

***Mentally Disordered Offender Working Groups: The value of collaboration and coordination in the delivery of services to individuals with a mental disorder in conflict with the criminal justice system***

by

Angus Duncan Monaghan  
B.A., University of Victoria, 1988  
B.S.W., University of Victoria, 1991

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We accept this thesis as conforming  
to the required standard

  
Dr. Andrew Armitage, Supervisor (School of Social Work)

  
Professor Barbara Whittington, Departmental Member (School of Social Work)

  
Dr. Michael Prince, Acting Dean (Faculty of Human and Social Development)

  
Dr. Brian Wharfe, External Examiner (Faculty of Human and Social Development)

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University of Victoria

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Supervisor: Dr. Andrew Armitage

## **Abstract**

While a majority of individuals with a mental disorder never commit a criminal offence or come in contact with the criminal justice system, there are some individuals that may repeatedly come to the attention of police and the courts as a function of their illness or personality. The need to coordinate and share information relating to the needs of mentally disordered offenders (MDOs), ensuring that they do not get lost between the services and/or that those services provided are consistent with treatment goals, is essential. In 1992, the Ministries of Attorney General, Health and Social Services developed the *Protocols for the Inter-Ministerial Coordination of Services for Persons with a Mental Disorder of Mental Handicap involved in the Criminal Justice System*. One of the major intended outcomes of the protocols was the development of local working groups throughout the province specifically mandated to coordinate services to MDOs.

The objective of this thesis was to consider the current status of working groups; their perceived value, limitations and factors for the success of future working groups. In order to adequately inform this inquiry, it was necessary to use both qualitative and quantitative methodologies. Four methods of data collection; my own experiences in several working groups, a questionnaire, observation of a rural and an urban working group and interviews of specific participants, were used. Findings suggest that there were, as of October 2001, 31 working groups throughout the province. The perceived value or outcome of the working groups was the development of working relationships among community service providers and the perception that MDOs received better service coordination and treatment as a result of the working groups. The significant issues identified were the need for regular attendance, development of resources, and a process and structure which includes direct linkages with senior management at a provincial level. In order for the working groups to be considered as a best practice example, more efforts to include the individuals discussed at the working groups should occur.

Examiners:

[Redacted]  
Dr. Andrew Armitage, Supervisor (School of Social Work)

[Redacted]  
Professor Barbara Whittington, Departmental Member (School of Social Work)

[Redacted]  
Dr. Michael Prince, Acting Dean (Faculty of Human and Social Development)

[Redacted]  
Dr. Brian Wharf, External Examiner (Faculty of Human and Social Development)

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## CHAPTER ONE: INTRODUCTION

The public perception of individuals with a mental disorder is that of their being violent, dangerous and in some way deserving of the disorder. Because of this stigma, many mentally disordered individuals do not access treatment or help. Meanwhile, it is believed that “ 1 in 4 people in B.C. will experience a mental illness in a given year” (Canadian Mental Health Association 2001, p.1).

Within Canada, the responsibility for providing treatment and support for individuals with a mental illness rests primarily with the health care system. The direct service provision responsibility has devolved to the individual provinces and in British Columbia, with the recent development of the regional health boards and community health councils this responsibility has been devolved further. The result has been varied degrees of funding and resources allocated to the needs of mentally disordered individuals in this province. With the current political focus on nursing shortages and ever increasing health care costs, the likelihood of any increased funding to mental health services would seem remote. Consequently, mental health services ‘will have to do more with less’.

Within British Columbia, mental health services are delivered to those individuals with a serious and persistent mental disorder through state funding. Health authorities throughout the Province have the mandate of providing access to both inpatient and community mental health treatment. The British Columbia *Mental Health Act* provides the authority to ensure that people with a mental disorder receive the treatment and

protection necessary when they are unable to comprehend that they are ill. It is not until such time that a person is at risk to themselves or others that the state must treat. In other words, a majority of individuals with a mental disorder are not forced or coerced into accepting treatment and have the insight required to access support and/or hospitalization as required. Unfortunately, there are some individuals that because of their illness, do not have the insight or ability to comprehend their own suffering and the potential risk they pose.

Regional hospitals throughout the Province have psychiatric units to treat and support an individual as required. However, Riverview Hospital in Port Coquitlam is the major Provincial hospital providing specialized acute psychiatric care and treatment and provides an intensive support to regional hospitals.

In addition to the services offered through Mental Health Services and Riverview Hospital, the Forensic Psychiatric Services Commission (FPSC) is mandated by the *Forensic Psychiatry Act* (1996), to provide Court ordered psychiatric assessments of individuals and to provide specialized forensic psychiatric services on an inpatient and outpatient basis to individuals in conflict with the law. Also in Port Coquitlam, the Forensic Psychiatric Hospital is a secure hospital for individuals found 'Not Criminally Responsible on Account of a Mental Disorder' (NCRMD), those believed to be 'Unfit to Stand Trial' and for those individuals requiring psychiatric assessment and/or treatment while sentenced to a correctional facility.

In addition to the Forensic Psychiatric Hospital (FPH), there are six regional forensic community clinics in Vancouver, Surrey, Victoria, Nanaimo, Prince George and Kamloops. These regional clinics provide treatment and support to individuals discharged from the FPH as well as those individuals subject to a Court order to attend for assessment or treatment as per a condition of bail, probation and/or conditional sentences.

While a majority of individuals with a mental disorder never commit a criminal offence, or come in conflict with the criminal justice system, there are some individuals that will frequently come to the attention of police and the Courts as a function of their illness or personality. These mentally disordered offenders may be receiving treatment and support from either Mental Health Services or the Forensic Psychiatric Services Commission (Forensics) and will often have some overlap and contact with both services. In some circumstances Mental Health and Forensics will coordinate resources and work collaboratively with mentally disordered offenders and in others, Forensics is seen as a specialized resource and case management will be their exclusive responsibility.

The Provincial Ministry of the Solicitor General Corrections Branch may also have a mandate for involvement with a mentally disordered individual and be required to supervise the offender in the community and ensure that the conditions for their release into the community are being followed. For example, an individual with a mental disorder may have 'to attend and participate in counseling and treatment as directed by the Probation Office' as a condition of probation. An even fewer number of mentally

disordered offenders may repeatedly come to the attention of Police and the Courts, resulting in even more community service providers being involved with one individual. As a result, the need to coordinate and share information relating to the needs of a mentally disordered offender to ensure that the individual does not get lost between the services or that those services provided are consistent with treatment goals, is arguably essential.

### ***Background***

In 1991, as I began my career of working with individuals with a mental disorder in Vancouver, Riverview Hospital had begun to discharge patients. With a view towards eventual closure, more and more individuals appeared on the streets in many communities throughout B.C. with significant mental health issues. Concurrently, many mentally disordered individuals found themselves before the Courts facing criminal convictions and sentences of incarceration and/or probation orders. Correctional centers became increasingly referred to as an alternative to tertiary psychiatric care (Buckley & Bigelow 1992, Roskes & Feldman 1999, Steadman et al 1999).

As Riverview was discharging patients into the community, I believe that Forensic Psychiatric Services was beginning to experience an increasing number of mentally disordered offender (MDO) referrals received from the Courts and Probation Services. In my work as a psychiatric social worker with Forensic Psychiatric Services (FPS) during

the early 1990s, I primarily worked with violent offenders convicted of a criminal offence and referred to FPS for counseling and/or treatment.

With the perceived increase in the number of individuals with a mental disorder coming into conflict with the legal system, initiatives such as the Multi-Service Network (Buckley & Bigelow 1992) emerged. In the early 1990s, the Multi-Service Network began as an attempt to coordinate and collaborate services for “the multi-problem, treatment resistant, difficult-to-manage person” (p.44). This initiative was implemented in the urban centre of downtown Vancouver.

I was introduced to the Multi-Service Network (MSN) in the first year of my employment with FPS. An individual (I will refer to as Rob) with whom I had been attempting to work was reviewed at one of the Multi-Service Network meetings. Rob had been diagnosed with paranoid schizophrenia and an anti-social personality disorder. He would actively resist taking any prescribed medication and was continually on the verge of being breached for not following through with probation orders compelling him to attend Forensics for ‘treatment purposes’. I would receive phone calls from the police informing me that Rob had been apprehended for setting fires in garbage cans, or committing Break and Enters to support his drug habit (heroin) and on occasion running in city traffic with little or no clothes on. During this time, the downtown eastside of Vancouver was being inundated with high-grade heroin and the media was continually reporting the large number of heroin overdoses occurring. Coincidentally, the overdoses were at times of the month that many welfare recipients were receiving their income

assistance cheques. Rob's heroin use and receipt of income assistance placed him at considerable risk whenever he 'came into some cash'. I recall feeling overwhelmed with the complexity and number of life threatening issues Rob presented, which to him, was not perceived as problematic.

It was at the first MSN meeting that I learned of the large number of community service providers having had contact with Rob. I was not aware of the degree to which he had been accessing other resources and the even higher frequency with which police were involved. It was clear by the initial tone of the discussion that many had resigned themselves to having little impact on Rob's dangerous behaviour. At this meeting we developed a community plan to work with him to ensure coordination of intervention and clarify our respective roles of involvement. The police had identified plans for following through with either charging Rob for his behaviour or transporting him to hospital due to mental health concerns. The (then) Ministry of Human Resources was going to begin administering his cheques weekly and pay his rent directly in order to minimize the potential to spend money for food and shelter on heroin. As well, the alcohol and drug programs were planning to work with Rob to consider harm reduction strategies and possible enrollment in a methadone program. My role was to focus on better housing, access to food banks and soup kitchens, and exploring the issues associated with taking medications prescribed. I believe that because of the meeting, organized by the Multi-Service Network, Rob received better, more appropriate and client-centered, services which could only have happened by having an organized plan of intervention developed by the community service providers.

In 1992, *Protocols for the Coordination of the Inter-Ministerial Services for Persons with a Mental Disorder or Mental Handicap Involved in the Criminal Justice System* were introduced. The intent of these protocols was to facilitate government ministries and community service providers involved with mentally disordered or mentally handicapped individuals, to share information and work together through regular meetings and case reviews, not unlike the Multi-Service Network. Although working groups were developed throughout the Province, many of those groups gradually dissolved within a few years.

Also in 1992, the *Freedom of Information and Protection of Privacy Act* was introduced, the ability to share information with agencies became increasingly unclear to community service providers. A subsequent survey of the MDO Protocols (FPSC) in 1996 found that less than half of the respondents were even aware of the protocols and the majority of respondents that were aware of the protocols perceived there to be minimal positive change.

Working groups throughout the Province did not begin to re-emerge until 1998. It was just prior to their reemergence that the concept, as described by Wharf and Clague (1997) of “convergence of interest” (p.317) could be perceived as having influenced Mentally Disordered Offender intervention and practice. In that, because of recent incidents involving MDOs, a ‘convergence of interest’ occurred when individuals with a mental disorder received significant political and media attention. In Vancouver’s

downtown eastside, there were incidents which resulted in individuals with a mental disorder being shot by city police. And in Victoria, a mentally ill man stabbed and killed his mother. The coroner's report from the Victoria death recommended amendments to *the Mental Health Act*, and changes in policy or practice to ensure that individuals with a mental disorder did not 'fall between the cracks' of the systems involved.

The Mental Health Plan introduced in 1998 saw \$125 million committed over seven years to fund its initiatives. \$2.1 million was to fund 30 positions throughout the Province mandated to "provide services to people with mental illness who are in conflict with the law" (Ministry of Health News Release, 1998). In addition to a specific court liaison role, a correctional centre liaison role and a community case management role, these positions were to liaise with community service providers and improve coordination of resources between the criminal justice system and the mental health system. The positions were referred to as forensic liaisons and one of the expectations of the positions was to redevelop and coordinate the MDO Working Groups within their respective communities.

**Table 1: Timeline of Significant Events Impacting the MDO Working Groups**

1992	<i>Protocols for the Inter-Ministerial Coordination of Services for Persons with a Mental Disorder or Mental Handicapp involved with the Criminal Justice System</i> introduced
1992	The <i>Freedom of Information and Protection of Privacy Act</i> proclaimed
1996	Survey of the Impact of the MDO Protocols conducted
1998	The Mental Health Plan released
1998	Forensic Liaison Positions created
2000	Forensic Liaison Evaluation completed

As of 2000, there were approximately 28 MDO Working Groups throughout the Province in various stages of development and operation. The broad mandate of the MDO Working Groups is to serve as a forum for information sharing, consultation and co-ordination of services for individuals with a mental disorder and/or mental handicap either directly or potentially involved with the justice system. Community collaboration and integration of services for mentally disordered individuals in the community, especially those individuals with frequent contact with multiple service providers and the legal system, may reduce the likelihood of hospitalization or incarceration. Each of the working groups had been developed locally with the specific needs of each community dictating membership, frequency of meetings and format. A majority of the MDO Working Groups have been meeting for at least one year and a minority have been convening since the original concept was introduced in 1992.

### ***Personal Context and Involvement in MDO Working Groups***

Through my experience working with mentally disordered offenders and involvement with several MDO Working Groups, I often hear the frustration expressed by representatives of the criminal justice system that mental health professionals do not hospitalize individuals that are continually brought to their attention either by police or by the Courts. I believe that individuals with a mental disorder/handicap in conflict with the legal system receive better and more appropriate services when there are ongoing meetings of professionals from both the criminal justice and mental health systems.

By way of an example, police were called to a relatively remote island near Vancouver Island where an individual was causing a disturbance. Once on the scene, the police member decided that the individual should be apprehended pursuant to the *Mental Health Act* S.28 which reads:

“A police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person


- (a) is acting in a manner likely to endanger that person’s own safety or the safety of others, and
- (b) is apparently a person with a mental disorder.”

In order to transport the individual off the island and to the nearest hospital, a B.C. Ferry was specially chartered. Several hours later, and after incurring significant expenses, the police officer finally arrived with the individual at the hospital emergency ward. After waiting some time the individual was seen by a physician. The officer was subsequently informed that, while the individual did suffer from a mental illness, he was not going to be admitted to the hospital. Needless to say, after the significant expenditure of time and

money there was an expectation on the part of the police officer and his superiors that this individual would be hospitalized. The following MDO Working Group meeting though animated, proved to be quite productive in the sense that the hospital psychiatrist was able to explain the parameters for an involuntary admission to the police officer and offer some specific training to police members. As the working relationship and forum to review this specific scenario was in place, the potential for escalating frustration was averted and replaced with a learning opportunity.

Similarly, workers in the mental health field contend that their counterparts in the criminal justice system refuse to pursue legal recourse for those mentally disordered/handicapped individuals needing to be held accountable for their actions. In that, even though an individual may have a mental disorder, the illness should not excuse the consequences of their actions unless those actions are a direct result of the illness. For example, an individual with a mental illness having assaulted someone at a shopping centre because the person bumped into him, should be held accountable for his actions. Conversely, if that same individual with a mental illness assaulted someone in a mall because he believed the victim was the devil and must be destroyed, his actions are the direct result of his illness and he should receive the appropriate medical treatment.

By having representatives of both systems meet to discuss and develop strategies to manage mentally disordered offenders, a forum to discuss and educate one another is made possible. Decisions that are made at these meetings are shared, and may have a greater likelihood of being followed through upon when an individual requires



hospitalization or incarceration. Finally, the MDO Working Group is potentially in a better position to identify ‘gaps’ in services and either develop local resources, or as a collective, seek changes in policy or resource allocation at the Provincial level.

### ***Purpose of the Study***

The MDO Working Groups are a major initiative throughout the Province of British Columbia but to this point they have not been the focus of an evaluation or a research study. There were, in March of 2000, 28 MDO Working Groups throughout the Province, little is understood about the impact or perceived success the working groups have had for clients and for service providers. Even though the rather limited mentally disordered offender literature reflects the value in coordination of services and the need to communicate with community service providers, there has been significant difficulty in firmly establishing the MDO Working Group initiative in some areas of the province. The reasons for the varying ‘success’ and perceived value of the initiative are not understood.

Through my own active involvement in several MDO Working Groups, I believe that they serve a significant role in communities, especially rural communities. I am concerned that this initiative will, once again, become secondary to other pressing mental health issues, and the ‘political will’ to fund this initiative will diminish. This thesis not only reviews the historical evolution of the MDO Working Group initiative but also explores if there has been a qualitative change in the delivery of services to individuals with a mental disorder or mental disability resulting from the initiative. Specifically the research questions are:

- (1) What is the current status and membership of working groups throughout the Province?
- (2) Who attends the meetings and do clients/advocates participate in the meetings?
- (3) What is the focus of the working groups?
- (4) What are the members' identified issues and concerns with regard to the working groups attended?
- (5) How would participants describe the value and success of the MDO Working Group?

This thesis could potentially provide initial evidence that the MDO Working Group initiative serves as an example of best practice for mental health intervention (Health Systems Research Unit, 1997).

In Chapter Three, the methodology of this study is outlined. This research uses both qualitative and quantitative methodologies. The distribution of a questionnaire to current MDO Working Groups assists in providing demographic information and provide as many members of the Working Groups as possible with the opportunity to discuss their perceptions of the Working Groups' value and what issues they currently face. To further inform this inquiry interviews and observations of two Working Groups, one rural and one urban, occurred.

