DOES PARTICIPATION IN MENTAL HEALTH COURT REDUCE RECIDIVISM?

by

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Abstract

The focus of this research was to provide descriptive research on the social phenomenon of Mental Health Courts (MHC). This thesis begins with a description of how a community in Northwestern Ontario developed a MHC to assist in reducing the involvement of mentally disordered individuals with the criminal justice system. This initiative was done without additional funds and was a unique response to a growing community issue. This research describes the demographic characteristics of the clients with the MHC in Kenora compared with those clients not involved in MHCs to determine if involvement with MHCs reduces mentally disordered individuals' involvement with the criminal justice system. This comparison study examined the characteristics of individuals involved within the Mental Health Diversion & Court Support (MHD&CS) program at the Canadian Mental Health Association, Kenora Branch in 2005 and compared them with characteristics of individuals who were involved in the program in 2010 who were also involved in the MHC in Kenora. The results from this analysis indicated that the following demographic characteristics yielded statistically significant differences between 2005 and 2010: if participants had residence support and to what level, if participants were presenting with anxiety symptoms, and if participants were presenting with depressive symptoms The results indicated those individuals from 2010 who were involved with the MHC reoffended less than those from 2005 who were in the regular court stream. Therefore, it could be concluded that individuals' participation in the MHC may have influenced recidivism rates of individuals involved in the MHD&CS program. The results for readmission to hospital indicated a lower percentage of participants in 2010 who were readmitted to hospital compared to participants in 2005.

Therefore, it could be concluded that having individuals participate in the MHC may have influenced individuals being readmitted to hospital.

When examining which of the significant descriptive variables were statistically significant with either re-offence rates or readmission to hospital rates within their prospective years, there was only one variable that was statistically significant; this was the variable in the 2010 sample of whether participants were experiencing symptoms of depression and if they were readmitted to hospital. The chi-square results indicated that there was an association between participants exhibiting signs of depression in 2010 and being readmitted to hospital. Therefore, it appears that those individuals with symptoms of depression who were part of the MHC were more likely to be readmitted to hospital.

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List of Abbreviations

Canadian Mental Health Association	CMHA
Canadian Mental Health Association, Kenora Branch	CMHAK
Centre for Addiction and Mental Health	CAMH
Mental health court	MHC
Mental Health Diversion and Court Support	MHD&CS
Ministry of Health and Long Term Care	MoHLTC
Not criminally responsible	NCR

Chapter 1: Introduction

Stigma is an ongoing and significant problem for people living with mental illness. It undermines a person's sense of self, as well as his or her relationships, well-being, and prospects for recovery (Centre for Addiction and Mental Health [CAMH], 2012b). Stigma is a stereotype and is based on myths and misunderstandings (Schizophrenia Society of Ontario [SSoO], 2013). Individuals with the mental disorder of schizophrenia can have a difficult time being accepted by society (SSoO, 2013). Thus, because of stigma, individuals with schizophrenia find themselves being discriminated against, and this in turn perpetuates the stereotypes of those individuals living with this illness (SSoS, 2013). On August 1, 2008, Vince Li ("Greyhound killer," 2012) brought mental illness, particularly schizophrenia, into the national headlines and reinforced the stigma attached to mental illness. Li killed and beheaded 22 year-old Tim McLean on a Greyhound bus that was travelling through Portage La Prairie, Manitoba. Since this incident, the criminal courts have found Li to be not criminally responsible (NCR) for the offence, indicating he was suffering from a mental disorder at the time of the offence.

The Li case caused controversy in terms of how to address mentally disordered individuals and how they are managed in the Forensic Mental Health System (CAMH, 2012a); members of society pressed the federal government to change the Criminal Code (Government of Canada, 1985) so people who are found NCR still serve time in jail. However, the real issue is why Li's mental illness was left untreated. This question raises discussions around mental health acts in every province and has brought the inadequacies of the current policies to the forefront.

