met criteria of methodological soundness concluded that interventions with offenders with mental illness can effectively reduce symptoms of distress, improve the offender's ability to cope with their problems, improve behavioral markers such as institutional adjustment and behavioral functioning and produce significant reductions in both psychiatric and criminal recidivism (Morgan et al., 2012).

Of course the 'how' and the 'when' programs should deliver services is critical, as is the emphasis on a number of other key factors such as co-occurring substance abuse disorders, a history of trauma (especially with female offenders), the severity of the psychopathology and whether there are multiple forms of mental impairment, physical health problems (chronic illness or disability), and various practical issues like housing or accommodation problems and employment. Table 4 lists a range of individual and demographic characteristics that clearly should be considered as programs are designed and delivered.

**Table 4**  
**Individual characteristics impacting on program design for MDOs**

Age	Family circumstances, including children
Comorbid health issues	Forensic and/or psychiatric history
Concurrent drug and alcohol abuse	Gender
Cultural background	Housing circumstances
Disability, including intellectual disability	Indigenous status
Educational attainment	Language and literacy
Employment	Socio-economic status

One particular consideration for program design merits special emphasis, namely gender (Leschied, 2011). It is now commonly accepted that gender-responsive strategies are needed to deal with female offenders (Blanchette, 2000), and this clearly applies as well to management of mentally disordered female offenders, where some specific approaches such as Dialectic Behavior Therapy have been shown to lead to significantly improved outcomes (Linehan et al., 2007). Important to remember in allocating treatment resources for dealing with women with mental health issues in criminal justice are some of the following points highlighted recently by the World Health Organization (2008):

- Gender is a critical determinant of mental health and mental illness;
- Gender influences the rates of depression and anxiety (e.g., unipolar depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women);
- Gender specific risk for common mental disorders that disproportionately affect women include gender-based violence, socioeconomic disadvantage, low income and income inequality, and low or subordinate social status;
- Lifetime prevalence rates of violence against women range from 16% to 50%;
- High prevalence of sexualized violence to which women are exposed and the correspondingly high rate of Post Traumatic Stress Disorder (PTSD) following the violence renders such women the single largest group affected by this disorder.

Gender and other characteristics of the individual should obviously drive the specifics of the intervention approach that is adopted, but more generally, creating correctional services and environ-

ments that are responsive to the needs of the mentally disordered requires adherence to some minimum standards of practice (Livingston, 2009). These should include:

- Providing a comprehensive and balanced continuum of services;
- Integrating services within and between systems;
- Matching services to individual need;
- Responding to population diversity; and
- Using evidence to make system-wide improvements.

On the side of treatment of mental illness per se, the treatment of choice in the mental health field for mentally disordered individuals is commonly referred to as psychosocial rehabilitation (Corrigan et al., 2007). The ultimate goal of this multi-faceted approach is to enable mentally ill individuals, as much as possible, to live independently by compensating for, or eliminating, functional deficits. The focus is on a range of social and educational services and supportive community interventions (e.g., intensive case management, supportive housing, social and vocational rehabilitation, substance abuse treatment, family support services). Deployed in an interconnected fashion, a number of particular treatment strategies have shown effectiveness and are widely considered evidence-based (Mueser et al., 2003).

- Collaborative psychopharmacology—where individuals are included in the medication decision-making formula.
- Assertive community case management and treatment—where provision of services occurs in the natural environment (e.g., community) rather than a clinical setting such as an outpatient clinic or psychiatric hospital.
- Family psycho-education—where family members are educated about the effects of mental illness, and assisted in maintaining positive interpersonal relations and creating a supportive ‘familial’ environment.
- Supported employment—to help the individual gain competitive employment and provide assistance as needed, regarding skill development and employment maintenance for job security.
- Illness management and recovery—so that the individual assumes responsibility for their recovery, managing their illness, and seeking assistance as needed to obtain personally meaningful and satisfying life goals.
- Integrated dual disorders treatment—where service providers target issues of mental illness and substance abuse simultaneously in an integrated fashion rather than treating these issues as separate disorders.