Chapter Four outlines the current status of the MDO Working Groups throughout the Province. Given their historical evolution, there appears to be continual changes to the very existence of the Working Groups. Therefore, it is important to provide a current

snapshot. Although this is out of the scope of the study, there are many areas of the Province which have never attempted to develop a Working Group and a brief discussion of the reasons for this is warranted.

Chapter Five contains the analysis of the data and discussion of the findings. While the MDO Working Group initiative has been once again reinforced by senior management as an important method of ensuring that individuals with a mental disorder access the treatment and receive the appropriate intervention, what is the perception of those directly involved in the meetings? In this research, it became clear that the very existence of a MDO Working Group is often dependent upon the role of the Forensic Liaison in coordinating, scheduling and even chairing the meetings. The participation of those individuals discussed in the Working Group meetings as well as the mandate to share information with other community service providers will be discussed.

The final chapter briefly revisits the initial purpose of the study and examines the implications of the findings. With recent announcements that parts of the provincial public sector could be reduced by up to 50%, and rumors of significant changes to the current health structure in British Columbia, the status of the MDO Working Groups could once again be perceived as an initiative without the ‘political will’ to continue. The tendency to become insular during times of restraint and reorganization may have community service providers opting not to collaborate or coordinate service delivery. Contrarily, with fewer resources it may very well be in everyone’s best interest to work together, to ensure that there is no duplication of services and needless waste of time.

## CHAPTER TWO: LITERATURE REVIEW

In 1857 Dr. Doug Jarvis wrote, “The insane criminal has nowhere any home: no age or nation has provided a place for him. He is everywhere unwelcome and objectionable. The prisons thrust him out; the hospitals are unwilling to receive him; the law will not let him stay at his house, and the public will not permit him to go abroad. And yet humanity and justice, the sense of common danger, and a tender regard for a deeply degraded brother-man, all agree that something should be done for him – that some plan must be devised different from, and better than any that has yet been tried, by which he may be properly cared for, by which his malady may be healed, and his criminal propensity overcome” (Roskes & Feldman, 1999, p.12).

There exists a relative abundance of literature describing the psychopharmacological treatment of the mentally ill, and to a lesser degree the psychosocial treatment of mental illness. As well, the incarceration rates and treatment of offenders are relatively easy to access. However, the literature available on the treatment of mentally disordered offenders especially in the community is limited. Clearly, not a new phenomenon, the treatment of MDOs has been focused on either the mental illness or the criminal behaviour (Rice & Harris, 1997). Effective case management is identified in the literature as another important aspect of the treatment of individuals with a mental illness. The following chapter will review the literature specific to the treatment of MDOs, the service coordination requirements and the best practices for service delivery.

### ***Treatment of MDOs in the Community***

Not unlike the typical treatment of individuals with a mental illness, MDOs will most likely be prescribed medications to treat the symptoms of their specific illness and

incorporate some form of psychoeducational and psychosocial support (Muller-Isberner & Hodgins, 2000; Rice & Harris, 1997; Liberman, 1988). While the prescribing of medications will be dependent upon the specific diagnosis and psychiatric illness, the psychoeducational and psychosocial support will often be in the form of life skills and social skills.

The prescribing of medication is a major form of treatment for MDOs both in hospitals and in the community. While the specific discussion of medications and mental disorders is beyond the scope of this study, it is important to recognize that pharmacological treatment is seen as an important intervention in the reduction of symptoms experienced by someone with a mental illness (Muller-Isberner & Hodgins, 2000; Citrome & Volavka, 2000; Rice & Harris, 1997; Liberman, 1988). Often the challenges include the determination of the appropriate medication at the proper dosage, while minimizing potential side effects an individual may experience. The side effects and perceived need for continuing to take prescribed medications is often a major issue for the MDO (Muller-Isberner & Hodgins, 2000).

Life and social skills programs typically focus upon basic skill development such as hygiene, meal preparation, communication skills and vocational training (Muller-Isberner & Hodgins, 2000; Rice & Harris, 1997; Liberman, 1988). The effectiveness of these programs is largely seen as being complimentary to psychotropic intervention and

needed to assist individuals beyond symptom management (Lieberman, 1988). The delivery of these programs can begin in hospital and continue through to the community.

An effective case manager is described by Muller-Isberner and Hodgins (2000) as one who “helps to ensure that patients comply with all the components of their individualized treatment programmes, and facilitate contacts with social service agencies to ensure adequate housing and income and, when possible, appropriate employment” (p.20). Not unlike traditional approaches with individuals with a mental disorder, effective case management of MDOs is seen as requiring several primary elements. First, assertive case management (Wilson, Tien & Eaves, 1995; Lafave, Souza and Gerber, 1996; Rice & Harris, 1997; Muller-Isberner & Hodgins, 2000) is described as the approach used to see individuals in their own environment rather than within the confines of the case manager’s office. Second, the relationship of case manager to the individual is seen as a major element to consider. To be effective it is important for the case manager to develop a positive and trusting relationship that is predicated upon tolerance and building individual responsibility. Finally, effective case management is long-term and consistent. The MDO is not transferred from clinician to clinician or expected to ‘re-tell’ their life over and over. The case manager retains primary responsibility and is accessible to the individual (Rice & Harris, 1997; Muller-Isberner & Hodgins, 2000).

While the treatment of MDOs in the community is not unlike treatment provided to non-offenders with a mental illness, the main distinctions are that MDOs are likely compelled to participate in treatment as per a legal order and that continual consideration of risk to

re-offend must occur. The *Forensic Psychiatry Act* specifically identifies the dual mandate to provide services to the individual while maintaining public safety. Even though a majority of offenses may be non-violent or property related, the MDOs potential to harm another individual must always be taken into consideration in their treatment plan (Rice & Harris, 1997; Muller-Isberner & Hodgins, 2000).

In general, Muller-Isberner and Hodgins (2000) have discussed the development of effective community treatment programs for MDOs as having:

1. Compulsory participation (ordered by the court or tribunal);
2. A recognition and acceptance by the mental health professionals who carry out the programme that they have a double mandate, which includes treating the mental disorder and preventing offending and/or violent behaviour;
3. Legal powers for the mental health professionals to rapidly rehospitalize patients against their will if they think that they may offend and/or behave violently;
4. Structure, intensity, and diversity to address the multiple problems presented by the mentally disordered offenders; and
5. Staff responsibility for ensuring compliance with all aspects of the programme. (p.23)

In addition to the treatment of MDOs, it is important to consider the ever increasing evidence that alcohol and drug use by individuals with a mental disorder significantly

increases the likelihood of contact with the criminal justice system and is an effective predictor of violence (Lindquist & Allebeck, 1990; Steadman et al, 1998; Swanson, 1994; Swartz et al, 1998). While there are isolated pilot programs being developed in British Columbia which focus upon concurrent disorders of substance misuse and mental disorders (Nanaimo Concurrent Disorders Demonstration Project), Alcohol and Drug Services have generally not been seen as investing much in the way of resources or expertise. Furthermore, the literature maintains the importance of monitoring substance use, especially when combined with medication non-compliance (Swartz et al, 1998). Often acting in relative isolation from one another, the mental health system and substance misuse system would seem to rarely share expertise in what the literature would contend as one of the stronger indicators of police contact and violence.

### ***Service Coordination***

Hassett and Austin (1997) discuss the evolution of service integration within the human services spectrum and the “variety of labels including ‘collaboration,’ ‘coordination,’ ‘human services integration,’ ‘one-stop shopping’ and many others. While these labels may signify different levels of intensity or differing focus, they all refer to efforts to reduce or eliminate divisions or boundaries between categorically defined and provided services” (p.9). Service coordination is seen as a process rather than an end result. The main motivation in developing better service integration and coordination “involves filling gaps in services to needy populations” and “as a means of providing existing services more efficiently” (p.13).

Service coordination can be considered from two different perspectives. The first perspective is that of service coordination at the organizational or systemic level. From this level, service coordination can be seen as attempting to address inefficiencies or gaps in services or addressing “political and organizational needs for reform and control” (Rein, 1983, p.61). Coordination at the organizational/systemic level will often make large scale changes in the way services are delivered by, what Wharf (1995) refers to as, the development of “multi service centres, and the folding together of previously separate agencies” (p. 6). The focus of organizational/systemic change will not be on the individual client so much as on addressing the system or process of delivering the services the organization/system is mandated to provide. Organizational/systemic level of change is not seen as having much success in improving client well being (Rein, 1983; Wharf, 1995).

The second perspective of service coordination is from the perspective of “starting ‘where the client is’” (Wharf, 1995, p.2). In this context, coordination is often at the local level of change and is specifically focused upon the client and/or community. The motivation for coordination at the local level can be to ensure a consistent approach to working with an individual by the multiple service providers involved, to ensure that services are efficient and not being duplicated, and attempt to problem solve potential gaps in services (Rein, 1983). Further, Rein (1983) describes an additional motivation in that “professionals may call for ‘coordination’ because they feel the service they provide is inadequate to the human problems they are charged with solving” (p.64). The complexity of issues and problems an individual may experience can be overwhelming to

individual service providers. The different perspectives of service providers can be invaluable in not only assisting the individual client, but also in supporting the case manager.

For the purposes of this thesis, service coordination is defined by the latter perspective, that of service coordination at the local level. Therefore, coordination is in the context of working with individual clients and their communities in attempting to better serve the client, share information, problem solve and even attempt to address service gaps at a local level. It is the coordination of services for specific mentally disordered offenders that often involves many service providers from the criminal justice system (police, probation officers and the courts), the mental health system (mental health clinics, forensic psychiatric services, and local inpatient psychiatric units) and other secondary systems (alcohol and drug services, income assistance offices).

Within British Columbia, the need for service coordination can be highlighted by considering services for children. Clague (1997) discusses the attempts during the 1980s to “improve interministerial collaboration through the Inter-Ministerial Child and Youth Committees regionally and locally” (p.101). He maintains that the main issue associated with this initiative was the “lack of political will to make them work. They were concerned with overcoming obstacles in the existing ministerial systems rather than with making systemic changes. They lacked accountability to consumers and the community” (p.102). The concept of “convergence of interest” as described by Wharf and Clague (1997, p.317) could be perceived as a major factor in the development of service

coordination initiatives especially within government. However, service coordination could easily be doomed to failure without the ‘political will’, resources and motivation of local and provincial level individuals to ensure that changes occur.

In their 1999 Annual Report, the B.C. Children’s Commission reported on all of the child deaths in the province from 1996 to 1999. In this report their most frequent category of recommendation was better integrated case management. The Children’s Commission defines integrated case management (ICM) as “a model that ensures service providers involved with a child or youth and his or her family work together to assess needs and plan for appropriate services for that child, youth or family” (p.68). Furthermore, “the general lack of a coordinated approach to service planning and delivery to vulnerable children and youth is a common theme running through the fatality reviews” (p.37). The report continues by maintaining that “more efforts are needed by all ministries and agencies that provide services for children to co-ordinate their services with those of others, particularly at the local level, but also at the provincial level. Clear protocols between ministries on key issues, and particularly for special needs children, need to be revised and implemented” (p.47).

The need for service coordination for MDOs is no different than that discussed by the Children’s Commission. By virtue of the very reference and term used to describe individuals with a mental disorder in conflict with the legal system, it is obvious that mentally disordered offenders will have connections with both mental health and criminal justice systems. As a result, the literature consistently maintains that ensuring

coordination and collaboration between the two systems is absolutely critical to adequately provide the treatment required (Caplan & Caplan, 2000; Heilburn & Peters, 2000; Hodgins & Muller-Isberner, 2000; Roskes et al, 1999; Roskes & Feldman, 1999; Rice & Harris, 1997; Watson et al, 2001).

Mentally Disordered Offenders as Roskes & Feldman (1999) discuss, have historically been marginalized and caught between two distinct systems; the criminal justice and mental health systems. Rice and Harris (1997) maintain that “there is no doubt that many people shift back and forth between mental health and criminal justice systems” (p.128) in discussing the issues associated with mentally disordered offenders. They proceed to describe “mental health and correctional facilities fight to ‘off-load’ difficult individuals onto one another in such rapid cycles that the bus ride between facilities seem to be the only ‘therapy’ provided” (p.128). Furthermore, the increase in correctional centres reporting inmates with a mental disorder continues to increase leading to speculation that “jails have become the mental hospital of last resort” (Watson et al, 2001, p.477) (Buckley & Bigelow 1992, Roskes & Feldman 1999, Steadman 1999).

In each community throughout the Province there are individuals with multiple issues and significant needs that overlap with other agencies or fall outside the mandate of any one organization. Buckley and Bigelow (1992) state that “although these multi-problem people are few in number, they consume extraordinary amounts of the most expensive services and pose the most difficult treatment challenges. At the same time, they do not obtain much benefit from those services” (p.44). The Multi-Service Network (MSN) was

an initiative implemented in the urban centre of downtown Vancouver and is an early example of attempts to coordinate and integrate services within British Columbia (Buckley & Bigelow, 1992).

The main function of the MSN was to facilitate case conferences when a minimum of three agencies working with an individual were identified and “an individual plan of care was drawn up by the participants in that case conference. The client either participates in the conference or the results are reviewed with the client immediately afterward” (p.46). Buckley and Bigelow contended that the MSN provided better communication and coordination of services. The agencies participating in the MSN reported that “gaining information on the client and other agencies serving the client were the most important outcomes. Almost as important was developing better strategies and options for dealing with the client” (p.49).

*The Protocols for the Inter-Ministerial Coordination of Services for Persons with a Mental Disorder or Mental Handicap involved in the Criminal Justice System* were developed in 1992 (Appendix B). The primary intent of the protocols was to “develop a coordination strategy to help ensure that persons with a mental disorder or mental handicap are properly served by government” (p.3). The major intended outcome of this initiative was the development of local working groups throughout the province.

“A Survey of the Impact of the MDO Protocols” in 1996 (FPSC) was conducted to determine the effectiveness of the MDO Protocols as developed jointly by the Ministry of

Attorney General, the Ministry of Health, the Ministry of Social Services and the FPSC. The survey was distributed to staff from the Corrections Branch, Mental Health Services, Social Services, Alcohol and Drug Program, RCMP/Police, Crown Counsel and the FPSC. Of 320 questionnaires returned, only 45% were aware of the protocols and of those aware of the protocols 61% had felt that the protocols did not result in any positive change in the way they worked with other agencies. The recommendations from this survey were not only for more staff education and training but to address as well “a critical need for leadership. This includes leadership to bring about sustainable changes, forge new relationships, and implement and support new programs consistent with the spirit of the MDO Protocols” (p.6).

The Mental Health Plan introduced in 1998 committed \$125 million over seven years to fund the initiatives that were outlined in the Mental Health Plan. One of the initiatives, was to fund “30 additional staff who will provide services to people with mental illness who are in conflict with the law” (Ministry of Health News Release, 1998:189). Later, these positions were referred to as Forensic Liaisons.

Given the Forensic Liaison positions were a new initiative by the Ministry of Health, Forensic Psychiatric Services conducted an initial evaluation of the initiative in 2000. The Forensic Liaisons were expected to track the nature of their contacts with community service providers and clients. In addition, data collection methods, which included focus groups and interviews of community stakeholders, occurred. From this evaluation 28 MDO Working Groups were identified in B.C., however several were identified as being

“informal” or “ad hoc”. Among the initial findings, “the [Forensic Liaison] Initiative appears to have had a positive impact and has generated more interest and given some MDO Working Groups a reason to work together” (Forensic Liaison Evaluation Report, p.17, 2000).

### ***Best Practices***

In a presentation at the *Forum on Best Practices in Mental Health for Rural and Remote Areas* (March, 2000), Judy Treherne describes best practice as a term that is “frequently used in discussions related to reform of mental health delivery systems “ (p.1). The Health Systems Research Unit (1997) describes best practice in mental health reform as the “various courses of action to develop mental health care systems that better support individuals with severe mental illness, maximizing their community tenure, independence and quality of life” (p.1). While best practice is not a new concept, the definition is consistently dependent upon the context in which it is used. For example, the study by Callahan et al (1998) defines best practice as “practice that is deemed by all participants to be superior, innovative and effective” (Appendix A, p.1).

The Health Systems Research Unit (1997) discussion paper “Best Practices in Mental Health Reform” approaches best practice in three phases: Phase 1 focuses upon the “critical evidence-based review of the current state of knowledge about ‘best practices’ relevant to mental health reform” and “they tell us what should be done” (p.v). Phase 2 involves “a situational analysis of mental health reform policies, practices and initiatives

in Canada which approximate ‘best practice’” and they tell us “what can be done” (p.v). Phase 3 discusses the “implementation of best practices across entire systems of care”(p.v). Generally, best practice is described as guidelines or elements that can inform practice and the delivery of services at an individual, program or system level (Treherne, 2000; Health Systems Research Unit, 1997; Canadian Centre on Substance Abuse, 2000).

Findings from the literature review completed by the Health Systems Research Unit (1997), “provides a comprehensive list of the key elements that should be present within a reformed system of care for persons with a mental illness” (p.17). The key elements identified were in the program areas of (1) individual support and case management, (2) inpatient and outpatient services, (3) crisis response and emergency services, (4) housing and community support, (5) employment and self-help. The Health Systems Research Unit (1997) also identified several system level key elements which include (1) mental health reform policy (2) ongoing monitoring and evaluation (3) clear governance and funding structure (4) and human resource management (Table 2 and 3).