One of the social values threatened by an inadequate mental health system is quality of life. Quality of life is defined as the overall general state of someone's well-being that is comprised of physical, material, social, and emotional well-being (Corring, 2002). This state of well-being, along with a person's development and purposeful activity, are weighted by the person's set of values (Corring, 2002). A mentally disordered individual's recovery is a concrete indicator of his or her quality of life. Therefore, when a mentally disordered individual does not have an effective support system, financial security, a place in the community, and a positive sense of self, there is no hope for that person overcoming the challenges of the illness and achieving recovery. Society expects individuals with mental illnesses to recover quickly but has not invested the necessary resources in the mental health care system, leaving it diluted and failing to meet the needs of those suffering from mental illness (Corring, 2002). Advocates for individuals with mental illness have developed mental health courts (MHCs) as an innovative approach to address the needs of mentally disordered individuals who commit crimes that require them to enter the criminal justice system (Schneider, 2009).

This descriptive research was conducted to describe the demographics of the type of individuals accessing the Mental Health Diversion and Court Support Program (MHD&CS) program at the Canadian Mental Health Association, Kenora Branch (CMHAK). The researcher examined whether the social phenomenon of MHCs contributed to a reduction of the participants' involvement within the criminal justice system. In the past, individuals within the Kenora Rainy River District who were suffering from a mental disorder, cognitive impairment, or brain injury who were involved in crimes were funnelled through the criminal justice system. Only those

individuals who presented with severe symptoms of their disorders were sent for

assessment to that province's designated forensic hospital. In 1999, MHD&CS programs

were established in Ontario as a way to provide mental health services and supports to

individuals with mental health needs who were in contact with the criminal justice system

(Ministry of Health and Long-Term Care [MoHLTC], 1999). MHD&CS programs divert

people with mental illness away from the justice system and also provide mental health

services to those already in the criminal justice system. The MHD&CS program

encompasses a variety of services that include crisis response and emergency services,

safe beds, housing, case management, peer support, and links to social, education, and

employment supports (MoHLTC, 2006). MHD&CS services are able to provide

diversion only for individuals whose alleged offences are labelled as low risk and whose

mental health needs can be seen as met through services that are based in the community

(MoHLTC, 2006). MHD&CS programs offer diversion services in place to provide pre-

and post-conviction links to community or institutional mental health services. The court

support services from the MHD&CS program provide the courts and other judiciary the

ability to support individuals with mental health needs and their families throughout the

legal process and to link individuals to the required services.

As the *Program Framework for Mental Health Diversion / Court Support

Services* (MoHLTC, 2006) indicates, the MHD&CS program: (a) provides links to a

comprehensive system of mental health services and supports; (b) facilitates access to

needed services and supports; (c) involves key players from the criminal justice, health,

and social service sectors; (d) provides referrals and consultation to those not suitable for

diversion; (e) offers support networks for family members; and (f) improves the person's quality of life.

The MHD&CS program in Kenora, Ontario, was developed in 1999 to keep individuals with serious mental illness out of the criminal justice system. The funding was provided by the MoHLTC in Ontario, as there was a need to reduce the continuing pressures felt by police, courts, and the criminal justice system associated with the number of individuals with mental health issues who were becoming involved with the criminal justice system.

In addition to describing the demographic characteristics of the clients within the MHD&CS program in Kenora, the purpose of this study was to examine those individuals involved in the MHD&CS program in 2005 prior to the introduction of MHC and compare them with individuals involved with the MHC in Kenora in 2010. This comparison study evaluated if there are different outcomes for individuals who have been referred to the MHC that commenced in 2010 than for those who received only diversion services. By examining the different program outcomes between 2005 and 2010, the researcher was able to determine if being involved with the MHC in Kenora reduced the involvement of mentally disordered individuals within the criminal justice system.

In order to examine if the MHC was effective in reducing the number of encounters of individuals within the criminal justice system, the researcher examined the participants in three areas: new charge under the Criminal Code (Government of Canada, 1985); readmission to a designated forensic hospital within Ontario for revocation of Ontario Review Board Disposition; and exit disposition by the courts of the individual. All of these areas were examined, as each individual was managed at different juncture

points within the criminal justice system, and some were diverted in terms of re-arrest to

the Forensic Mental Health System (CAMH, 2012a).