The adaptation of psychosocial rehabilitation and Assertive Community Treatment (ACT) to forensic populations has been successful in improving a host of indicators such as future psychiatric hospitalizations, quality of life and symptom severity (MacKain & Mueser, 2009). However some evidence suggests that that ACT has been generally less successful in reducing re-offending or rates of arrest and incarceration, possibly in part because of the limited emphasis on criminological risk factors (Morrissey et al., 2007). It has been noted (Hodgins et al., 2007) that in order to reduce re-offending, community-based programs should:

- Be highly structured, intense and make use of multiple problem-specific interventions;
- Encourage clinicians to go beyond their clinical focus and accept an active role in preventing offending and guiding program participants through their personalized program;
- Allow for rapid hospitalization when necessary; and
- Employ court orders for some patients to support compliance.

*Project Link* in New York is a good example of an ACT-based approach with a simultaneous



structured emphasis on criminological risk factors. *Project Link* is a multi-site consortium of five community agencies that provide a mobile treatment team to service people with mental illness and past convictions, people diverted from current charges or transitioning out of prison. Within an ACT out-reach model of wrap-around services, the program incorporates a supervised residential program for people with mental health and substance use problems. Evaluations have demonstrated significant reductions in arrests, days in jail, hospitalizations and average hospital days. A follow up of clients enrolled in the first year in *Project Link* found a reduction in both the average number of days in jail (from 104 to 45) and hospital (114 to 8) and the average cost of care per individual fell from US\$74,500 one year prior to enrolment to US\$14,500 one year after enrolment. The program's success has been attributed more particularly to a combination of effective service coordination and culturally sensitive service delivery (Weisman et al., 2004). Many similar ACT-based programs have been developed throughout America (see <http://www.nami.org>) as well as in the UK (Fiander et al., 2003), Europe (Burns et al., 2001), Canada (Wilson et al. 1995), Australia and elsewhere (Ogloff et al., 2004b).<sup>11</sup>

Although not as broad in scope as the psychosocial rehabilitation approach adopted by *Project Link* and other similar programs, a number of innovative, curriculum-based interventions for use with people with mental illness also deserve mention.

The first is the *Illness Management Recovery* (IMR) program, a standardized, curriculum-based intervention that has been translated into ten languages and is supported by considerable evaluative research (McGuire et al., 2014). The program can be delivered in a variety of settings (e.g., community mental health center, correctional facility) by trained behavioral health practitioners in either one-to-one or group format in 40–50 weekly or twice weekly sessions over a period of 6–12 months (Gingerich & Mueser, 2011). Essentially, the program adopts motivational, educational, and cognitive-behavioral techniques to help individuals set personal goals and learn more effective strategies for dealing with their own psychiatric disorder. The curriculum is organized so that specific information and skills related to illness management are taught in a set of modules that includes: *Recovery Strategies; Basic Facts About Mental Illness; The Stress-Vulnerability Model; Building Social Support; Using Medication Effectively; Drug and Alcohol Use; Reducing Relapses; Coping with Stress; Coping with Persistent Symptoms; Getting Your Needs Met in the Behavioral Health System; and Healthy Lifestyles*.

A number of randomized controlled studies, conducted in the U.S., Sweden, and Israel, have shown that IMR improves illness management outcomes significantly more than traditional services (McGuire et al., 2014). IMR has been implemented extensively in America and elsewhere with individuals involved in the criminal justice system. In order to make the program more accessible for persons with both intellectual disability and a psychiatric disorder, an adapted version that appropriately condenses and simplifies the curriculum has also been developed, the *Happy and Healthy Life Class*, (Gingerich et al., 2009).

The second curriculum-based intervention worth noting is an adaptation of the *Reasoning & Rehabilitation Program (R&R)*, one of the earliest (Porporino et al., 1991) and perhaps most well researched and widely applied correctional interventions adopting cognitive-behavioral principles to teach offenders a variety of new skills for 'thinking and behaving' more pro-socially.<sup>12</sup> Evaluations with heterogeneous groups of offenders in different countries have shown that R&R can reduce risk of

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<sup>11</sup> The ACT approach that originated in America is of course heavily driven and managed by mental health professionals. In contrast to this, many European jurisdictions focus much more deliberately on lay community involvement and support for reintegration of the mentally ill. A world-renowned example is the oldest continuous community mental health program in the Western world in Gheel, Belgium, a small town of 35,000 located in the province of Antwerp. Gheel is internationally known for the centuries old tradition of foster family care for the mentally ill associated with the legend of St. Dymphna, the patron saint of the mentally ill. Gheel and other similar initiatives in Belgium and elsewhere in Europe promote the concept of 'community recovery' where communities should strive to live with rather than fear the realities of mental illness. Hundreds of mentally ill individuals live their daily lives in Gheel without any stigmatization of any kind, and with broad based community acceptance and ongoing support.