**Table 2: Checklist of key elements of a reformed system of care: Core Programs (Health Systems Research Unit, 1997, p,11)**

<b>Best Practice Area</b>	<b>Checklist Criteria</b>
<b>Case Management/ACT</b>	<p>An array of clinical case management programs are in place that follow rehabilitation, personal strengths and Assertive Community Treatment (ACT) models.</p> <p>There is an emphasis on ACT models for those who need intensive support, including special needs groups such as the homeless and persons with dual disorders.</p>
<b>Crisis Response/Emergency Services</b>	<p>A continuum of crisis programs are in place to help people resolve crises using minimally intrusive options.</p>
<b>Housing</b>	<p>There is a variety of housing alternatives available, ranging from supervised community residences to supported housing, with emphasis on supported housing.</p> <p>Housing needs of the homeless mentally ill are addressed.</p>
<b>Inpatient/Outpatient Care</b>	<p>Inpatient stays are kept as short as possible without harming patient outcomes.</p> <p>An array of treatment alternatives to inpatient hospitalization are available, including day hospitalization and home treatment.</p> <p>Long stay patients in provincial psychiatric hospitals are moved into alternative care models in the community.</p> <p>Service delivery models link family physicians with mental health specialists</p>
<b>Consumer Initiatives</b>	<p>Consumer initiatives are in place that have diverse purposes such as mutual aid, skills training and economic development.</p> <p>Consumer initiatives are supported through funding, consumer leadership training, education of professionals and the public about consumer initiatives, and evaluation using appropriate methods.</p>
<b>Family Self-Help</b>	<p>Funding is provided to family groups who also participate in planning and evaluation of care delivery.</p>
<b>Vocational/Educational Supports</b>	<p>There are supported employment programs in place, and plans for implementing and evaluating pilot programs in supported education and social recreation.</p>

**Table 3: Checklist of key elements of a reformed system of care: System Strategies (Health Systems Research Unit, 1997, p,12)**

<b>Best Practice Area</b>	<b>Checklist Criteria</b>
<b>Policy</b>	<p>There is a free standing mental health reform policy based on an explicit vision that is shared among various stakeholders, including consumers and families.</p> <p>There is a planned strategy for implementing policy.</p> <p>Policy preserves the mental health envelope, prevents losses due to downsizing institutions, and increases the proportion of funds spent on community care.</p> <p>Policy defines concrete, measurable targets for reform</p>
<b>Monitoring and Evaluation</b>	<p>Regular monitoring of all services and supports is the basis for program and system accountability, and for continuous quality improvement.</p> <p>Preset goals, performance measures and time lines are established.</p> <p>An information system has common elements for system evaluation (provincial) and local elements for program evaluation (agency level)</p> <p>There is a sufficient, protected evaluation budget.</p>
<b>Governance and Funding</b>	<p>At the regional/local level one organizational entity or mental health authority is responsible for metal health care, and is a clear point of accountability for system performance.</p> <p>The authority uses clinical, administrative and fiscal mechanisms to promote cost containment, transfer resources from institutional to community care, implement best practices and increase accountability.</p> <p>Diverse funding sources are consolidated into a single funding envelope that can be used flexibly.</p> <p>Funding allocations to a region or local area are linked with unique characteristics and needs of residents.</p> <p>A consumer-centred information system supports decision-making in planning, funding and managing the system.</p> <p>Administration of mental health care is connected with the broader health system and generic services.</p>
<b>Human Resources</b>	<p>A detailed strategy is in place to facilitate redeployment of staff.</p> <p>Strategies enhance consumer involvement as providers and educators.</p>

The literature review conducted by the Callahan et al in 1998 found several common best practice elements in “the literature on the human services field and organizational theory” (Appendix A, p.2).

1. The services are ‘client orientated’ and are based upon respect, caring and building upon the strengths of the individual. The services are delivered in consultation with the client and in support of their needs.
2. Sensitivity to the cultural backgrounds of those served was identified as important not just in the attitudes of the service providers but also in the very delivery of services.
3. The services offered are delivered in a manner that is “comprehensive, accessible, responsive, flexible and adaptive to community needs”
4. The services delivered are consistent with the mandate and philosophy of the agency/organization.
5. The staff are supported in an environment that allows for staff to develop and take risks.
6. A continual commitment on the part of the staff to improve service delivery and practice is evident.

7. Opportunities to problem solve and provide leadership is evident. The leadership may be informal or formal and encourages independence and team work.
8. Outcomes of practice are evident and provide the basis for standards of practice and focus upon process and practice.
9. Organizations/agencies working collaboratively to provide seamless service delivery.

While the Callahan et al (1998) research identified nine elements of best practice in child welfare and the Health Systems Research Unit (1997) identified several key elements for a reformed system of care both in terms of core programs and system strategies, there are similarities worth noting. First, the attention paid to client-centred service delivery would appear in both research findings in terms of responsive and comprehensive case management programs, consumer initiatives, supporting personal strengths and client/consumer involvement. Second, recognition that services should be openly consistent with vision and policy, which is shared. Third, both the Callahan et al (1998) research and the Health Systems Research Unit (1997) identify the importance in ensuring that evaluation measures are in place and are regularly ensured for quality improvement. Finally, the consideration of staffing and professional development are both identified as key elements.

The elements that have not been as clearly articulated in the Callahan et al (1998) research would likely be the larger systemic issues concerning governance and funding.

It would appear that the majority of the elements identified were more specific to individual or program delivery rather than organizational or systemic level best practices. Contrarily, there is limited discussion about the need to link and coordinate services with other agencies or organizations involved with clients in the Health Systems Research Unit (1997) research. While both discuss the importance of coordination and integration of services, the Best Practices in Mental Health Reform largely refers to better coordination and integration of services within the mental health system. The explicit identification of “an element of best practice is working collaboratively with other agencies” (Callahan et al, 1998, Appendix A, p.5) was not identified in the Health Systems Research Unit (1997) research findings.

### ***Summary***

The intent of this chapter has been to review the literature that is applicable to the intent of this thesis. I have concentrated upon the treatment of MDOs in the community, the most common forms of intervention which include the prescribing of medication, psychosocial and psychoeducational support and effective case management. While monitoring of risk to the public and re-offending is not a specific aspect of treatment, it must be a continual consideration and is a distinction from the majority of individuals with a mental illness.

Service coordination and integration is not isolated to MDO treatment, but remains a major issue across the human services spectrum especially those services intended for

children, youth and families. Within B.C., there have been several attempts to address service coordination with varying degrees of success. The “Survey of the Impact of the MDO Protocols” in 1996 highlighted the failure to adequately inform line staff about the protocols and the lack of leadership in the coordination of services to MDOs. A subsequent evaluation of the Forensic Liaison Initiative (2000) maintained the impact the Forensic Liaisons were having in the renewed interest in the MDO Working Group Initiative. While the literature highlights the need for service coordination, there is very limited research describing initiatives that are currently in operation or serve as examples of service coordination for mentally disordered offenders.

Finally, I believe it is important to discuss the concept of ‘best practice’ in the literature review as an objective of this thesis is to consider the MDO Working Group Initiative as possible evidence of best practice. This literature review has identified and defined what is meant by best practice in relation to mental health services. In addition, a literature review conducted by Callahan et al in 1998 of best practices identified nine common best practice elements found in the human service field.

The treatment of MDOs in the community, service coordination, and best practices all have specific relevance to this thesis. However, it would appear that while the literature contends the need and importance for service coordination and collaboration, the best practices in mental health reform does not specifically reference mentally disordered offenders or recognize the need for working beyond the mental health system. I believe it

is important to consider the human costs of the 'bus therapy' provided in the mental health and correctional facilities fight to 'off-load' mentally disordered offenders.

## CHAPTER THREE: RESEARCH METHODOLOGY

The purpose of this inquiry is to explore possible qualitative changes in the delivery of services to mentally disordered offenders resulting from the MDO Working Groups. By considering the perceived value and elements attributed to success for the initiative, the service providers in the field may very well offer the initial evidence of efficacy for the Working Groups.

### ***Research Assumptions***

From my direct involvement in seven MDO Working Groups on North Vancouver Island and previous experience with the Multi-Service Network, I made certain assumptions about the research proposed. First, there are existing differences within each of the communities in terms of professional membership, frequency of meetings, and focus of discussion. What is not known, is what differences and similarities exist on a broader Provincial basis? Second, involving clients/consumers in their case discussions has been a significant issue and potential source of criticism of the MDO Working Groups as an example of best practice. It was therefore important to determine if any of the MDO Working Groups in the Province had attempted to include clients/consumers in the meetings and/or alternatively, what some of the struggles had been around the inclusion of clients/consumers.

### ***Scope of Research***

Given that there was a limited understanding of the number and function of each MDO Working Group throughout the Province, an objective of this inquiry was to attain a 'snapshot' of the current MDO Working Groups in existence and attain some demographic information about each group. After the basic demographic information was attained, a subsequent objective was to explore and learn from the experiences of those groups throughout the Province. Questions such as the participants included in the meetings, the general discussions that went on, the benefits or issues each group had experienced and perceptions of participants to the overall initiative were answered.

Another objective of this inquiry was to explore whether any of the MDO Working Groups included clients in the meetings. The non-inclusion of consumers has continually been identified as a potential limitation of the initiative. While I was presenting at the "Forum on Best Practices in Mental Health for Rural and Remote Areas" in March, 2000 on the Courtenay MDO Working Group experience, much discussion took place regarding consumer participation and issues associated with both inviting consumers to attend and case planning without client input. I could only comment on the experiences of the MDO Working Groups I participated in, and was unsure as to whether other groups have had different experiences of including consumers in the meetings.

## ***Study Design***

In order to develop a better understanding of the perceived value and success of the MDO Working Group initiative, it was necessary to use both qualitative and quantitative methodologies. A mixed methodology design was used in order to adequately inform and expand the scope of the study. In this study, there were four methods of data collection; my own experiences in several working groups, a questionnaire, observation of a rural and an urban MDO Working Group and interviews of specific participants.

A data source used throughout this thesis was my own personal work experience. From my initial experience with the Multi-Service Network to my subsequent move to Vancouver Island where I began attending a working group in Courtenay and soon after developed several other working groups from Nanaimo to Port Hardy, I believe these experiences are valuable and warrant inclusion in this thesis. While my role of psychiatric social worker has changed to that of regional manager for the central and upper Vancouver Island region, I continue to attend the seven working groups in this region whenever necessary and possible.

The survey of the MDO Working Groups provided quantitative and qualitative data which described membership, (inclusion of clients/consumers), frequency of meetings, scope of issues focused upon (client specific and/or systemic/policy issues) and the perceived value and success of the working groups. As the current status and existence of the MDO Working Groups was not certain, I made the assumption that the Forensic Liaisons would be the most likely participants, if not coordinators, of most MDO

Working Group meetings. I made the assumption that the Forensic Liaisons would be the most likely participants of any working groups given their role within most communities in the province and mandate to work with the working groups in their communities. Therefore, I distributed the questionnaires through the Forensic Liaisons and asked that they in turn forward them to all participants attending the MDO Working Group in the community or communities they service. Once again the challenge was in determining the ever-changing number of MDO Working Groups in existence, the frequency with which they met and the number of participants at each group. With the exception of the Forensic Liaison Evaluation in 2000, I did not have any data that identified where the working groups were located and who attended them. One of the most significant challenges of this thesis was in identifying the very existence of the working groups and the specific representatives attending.

It was predetermined that a response rate of at least one questionnaire from each Working Group was essential, with an ideal of 50% of participants in each group completing the survey was required.

The data from the questionnaires were collected over the course of four months from June to September 2001. At least one response from each of the working groups was attained with a total of 61 returned questionnaires. Of the working groups identified, seven are located in the central and upper Vancouver Island area. As discussed in more detail in the ethical issues section, given my current employment and supervision of staff within the central and upper Vancouver Island area, only demographic information was

gathered from those working groups. Therefore, the analysis of subjective data is restricted to those groups outside the central and upper Vancouver Island area. An average of 2.25 responses from each working group was received from the remaining working groups. With the number of representatives at each working group fluctuating and uncertain, the base of agencies/organizations represented would appear to be between four and five. As a result, I would estimate that between 45% and 56.25% (24 groups surveyed with 54 responses = average 2.25 responses / 4 and 5 participants) of representatives completed the questionnaire.

The use of observations and interviews with the members of specific urban and rural MDO Working Groups formed the basis for greater depth in qualitative data. As a researcher, I observed both a rural and an urban MDO Working Group meeting. By collecting data through observation of two different working groups, I was in position to explore themes and patterns of topics and interactions. The location of each observed group was determined by selection of respective and receptive MDO Working Groups that were from an urban and a rural community. In conducting observations of both a rural and an urban group, it was hoped that a 'snapshot' of B.C.'s diversity would be reflected.

From the urban and rural working groups observed, I interviewed representatives from the criminal justice system, the mental health system and a representative from a secondary agency such as Community Living Services or Alcohol and Drug Services. A semi-structured interview with open-ended questions focusing upon the participant's

perspectives was used. By interviewing a working group participant from both the criminal justice and the mental health systems as well as a secondary agency participant, I was able to specifically attend to the similar and contrasting themes and/or patterns which emerged. Specific, open-ended questions were designed in order to provide some structure to the general areas that I explored. Moreover, the nature of the interviews allowed for clarification, or further discussion, as necessary. I believe that this allowed for the greatest degree of exploration within the confines of the interviews.

Analysis of data gathered was inductive. From the questionnaires basic demographic information was attained and specific themes was identified. Similarly, data gathered from the observations and interviews provided themes, concepts, paradoxes and tensions to be analyzed. In addition to a thematic analysis, I believe it was equally important to discuss the individual stories and subtleties within the data.

### ***Participants***

Initially, I had intended to distribute questionnaires only to the Forensic Liaisons throughout the Province, given the likelihood that each would be directly involved in a local MDO Working Group. If I had limited my inquiry in this way, while I would have been able to attain the specific demographic information required for this inquiry, I would not have accessed the perceptions of the participants as to the value or ‘success’ of the initiative.

Equally important in this inquiry was the perceptions of the organizations or systems represented at the MDO Working Group meetings. The criminal justice system (which includes representatives from the Royal Canadian Mounted Police (RCMP) and/or municipal police, Crown Counsel, Probation Services and regional correctional centres), is predominately mandated to ensure public safety and to hold those who commit criminal offences accountable. Whereas the role of representatives of the mental health system, including community mental health services and the local hospital, generally attends to the individual suffering from a mental disorder, and their specific treatment needs. It is for those individuals that have contact with both systems that the MDO Working Group is intended.

Frequently, there are representatives from other services that attend and participate in the MDO Working Groups, such as Alcohol and Drug Services. It is possible that the perceived value and motivation of these participants may differ from the other two primary systems.

Those participants completing a questionnaire have been organized into one of four main regions of the Province that are similar to the current breakdown of regions within Forensic Psychiatric Services. The four regions are Vancouver Island including Powell River, the Lower Mainland (as far north as Sechelt and Squamish and as far east as Hope), the North Region (including area north of Kamloops) and the Thompson, Okanagan, Kootenay (TOKO) area. This approach provided a clear categorization of regions geographically, and therefore ensured representation from a wide variety of urban

and rural communities. In so doing, not only is it possible to consider regional issues and organization of the MDO Working Groups but also to ensure the anonymity of participants.

### ***Ethical Issues***

In consideration of ethical issues, a letter describing the nature and scope of the survey was included with the package sent to each of the Forensic Liaisons. It was important that each of the Forensic Liaisons were informed that the study was not in any way a reflection of their practice, but rather a study of the Provincial MDO Working Group initiative. The Forensic Liaisons were not compelled or obliged to identify themselves. All information attained was confidential attributable only on the basis of region (i.e. a North Region MDO Working Group instead of the Smithers MDO Working Group). Finally, all participants of the project were informed of their ability to peruse the final document if they wished, in order to ensure that it was consistent with the participant's initial expectations and understanding of the project.

Completion of an application request and an agreement to conduct research was submitted to the Forensic Psychiatric Services Commission and approval attained prior to beginning the inquiry. Also, an Application for Ethical Review of Human Research of the University of Victoria was submitted and approval was received.

A letter of informed consent was completed by all participants prior to being observed and interviewed. The participants of the two MDO Working Groups (rural and urban) were informed of the inability to control for complete anonymity, however confidentiality was ensured. As I believed that a major aspect of this study was exploring the different systems represented (Criminal Justice, Mental Health and other secondary organizations) at the meetings, it was essential for the participant to identify whether they were representing the criminal justice, the mental health or a secondary system. Rather than specifically identify the organization and risk identification of the individual, I believe that the identification of system still allowed for some anonymity. Comments and responses to questions, even if the participant identified herself or himself, were not such as to result in any potential harm.