Chapter 2: Literature Review

Canada has one of the "lowest rates of mental health spending relative to health spending of all OECD [Organization for Economic Cooperation and Development] countries" (Lurie, 2008, p. 1), and Ontario has one of the lowest rates of per capita spending on mental health in Canada. Indigenous people make up 3.8% of Canada's population (Sapers, 2013); this group comprises the majority of the population in the northern half of the territories, including northwestern Ontario, where the people are significantly disadvantaged (Barsh, n.d.). The Aboriginal incarceration rate is said to be 10 times higher than the national average, and the Aboriginal federal inmate population is said to be 22% (Sapers, 2013). These disproportionate rates of Aboriginal incarceration are due to the history of colonialism, the displacement of Aboriginal people, and the impact of the residential schools (Sapers, 2013). This history has resulted in Aboriginal people having lower education levels, lower incomes, a higher unemployment rate, much higher rates of substance abuse, and increased suicide attempts (Sapers, 2013). Despite facing these odds, there is no increase in funding for resources for Aboriginal peoples in relation to mental health services. The overall theme is that mental health systems are failing to meet people's needs and that stigma and discrimination are pervasive all over Canada (Lurie, 2008). Knowing this, the Senate Committee on Social Affairs called for the establishment of a mental health commission that would become a catalyst for mental health reform in the country (Lurie, 2008). This mental health commission aimed to improve the knowledge of Canadians in regard to mental health by introducing best practices and campaigns to reduce stigma and discrimination (Lurie, 2008).

Thousands of people in Ontario have no access to mental health services (Canadian Mental Health Association [CMHA], 2014a). Northern Ontario covers approximately 89% of Ontario's land mass and is home to around 745,000 people representing 7% of the provincial population, 29% of Ontario's francophone population, and 43% of the province's Aboriginal population (Northern Development Ministries, n.d.). Canadian data demonstrate that 4.9% of Canadians met the criteria for having a mood disorder within the past 12 months, and 4.7% of Canadians have met the criteria for an anxiety disorder within the past 12 months (Steele, Dewa, & Lee, 2007). However, despite the availability of effective treatments, only 32% of individuals with a mental disorder will have spoken to a health professional (Steele et al., 2007). The majority of individuals with mental disorders do not even receive minimal treatment (Sareen et al., 2007).

Individuals with a mental disorder in Ontario report that they are dissatisfied with available services, that services are not helpful, and that they might be hospitalized involuntarily (Sareen et al., 2007). This creates a distrustful environment, and those who require support tend to shy away from accessing or utilizing the current mental health system.

In Ontario, community mental health services are seeing the criminalization of the mentally ill instead of access to mental health service (CMHA, 2014a). Mentally disordered individuals are at risk of increased contact with police and increased involvement in the criminal justice system as their ability to access mental health services is unmet. Centuries ago, individuals with mental illness were seen as "being possessed by the devil" (Gibbs, 2005, p. 3), were held in psychiatric institutions, and were treated like

criminals (Gibbs, 2005). Since then, there has been a shift from traditional institutional

settings to non-traditional, non-institutional settings in the community (Kravitz & Kelly,

1999). This de-institutionalization movement advocated that the mentally ill be treated in

the community where they could maintain their connections with families and loved

ones, but also strengthen their chances of recovery due to benefits from treatment (Gibbs,

2005).

      De-institutionalization and changes to Canada's mental health laws in each

province have resulted in individuals having limited access to services in the community

(Watson, Hanrahan, Luchins, & Lurigio, 2001). The mental health care systems in

Canada are underfunded and over capacity, and there has been a movement toward

community-based treatment of individuals with major mental illnesses (Schneider, 2009).

However, with the closure of psychiatric hospitals, these funds have not been re-invested

into community treatment (Schneider, 2009). Therefore, those who do not receive mental

health services often find themselves involved with the criminal justice system that seems

to have to "sort out the mess" (Schneider, 2009, p. 2). This increase in demands on the

criminal justice system has caused a "criminalization" of mental illness (Schneider 2009,

p. 3); mentally disordered individuals seeking services within the civil system now have

to receive those same services in the criminal justice system (Schneider, 2009). This

undoubtedly has brought society back to where it was 200 years ago—placing mentally

disordered individuals in prisons and out of society (Schneider, 2009).

      With the closure of institutions, community treatment programs and facilities

have not been able to replace these services adequately (Gibbs, 2005). The result is that

many mentally disordered individuals do not receive treatment of any kind.

Unfortunately, this lack of support has led to many mentally disordered individuals being

criminalized. The province of Ontario has had many tragic experiences that have resulted

in individuals not receiving psychiatric assessment through the civil system (Gibbs,

2005); the numbers of mentally ill individuals who are in prisons due to the lack of

assessment space in psychiatric hospitals is increasing (Gibbs, 2005). Despite the

accepted ideology of moving away from criminalizing the mentally ill, it is sad to see that

history continues to repeat itself. This highlights the inadequacies of mental health

services within society as well as the huge gap in service for mentally disordered

individuals (Gibbs, 2005).