<sup>12</sup> Among the skills the program tries to teach are to problem solve and consider the consequences of their actions, think more critically and avoid biased or unfounded assumptions, assess the impact of their behavior on others, make better decisions, and learn more socially skilled ways of interacting with others.

re-offending by up to more than 20% (Antonowicz, 2005; Tong & Farrington, 2006).

*R&R* has been adapted recently to be more particularly responsive to the needs of mentally disordered offenders (*R&R2 MHP*; Young & Ross, 2007). At only 16 sessions (rather than the original 38), the program has been modified so as to maintain engagement with individuals who commonly present with cognitive deficits (e.g., in attention and memory). It also incorporates guided individual mentoring between group sessions to consolidate the material introduced in the group and transfer acquired skills into daily activities. A recent multi-site controlled trial of the program with a sample of 121 adult males drawn from 10 forensic mental health sites in the UK showed significant improvement across a number of measures from baseline to post-treatment (Reese-Jones et al., 2012). Close to 80% of group participants completed the program and in contrast to controls, there were significant treatment effects on self-reported measures of violent attitudes, rational problem solving and anger cognitions. Importantly, improvements were endorsed by informant ratings of social and psychological functioning within the establishments.

The final curriculum-based intervention worth noting deals with only one, but one particularly critical issue for the mentally ill, assisting them to access meaningful employment. As part of community-based vocational rehabilitation efforts, the *Ready Set Go* program takes an innovative approach to motivate mentally ill individuals to find and hold on to employment. Delivered in about thirty 3-hour group sessions, interspersed with one-on-one work, *Ready Set Go* adopts a three-staged strategy to vocational rehabilitation. Participants are initially guided in evaluating and committing to their own goals for self-sufficient living. The program then helps them understand their own self-sabotaging thinking and learn new problem solving and coping skills. Finally, using key principles of motivational theory, the focus turns to building intrinsic motivation to seek and retain employment. Recent evaluations of the program in a number of community settings in the US and Canada have shown that more than 70% of participants actually gain employment within 30 days of program completion and the length of job retention more than doubles compared with usual practice (Fabiano, 2012).

Particular interventions can make a significant difference in the lives of mentally disordered offenders. Applied singly or in combination, life outcomes can be affected quite substantially for these individuals. As a summary, the findings from a recent comprehensive review are instructive. The review identified at least six *evidence-based practices* for their potential in reducing both risk of re-offending and improving mental-health outcomes for mentally disordered offenders (Osher & Steadman, 2007). These are outlined in Table 5 below.

Table 5

<b>Interventions with potential to improve health and recidivism</b>		
A 2007 review examined six evidence-based practices for their potential to improve behavioural health and public safety. <sup>27</sup>		
<b>Evidence based practice</b>	<b>Potential to achieve*</b>	<b>Data to support*</b>
• Integrated treatment for co-occurring disorders	++++	++++
• Supportive housing	++++++	+++
• Supportive employment	+++	+
• Trauma-specific interventions	++	+
• Illness self-management	++	+
• Assertive community treatment	+++++	+++
* The possible number of positive icons ranges from 1 to 6, with higher numbers indicating a higher degree of potential impact and available data.		

What we can conclude, therefore, is that based on the treatment evidence we have to date, we can be effective in dealing with mentally disordered offenders when we attend to both mental health needs

and what are commonly referred to as 'criminogenic' needs.<sup>13</sup> For example, integrating drug and alcohol treatment with mental health services (and thereby targeting an important 'criminogenic' need) is generally considered not only best practice but also essential practice (Clearly et al., 2008). The emphasis should be on early intervention, as well as relapse prevention and support, and should adopt an approach that promotes engagement but also challenges drug taking and its link with offending behavior. Unstable accommodation and/or homelessness and lack of access to the labor force for stable employment are several other key 'criminogenic' factors that significantly increase risk of offending, including among mentally disordered offenders (Mullen & Ogloff, 2009).