Further, as I was an employee of forensics and was also conducting the observations and interviews, it was important to identify and discuss potential issues associated with my position within Forensic Psychiatric Services and as the researcher. In the letter of informed consent, participants were advised that data would not be used beyond the scope of this inquiry. As there are individuals that I supervise in the Central and Upper Vancouver Island Region, I did not conduct observations and interviews within that area, however I did include basic demographic information associated with the MDO Working Groups within this region.

The principles of respecting the individual's right to privacy, and of addressing issues of confidentiality was considered throughout the study. The gathering of data from the

survey, observations and interviews was carefully perused and any client/consumer identification or references was coded so as to ensure confidentiality. Finally, I ensured that I complied with the *Freedom of Information and Protection of Privacy Act* (1992) Section 35, whereby I removed any means to identify a client/consumer in the study as soon as possible.

## CHAPTER FOUR: A 'SNAPSHOT' OF THE MDO WORKING GROUPS

Since 1992, it has been widely recognized by those mandated to work with mentally disordered offenders that, because of the complex nature of many of these individuals, it is imperative that agencies/organizations coordinate and share information. This importance is mainly to ensure that such individuals do not 'fall between the cracks' of the criminal justice and mental health systems. Even though this recognition exists it is clear that there continues to be numerous hindrances to the existence of local MDO Working Groups. Given their dynamic nature, this chapter provides a 'snapshot' of the current MDO Working Groups based upon the data collected and is organized into two main sections: 1) Current MDO Working Groups; and 2) Structure of the MDO Working Groups.

### ***Current Regional MDO Working Groups***

With the exception of the Forensic Liaison Initiative Evaluation in March of 2000 in which a list of current MDO Working Groups was identified, there does not appear to have been a breakdown of MDO Working Groups in operation throughout the Province. Therefore, it was virtually impossible to conduct a comprehensive comparative analysis of functioning groups with those that may have dissolved, or were unsuccessful. What was evident was that even during the time of this inquiry there were some working groups that were suspended, on the verge of discontinuing, or were in the process of being formed. I had received telephone calls indicating that the MDO Working Groups in three specific communities were suspended because of forensic liaison vacancies or leave

of absences. Further, two reports indicated that because of poor attendance by the community service providers the local MDO Working Group was likely going to be terminated.

Thirty-one MDO Working Groups were in operation during the period of March to September 2001 (see Table 4). By comparison, there was 28 MDO Working Groups in existence when the initial Forensic Liaison Evaluation was completed in March of 2000. Further, of the communities listed in the Forensic Liaison Evaluation (see appendix B) only 23 working groups were also identified in the data received from the questionnaires (see Table 4).

**Table 4: Provincial MDO Working Group by Region**

	<b>September, 2001 (MDO Questionnaire, 2001)</b>	<b>March 2000 (Forensic Liaison Evaluation Report, 2000)</b>
<b>Lower Mainland:</b>	Hope Chilliwack Abbotsford Maple Ridge Langley Surrey SPSC Port Coquitlam New Westminster Burnaby North Shore	Hope Chilliwack Abbotsford Maple Ridge Langley Surrey SPCS Port Coquitlam (new)  Burnaby North Shore
<b>North:</b>	Prince George Quesnel 100 Mile House Williams Lake Dawson Creek Fort St. John	Prince George  Williams Lake  Terrace
<b>Interior TOKO:</b>	Kamloops Kelowna Vernon Salmon Arm Cranbrook Princeton	Kamloops Kelowna Vernon Salmon Arm  Princeton (ad hoc) Penticton Trail/Rossland (ad hoc) Revelstoke (informal) Oliver (ad hoc)
<b>Vancouver Island</b>	Victoria Duncan Nanaimo Parksville Port Alberni Courtenay Powell River Campbell River Port Hardy	Victoria  Nanaimo (new)  Port Alberni Courtenay Powell River Campbell River Port Hardy

Within the Lower Mainland region, each of the groups identified in the Forensic Liaison Evaluation are also identified in the data attained in this inquiry. The New Westminster MDO Working Group would appear to have been only recently developed given that it is the only new addition to the list. Only Langley and the North Shore reported having attendees dating back to 1992. The remainder of groups for this region have been initiated after the introduction of the Forensic Liaison Initiative in 1998.

The absence of Vancouver, Richmond and Surrey in the MDO Working Group Initiative was mainly due to the size and large number of service providers in each location. Through informal discussions with administrators in the region, it was learned that attempts had been made to form a MDO Working Group in each city, however determining or limiting the size of the working group proved too difficult given the large population and number of potential community service providers attending. What has apparently happened in Vancouver has been the development of smaller groups specific to areas within the city, and not exclusive to mentally disordered offenders. For example, the Downtown Eastside and St. Paul's Hospital have service provider meetings to coordinate services to mental health consumers in general.

As for the north region of British Columbia, only Prince George and Williams Lake are identified in both the Forensic Liaison Evaluation and the data obtained in this inquiry. For Williams Lake however, it appears that in 2000 the working group was sporadic and not specific to MDOs and as indicated in the survey response, the first MDO meeting is scheduled for October of this year. Fort St. John, 100 Mile House, Quesnel and Dawson Creek have all been initiated after the Evaluation was completed. The Terrace MDO Working Group meetings have recently been terminated. It was reported that the forensic

liaison position had recently been vacated and apparently there has not been anyone to follow through with the scheduling and chairing of the meetings.

The Interior TOKO region made some significant changes to the MDO Working Groups between the completion of the Forensic Liaison Evaluation (2000) and this year. While Kamloops, Kelowna, Vernon, Salmon Arm and Princeton continue to report having MDO Working Groups, Penticton, Revelstoke, Trail, and Oliver, have either not been meeting or have been meeting informally. In Cranbrook, a MDO Working Group has recently been initiated. For the West Kootenays, which includes Nelson, Castlegar and Grand Forks a working group has not been initiated, because the forensic liaison in that area maintains that the large geographical area covered limits current availability to clients. She prefers to work with community service providers as needed, and as required for individual clients.

Similar to the Lower Mainland region the Vancouver Island region remains relatively stable with the addition of a Duncan and a Parksville MDO Working Group. Both groups appear to have been initiated after the Evaluation. There has not been any groups disbanded or suspended since that time. With the exception of Courtenay and Victoria, all groups were developed after 1998.

### ***Structure of the MDO Working Group Meetings***

After considering the actual MDO Working Groups in existence it is beneficial to explore how the various working groups are structured and organized. With 31 different MDO Working Groups currently meeting it is not surprising to find that those in attendance, the frequency of meetings, and general process have both similarities and differences.

### ***Agencies/Organizations Participating in the MDO Working Groups***

As already discussed, the 1992 *Protocols for the Coordination of the Inter-Ministerial Services for Persons with a Mental Disorder or Handicap Involved in the Criminal Justice System* were jointly developed by the then Ministries of Health, Attorney General and Social Services as well as the Forensic Psychiatric Services Commission. Those impacted by the Protocols were primarily service providers such as Community Mental Health Services, Probation Services, Crown Counsel, police/RCMP and Forensic Psychiatric Services.

While the individuals and frequency of their attendance at the MDO Working Group meetings may change, the primary agencies/organizations attending the working groups has not changed significantly from the original intent of the Protocols. Of the 31 MDO Working Groups, the majority of agencies/organizations identified as attending regularly were the RCMP/police, Crown Counsel, Probation Services, Mental Health Services and Forensic Psychiatric Services (See Table 5). In all of the questionnaires returned which

identify the attendees (four surveys did not indicate membership), Forensic Psychiatric Services is consistently represented at the meetings (27 of 27 or 100%). Crown Counsel was identified as regularly attending the local MDO Working Groups with a 92.6% attendance rate. Both RCMP/police and Probation were reported to be attending 88.9% (24) of the meetings compared with Community Mental Health regularly represented at 85.2% (23).

**Table 5: Attendees at Local MDO Working Groups**

<u>Agency/Organization</u>	<u>Frequency (N=27)</u>	<u>Percent</u>
Forensic Psychiatric Services	27	100%
Crown Counsel	25	92.6%
RCMP/Police	24	88.9%
Probation Services	24	88.9%
Mental Health Services	23	85.2%

In addition to what I would refer to as the core community service providers consistently attending the MDO Working Groups, there were several agencies/organizations identified which attend in some communities on a regular basis (See Table 6). These secondary service providers include the Ministry of Child and Family Development, Community Living Services (CLS) branch, which were reported to attend 29.6% (8) of all MDO Working Groups. As the 1992 Protocols involved the then Ministry of Social Services, the scope of the protocols was intended to include individuals with a “mental handicap involved in the criminal justice system”. CLS is mandated to provide services to those individuals with a developmental disability and therefore would likely be seen as playing

an important role at the MDO Working Group meetings. The infrequency with which CLS is reported to attend may warrant further inquiry.

The data attained from the questionnaires returned from the MDO Working Groups would indicate that Alcohol and Drug Services are actively attending 25.9% (7) of the MDO Working Groups currently in existence. There does not appear to be any specific evidence to determine the reason(s) for the number of groups with alcohol and drug representation. Whether Alcohol and Drug Services has not been invited to participate, or they have declined most invitations, was not clear. The seven MDO Working Groups with Alcohol and Drug representation are found in all four regions identified with the most predominant involvement being found in the Northern region which had participation in four groups.

Although not all communities have a local inpatient psychiatric unit, representation was reported in 22.2% (6) of the 27 MDO Working Groups identified. Of the 22.2% represented at the MDO Working Groups, 50% are groups within the Lower Mainland region. In reviewing the data, there are only two communities which seem to have hospital representation and are also defined as rural. Given that a majority of the hospitals in the Province with a psychiatric unit would be regional hospitals based in larger communities, it may be unrealistic to expect hospital representation at all groups due to the geography of the region serviced.

The Provincial Brain Injury Program and Ministry of Human Resources are also represented at some of the MDO Working Groups. The Brain Injury Program has a

representation rate of 11.1% (3) while the Ministry of Human Resources has a representation rate of 7.4% (2).

**Table 6: Other Attendees Identified at Local MDO Working Groups**

<u>Agency/Organization</u>	<u>Frequency (N=27)</u>	<u>Percent</u>
MCF Community Living Services	8	29.6%
Alcohol & Drug Services	7	25.9%
Local Hospital	6	22.2%
Provincial Brain Injury	3	11.1%
Ministry of Human Resources	2	7.4%

### **Advocacy Group and Consumer Participation in the MDO Working Groups**

The inclusion (or lack of inclusion) of consumers and advocacy groups could be an area that is perceived as a major gap in the MDO Working Group Initiative. This is especially evident in relation to best practices research, which specifically highlights the importance of consumer input into their own care and treatment and/or advocacy group inclusion (Best Practices for BC Mental Health Reform, 2000). An objective of my inquiry was to determine the consumer or advocacy group representation at the MDO Working Groups currently in existence.

The data received from the questionnaires indicate that of the 27 groups reporting membership, 55.6% (15) have representation from an advocacy group/organization. Legal Aid, the Mental Patients Association (MPA), the Mental Health Advocate (MH Advocate), John Howard Society (JHS), Elizabeth Fry Society (E.Fry Society), Salvation

Army (SA), the Native Friendship Centre (NFC), Victim Services (VS) and a Native Court Worker (NCW) were identified as members of at least one of the MDO Working Groups surveyed (See Table 7).

The B.C. Schizophrenic Society (BCSS) and the Canadian Mental Health Association (CMHA) had a 25.9% (7) representation rate attending the working groups. Of the 27 groups responding to the survey question concerning client attendance, only 7.4% (2) indicated that clients to be discussed at the meeting were invited. Of those two groups inviting clients to attend, neither reported client attendance and indicated that clients were not interested in attending.

**Table 7: Advocacy Group/Organization Representation**  
(MDO Questionnaire Respondents)

<b>Advocacy Group</b>	<b>Frequency (N=27)</b>	<b>Percent</b>
CMHA	4	14.8%
BCSS	3	11.1%
MPA	2	7.4%
SA	2	7.4%
NFC	2	7.4%
Legal Aid	2	7.4%
JHS	2	7.4%
MH Advocate	1	4.2%
E Fry Society	1	4.2%
Victim Services	1	4.2%
Native Court Worker	1	4.2%

## Frequency and Organization of the MDO Working Groups

With the general premise of the MDO Working Groups evolving from the 1992 Protocols and then in 1998 with the introduction of the Mental Health Plan, the MDO Working Groups have been in existence in various forms and capacities for nearly 10 years. Much of the functioning and general process has been left to the individual communities to orchestrate and develop. As a result, it is not surprising that there will be differences in the frequency of meetings, the focus or mandate of the working groups and as already discussed the composition of the groups themselves were found.

While there were no prescribed frequency of meetings identified in the 1992 Protocols or the 1998 Mental Health Plan, the data attained from the questionnaires provides an understanding of the frequency with which the MDO Working Groups convene. Of the 31 working groups identified six did not indicate the frequency of meetings either because they were in the process of developing the working group (2) or did not complete the question (4). Meetings convening monthly were the most common with 48% (12); bi-monthly was next at 24% (6), quarterly at 16% (4), and finally, semi-annually at 12% (3).

**Table 8: Frequency of MDO Working Group Meetings**

Monthly (includes up to six weeks)	48% (12)
Bi-Monthly	24% (6)
Quarterly	16% (4)
Semi-Annual	12% (3)

The majority of MDO Working Groups are currently being chaired and coordinated by the respective forensic liaison in the community. Of the 27 respondents indicating who chaired the meetings, 77.8% (21) were chaired by a forensic liaison, 18.5% (5) were chaired by a regional manager of FPS and 3.7% (1) group was chaired by Probation Services. It is worth noting that the 1992 Protocols specifically identified Probation Services as the primary coordinators and chairs of the local working groups. Conversely, the recent resurgence of the MDO Working Groups through the 1998 Mental Health Plan had identified Forensic Psychiatric Services as the lead organization to coordinate working groups. Only one of the 27 working groups identified is chaired by Probation Services, the rest are facilitated by the FPS.

**Table 9: Organization Chairing MDO Working Group Meetings**

Forensic Liaisons	77.8% (21)
Forensic Regional Manager	18.3% (5)
Probation Services	3.7% (1)

Another important factor was the focus or mandate of the MDO Working Groups currently in existence. Through my experience in attending several working groups and my understanding of the 1992 Protocols, I proposed three broad areas of focus: (1) Individual Client Review (2) Systemic Issues and Problem Solving and (3) Resource Development in the questionnaires (see Appendix A). Respondents were asked to identify primary and secondary focus(es) of the meetings based upon the three areas or provide additional subjects attended to within their respective working group. Further,

many respondents indicated more than one primary and/or secondary focus of their working groups (see Table 10).

**Table 10: Perceived Focus of MDO Working Groups**

	<b><u>Primary (N=55)</u></b>	<b><u>Secondary (N=29)</u></b>
Systemic Issues and Problem Solving	34.5% (N=19)	20.7% (N=6)
Individual/Client Review	27.3% (N=15)	20.7% (N=6)
All of the Above	27.3% (N=15)	N/A
Resource Development	10.9% (N=6)	58.6% (N=17)

Of the 46 respondents describing their perceived focus of their local working groups, 34.5% (19) identified ‘Systemic Issues Review and Problem Solving’ as the primary focus of the meetings attended. ‘Individual/Client Review’ was perceived as the primary focus of 27.3% (15) of the respondents. It is interesting to note that 27.3% (15) of the respondents indicated that all three proposed areas were attended to in each working group. The secondary focus of the working groups was identified as ‘Resource Development’ by 58.6% (17) of the respondents. Several of the respondents also identified other areas of focus for the meetings they attended. One of the respondents indicated that the working group was a venue for providing educational presentations on such topics as “Stalking, New Legislation and doing DBII [disability benefit] Applications”. Two other respondents wrote “Information Sharing” and “Information Dissemination” as a primary focus of their respective working groups.

## **SUMMARY**

This chapter has provided a 'snapshot' of the current MDO Working Groups in existence as of September 2001. Based upon the responses from the questionnaires distributed, there are 31 working groups throughout the province in various stages of development and organization. Compared to the preceding year, when the Forensic Liaison Evaluation (2000) reported 28 working groups, it would seem that there were three new working groups developed. This is however, not the case, as evident by the finding that only 23 of the groups reported in the Forensic Liaison Evaluation are also identified as functioning in this inquiry.

Membership at the working groups is consistently reported as Forensics (100%), Crown Counsel (92.6%), RCMP/Police (88.9%), Probation (88.9%) and Mental Health (85.2%). It is not surprising that FPS is reported to attend each of the MDO Working Groups given the entry point of this thesis was with the forensic liaisons, and that the mandate of Forensics is predominately focused upon working with the MDO population. Crown Counsel, RCMP/police and Probation Services all have direct contact with offenders and by default some will be mentally disordered therefore motivating these organizations to attend. It is surprising that the rate of attendance for Mental Health is not closer to that of Forensics given the mandate of working with mentally disordered individuals unless the distinction for Mental Health is that of the offender determination.