Canadian research indicates that 7.7% of federal inmates reported having a

psychotic disorder, 21.5% reported a depressive disorder, and 44.1% reported an anxiety

disorder (MoHLTC, 2006). The Aboriginal inmate population in Canadian federal

prisons is said to be 23% (Sapers, 2013). This is a 40% increase in the Aboriginal

federally incarcerated population from 2001 to 2002, and 2011 to 2012 (Sapers, 2013).

The Office of the Correctional Investigator report from 2012-2013 indicates that on any

given day there are approximately 3,500 Aboriginal people in federal penitentiaries

(Sapers, 2013). Within Canadian provincial institutions, it is said that the Aboriginal

population is 6.8% with the highest proportion in Ontario and in the Prairies (Barsh, n.d.).

Of those individuals detained in the Canadian provincial corrections system,

approximately 15% to 20% have a mental disorder that requires a clinical intervention

(MoHLTC, 2006).   Based on a sample of 25,000 inmates, the US Department of Justice

concluded that more than half of inmates in the United States prison system have mental

health problems (Kuehn, 2007). Research indicates that there is an increase in the number

of individuals in correctional facilities in Ontario and that this increase has raised

concerns about the availability of resources, treatment and assessment, the institutional

capacity, and how policing and court services are delivered (MoHLTC, 2006). Thus,

correctional facilities in both the United States and Canada have become the de facto

psychiatric hospital for many individuals with mental illness (Watson et al., 2001). For

people of Aboriginal ancestry, this situation represents multiple, intersecting forms of

oppression.

Aboriginal people are far more likely to be to be convicted of offenses under the

Criminal Code of Canada and are more likely to serve more time in prison (Barsh, n.d.,).

This overrepresentation in correctional institutions is a reflection of the effects of the

impact of colonization. The colonization of Aboriginal people has contributed to the

poverty, frustration, and the disruption of families and communities of Aboriginal people

(Barsh, n.d.). When the *Indian Act* was passed in 1867 (Indian Act, 1985), the

Department of Indian and Northern Affairs Canada was handed the "primary

responsibility for the constitutional and statutory obligations and responsibilities of the

federal government to Indian and Inuit people" (Standing Senate Committee on Social

Affairs, Science and Technology [SSCoSA, S&C], 2005, p. 288). Through this

administration of the *Indian Act,* the department deals with the social determinants of

health: "economic, educational, cultural, social and community development for

registered Indians and certain Inuit" (SSCoSA, S&C, 2005, p. 288). The primary federal

responsibility for health services, including mental health services to First Nations and

Inuit on all reserves and in many remote and isolated communities is therefore delivered

by Health Canada (SSCoSA, S&C, 2005.). Realistically, this does not come without its

challenges; for example, First Nation communities face continuous challenges when

submitting proposals for funding to deliver mental health services that are community

based (Niezen as cited in Kirmayer & Valaskakis, 2009). The criminalization of people

with mental illness is a concern because these individuals face increased risks of

homelessness, isolation from community services, lack of future access to treatment, and

increased risk of experiencing symptoms of mental illness (MoHLTC, 2006). The

question is why individuals with a mental illness involved in the criminal justice system

are being incarcerated and not being provided with hospital or community-based mental

health services and supports.

The reality is that more than 90% of all offenders acquitted for being NCR due to

their mental disorder are released from the hospital to the community (Kravitz & Kelly,

1999). Proper risk assessment and treatment of this population in the mainstream

community mental health setting is needed as the numbers of forensic clients returning to

communities is increasing, and the unmet needs and risks of these clients requires urgent

attention from mental health practitioners, service providers, and policy-makers (Gleeson,

Nathan, & Bradley, 2006). More effective methods for managing the forensic population

are needed, as well as the development of programs that can treat these individuals cost-

effectively (Kravitz & Kelly, 1999). Therefore, guidelines should be developed for

assessing and managing risk for this population.

Other contributing factors are the inability of inmates to coordinate services for

themselves, as well as ensuring the continuity of their care (Watson et al., 2001). Many of

these inmates are released from correctional facilities without any medication or

organized follow-up with mental health services. Thus, if Canada is not going to re-invest

in its mental health care system, MHCs will continue to be responsible for providing solutions that allow individuals access to mental health services.