Quite interesting to note as well, however, is that the emphasis on the *recovery model* and illness self-management within the mental health field, strongly agrees with another emerging rehabilitation theory within criminal justice — the "Good Lives" model of offender rehabilitation, which seeks to reduce recidivism by equipping individuals with "the tools to lead more fulfilling lives" (Ward & Brown, 2004).<sup>14</sup>

Another comprehensive overview of treatment alternatives with mentally disordered offenders makes the point that many of the strategies that have been applied to date have been borrowed from use with other populations (Knabb et al., 2011). Of the ten treatment options found in the literature, it was concluded that only five have been empirically validated with mentally disordered populations (i.e., behavior therapy, cognitive behavioral therapy, dialectical behavior therapy, assertive community treatment, and therapeutic communities). Others may be of some value as adjunctive therapies but evidence has not been accumulated (e.g., music therapy, art therapy, analytical therapy, attachment theory). In dealing with mentally disordered offenders there are a variety of clinical problems that can emerge quite regularly (e.g., including aggression, criminal tendencies, institutional management, poor life skills, substance abuse, social isolation, and psychotic and mood symptoms) (Rice & Harris, 1997). Future treatment integration efforts should combine the strengths of existing interventions, address the plethora of clinical concerns presented by mentally disordered offenders, and more reliably measure efficacy with well-designed randomized controlled trials.

#### **D. Assessment Issues in Managing Mentally Disordered Offenders**

Treatment planning and effective delivery of services hinges on proper assessment. You can't treat what you don't identify, and you can't monitor how well your treatment might be doing without some clear indicators of outcome. As we have already seen, in dealing with mentally disordered offenders, there is the prerequisite to assess both risk for offending, so as to address some of the criminogenic factors that can reduce that risk, as well as to screen for mental health needs and/or diagnosis of actual disorder.

Over the last several decades, a number of state-of-the-art assessment tools have been developed to assess the risk/needs of offenders. Andrews and Bonta (2003) have popularized reference to what have been coined as the central eight 'risk factors' for offending. These include four considered as high in predictive ability (history of antisocial behavior, antisocial personality pattern, antisocial cognition, antisocial associates) and another four considered as moderate (family, school, leisure/recreation, substance abuse). Other than the history factor which follows the old adage that past behavior predicts future behavior, the remaining set of risk factors are seen as 'changeable' in some fashion; that is, programs and services can do something to minimize their influence on possible future offending (see Table 6 below for an elaboration of these factors). Although with some different emphasis on one or

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<sup>13</sup> The well-accepted RNR 'rehabilitation theory' framework for reducing re-offending is based on three key principles: Some offenders are at higher risk to reoffend than others and so we should try to give them more intensive and/or enhanced levels of service. (Risk Principle); Some areas of need in offenders are more important than others to attend to because they relate more reliably and predictively to risk for re-offending (e.g., substance abuse) (Need Principle); and finally, though a principle that still remains relatively under-developed, the concept of 'responsivity' points to the fact that offenders, like people more generally, will respond better in receiving certain kinds of support or help, and certain types and styles of intervention. In other words, one size will not fit all. (Responsivity Principle).

<sup>14</sup> Tony Ward's Good Lives Model suggests that offending continues (regardless of how it originated) because offenders: 1. Apply inappropriate and shortsighted *means* to secure their needs, 2. Lack *scope* or coherence in their overall life plan, 3. Experience *conflict* among goals that they are not aware of, and 4. Lack the *capacities* or skills to adjust in achieving their needs in some other ways.

other of these eight factors, most risk/needs assessment tools that have been developed and validated over the years include some detailed analysis of one or more of these eight dimensions.<sup>15</sup>