Representatives from other organizations/agencies also included the Ministry for Children and Family Development Community Living Services (29.6), Alcohol and Drug

Services (25.9%), a local hospital psychiatric unit (22.2%), the Provincial Brain Injury Program (11.1%) and the Ministry of Human Resources (7.4%). Based on my experience, a large proportion of those individuals reviewed at meetings that are in receipt of welfare and disability benefits often because of their mental disorder, and the receipt of welfare cheques on a monthly basis (frequently referred to as 'Welfare Wednesday') will increase the potential to trigger police contact. As already discussed the use of alcohol and/or drugs among individuals with a mental disorder will increase the likelihood of police contact and violent behaviour. With many mentally disordered offenders also addicted to alcohol and/or drugs the sudden access to money can prove to be too much of a temptation. Individuals with a mental disorder and not concurrently addicted to alcohol and/or drugs are also at risk of potentially being victimized at this time due to their sudden access to money. The attendance of the Ministry of Human Resources may provide some strategies to avoid such scenarios.

The representation of advocacy groups at the working groups is not consistently occurring. The attendance of several different advocacy groups was reported with a frequency rate between 14.8% and 4.2%. The reason for this limited attendance is not known and could warrant further inquiry. The client representation was found to be non-existent, with none of the respondents reporting client attendance when they were to be reviewed at the working group. One group did report that clients were invited to attend the meeting when discussing their specific circumstances, however none had attended.

The meeting frequency ranges from monthly to semi-annually with the forensic liaisons chairing the majority of the meetings. While the findings indicated that the focus of the meetings were on problem solving and addressing systemic issues (34.5%), individual client review, and resource development, some respondents also used the working groups to share information and provide educational workshops.

## **CHAPTER FIVE: MDO WORKING GROUPS: PERCEPTIONS OF SUCCESS**

As the MDO Working Group Initiative enters its tenth year of existence, the evolution of this initiative has had a recent revitalization. The two most critical limitations of the MDO Working Group Initiative identified in the Survey of the MDO Protocols (1996), were the lack of resources and leadership coordination. With the introduction of the Mental Health Plan in 1998 infusing 30 forensic liaisons into the Province and the identification of FPS as the primary lead for local working groups, the limitations identified could be seen as being addressed.

The objective of this inquiry was not to compare the current MDO Working Groups with any data previously gathered or the original intent of the initiative, but rather to consider the status of current working groups; their perceived value, limitations and factors for the success of future working groups. Emerging from the analysis of data in this inquiry were concepts, themes and tensions warranting discussion. The following chapter explores the themes which emerged, the issues identified, perceived value of the working groups and ultimately factors for the success of the MDO Working Group. As part of the analysis, I also attended to the paradoxes, barriers and contradictions that became evident.

## ***Identified Issues***

The bringing together of several different agencies/organizations on a regular basis can present multiple challenges and limitations for those invited to participate. Furthermore, concepts of collaboration and coordination of services, although worthy aspirations, may prove impractical or difficult to achieve, or even commence. Often the process of collaboration or coordination of services requires the use of already limited resources; resources which may not exist or may be allocated to a specific agency/organization for a defined population. From the data collected, there were three main issues identified as (1) Attendance and Participation, (2) Resources, and (3) Process and Structure. The following section will review these findings.

### **Attendance and Participation**

The attendance and participation of key community service providers emerged as an issue which ultimately could be a determining factor in the ongoing success of the working groups. Of the respondents surveyed 30.9% identified attendance of key stakeholders as a major issue, 38.1% perceived it as a moderate issue and 30.9% did not see it as an issue at all. In response to a question regarding issues or limitations associated with the MDO Working Groups, respondents from all regions identified attendance as an important factor in order for the working groups to have 'value'. Many identified the specific absence of community service providers as an issue or limitation. Comments such as "poor showing of invited members especially from the legal profession", "there are key stakeholders missing in group from Ministry of Child and Family, Drug and Alcohol

Services” and “MDO meetings have potential to do more if key stakeholders such as mental health would agree to participate” are a few examples.

While attendance was identified as an issue and factor for success of the working groups, one interview with a mental health service provider could provide some rationale for the decision not to attend. The participant stated that his perception had been “initially, when it started, [there] was a lot of misconceptions as to what it, [the MDO Working Group], was all about. I think a lot of people were fearful that this was a way of dumping Forensic Clients”. While this perception did not consistently present as a theme to the analysis, there may be some benefit to further exploring the undertone of this comment. If this anxiety were an accurate perception of some service providers, there may be little, if any motivation to attend the meetings.

Conversely, a criminal justice system participant interviewed discussed his inability to access mental health services. On occasion individuals would have to be sent to a local mental health centre without informing mental health of the individual’s criminal conviction. In attending the local MDO Working Group, this participant indicated that he was able to identify resources and better access the resources needed.

Another possible explanation for poor attendance, could be in the perceived value, and the limited time that was available to meet on a regular basis. In one of the meetings observed, a participant from the mental health system did not speak or provide input into the individuals reviewed and the individual left before the end of the meeting. There may

have been many possible reasons for not providing input and leaving the meeting early, however an obvious reason could be found in reviewing the agenda and subsequent discussion. None of the individuals reviewed at the meeting were receiving services from the participant's agency and the only systemic issue discussed also did not have anything to do with the participant. One participant offered the perspective that he did not see the majority of those clients for whom he provided services having "that much exposure to the criminal justice system" and "we don't really get involved that much with the RCMP".

While there may be multiple issues associated with the attendance and participation of community service providers, the consistent identification of attendance as being a significant factor for the working groups to have success is compelling. The analysis of the data suggests that the attendance of key stakeholders is important and that attention should be directed upon those not attending to determine what issues need to be addressed.

The rationale and explanation for non-attendance may vary from a representative's perceived value of the working group and limited time available, the limited applicability to a representative's mandate or the perception that the working group may call upon a representative to access their already limited resources to suggest a few. In any case, it is clear that participants perceived both consistent and regular attendance to be not only an issue, but also a factor for the success of the MDO Working Initiative.

## Resources

In all methods of data collection, participants identified resources (such as access to appropriate programs, housing or staffing), or the lack thereof, as consistently presenting a significant barrier in working with mentally disordered offenders. This finding is not unlike the findings reported in the Survey of MDO Protocols (1996). However, since that report 30 forensic liaisons were hired and placed throughout the Province. It is clear from the data gathered on this occasion that resources remain an issue.

When asked to rank their perception of resources as a major, moderate or non-issue, 62.5% of the respondents indicated that they believed resources to be a major issue, 32.5% contended that resources were a moderate issue and only 5% ranked resources as not an issue. Furthermore, all of the regions identified resources as a major issue and it was the most identified major issue of the six presented at 52.1% (25). Respondents frequently described their perception of issues or limitations associated with the MDO Working Group as being “under resourced”, “no monies to do anything” and “resource planning is difficult”.

Although participants interviewed were not asked to identify issues or specifically discuss their perception of the MDO Working Groups’ access to sufficient resources, one participant interviewed made statements such as ‘we have to stretch ourselves because of the lack of resources’ and the desire to “see more collaborative funding of resources with Forensics and AG (Ministry of Attorney General)”. Also, during the observations of the two MDO Working Groups, the adequacy of resources was discussed in each of the

meetings. At the rural MDO Working Group observed, time was spent discussing possible avenues to explore in gaining access to resources through either ICBC or WCB for an individual in need of additional support resulting from a severe head injury. Whereas the urban working group observed discussed access to physicians as a resource issue and the need to be sensitive to the priority of need before referring an individual to see a psychiatrist.

With respondents and participants identifying resources as an issue and a factor in the continued success of the working groups, there may be a subtle, under explored theme, to which the mental health and secondary system interviewee alluded. Both made comments with similar connotations in reference to an agency's acceptance of responsibility for funding services for an individual(s) who may not necessarily 'fit' their mandate. One participant expressed an initial "misconception" that the working groups were a way "of dumping Forensic clients". The other participant stated; "we feel that some of the clients that we have that have gone through the forensic system or the criminal justice system, we end up being responsible for them, you know 365 days of the year and also paying the cost, where we feel this should be cost shared". Again, when resources appear to be a significant issue to many of the service providers, the willingness to expend already limited resources on someone arguably outside their mandate may lead to apprehension and resistance to attend and participate in the meetings.

## **Process and Structure**

In considering the responses to the questionnaires, consistent themes began to emerge which were specific to the working group process and structure. By process and structure, I have broadly categorized phrases or statements that relate to elements perceived to be key to the general organization of a working group meeting. Additionally, I found notable themes relating to the process of a working group that extends beyond the local working groups. Several issues relating to the process and structure of the local working groups became apparent in conducting the analysis of the data: (1) confidentiality, (2) guidelines and agenda for meetings, (3) open communication, (4) sharing of information, and (5) access to senior officials in government.

### Confidentiality

First, respondents identified ensuring confidentiality as important given that many meetings focus on specific individuals and the issues discussed, may at times, be contentious. Unfortunately, the word 'confidentiality' was frequently identified as a factor for success of the working groups but none of the respondents elaborated on what was meant by their choice of the word. From my experience, I would suggest two possible applications of confidentiality; respondents concern for the privacy of those individuals reviewed and the potential for the disclosure of what had been discussed in the meetings. Confidentiality is closely linked with sharing of information in this regard as an individual's privacy and the need for other service providers to know information must continually be considered.

While concern for the privacy of the individual reviewed and disclosure of meeting discussions are legitimate issues, it is important to remember that 67.5% of respondents did not rank confidentiality as an issue in the current function of the groups they attended.

### Guidelines and Agendas for Meetings

Second, several respondents identified the need for “set guidelines”, a “clear agenda prior to meetings” and “regular meetings” as important to the future success of working groups. From my experience of working groups they can be relatively informal with a limited to non-existent framework from which to work. It is interesting to note that of the 27 groups responding 63% did not have ‘Terms of Reference’ for their specific working group. The terms of reference for a working group or committee will often highlight the membership, structure, mandate and even such specifics as meeting frequency, agendas and minutes. Further, statements by individual respondents describe having concerns such as “meetings have become gossipy” or “no agenda input by partners” and “varying definitions of MDO” may speak to the confusion and lack of clear understanding for some members of the working groups. In addition, many participants are invited to attend working groups because of their roles and responsibilities within their agency/organization. But for at least for one respondent “understanding various stakeholders’ roles, issues and areas of responsibility” was an issue. The clear understanding of roles and responsibilities both in terms of what an individual brings to a working group and as a member of that working group must be clear and transparent to all participants.

## Open Communication

Third, factors relating to ensuring communication emerged as an apparent issue and ultimately, were a factor if the working groups were to have value. Words such as “open communication ” and “two-way communication” were used in this context. The importance of communication for members of working groups may derive from the potential for frustration and misunderstandings both during and between meetings. In working with complex and multi-problem individuals, a formalized forum to communicate clearly would be critical to ensuring working relationships exist.

## Sharing of Information

Fourth, the sharing of information was seen as both an issue and a factor in the success of the working groups. Should members of working groups withhold essential information to other participants, trust and respect for the members may jeopardize the functionality of the working group. Again, the sharing of information is distinct from confidentiality in the degree and circumstances in which information is disclosed. How much is disclosed about an individual and discerning static information from opinion is essential.

While the sharing of information is an important concept, it would be challenging to incorporate it into the structure of a working group without the explicit expectation and acknowledgement of authority by the participant’s agency/organization leaders. *The Inter-Ministerial Coordination of Services for Adults with a Mental Disorder or Mental*

*Handicap Involved in the Criminal Justice System: A Protocol for the Sharing of Information across Ministries and Agencies* (the Protocol) document was developed by the Ministries of Health, Social Services and Attorney General in February of 1995. The Protocol attempted to specifically address the sharing of information by referring to the *Freedom of Information and Protection of Privacy Act (FOIPP Act)* and the ability to disclose information “for the purposes for which it was obtained or compiled, or for a use consistent with that purpose (Section 33). Even though this Protocol exists, it is not clear the extent to which these protocols are known, and there have been significant changes to the organization of the Ministries represented at the local working groups (regionalization of health which includes mental health services, Ministries of Social Services and Attorney General no longer exist in name). Therefore, some members of the working groups may be unsure of current policy and direction of their Ministry or agency, and if this includes those other agencies/organizations represented at their respective working group.

#### Access to Senior Officials in Government

And finally, the most consistent issue and factor for success that emerged from respondents was the identification of a process to inform decision-makers at a senior government and organizational level of issues or resource requirements that are not within the local working groups capacity to resolve or develop. One respondent from the Lower Mainland stated that a major issue was “not being able to influence changes (financial/programs), i.e. those that do not fit with available resources – 70-85 IQ with

Forensic/MH by default”. Another respondent from the TOKO region stated that there was “no clear way to get issues/solutions up the line” and similarly a respondent from the Lower Mainland raised the issue of “accountability – where do we go with ideas or developments”? When asked to identify factors in order for there to be ‘value’ in the working groups, one respondent stated “clear support from all the Ministries from the community/regional areas. Victoria is a long way away and has only some input into fund allocation and regional priorities”. A final example came from a respondent in the Vancouver Island region who stated that the “support from organization to plan and develop services at a local level” was an important factor for success. Generally, if any respondent discussed limitations or elements beyond the scope or ability of the local working group they attended, a subsequent level of decision-making authority was seen as imperative. The 1992 Protocols were written with the intent of creating the forum to discuss and review services to mentally disordered offenders, unfortunately there has not been any protocols or process identified which ensures a ‘feedback loop’ with senior management.

### ***Value and Outcome of the MDO Working Groups***

While the issues identified by respondents and participants are significant, the perceived value and success of current working groups is convincing. Participants offered generally positive perceptions of the working groups they attended. Respondents to the questionnaire were asked to rank their perceived value of working groups attended as having no value, moderate value or major value. They were also asked to describe the

overall value of the working groups. Those interviewed were asked to discuss the benefits of attending the working groups and if they perceived a qualitative change in their working relationship(s) with criminal justice system or mental health system. Findings from the analysis have been organized into four main categories describing the value and outcome of the MDO Working Groups; working relationships, client treatment, coordination of services and the identification of 'gaps' in services.

### **Working Relationships between Community Service Providers**

As highlighted early in this inquiry, it has been my experience that with two (and arguably more) major systems interacting with complex multi-disordered individuals, the potential for misunderstandings and frustration with one another is considerable. Therefore, I wanted to explore what, if any, impact the working groups had in developing working relationships, or a relationship amongst community service providers, whereby they felt comfortable discussing issues and working together. From the questionnaire and interviews it was clear that participants felt a working relationship was of significant value, and clearly a positive outcome of the working groups attended.

The development of a working relationship between community service providers was ranked as a major value of the working groups by an overwhelming 90.7% (n=39) of the respondents. The remaining 9.3% ranked the working groups as having a moderate value in developing working relationships. None of the 43 respondents to this question

indicated that working groups were of no value in the development of working relationships.

When asked to describe their perceived value of the working groups, statements such as “networking and establishment of key working relationships in effort to get clients the service that they need in the community”, “the value has been getting other stakeholders together to meet and increase the working relationships between systems and services – increased networking” and “getting to know each other, therefore better communication/problem solving for the client” reflect some of the responses to the overall value of the working groups. Words such as networking, relationship building, team building, getting to know each other and meeting key players were used to describe the value they gained from the working groups attended.

The interview questions I asked were designed to solicit each participant’s perspectives on the negative and positive aspects of their working relationship with the criminal justice system and/or mental health system. The negative theme which emerged predominately revolved around understanding mandates, and the frustrations which result because of exclusionary criteria an organization may have. For example, a participant from a secondary system discussed his frustration with the mental health system for not working with an individual because of their dual status as mentally disordered and mentally handicapped. Yet another participant described the frustration felt when the mental health system refused services to individuals because they were subject to a probation order. It is important to note that none of the critical comments could be

attributable to specific working group members, rather to the organization they represented. One participant described an example where he had recently called a participant of the local working group to interview an individual in police cells after a stabbing. While he saw this positively, he maintained that the individual was seen in police cells rather than taken directly to the hospital because of the frustration experienced with the local hospital psychiatric unit. He contended, “we have a lot of problems there. They’ll make the members (police) wait an hour with somebody when we don’t have the time”. He went on to note that the psychiatric unit does not attend the working group.

The positive aspects of the criminal justice and/or mental health system working relationships predominately resulted from the education and sharing of information in the working groups. One Crown Counsel interviewed stated the “I didn’t know what the mental health system, if I can call it that, had to offer either us or the court system or offer the community. I really didn’t know anything about it. I went there in a kind of state of ignorance and learned things”. The understanding and learning attained from participation in the working group is further highlighted by a police officer’s response to the interview question which asked the interviewee to describe what would be lost or gained if the MDO Working Group did not exist. He states; “I think we would lose that communication and the understanding would be a big loss because I think the mental health end of it is confusing for a lot of members (police)”.

Education and sharing of information was also very evident in both of the working groups observed. Both the urban and rural working group observed discussed specific individuals and issues specific to resources or accessing services. In both contexts the members of the working groups were informed of the limitations an organization or agency may have and the process of referring an individual for services. This information could not only provide immediate assistance with the individual discussed but also serve as a method to increase the mental health and/or criminal justice systems' mutual understanding.

From my experience, there is an additional benefit attained from the working groups which was not evident elsewhere in the data. As the majority of individuals discussed at the MDO Working Groups present with significant needs and risk to themselves or the community, the support participants receive from one another is an aspect of the working relationships. For example, an individual who was frequently discussed at a local working group unfortunately committed suicide. The case manager was quite upset and shaken as a result of the suicide. The subsequent working group provided support to her and attempted to minimize any feelings of guilt which are often associated with suicide.