In January 2006, the Ministry of Health and Long Term Care (MoHLTC)—now known as the Local Health Integration Network—announced an investment of $27.5 million annually to be funnelled to community mental health services in order to help people with mental illness stay out of the criminal justice system and receive the care and support they need. Part of this initiative was the development of MHD&CS programs in Ontario. The focus of these programs was to meet the needs of persons who are considered low risk by managing their needs appropriately through community- or hospital-based services. MHD&CS programs were meant to reduce the number of individuals in correctional systems who have mental illness.

The other push from governments is to develop MHCs to assist in reducing the number of mentally ill individuals within correctional facilities (Kuehn, 2007). These courts adapted the drug court models created in 1989 in the United States (Kuehn, 2007; Schneider, 2009). Evaluations of these drug courts have produced results indicating that involvement in this court reduces the individual's drug use as well as reduces his or her criminal behaviour (Hiday & Ray, 2010; Watson et al., 2001).

CMHA Kenora Branch Forensic Services, Forensic Psychiatry Program

Forensic Mental Health Systems (CAMH, 2012a) were developed as society believed that it was unfair to punish people for criminal acts if they suffered from a mental illness (Bettridege & Barbaree, 2004). Society viewed individuals with mental disorders as unable to understand their crimes or the consequences of their actions (Bettridege & Barbaree, 2004). From this view, the Forensic Mental Health System was

developed. Therefore, individuals in Ontario with a mental illness who break the law become involved in the Forensic Mental Health System.

People who are involved in the forensic system have special needs. The mental health system or the criminal justice system alone cannot always meet those needs; therefore, the Forensic Mental Health System (CAMH, 2012a) is the place where the mental health system and criminal justice system meet (Bettridege & Barbaree, 2004). Individuals found NCR in the Forensic Mental Health System are governed by a review board. The Ontario Review Board was established under Part XX.1 of the Criminal Code (Government of Canada, 1985) and is defined as follows:

> A Review Board shall be established or designated for each province to make or review dispositions concerning any accused in respect of whom a verdict of not criminally responsible by reason of mental disorder or unfit to stand trial is rendered, and shall consist of not fewer than five members appointed by the Lieutenant Governor in council of the province. (Carruthers, 2008, p. 3)

Due to this stipulation in the Criminal Code (Government of Canada, 1985), the CMHAK developed the Forensic Psychiatry Program that is a component of the existing MHD&CS program. This program originated from the underserviced area program in Ontario and is funded by the Alternative Payment Plan and Health Force Ontario (Government of Ontario, Health Force Ontario, 2013). The Forensic Psychiatry Program allows for specialized forensic psychiatric services to be delivered to the Kenora Rainy River District by providing the program with 30 psychiatric days within a fiscal year. Currently the program has three psychiatrists from the Toronto area who come to Kenora to provide assessments to the Forensic Psychiatry Program.

The psychiatrists within the Forensic Psychiatry Program at CMHAK offer five

types of assessments: (a) fitness to stand trial, (b) criminal responsibility, (c) risk

assessment, (d) sexological assessment, and (e) diagnostic and treatment planning

assessments. Fitness to stand trial as defined by the Ontario Review Board (2011a)

means:

> unable on account of mental disorder to conduct a defence at any stage of the
>
> proceedings before a verdict is rendered or to instruct counsel to do so, and, in
>
> particular, unable on account of mental disorder to (a) understand the nature or
>
> object of the proceedings, (b) understand the possible consequences of the
>
> proceedings, (c) communicate with counsel. (para. 1)

Criminal responsibility as defined by Ontario Review Board (2011b), when defining

NCR, says:

> No person is criminally responsible for an act committed or an omission made
>
> while suffering from a mental disorder that rendered the person incapable of
>
> appreciating the nature and quality of the act or omission or of knowing that it
>
> was wrong. (para. 1)

Risk assessment (Canadian Mental Health Association, Kenora Branch

[CMHAK], 2008) aims to identify the rate of reoffending of an individual. This

assessment specifically focuses on the prevention of identifying risk factors and

recommendations on how to manage these risk factors. Sexological assessments aim to

identify if there is a sexual or gender identity disorder as indicated in the *Diagnostic and*

Statistical Manual of Mental Disorders (*DSM-IV-R;* American Psychological Association

[APA], 2000). The assessment then focuses on preventing risk factors specific to the

individual's sexual deviance and provides recommendations on how to manage this

deviance. Diagnostic and treatment planning assessments as indicated in the *DSM-IV-R*

(APA, 2000) establish if there is a mental health disorder and provide recommendations

on how to assist the individual in achieving recovery.