**Table 6**  
**Major ‘Criminogenic’ (Dynamic Risk) Factors**

<i>Most Related to Recidivism</i>	<i>Also Related to Recidivism</i>
<b>Antisocial Personality Pattern</b> impulsive, adventurous pleasure seeking, restlessly aggressive and irritable	<b>Substance Abuse</b> abuse of alcohol and/or drugs
<b>Procriminal Attitudes</b> rationalizations for crime, negative attitudes towards the law	<b>Family/Marital Relationships</b> inappropriate parental monitoring and disciplining, poor family relationships
<b>Social Supports for Crime</b> criminal friends, isolation from prosocial others	<b>School/Work</b> poor performance, low levels of satisfactions
<small>Bonta &amp; Andrews (2007, p. 6)</small>	<b>Prosocial Recreational Activities</b> lack of involvement in prosocial recreational/leisure activities

References for some of the most popular risk/needs assessment tools in the field of criminal justice are shown in Table 7, including the Level of Service/CM Inventory (LS/CMI), the Violence Risk Appraisal Guide (VRAG), and the Structured Assessment of Violence Risk in Youth (SAVRY).

<sup>15</sup> For example, the well-respected Psychopathy Checklist (PCL, Hare, 2003) mostly emphasizes a set of personality traits that have been related to antisocial personality disorder (e.g., narcissism, callousness, manipulativeness).

**Table 7: References to Standard Risk/Needs Assessment Instruments**  
**Adult instruments**

Level of Service Inventory Revised (LSI-R)	Andrews, D.A. & Bonta, J. (2001). <i>The Level of Service Inventory—Revised user's manual</i> . North Tonawanda, NY: Multi-Health Systems.
Risk Assessment for Sex Offender Recidivism (RRASOR)	Hanson, R.K. (1997). <i>The development of a brief actuarial risk scale for sexual offense recidivism</i> . Ottawa, Ontario, Canada: Department of the Solicitor General of Canada.  Harris, G.T., Rice, M.E., & Quinsey, V.L. (1993). Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. <i>Criminal Justice and Behavior</i> 20: 315-335. SORAG:
Violence Risk Appraisal Guide (VRAG)	Quinsey, V.L., Harris, G.T., Rice, M.E., & Cormier, C. (2005). <i>Violent offenders: Appraising and managing risk</i> (2nd ed.). Washington, DC: American Psychological Association.
HCR-20; Assessing Risk for Violence	Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). <i>HCR-20: Assessing risk for violence</i> (Version 2). Vancouver, British Columbia, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.
PCL-R; Hare Psychopathy Checklist	Hare, R. D. (2003). <i>Manual for the Revised Psychopathy Checklist</i> (2nd ed.). Toronto, ON, Canada: Multi-Health Systems.
<b>Juvenile instruments</b>	
Structured Assessment of Violence Risk in Youth (SAVRY)	Borum, R., Bartel, P., & Forth, A. (2006). <i>Structured Assessment of Violence Risk in Youth (SAVRY)</i> . Oxford, United Kingdom: Pearson Education.
Youth Level of Service/Case Management Inventory (YLS/CMI)	Hoge, R.D. & Andrews, D.A. (1995). <i>The Youth Level of Service/Case Management Inventory: Description and evaluation</i> . Ottawa, Ontario, Canada: Carleton University, Department of Psychology.

An effective risk and needs assessment tool should obviously have several key theoretical and psychometric qualities (e.g., Bonta, 2002). It should sample a number of factors that research shows are predictive of criminal behavior, assess dynamic factors that can be used to guide treatment decisions, and demonstrate satisfactory reliability and validity across a number of independent studies. Importantly, there should always be some attempt to locally validate both the relevance and accuracy of selected risk assessment tools since information from these tools can lead to inaccurate classification of all or part of the local population. Subsequent 'best practice' treatment decisions based on those classifications could actually be quite misdirected. This has been referred to as the 'validation problem' where many jurisdictions simply adopt tools but are unable to speak to the accuracy of the assessment and classification schemes they use with their local populations (Byrne & Pattavina, 2006).