### **Improved Client Treatment**

A second theme emerging from the data involves the client reviewed or discussed, and the perception by members of working groups that clients are better served by having a working group. Given that many respondents to the questionnaire maintain that the

primary and/or secondary focus of the working groups have to do with individual/client review, it would seem consistent that many participants of this study attributed some value to client treatment.

Of those surveyed, 52.4% (n=22) perceived that a major value of the working groups has been client treatment. A further 42.9% (n=18), saw client treatment as a moderately valuable outcome and only 4.8% (2) of the respondents believed client treatment to be of no value.

Phrases such as “inter-agency case management”, “better client service”, “promotes comprehensive timely treatment to clients” and “improved client services – proactive re-service involvement” are examples of respondents’ perceptions of the value of the working groups. Improved client treatment was categorized as a major theme based on the statements of respondents and their perceived value of the working group. Within this category there were several factors identified by respondents which facilitated client treatment and a perception of value for the working group.

Problem solving was a term used to describe the value of the working groups and ensuring that individuals access the treatment required. The complex and multiple problem individuals are “case conferenced and constructive solutions identified”. Additional comments such as “looking at issues/cases and working together to solve problems” and “troubleshooting about MDOs in the community” reflect the perception of some participants of working groups. A second factor that seemed to be prominent and

relates to client treatment was the proactive nature of the working group. Rather than wait for an individual to become psychotic and require hospitalization, or re-offend and be incarcerated, representatives of the working group attempt to minimize the risk to re-offend or become aware of the signs of psychosis. Finally, respondents to the questionnaire describe the working group as “an invaluable experience as it allows the experience of various agency colleagues input on client interventions”. By having several representatives with differing expertise and perspectives, the potential to develop innovative and community orientated treatment plans could be a positive outcome of the working groups.

An important tension to consider is highlighted by one respondent’s comment: “At times the meetings have become ‘gossipy’ which has concerned me – this involves speaking about some of the frequent users of the Court system in a disrespectful way”. Discussing and reviewing individual clients is perceived to be valuable, yet the concern is that a balance between right to privacy of an individual and the best interests of the individual and public should occur. When such discussions would seem warranted, it is important to ensure that they are done in a respectful and factual manner. While this was the only respondent to identify this concern, it is a poignant reminder that discussions are about people in a community and it is imperative that discussions are professional and respectful at all times.

The interviews of working group members both in a rural and an urban setting consistently reflected the value of working groups to individual client interventions and

treatment. One participant described the working groups as worthwhile because “we find we’re dealing with the same people and it’s good to have that communication between the various departments [representatives]”. The ability to communicate with other service providers in the community about individuals with complex multi-problems was seen as important. Through the regular meetings, representatives from the criminal justice, mental health and other systems are able to provide “input, share some knowledge and make some suggestions”. This would seem to be especially important for those individuals perceived as “high risk clients in the community that need to be followed by different agencies but also collaboratively in a setting like we have with the MDO committee”. Participants indicated their perceptions that developing case plans collaboratively provided for better services for clients. By communicating with other agencies, those involved with the individual can provide a consistent intervention.

The challenge in reviewing specific individuals when not all the working group members have an interest and/or jurisdiction, was identified as an issue by one of the participants interviewed. He questioned the need to “involve nine or ten people and really only three or four deal with the case”. This is not only a privacy issue but could influence the perceived worth in attending meetings if those individuals discussed have little or minimal connections with representative agencies/organizations.

It was clear from observing the MDO Working Groups that a significant proportion of the meetings revolved around the discussion of specific individuals. The agendas for both the urban and rural group observed were predominated by client names. In most circumstances those individuals discussed were seen as high risk, multi-problem

individuals with alcohol and/or drug misuse problems, numerous contacts with police and the courts, as well as questions around their mental health status or previous brain injuries. A brief background of each individual was presented, including input from several service providers, followed by a discussion of options and strategies to adequately provide service to the individual or alternatively ensure that they are held accountable for their actions.

### **Coordination of Services**

A main objective of the MDO Working Group Initiative was to improve the coordination of services for those individuals with a mental disorder or developmental disability in conflict with the legal system. From the data, it is clear that a third major theme identified by participants attending local MDO Working Groups has been the coordination of services. One respondent stated the value of attending the working group is “targeting areas where clients are ‘falling through the cracks’ [and] finding the best options for the client which better protects the public”.

Coordination of services was perceived as a major value of the working groups for 76.7% of those surveyed. Another 21% perceived the working groups as being of moderate value in the coordination of services. Only 2.3% maintained that the coordination of services was not an outcome of the working groups. Based on these findings, the coordination of services for mentally disordered offenders is seen as a significant success or outcome of the meetings. This finding is consistent with the identified focus of a

majority of working groups as attending to systemic issues and problem solving those barriers to service delivery.

A common theme respondents identified in their discussion of perceived value of the working groups was the learning or greater understanding of what resources existed in the community as well as who and how to access those resources. Words like linkage, coordination, collaboration, education and communication were frequently used to describe the benefits of the working groups. One respondent from the Lower Mainland stated, “I think it is useful in that it allows agencies to better coordinate services to individuals, to update each other on work being done on behalf of individuals and to educate each other regarding the role and mandate of various agencies and Ministries”. Similarly, another responded that “knowing the players and resources in the community is the absolute best way for coordination of services – talking on the phone is useless in most cases” and that “the program and meetings are extremely beneficial to those of us in the criminal justice system dealing with mentally disordered offenders – (it) gives us many more options in dealing with these people”. It is clear that the working groups benefit representatives by educating each other about resources that are available in the community and what options may exist in working with mentally disordered offenders.

### **The Identification of ‘Gaps’ in Services**

An additional element associated with the coordination of services that became evident in the analysis has to do with the identification of ‘gaps’ in services. The identification of barriers or systemic issues that prevent individuals from accessing the intervention most

appropriate to their needs may be a valuable result of the working groups. Comments such as “reducing barriers to service in the community”, “identifying service gaps” and “getting partners together at the table to dialogue shared issues regarding the mentally ill and service delivery” reinforce the notion that the working groups have some success in addressing those individuals who may not ‘fit’ within specific mandates or lack sufficient resources. The ability to problem solve at the local level was perceived as a valuable function of the working groups and they may very well be a forum to identify service inadequacies or ‘gaps’ and attempt to resolve those issues in a pragmatic fashion. A respondent from Vancouver Island summarized the value of the working group; “it has been an excellent opportunity to raise issues that separately, each agency has been dealing with, and collectively we can pursue solutions”.

Participants interviewed were asked to describe their perceptions of the working group they attended in terms of value and whether they perceived meetings to be ‘worthwhile’. One of the common themes that was identified by those interviewed consistently made reference to not only the working relationships but the appreciation of knowing who to contact when accessing resources or services and how the services are delivered. As one participant from the criminal justice system maintains that “the more you know how these systems operate on the health care side, the better solutions you get in court”. This knowledge of resources and contact people could support the perception that services are better coordinated as a result. Another participant interviewed, while describing ‘key players’ outlines the value of coordinating services: “Crown Counsel is a very key player in that they be in tune with and try to understand what mental illness is about and how it

can effect somebody and if they're non-compliant how that can manifest in other ways. So that they're not just thrown in jail. And the RCMP of course because they're your front line kind of people that are exposed to the offender first. Generally they have the first contact and then the Crown gets the second". Finally, in describing the process of prosecuting a mentally disordered offender, one participant describes the "bridging" that has occurred and the role of a specific mental health professional:

She plays an important role, now I tell people if we have a new prisoner in custody and we understand they have a mental disorder we will call her and ask her to give us some support in figuring out what to do. She may say quite often, she knows the person from the mental health sector, and now we have somebody who can say well yes, 'Mr. Smith, he's been in and out of Riverview or wherever, he's been on medications and stuff for many years and we've seen him in our offices and he just needs his medications regulated and then he won't be a bother to anyone' that's just a specific example.

From the two working groups observed both in a rural and urban context, it was evident that while coordination of services was not a specific topic for discussion, the process of reviewing specific individuals could arguably result in better coordination of services overall. Through the working groups meetings, representatives not only attempted to address the service needs of a specific individual but in so doing jointly addressed many systemic barriers or resource issues. For example, the rural working group observed discussed a specific individual who was repeatedly offending in the community and explored roles for coordinating intervention as this individual was seen as needing to be "held accountable for her actions" rather than followed through the mental health system. The urban working group observed while discussing specific individuals, also attended to systemic issues. From the minutes of the previous meeting, a participant had identified

the concern she had regarding the “lack of ability to problem solve in dealing with difficult clients that use all systems (i.e. Mental Health, A.G. [Attorney General] Services and FPSC Services). [There is] no group higher to forward issues for resolution. Wanting to focus more on type of clientele that falls into the gaps and services that are needed to forward to upper management in all areas”. Also from this working group, participants discussed an individual that was discharged from a tertiary care facility with limited planning and follow up. A discussion followed which focused upon possible options to pursue in ensuring that appropriate discharge plans are completed and communicated to the community service providers.

In general, respondents were asked to rank their overall perceived value in the local working group they attended and a majority (68.3%) maintained that they considered the working group to have a significant value. Also, 31.7% saw the working group of moderate value whereas none of the respondents believed the working groups to be of no value. This is further consistent with those interviewed, as all maintained that the working group they attend is ‘worthwhile’. However, a participant interviewed representing a secondary service provider did indicate some concern regarding the “focus” and that “we don’t seem to be discussing particular cases”. He did continue by stating that by not having the working groups “the loss would be the community partnership that we have when we do meet”.

## ***Summary***

This chapter reviewed the themes and patterns which emerged from the data; those factors participants identified as contributors to the success of the MDO Working Groups they attend. Several key issues that could impact on the future success of the working groups was discussed. The attendance and participation of community service providers was seen as important in order for their to be value in meeting. Without their regular and consistent attendance at the working groups, the benefit gained from meeting may be jeopardized. Access to such resources as appropriate programs, housing or staffing was perceived to be a barrier to working with mentally disordered offenders. The overall process and structure of the working groups was identified as a major issue and ultimately, a factor for success of the working groups. Issues concerning confidentiality, specific guidelines or terms of references, clear agendas, good communication, the ability to share information and access to organizational and government leaders were identified. Of all the issues that were identified, the most consistent concern that emerged was the lack of connection and formalized process for access to senior government officials at a provincial level.

Participants reported that the value and outcome of the working groups was quite positive. Four main categories were organized to describe the value and outcome of the working groups. First, the working relationship between community service providers was found to be a direct benefit of attending and participating in the working groups. Second, working group members believed that clients were better served as a result of the working groups. The ability to problem solve and proactively respond to client needs

was seen as beneficial. Third, improved coordination of services was identified as a direct result of the working groups. Participants reported having a better sense as to what services were available, how to access them and who to contact to coordinate services. Finally, and closely related to coordination of services, was participants' perceived ability to identify 'gaps' in services for mentally disordered offenders. Given the complex and multiple needs of the mentally disordered offenders, the working groups were seen as a forum to creatively problem solve systemic inadequacies or limitations at a local level.

## CHAPTER SIX: CONCLUSION AND IMPLICATIONS

The Mentally Disordered Offender Working Group Initiative in British Columbia is intended to provide the linkages, and a forum for the coordination and collaboration of services for individuals with not only a mental illness but also a developmental disability who are in conflict with the criminal justice system. This initiative has been in place, with varying degrees of support, over the course of 10 years. While the need to coordinate and collaborate services may be recognized provincially, the ‘value’ of the initiative from a local working group perspective has never been explored.

The impetus for this study results from my personal experience in working with individuals with a mental disorder and in conflict with the criminal justice system both directly and as a manager. I am currently attending and participating in seven local working groups throughout the Central and Upper Vancouver Island area. It has been my belief that the working groups serve a valuable purpose in the community. From this personal interest, I wanted to better understand the MDO Working Group Initiative and the current status and composition of working groups throughout the Province. I wanted to begin to explore the issues, value and perceived ‘success’ of the working groups participants attended.

In order to adequately inform and expand the intent of this study, a mixed methodology design was chosen. To me, this method of inquiry espouses a pragmatic approach to “understanding social phenomena” (Cresswell, 1994, p.176). Data were collected using questionnaires, interviews and observations. The challenge was in ensuring that the

questionnaires were distributed to and reaches participants attending working groups. Furthermore, the continually changing status of the very existence and membership of the working groups was also a major challenge. I decided to access the forensic liaisons in order to distribute the questionnaire, as I believed that they were the most likely to be connected with any working groups in a community. An additional concern was in the timing of distributing the questionnaire and requesting returns by a specific date. I sent the first questionnaires out in June and hoped that they would be returned prior to the summer months of July and August. Unfortunately, many of the working groups do not convene during the summer and therefore, the distribution of the questionnaires was potentially delayed until September. In an attempt to ensure that the questionnaires were not forgotten, I directly contacted those liaisons from whose areas I had not received a questionnaire to remind them and ask them if they were experiencing any difficulties with completing the questionnaires. The last questionnaire received and incorporated into the inquiry was on October 19, 2001. The questionnaires allowed for both qualitative and quantitative data to be gathered by using both open and closed questions and asking respondents to rank specific factors (Baxter, 1997).

The observations of the working groups were conducted in a rural and urban setting. Once again, there were some challenges in the gathering of data using this method. The urban working group had been scheduled for observation on July 11, 2001 and of the fifteen identified participants only five were able to attend. This is likely due to the working group meeting in the summer months. As well, there was some discussion about all members not being informed of the scheduled meeting. As for the rural working

group, I had originally been scheduled to observe the working group on July 26 via video-conference but this meeting had to be cancelled due to the nursing job action occurring that day. The rural working group was rescheduled to September 27, 2001 and the video-conference observation occurred without any major difficulties.

In order to further inform this inquiry, individual interviews was also a method used to collect data. The original intent had been to interview three participants from each working group observed, representing the criminal justice system, the mental health system and a secondary system such as Alcohol and Drug Services, or Community Living Services. While the rural working group had the three systems identified and a representative from each agreed to be interviewed, the urban working group observed stated that they did not have any representatives from a secondary system. It was explained to me that initially, they did have such a representative, but due to “issues of confidentiality we have found it better without them”. As a result, the three interviews conducted at the urban location were with two criminal justice and one mental health system participant.

### ***Tensions to Consider***

In conducting this inquiry, there were several tensions that became apparent when analyzing the data and warrant further reflection. These tensions are paradoxes or concerns relating to some of the themes already discussed.

## 1. Communication with Senior Government Officials

One of the major issues identified by participants was the lack of linkage or coordination with senior management or administrators beyond the local level. While the local working groups work together to resolve local issues and address potentially dangerous and/or complex mentally disordered offenders, there is no formal connection with a similar working group at the senior Ministerial or organizational level. This tension is similar to the recommendations made in the 1999 B.C. Children Commission's Annual Report that coordination of services needs to occur at both the local and provincial level of government when discussing services to children and youth. The report continues to recommend "clear protocols between ministries on key issues, and particularly for special needs children, need to be revised and implemented" (p.47). While the report was directly intended to address the services for children, I would argue that this intent could be equally applied for mentally disordered offenders.

The issues or problems that the local working group may identify and be unable to resolve currently do not have a formal mechanism to seek broader systemic resolution or assistance. Many participants indicated their frustration with the inability to have major issues or resource requirements addressed. In addition, with the significant changes to the organizational structure of the public sector, many participants may be unclear about their organization's support and policies relating to the working groups. This 'feedback loop' with senior management is not only an important issue for the local working groups

to access but also for the respective organizations to ensure that the decisions made or actions taken are not indicative of what Wharf (1992) discusses as “acute localitis” (p.120). It is important that standards be developed, regularly updated and monitored so that the actions of the local working groups are consistent with the expectations and goals of the organizations/agencies represented.

While access to senior government officials is important, the tension of systemic/organizational level change and local level change warrants discussion. The literature clearly maintains that systemic level change has often resulted in minimal success in coordinating services through such changes as realigning agencies and/or ministries (Rein, 1983). However, at the local level, the working groups are better positioned to serve the client and the community by working from their needs and concerns on a more intimate basis (Wharf, 1995). Therefore, while access to senior government officials for support, resources and direction is important, the distinction is in the value of maintaining service coordination at a local level (working group) as opposed to the organizational/systemic level.

## 2. Exclusion of Client Participation

An additional tension that was evident involves the inclusion of those individuals discussed at the working groups. As discussed in the literature review, the *Best Practices for B.C.'s Mental Health Reform* (2000) report highlights the need for individuals receiving mental health treatment and services to actively participate in the decisions

made with regard to the treatment and services received. However, the majority of local working groups do not have any consumer participation or attendance. Of the 31 working groups only two working groups reported that invitations to individuals to be discussed at the next working group meeting were extended. Both of these groups reported that the consumers invited have not attended and apparently were not interested in attending.