When we turn to the other key aspect of assessment for mentally disordered offenders, the obvious goal is to identify, for the purposes of treatment, the nature and extent of any mental-health issues and/or any possible 'diagnosable' disorder. The most reliable sources of information for this come

from structured interview schedules in the hands of a competent clinician. A good example is the *Diagnostic interview Schedule* which has been used extensively in epidemiological studies of the prevalence of mental illness (Robins et al., 1981). However, on practical grounds, reliance on these interview-based measures can be unrealistic. It has been noted that “budgets could never afford enough psychiatrists or psychologists to meet the demand [for correctional mental health assessment]” (Grisso, 2006, p. 5). The design of tools for use by non-mental health professionals has consequently been a major concern in the field. We know that measures are needed as well for screening early in the correctional process, preferably in the first few days in custody, and “self-report measures offer a better alternative to lengthy clinical interviews given the large number of prisoners” (Krespi-Boothby, et al., 2010, p. 93).

A number of brief, reliable and relevant tools to screen for offender mental health have been developed. Several of these are briefly summarized below.

*Brief Jail Mental Health Screen (BJMHS)*: This rather brief assessment form (which takes an average of 2.5 minutes to administer) is considered a practical and efficient screening tool that correctional officers can give detainees on intake screening (Steadman et al., 2005).

*Jail Screening Assessment Tool (JSAT)*: The JSAT is a brief, semi-structured interview developed in Canada to identify mental health problems and risk for suicide, self-harm, violence, and victimization among new admissions to jails and pretrial facilities (Nicholls et al., 2005).

*Offender Assessment System (OASys)*: As part of a more comprehensive assessment protocol for assessing the risk/needs of offenders (OASys), the Home Office in the UK has included some mental health screening indicators that provide a preliminary analysis of mental health risk, which can then be examined further with other tools (Fitzgibbon & Green, 2006).

*General Health Questionnaire (GHQ)*: Twelve items from the GHQ formed this self-report inventory developed to assess for clinically significant emotional distress with offenders. The instrument has been shown able to detect risk for self-harm and suicide and/or mental health problems requiring long-term care (Krespi-Boothby, et al., 2010).

*Computerized Mental Health Screening*: Developed by Corrections Canada as a 30 to 40 minute computer-assisted assessment of mental health indicators adopted from the Brief Symptom Inventory of mental health along with a depression, hopelessness and suicide scale, developed within Corrections Canada. The information is collated into a report that goes to the offender’s confidential medical file and if the score exceeds a certain threshold, there is an automatic referral to a psychologist for a more thorough assessment (Correctional Service of Canada, 2008).

It is worth noting that specialized assessment tools may also be required for assessment of mental health issues in female offenders, for example, in order to focus on trauma and trauma-related disorders like PTSD (Weathers et al., 1994).

Before concluding this section of the paper, there is one particular mental health assessment tool that merits some brief description both because of its rather innovative approach and the extensive validation studies that have been conducted to support its use. The *Massachusetts Youth Screening Instrument-Version 2* (MAYSI-2) (Grisso & Barnum, 2006) was designed specifically as a self-report 15-minute screening (triage) tool to be administered, often by non-clinical personnel, to all youth at the time of intake (within 1-3 hours after admission) in juvenile probation offices, juvenile pre-trial detention centers, and juvenile justice corrections and residential facilities. Its primary purpose is to identify symptoms (represented by thoughts, feelings and behaviors) that are found in many psychiatric diagnostic conditions of youth, but as well in adults. In a set of seven key areas (see Table 8 below), the tool provides information for whether individuals might require an immediate mental health response (e.g., suicide precautions, need for further evaluation, referral for clinical consultation). Importantly, through the use of specific cut-off scores, the tool also differentiates whether the individual is in the ‘caution range’ of clinical significance for symptoms, or in the ‘warning range’ of very high level of disturbance.

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Released 12 years ago, the MAYSI-2 is now registered for use in over 2,000 sites in 47 states in America, including statewide use in all intake probation, detention and/or corrections facilities in 44 American states. Researchers have also translated the MAYSI-2 into 13 languages.

**Table 8**  
**Scales in the MAYSI-2**

<i>Acronym</i>	<i>Scale Name</i>	<i>Number Of Items</i>	<i>Brief Description</i>
ADU	Alcohol/Drug Use	8	Frequency and pervasiveness of use of substances
AI	Angry-Irritable	9	Feelings of preoccupying anger and vengefulness, irritability and "touchiness"
DA	Depressed-Anxious	9	Depressed and/or anxious feelings
SC	Somatic Complaints	6	Bodily aches and pains often related to depressed or anxious feelings
SI	Suicide Ideation	5	Thoughts and intentions about self-harm, feelings of hopelessness
TD	Thought Disturbance	5	Altered perceptions of reality, things not seeming "real"
TE	Traumatic Experiences	5	Self-reported exposure to events that have potential traumatizing effects

In both the fields of criminal justice and mental health, the design of assessment tools to determine the risk and needs of individuals has proliferated in the last several decades. But assessment processes should aim to collect more than initial baseline information. Methods are needed as well to track individual progress and response to our interventions, both to determine program effectiveness and to plan further interventions to address emerging and outstanding needs. This is where structured Case Management procedures come into play where there should be vigilant and continuous monitoring of a whole variety of life indicators. For managing mentally disordered individuals, this should include at a minimum the monitoring of a whole range of criminal justice, mental health and broader health/social indicators (as briefly described in Table 9 below).

Important to capture as well are early signs of disruptive behavior (e.g., whether the person is difficult to manage; if they are verbally aggressive or attention seeking) and any deterioration in social and psychological functioning (e.g., insight into behavior, feelings of guilt, social interactions with others). It goes without saying that issues that are caught early are easier to manage and less likely to exacerbate. The very successful *Assertive Case Management* model for managing the mentally ill is based on this fundamental assumption (Ziguras & Stewart, 2000).

**Table 9**  
**Key Indictors for Monitoring Intervention Outcomes**

<b>Criminal justice indicators</b>	<b>Health and social indicators</b>
— Arrests and police contacts	— Active substance use
— Nature and seriousness of offending	— Current health status
— Frequency and duration of incarceration	— Housing status
<b>Mental health indicators</b>	— Family relations
— Status of diagnosis	— Employment participation
— Severity of symptoms	— Social and emotional wellbeing
— Service utilization (e.g., hospitalizations)	— Participation in community and cultural life
— Medication compliance	— Pro-social associates
	— Quality of life
	— Experiential indicators

#### **E. Training and Development of Staff in Managing Mentally Disordered Offenders:**

In both community and institutional settings staff training is key to affect a more appropriate response to the challenges presented by mentally disordered offenders. The first point of contact with an individual who is displaying bizarre or disruptive behavior because of mental health reasons is often not a professional mental health worker. In the community, it is typically law enforcement officers, and in prisons or jails it is prison officers. In both types of settings, training of these on-the-line staff needs to focus: first, on recognizing the various behavioral manifestations of mental illnesses; second, on how to manage and de-escalate as necessary, and finally, on how to appropriately respond to incidents, including to ensure that timely access to professional, clinical intervention will occur.

Considerable success has been shown in various community programs where specialized training of law enforcement officers encourages diversion of the mentally ill towards mental health care rather than further criminal justice involvement. One excellent example is the New South Wales Police *Mental Health Intervention Team* (MHIT) model in Australia (Laing et al., 2009) based on the *Crisis Intervention Team* approach that emerged in America in Memphis, Tennessee (Steadman et al., 2000). The MHIT program involves four-days of intensive training for police officers on how to work with mentally ill or disordered people in a sensitive, safe and efficient manner. Training gives participants an understanding of mental health legislation applying in NSW and provides them with an array of communication strategies they can employ, as well as risk assessment, de-escalation and crisis intervention techniques. The overall aims of the program are to reduce the risk of injury to both police and mentally ill individuals, improve collaboration with agencies in the response to, and management of, mental health crisis incidents, and finally, increase the likelihood and reduce the time taken by police in the handover of individuals to the mental health care system. It has been demonstrated that these kinds of training approaches to alter police response can lead to significant reductions in arrest rates for mental-health crisis incidents; to as low as 2% (Steadman et al., 2000).