The rationale for the individuals discussed at local working group meetings to be either not invited or not interested in attending may be numerous and is beyond the scope of this inquiry. What is evident however, is the potential criticism that the working groups are patriarchal and assume a 'we know best' type of attitude, dismissing the individual's potential contribution or insight into their needs. This is especially challenging given that those individuals presented at the local working groups are often resistant to treatment with limited insight and pose significant risk to the community or themselves. In order for the MDO Working Group Initiative to be consistent with the principles of best practices, it would be imperative that attention to including the individuals discussed at the working groups occur. Such inclusion or participation may not necessarily be in the form of attending the working groups directly, but a process developed whereby the individual could have meaningful input into the decisions made (Best Practices for B.C.'s Mental Health Reform, 2000; Callahan et al, 1998; Wharf & Clague, 1997).

### 3. Sharing Information and "Confidentiality"

A final tension that I believe important to discuss involves the complexity of sharing information and ensuring confidentiality in working groups. From my experience, the uncertainty of sharing information about an individual and respecting the confidentiality of the individual is a continual tension. The sharing of information about an individual does not mean ignoring his/her right to confidentiality, rather ensuring that the information disclosed is limited to the needs of the individual and the community. One participant's statement that "meetings have become gossipy" is an example of one end of a continuum that extends from little regard or respect for the privacy of an individual to the absolute refusal to share any information about an individual regardless of its importance. The intent of the 1992 MDO Protocols were to assist in clarifying these issues, however there has been significant change in the structure of ministries and organizations which have left the protocols antiquated and arguably, not applicable to many.

The very connotation of discussing someone at a 'mentally disordered offender' working group may have repercussions and result in further marginalizing an individual. While *the Freedom of Information and Protection of Privacy Act* identifies the parameters for disclosure, the working groups will often include some representatives from agencies/organizations that will never have any contact with an individual discussed. Some of the working groups reported that they did not invite 'secondary' community service providers because of issues of confidentiality. Still, other working groups would meet separately to discuss specific individuals in order to address concerns of confidentiality. The value of the working groups is clearly evident in this inquiry and

partly has to do with direct case planning and coordination of services for specific individuals. However, the need to respect the privacy of an individual should never be ignored.

## ***Discussion***

Findings from this study have yielded some interesting insights and provided further understanding of the MDO Working Group Initiative in British Columbia. While there had been a survey of the original 1992 Protocols in 1996 and a subsequent evaluation of the Forensic Liaison Initiative in 2000, research has never focused upon the working groups specifically. This study has identified the current status of working groups in B.C. as well as what participants perceive to be the issues, focus and value of the working groups attended.

As of September 2001, there were 31 working groups in different communities throughout B.C. Of the 31, 14 were from urban centres, and 17 were located in rural communities. The agencies/organizations attending the working groups varied with each community, but the most likely agencies/organizations represented at local working groups are Forensic Psychiatric Services, Crown Counsel, RCMP/Police, Probation Services and Mental Health Services. The secondary systems tend to consist of organizations/agencies such as the Ministry for Child and Family Development Community Living Services, Alcohol and Drug Services, local hospital psychiatric units, the Provincial Brain Injury Program and the Ministry of Human Resources. Representation from these agencies/organizations tends to be inconsistent and dependent

upon the local working group extending an invite or the motivation of local representatives.

The need to include community service providers should extend beyond those identified as primary. As the literature indicates that the use of alcohol and/or drugs can be a major predictor for violence, especially when combined with medication non-compliance (Swartz et al, 1998), therefore, the inclusion of alcohol and drug expertise would seem convincing. The Ministry of Human Resources could offer invaluable assistance with the management of disability benefits and therefore could be a valuable addition to working group. Similarly, the other organizations identified could have a valuable role to play in the overall case management and service coordination of mentally disordered offenders. The challenge will be in maintaining the balance between appropriate inclusion and the sharing of information with agencies that may not have any clear mandate for involvement with an individual reviewed at a working group.

One of the major recommendations coming from the 1996 "Survey of the Impact of the MDO Protocols" was the identified need for leadership. I would maintain that part of this recommendation has been followed through with the creation of the forensic liaisons positions throughout B.C.. It would appear that a significant role of the forensic liaisons has been the coordination and chairing of the working groups. At a local level the leadership issues have been addressed

Unfortunately, at the provincial level, leadership remains an outstanding issue. Clear policies and revised protocols are necessary given the changes to ministries and organizational structure. Furthermore, the ongoing evaluation and monitoring of the working groups is necessary. Finally, the need for the development of a provincial level mentally disordered offender working group with clearly articulated and understood methods of interactive communication and reporting mechanisms would add significant credibility to the MDO Working Group Initiative.

As I reflect upon the impact of this research on my practice, I have found myself more attentive to the working groups in the communities in which I work. For example, I can see opportunities to ensure that the individuals discussed at working groups are included as much as possible with at least an invite to attend the working group or a follow up meeting with the case manager to review what was discussed. Similarly, the need to develop a more structured and standard approach to working groups has become increasingly clear. Prior to this research, I had maintained the importance of keeping the working groups as informal and unstructured as possible so as to not impede participant's willingness to attend meetings. I realize now, that by being informal and unstructured, their willingness to attend may be a direct result of not clearly understanding the mandate or format of the working groups. I would continue by advocating for the development of standards and principles that working groups should follow. Overall, this thesis has further reinforced my belief that the working groups serve a valuable function and I will continue to do my best to ensure that they continue.

## **Summary**

This study has provided evidence that the MDO Working Group Initiative remains a viable and a valuable initiative to those people in the local communities providing the direct intervention and services to individuals with a mental disorder or developmental disability in conflict with the criminal justice system. Overwhelmingly perceived as valuable and worthwhile by participants, it is clearly seen as a successful initiative by those in attendance. The direct problem-solving of systemic issues and planning for individual treatment as well as the development of working relationships was seen as the major value of the working groups. Attendance of key organizational/agency representatives, resource availability and several elements of the working group process and structure were identified as issues in need of address. A direct connection with a Provincial Working Group was a major recommendation stemming from this inquiry.

Furthermore, this study may also provide some initial evidence that the working groups are examples of a best practice in serving individuals with mental disorders or developmental disabilities in conflict with the criminal justice system. While the rather limited mentally disordered offender literature identifies the importance of collaborating and coordinating service delivery between mental health and the criminal justice systems, little information exists that describes the process or means for these systems to work together. The 'experts' or practitioners attending MDO Working Groups throughout British Columbia may serve as a practical example of the different systems working with mentally disordered offenders communicating and coordinating services.

There is evidence that the working groups are an example of service coordination and collaboration for a defined population, which is consistent with one of the key elements found in the human services best practice literature (Callahan et al, 1998). To firmly establish the MDO Working Groups as a best practice, further research is required. I believe that this study may identify the value and success of the working groups as perceived by those attending the meetings. However, this inquiry is limited in the ability to offer the perspectives of organization/agency representatives that have either opted not to attend or were never invited to attend the working groups. In addition, I would argue that a next step could explore the perceptions of those mentally disordered offenders discussed and reviewed at the working groups. For example, has an individual discussed at a working group meeting perceived any qualitative changes in the services they receive? A subsequent step would be exploring the perceptions of community service providers in communities without working groups and whether there were any differences in the working relationships, coordination of services and client treatment. Finally, possible ways of including clients in a meaningful way in the working groups could be explored.

The current political atmosphere within British Columbia, as the Provincial Government conducts a Core Services Review (2001), has many community service providers wondering about such important issues as ongoing funding and their own future employment status. The Core Services Review asks questions that specifically focus upon efficiency, accountability and effectiveness. I maintain that it is quite timely to be

researching the MDO Working Group Initiative as this inquiry provides some initial evidence of the value and its effective use of community service resources.

In essence, this inquiry has allowed me the opportunity to explore the value of community service provider's work in collaborating and coordinating services for mentally disordered offenders, which from my first year as a Social Worker in Vancouver, I began to appreciate. I hope that this research may strengthen the 'political will' for continuing the MDO Working Group Initiative and reinforce the work so many community service providers throughout British Columbia are committed to doing.

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## **APPENDIX A: Glossary of Terms**

**Advocacy:** The act of informing and supporting an individual(s) or acting on their behalf in order for their best interests to be considered.

**Client:** An individual for whom mental health services are intended.

**Decompensate:**  
An individual's psychotic symptoms returning, to the point of potentially requiring hospitalization.

**DSM-IV:** Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – The American Psychiatric Association's classification tool to assist care practitioners in classifying mental disorders.

**Mentally Disordered Offender:**  
An individual suffering from a mental illness having come in contact with, or is at serious risk of coming in contact with the criminal justice system.

**Serious Mental Illness:**  
An illness such as schizophrenia, bi-polar disorder and depression are some of the most serious forms of mental illness. The degree of mental illness is often distinguished by the risk to self or others and functional impairment.

## **Appendix B: MDO Protocols**

### **PROTOCOLS FOR THE INTER-MINISTERIAL COORDINATION OF SERVICES FOR PERSONS WITH A MENTAL DISORDER OR MENTAL HANDICAP INVOLVED IN THE CRIMINAL JUSTICE SYSTEM**

#### **Report to Deputy Ministers**

#### **Preamble**

There are a substantial number of persons with a mental disorder or mental handicap who move back and forth between the criminal justice system and mental health system. These individuals often have multiple challenges, which include a combination of psychiatric, behavioural, and substance abuse problems. As a result, more than one ministry is involved with these persons at the same time. These individuals, whether in the community, in prison, on probation, or before trial, present unresolved issues and challenges. Some of these persons have been arrested and incarcerated simply because they were felt to be in need of both treatment and a secure environment, yet mental health services proved difficult to access. In the past there has been, often, a lack of coordination between government agencies. In addition, it has been difficult for the criminal justice system to provide specialized treatment planning, longterm support, and continuing assistance after release.

This report outlines the Protocols that were developed to guide inter-ministerial coordination of services for persons with a mental disorder or mental handicap involved in the criminal justice system.

#### **Definitions**

These protocols address those persons with a mental disorder or mental handicap involved in the criminal justice system who require clinical intervention to address their behavioural and mental health problems. They include a range of persons, from those who are clearly certifiable under the Mental Health Act, those who have a mental handicap, and those with situational disturbances.

Five levels of support and intervention are noted for those persons with a mental disorder or mental handicap. A person may move from one category to another at different times and individuals in Category I and Category II may have social or behavioural problems in addition to having a mental disorder.

#### **Category I - Certifiable**

These persons suffer from severe psychotic illnesses, rendering them out of contact with reality. Often they have a thought disorder, delusions, hallucinations, or profound abnormalities of mood. Their disturbance presents a threat to self or others. Some may be unfit to stand trial, others may be incapable of giving informed consent to treatment.

#### **Category II - Mentally Ill, Not Certifiable**

These persons are seriously disturbed and often show clear signs of mental illness, but they do not present as immediately at risk to self or others. Most persons in this group would be capable of giving consent and capable of instructing their counsel.

Two sub-groups exist: (a) those who have sub-acute illness (b) those whose symptoms are largely or wholly controlled by medication. Both groups require close monitoring by medical and nursing staff, since they are prone to decompensation and sudden changes in mood or behaviour.

### **Category III**

This group comprises those who may show only borderline features of mental illness, but their behaviour is frequently disturbing to others. They often present with multiple challenges which aggravate their situations: organic disorders, substance abuse, borderline mental handicap, and personality difficulties.

Such persons are often described as "dysfunctional", in that they can be erratic and impulsive, show poor judgement, have low stress levels, be demanding and require immediate gratification. Mood disorders, emotional lability and poor anger control can result in suicidal ideation, and render them victims or victimizers in the correctional system and outside.

### **Category IV - Situational/Short Term Disorders**

These persons are not seriously disturbed, but are generally reacting to some pressure in their lives. They generally lack the features of a major mental illness. They develop acute adjustment problems, which are reactive in nature and are generally treatable. The main symptoms are anxiety or depression, and while rarely a threat to others, they may present, for short periods, a high risk of danger to themselves.

### **Category V - Mental Handicap**

These persons have significantly sub-average general intellectual functioning resulting in, or associated with, concurrent impairments in adaptive behaviour and manifested during the developmental period.

### **Background**

During the past two years, representatives from the Ministries of Attorney General, Health, and Social Services have been involved in the development of a report regarding services to individuals with a mental disorder and mental handicap who come into contact with the criminal justice system. The result was a draft report circulated in November 1990 that describes the mandates and programs of the different ministries involved.

Following the presentation of this document to the Assistant Deputy Ministers' Committee on Deinstitutionalization, it was agreed that the next step in the process would be to develop a coordination strategy to help ensure that persons with a mental disorder or mental handicap are properly served by government. It was further agreed that Corrections Branch, Ministry of Attorney General, would accept a major coordinating role.

A report on the draft inter-ministry protocols was prepared in June 1992 and was accepted by the Assistant Deputy Ministers'. Three outstanding issues were identified in the report (see Addendum) and the Assistant Deputy Ministers have asked the Committee on the Effects of Deinstitutionalization on the Criminal Justice System to reconvene to resolve the issues.

The report on the inter-ministry protocols was presented to the Deputy Ministers' in October 1992. The report was approved, pending consultation with community services. The following report has been revised to incorporate recommendations made by the community. A fourth outstanding issue, consultation with community agencies, will also be resolved by the inter-ministerial committee.

### **Guiding Principles**

The following principles are felt to be important in the management of persons with a mental disorder or mental handicap who come into conflict with the criminal justice system:

1. It is to be clearly understood that prior to conviction, all accused persons, including persons with mental disorders or mental handicaps, are presumed innocent before and under the law.
2. At different stages in the criminal justice process, all persons with a mental disorder or mental handicap should be advised of their rights, including their right to be represented by legal counsel.
3. It is acknowledged that the coordination of services for persons with a mental disorder or mental handicap is a shared inter-ministerial responsibility.
4. The primary focus of the criminal justice system, upon the conviction of a person with a mental disorder or mental handicap, remains the protection of the public and the prime role of the judiciary in decision-making on this matter is clearly acknowledged.
5. The sentencing of persons with a mental disorder or mental handicap should be based upon the use of the lowest level of correctional intervention necessary in accordance with:
  - a) the protection of the public;
  - b) treatment appropriate to the individual offender; and
  - c) information about available resources
6. The Diversion of criminal charges for persons with a mental disorder or mental handicap is to be undertaken by Crown Counsel wherever it is deemed appropriate.
7. Sensitivity to the particular problems and needs of persons with a mental disorder or mental handicap at all "key junctures" in the criminal justice process should be actively encouraged.
8. All persons with a mental disorder or mental handicap, consistent with their rights under the Charter of Rights and Freedoms, should be provided with treatment appropriate to their condition.
9. In the coordination of services for persons with a mental disorder or mental handicap, it is agreed that the tasks assumed by a ministry should be consistent with the ministry's strengths, and specific program expertise and allocated resources.
10. It is agreed that B.C. Corrections Branch should play the major role in coordinating the matching of resources from appropriate ministries and agencies to the service and programme needs of persons with a mental disorder or mental handicap. Participation of the Ministry of Social Services will be restricted to cases involving persons with mental handicaps, including persons suffering a concomitant mental disorder.
11. Nothing in these principles is to be viewed as precluding the desirability of different ministries pooling their resources in the development of specific responses to solving problems.
12. When offenders with a mental disorder or mental handicap are released from a correctional facility, all reasonable steps should be taken to ensure their reintegration into the community. Discharge planning should occur as earliest as possible.
13. Special attention will be paid to the provision of community support and services for persons with a mental disorder or mental handicap.

## Overview

The protocols are based on the following assumptions:

1. It is envisaged that local working groups will be established in all areas of the province. The coordination for the local working groups will be undertaken by officials with Corrections Branch, Ministry of Attorney General. The coordinating officer will arrange an initial meeting with the local Working Group to determine the best format for coordination and liaison. Subsequent meetings will be held on an "as needed" basis, with the bulk of the coordination occurring through informal contacts. The coordinating officer will be responsible for providing the recommendations from the local Working Group to the office or person in the criminal justice system who is dealing most directly with the accused person.

2. The protocols set out below presume the development of specific regional and local inter-ministry protocols that will detail the administrative and organizational arrangements that will need to be put in place for the effective functioning of local services for the accused person with a mental disorder or mental handicap.
3. The tasks to be assumed by the various inter-ministry staff who form the local working groups are to be those that are consistent with each ministry's strength and specific program expertise.
4. One of the main functions of the members of the local working groups will be to advise the coordinator of available community resources that may be appropriate to an individual accused's needs and legal status. It is expected that the local working groups will consult with community agencies who have been involved with, or may become involved with, a person with a mental disorder or a mental handicap.
5. While these protocols are intended to be generally applicable to Aboriginal persons and persons in other minority groups, specific protocols will be developed, where appropriate.

To summarize, the protocols below have been developed to address particular problems in the coordination of services for persons with a mental disorder or mental handicap involved in the criminal justice system. Each protocol is prefaced with a brief narrative that describes the problems that the protocol is intended to resolve.