Within institutional correctional settings, there should be by the very nature of incarceration, a greater likelihood of close observation and supervision of the mentally ill. Unfortunately, the prison officer 'culture' in these settings is often unsupportive of intervention with the mentally ill, other than for punitive reactions to misbehavior (Kropp et al., 1989; Rotter et al., 2005). The control of these individuals consequently becomes more 'punitive control' rather than 'caring control'. It is axiomatic in prison settings that the more active and involved correctional staff are with a program, and the more input they are encouraged and allowed to have on the development of policies and programs, the more successfully the program will be implemented. When the advantages of providing professional intervention and programming for the mentally ill are couched in terms of the benefits for line staff (i.e., less stressful day-to-day interactions), prison officers will be much more likely to get on board. Interestingly, even relatively brief exposure to appropriate training seems able to alter prison officer behavior quite dramatically. For example, in one study it was found that a ten-hour mental health training program developed by the National Alliance on Mental Illness (NAMI-Indiana) for correctional officers on a prison ('supermax') special housing unit significantly reduced the frequency of 'use of force' with mentally disordered prisoners (Parker, 2009).



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Strong arguments have been made to include correctional officers as essential and fully participating members of multidisciplinary treatment teams for offenders with mental illness, rather than simply relegating them to the role of 'turn key guards' (Applebaum et al., 2001). Dvoskin & Spiers (2004) quite accurately describe the culture of the community inside prison walls and argue that correctional officers can play a vital role in the provision of specialized mental health services to offenders, for example, by learning to talk with offenders in a therapeutic manner, informing the mental health consultation process with their observations, and observing medication effects and side effects.

A number of jurisdictions have developed standardized training curricula to educate prison officers on the basics of mental illness and strategies for improved management of these individuals. Some excellent examples include the Correctional Service of Canada and their recent development of a two-day mental health awareness-training package tailored to the specific needs of various front line groups including case management staff, institutional health care nurses, and correctional officers. Another is the State of Colorado's Mental Health Training Course for Law Enforcement and Corrections Officers (Sherman, 2001).

There is certainly no magic bullet curriculum that can make law enforcement or correctional staff members do what they should do in dealing with the mentally ill offender. Undoubtedly, if there is a key ingredient to success, it is to allow these line staff to become core members of a multidisciplinary team, not to remain peripheral to it. Some of the basic tenets of the Assertive Case Management model are a good way to conclude what this should involve:

- A clear focus on those individuals who require the most help from the service delivery system;
- An explicit mission to promote the mentally ill offender's rehabilitation and recovery;
- A 'total team approach' where all of the staff work with all of the mentally ill clients, under the supervision of a qualified mental health professional who serves as the team's leader;
- An interdisciplinary assessment and service planning process that typically should involve a psychiatrist or psychologist and one or more nurses, social workers, substance abuse specialists, vocational rehabilitation specialists, occupational therapists, and where possible certified peer specialists (individuals who have had personal, successful experience with the recovery process);
- A willingness on the part of the team to take ultimate professional responsibility for the mentally ill individual's well-being in all areas of institutional or community functioning, including most especially the "nitty-gritty" aspects of everyday life;
- A conscious effort to help people avoid crisis situations in the first place or, if that proves impossible, to intervene at any time of the day or night to keep crises from turning into unnecessary incidents; and
- A commitment to work with people on a time-unlimited basis, as long as they continue to demonstrate the need for this unusually intensive and integrated form of professional help.

### IV. CONCLUSION

The effective management of mentally disordered offenders raises a host of interconnected and complicated issues. It stretches the expertise of corrections to its limits and exposes the reality that the criminal justice system does not really function as a 'system', much less connect very well with other social service and health care systems. A focused and integrated strategy is needed to divert mentally disordered offenders away from the experience of imprisonment as much as possible, lessen the harm of the experience for those who must be incarcerated, and ensure there is adequate after-care post-release to prevent reoffending. *'Primum non nocere'* (first do no harm) should be a motto for correctional services worldwide and not just the Hippocratic oath of the medical profession. Many offenders enter prisons with pre-existing mental health issues that are then exacerbated. For others, imprisonment itself serves as the catalyst for igniting mental disorder. Though it is not just a correctional problem, but a community and broader social problem, corrections should aspire to do more in managing these special needs offenders with determined and innovative evidence-informed approaches.

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