#### **Protocol #1: Investigation of Offence in the Community / Arrest**

This protocol was developed in an attempt to deal with those individuals with a mental disorder or a mental handicap who come into contact with the criminal justice system. In addition, access to traditional mental health services for this client group remains problematic. This is exacerbated by the often resistant nature of these clients and their consequent refusal of voluntary attendance. To address this issue, the Inter-Ministry Committee on Protocols and Guidelines have agreed to the following:

1. In each region, member agencies coordinated through Corrections Branch as the local Working Group, will provide to Police options for dealing with individuals with a mental disorder or mental handicap who are arrested for alleged criminal acts.
2. The provision of options or referral alternatives from service agencies will not preclude the laying of criminal charges and the adjudication of criminal responsibility being proceeded with in the normal fashion.
3. The Ministry of Social Services will be the agency of first contact for arrested persons with a mental handicap, where a referral to a service agency is appropriate.

#### **Protocol #2: Coordination of Roles for a Public Interest Assessment**

Crown Counsel and Corrections Branch policy allows for a pre-court inquiry (public interest assessment) to be made at the request of the Crown; however, this process has not been used specifically for offenders with a mental disorder or mental handicap, and has not been used to help Corrections in assuming a case coordination role with the available community resources.

A "public interest assessment" has been defined as an inquiry into whether or not it is in the best interests of the public for criminal proceedings to start or continue with regard to an individual accused. It includes an assessment into the mental state of the accused both at the time of the alleged offence and at the present time; with reference to what is already known about the accused's social history, medical history, criminal record,

and willingness and/or suitability to access available community resources. The means by which this information may be communicated to Crown Counsel for their decision is left to the choice of the local working group, but the assessment should address voluntary access of community resources that would provide benefit to the accused's mental condition and needs for social, economic, and psychological support. The assessment should also address whether service alternatives might provide any anticipated decrease in the likelihood of future re-offending behaviour.

It was agreed that the following would be able to address this issue most appropriately:

1. Crown Counsel must first be satisfied that there is a substantial likelihood of a conviction if charges were to be proceeded with in the normal fashion.
2. Where requested, in order to aid Crown Counsel in their determination of whether a public interest assessment is advisable with respect to a given accused person with a mental disorder or a mental handicap, Corrections Branch, Ministry of Attorney General, will designate a local Coordinating Officer to provide advice to Crown Counsel.
3. The following Branches or Ministries have agreed to membership in the local Working Groups to be established to provide advice to the Coordinating Officer:
  - Alcohol & Drug Programs, Ministry of Health;
  - Forensic Psychiatric Services, Ministry of Health;
  - Mental Health Services, Ministry of Health;
  - Ministry of Social Services.
4. It shall be the responsibility of the local Corrections or Probation Office to co-ordinate the local Working Groups in the provision of services and case management to accused persons with a mental disorder or a mental handicap from the point of arrest through to trial and determination.

### **Protocol #3: Persons Held in Custody Who Have a Mental Disorder**

It is often difficult to identify individuals in custody who have a mental disorder or mental handicap and who may be in need of treatment. The following "identification and communication" protocol was developed to make certain that appropriate agencies have the information they need to respond. The protocol itself sets out many of the current problem areas.

1. The director of each facility has the obligation to organize the mechanism by which his or her staff can identify and communicate to Crown Counsel information relating to those accused persons held in custody who may be unfit to stand trial or who may be certifiable under the Mental Health Act.
2. Where an accused person in custody has been identified to Crown Counsel as unfit to stand trial and/or has been certified under the Mental Health Act, Crown Counsel will review the case to determine whether it is still in the public interest to proceed with charges, and, if so, whether it is necessary to bring the accused before the court at an early date to address the issue of the accused's fitness.
3. Where Crown Counsel determines it is in the public interest to proceed to trial, and the accused person (being held in custody) has been certified under the Mental Health Act, Forensic Psychiatric Services agrees to accept the transfer of the person to the Forensic Psychiatric Institute for treatment in a secure environment. A specific protocol will be developed between Corrections Branch and Forensic Psychiatric Services to take effect

where the accused person is not certifiable under the Act, but whose mental condition is deteriorating or who is in urgent need of emergency medical care.

4. Where charges are stayed, Crown Counsel will communicate this decision at the earliest possible moment to the accused, his or her counsel, and to the facility where the person is held. The responsibility to transport the accused person shall rest with Emergency Health Services (EHS). EHS shall be notified by Court Services (if the accused is in court) or by the Corrections Branch (if the accused is in a custody centre). If the certified person is a female, a female escort may be required. Police escort may be necessary for violent persons.

#### **Protocol #4: First Court Appearance: Coordination of Community Case Management**

Fitness to stand trial, judicial interim release (bail), and remand in custody are the options available to the accused at this stage. While procedures regarding custody and fitness are already clearly developed, bail release into the community requires the development of community plans. As a result, there is a need for a consistent use of Pre-Bail Reports to ensure that all community alternatives to custody for offenders with a mental disorder or mental handicap are explored. The following have been agreed to:

1. The participating Branches or Ministries will provide case management information to the coordinating officer for use by the Court in addressing the issue of judicial interim release (bail).
2. In undertaking this task, the local Working Group members will provide information on available and appropriate community resource alternatives relevant to the accused person's mental condition and ability to fulfil the conditions of interim release.
3. It shall be the responsibility of the local Corrections Branch staff to ensure that the pre-bail report to the Court contains, among other things, the recommendations of the local Working Group.
4. After the accused's initial appearance in Court, the coordinating officer is responsible for ensuring that community resource alternatives are identified to the accused person and/or defence counsel.

#### **Protocol #5: Trial (Adjudication and Sentencing)**

There is a need to identify community services for persons with a mental disorder or mental handicap who are found not guilty. In addition, the sentencing process can sometimes occur without adequate pre-sentence enquiries or professional consultation for offenders with a mental disorder or mental handicap. This protocol was developed to better assure that sentencing recommendations take into account the nature and level of community services that are available.

1. The local Working Group should be consulted prior to the judicial interim release hearing and any information thus obtained should be provided to the accused and/or defence counsel and to Crown Counsel as soon as possible and, in any event, prior to trial.
2. Crown Counsel or the defence may ask the Court to direct that a psychiatric/psychological assessment take place as part of a pre-sentence report and Forensic Psychiatric Services agrees to conduct an assessment of the accused if one is ordered. The referral for the assessment will be made by Crown Counsel.

3. Where a pre-sentence report and a psychiatric/psychological assessment has been ordered, there will be a full exchange of information between the mental health assessors and the Corrections Branch staff preparing the pre-sentence report.

#### **Protocol #6: Incarceration and Release Planning**

While Corrections Branch provides short-term psychological services for incarcerated and remanded offenders with mental disorders or mental handicaps, it is difficult for them to provide specialized treatment planning, longterm care, continuing care after release, and housing and treatment for Order-in-Council patients awaiting transfer. It was agreed that the following would be able to address these issues most appropriately:

1. Each provincial correctional centre will have a Working Group, coordinated by the Corrections Branch, with representation to also include:

Alcohol and Drug Programs (Ministry of Health)  
Forensic Psychiatric Services (Ministry of Health)  
Mental Health Services (Ministry of Health)  
Ministry of Social Services

and other local agencies and individuals as appropriate. This institutional Working Group may include members of a community Working Group.

2. The Working Group will identify case management issues, including the need to protect vulnerable people, and then identify responsibilities to implement the case management strategies.
3. The Working Group will assist the Corrections Branch in the release planning process, and, where appropriate, will communicate release plans to the local community Working Group where the offender will reside.
4. Forensic Psychiatric Services shall be primarily responsible for the provision of services while the offender is in custody, where resources permit. Where feasible and appropriate, additional case management initiatives undertaken by the Ministry of Social Services, Alcohol and Drug Programs, and Mental Health Services will be continued or initiated while the offender is in custody. This may be facilitated through Institutional Programs or the use of the Temporary Absence Program.

**Protocol #7: Community Supervision**

Offenders with a mental disorder or mental handicap who are on probation or parole are often unable to find appropriate housing and other basic services. While probation and parole includes the supervision of conditions, it does not include the authorization or control of medical treatment. Accessing services and professional expertise requires the assistance and coordination with other agencies and Ministries, as set out in the following protocol:

1. An offender released on parole or placed on probation shall not be denied access, by virtue only of he or she being placed on probation or released on parole, to community programs by:

Alcohol and Drug Programs (Ministry of Health)  
Mental Health Services (Ministry of Health)  
Ministry of Social Services

2. Each community shall have a Working Group coordinated by the Corrections Branch. Primary responsibility for supervision rests with the Corrections Branch and primary responsibility for therapeutic intervention rests with Forensic Psychiatric Services, with support from Alcohol and Drug Programs, Mental Health Services, and Ministry of Social Services programs.
3. The Working Group will identify case management issues, and then identify responsibilities to implement the case management strategies.
4. When a case plan has been identified for an offender, the Working Group will designate a case manager. The case manager shall usually be the primary service provider.
5. Case management strategies will support long term intervention where appropriate. It is recognized that the involvement of the Corrections Branch and Crown Counsel shall cease at the termination of Court sanctions.

**Recommendations**

1. Approve the protocols.
2. Invest the Corrections Branch as the lead agency to implement the protocols and to oversee the establishment of the local working groups, where resources permit.
3. Allow the Committee on the Effects of Deinstitutionalization on the Criminal Justice System to resolve the outstanding issues.

We hereby approve of the above recommendations:

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E. Robert A. Edwards, Q.C.  
Deputy Attorney General  
Ministry of Attorney General

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Douglas E. Allen  
Deputy Minister  
Ministry of Health and  
Ministry Responsible for Seniors

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R. F. Cronin  
Deputy Minister  
Ministry of Social Services

## Appendix C: Consent Form for Participation

March 2, 2001

Dear Participant:

**Re: MDO Working Group Research Project  
Observation Consent Form**

You are invited to participate in a project entitled Mentally Disordered Offender (MDO) Working Groups: The Value of Collaboration and Coordination in the Delivery of Services to Individuals with a Mental Disorder in Conflict with the Criminal Justice System that is being conducted by Angus Monaghan. Angus Monaghan is a graduate student in the department of Human and Social Development at the University of Victoria and you may contact him if you have further questions by calling (250) 729-0424.

As a graduate student, this research is part of the requirements for a Master's Degree in Social Work and it is being conducted under the supervision of Professor Andrew Armitage. You may contact him at (250) 721-8333.

The MDO Working Group is a major initiative throughout the Province of British Columbia. To this point there has not been an evaluation or a research study specifically focusing upon the Provincial MDO initiative. Even though the rather limited literature reflects the value in coordination of services and the need to communicate with community service providers, there has been significant difficulty firmly establishing the MDO Working Group in many communities. The purpose of this research project is to explore how participants would describe a successful MDO Working Group and the perception of value and impact the MDO Working Groups have had in different communities. The importance in conducting this type of research is in developing an increased understanding of approaches to inter-agency/organization communication and collaboration as pertaining to Mentally Disordered Offenders. In so doing, potentially provide initial evidence that the MDO Working Group initiative serves as an example of best practice for mental health intervention (Health Systems Research Unit, 1997).

You are being asked to participate in this project because of your current attendance and participation at the *insert specific location* MDO Working Group in your community. If you agree to participate voluntarily in this research, your participation will include your permission to observe the MDO Working Group meeting of which you attend.

Participation in this project may cause minimal inconvenience to you, including the time required to complete the review this letter and clarify any concerns you may have. There are no known or anticipated risks to you by participating in this research. The potential benefits of your participation in this project will be in the overall increased understanding of the MDO Working Group initiative and the perceived value this initiative has in the work you do.

While the Forensic Psychiatric Services Commission (FPSC) has approved this research, you are in no way compelled to participate in it. Your participation in this research must be completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data from the interview will not be used in the analysis unless removal of the data is logistically impossible. Every effort to retain individual anonymity will be ensured. In terms of protecting your anonymity, with the exception of voluntarily identifying yourself as either a criminal justice or mental health professional, your identity and the specific community the MDO Working Group observed will remain anonymous. Your confidentiality and the confidentiality of the data are ensured. Only the researcher and the research supervisors will have direct access to the data collected. Data from this project shall be disposed of by erasing the tapes and destroying the transcriptions upon completion of the thesis and acceptance that the thesis conforms to the required standards. Data will be kept no longer than February 28, 2002. Only the final thesis shall be retained

All participants in this project will have an opportunity to review a draft copy of the final report, if you so wish, to ensure that it reflects in an ethical manner, the intent of this research outlined in this letter.

It is anticipated that the results of this study will be shared directly with the participants of this project and the research supervisors.

In addition to being able to contact the researcher and the research supervisors at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice President Research at the University of Victoria (250) 721-7968.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

A COPY OF THIS CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL BE TAKEN BY THE RESEARCHER

## **Appendix D: Questionnaire**

### **Mentally Disordered Offender (MDO) Working Group Research Project**

#### **Introduction**

This questionnaire has been developed as part of a Master's Thesis in the faculty of Human and Social Development at the University of Victoria. It will assist in the research project specifically focused upon the MDO Working Group initiative throughout the Province.

The following items have been written in a manner that should allow you complete this questionnaire in as short a time as possible (25 –30 minutes) and to elicit information in a common format from all Forensic Liaisons being surveyed.

Your response will be confidential and any presentation in writing or verbally of the findings of this study will not be conducted in a manner that would identify you.

Note: If you do not wish to participate in this research please send the blank questionnaire back.

#### **Return of Questionnaire:**

Please return the questionnaire to:

Angus Monaghan  
Forensic Psychiatric Services Commission  
101-190 Wallace Street  
Nanaimo, BC V9R 5B1

OR FAX: 250-741-5740

#### **Please Note:**

Please return the completed questionnaire within 2 weeks of receipt. Your assistance is greatly appreciated.

Should you require any further information, assistance or results of this study, please contact Angus Monaghan at (250) 729-0424 or Professor Andrew Armitage at (250) 721-8333.

## Survey Questionnaire

Person Completing (optional) \_\_\_\_\_

Phone Number (optional) \_\_\_\_\_

1. Please identify the region/location of each MDO Working Group you attend.
  
2. Would you describe the location of each MDO Working Group you attend as rural (pop. less than 50,000) or urban (pop. more than 50,000)?  
\_\_\_\_\_

3. How long has each of the MDO Working Group(s) you attend been convening?

Before 1992

1998 – 1999

1992 – 1997

2000 - Present

4. What is the frequency of the MDO Working Group meetings?

Every 2 weeks  
monthly

every 2 months  
once every 3 months

Other \_\_\_\_\_

5. a) Do the MDO Working Group meetings have formal/written terms of reference or mandate specific to your location? \_\_\_\_\_

If yes, please include in return of questionnaire? Or provide written description

b) How are the meetings run?(ie: rotating chair, minutes taken, agenda developed prior to meeting)

6. What agency/community service providers regularly attend MDO Working Group meetings?

RCMP  
Crown Counsel

Probation  
Mental Health

FPS  
Other \_\_\_\_\_

7. a) What would you describe as the focus of the meetings?

Individual/Client Review  
 Systemic Issues Review and Problem Solving  
 Resource Development  
 All of the above  
 Other \_\_\_\_\_

7. b) What would you describe as the secondary focus of most meetings?

Individual/Client Review  
 Systemic Issues Review and Problem Solving  
 Resource Development  
 All of the above  
 Other \_\_\_\_\_

8. Are clients/consumers invited to participate/attend working group meetings?

Yes                      No

If yes, please describe if they are invited for the entire meeting or specifically and only for discussion as pertains to them \_\_\_\_\_

9. Please identify any issues or limitations associated with the MDO Working Groups.

10. Please rank the following:

0 – Not an issue              3 – moderate issue              5 – major issue

\_\_\_\_\_ Confidentiality  
 \_\_\_\_\_ Attendance of key stakeholders  
 \_\_\_\_\_ Resources  
 \_\_\_\_\_ Attendance of Clients/Consumers  
 \_\_\_\_\_ Scope of Inclusion  
 \_\_\_\_\_ Frequency of Meetings  
 \_\_\_\_\_ Other \_\_\_\_\_

11. Please rank perceived value of meetings:

0 – No value

3 – moderate value

5 – major value

\_\_\_\_\_seamless access to resources

\_\_\_\_\_client treatment

\_\_\_\_\_coordination of services

\_\_\_\_\_development of working relationships between community service providers

12. Please rank the overall value of the MDO Working Group :

0 - no value

3 – moderate value

5 – significant value

13. From your experience and perspective what is the overall value of the MDO Working Groups?

14. What factors are most important in order for there to be 'value' to the MDO Working Groups?

15. Any other comments or areas you would like to discuss?

Thank you for your time and participation



**Appendix F: Key Acts**

Criminal Code of Canada

Freedom of Information and Protection of Privacy Act

Forensic Psychiatry Act

Mental Health Act

## VITA

Surname: Monaghan

Given Names: Angus Duncan

Place of Birth: Edmonton, Alberta, Canada

### Educational Institutions Attended:

University of Victoria	1990 – 1991
University of Victoria	1986 – 1988
Grant McEwan Community College	1984 – 1986

### Degrees Awarded:

B.S.W.	University of Victoria	1991
B.A.	University of Victoria	1988

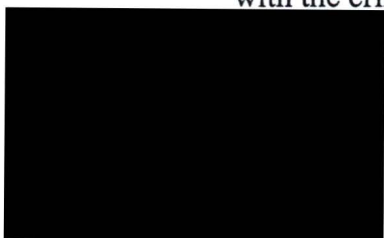
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Author:



Angus D. Monaghan

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