Mental Health Diversion & Court Support Program at the CMHA, Kenora Branch

The MHD&CS program's mandate was to serve the vast geographical area of

North Western Ontario, home to 95 communities, some of which are only accessible by

air, and 45 of which are First Nations. This region is culturally diverse with 20% to 25%

of its population being First Nations (Major & Davidson-Hunt, 2001).

MHD&CS programs involve the cooperation of key players from across the

mental health, criminal justice, and social service sectors. The ministerial partners are the

Ministry of the Attorney General, Health, Community and Social Services, and the

Solicitor General and Correctional Services (MoHLTC, 2006). The Ministry of Attorney

General's concern is the safety of the public and focuses on supporting the fair and

compassionate treatment of individuals who have a mental disorder and who are in

conflict with the criminal justice system (MoHLTC, 2006). The *Crown Policy Manual*

(Government of Ontario, Ministry of Attorney General, 2005) encourages that the crown

explore alternative options when working with individuals who have a mental disorder.

The MoHLTC and the Ministry of the Attorney General work together to discuss how to

link individuals involved with the criminal justice system to mental health diversion,

court services, and mental health resources in a coordinated system (MoHLTC, 2006).

The Ministry of Community Safety and Correctional Services faces increased

pressures in servicing individuals in the correctional system who have mental disorders

(MoHLTC, 2006). By looking at a shared service development, training, and educational opportunities, this ministry in collaboration with the MoHLTC can work to increase the effectiveness of the MHD&CS programs (MoHLTC, 2006). As there is an overlap of roles of service providers in the MoHLTC and the Ministry of Community and Social Services, there are opportunities to collaborate to develop service agreements, make referrals, develop linkages, and create a shared awareness of services to ensure that people have timely access to needed and appropriate services (MoHLTC, 2006).

The key stakeholders at the community level include justice officials: the local crown attorney's office, defence council, Kenora District Jail, and Probation and Parole Services, both adult and youth. Mental health services include Integrated Services Northwest; Brain Injury Services of Northwestern Ontario; CMHAK (including the Mental Health Therapy Team, Kenora Supportive Housing Program, Case Management Program, and Assertive Community Treatment Team); and the Fort Frances Branch. Other community services include Legal Aid Ontario, Creighton Youth Services, Child and Family Services, Restorative Justice members, Community Mental Health Support Services, Sakatee House, as well as the clients themselves.

The assumptions of the MHD&CS programs are that there will be improved mental health functioning and outcomes for clients, reduced recidivism and hospitalization, reduced pressures on the criminal justice system, and increased access to mental health services (MoHLTC, 2006). The core principles for MHD&CS programs are (a) safety and security, (b) informed decision-making, (c) recovery-focused approach, (d) accessible and appropriate services; and (e) service collaboration.

Safety and security is the first priority of MHD&CS programs and is the key

consideration throughout service delivery. The MHD&CS programs must be able to

balance public safety and security with the safety and autonomy of the client. When

balancing these two principles, what are considered are the least restrictive, intrusive, and

stigmatizing interventions to ensure that both the client and the public are safe

(MoHLTC, 2006). Informed decision-making indicates that service providers will have

all the relevant information to assist in determining when diversion is the best option of

the client and the public (MoHLTC, 2006).

The recovery-focused approach (MoHLTC, 2006) is to be used when delivering

MHD&CS services in Ontario. The fundamentals of this approach are that mental health

services emphasize "client choice, flexibility of services, individualized supports, and the

importance of peers, families, significant others and communities in supporting people

with mental health needs" (MoHLTC, 2006, p. 10). The recovery-focused approach also

considers the impact of poverty, poor housing, unemployment, and stigma on people with

mental illness (MoHLTC, 2006).

The principle of accessible and appropriate services (MoHLTC, 2006) indicates

that clients have timely access to appropriate services and supports. These services and

supports are to be offered through an interdisciplinary approach coordinated by the

mental health diversion worker to streamline client access.

Service collaboration (MoHLTC, 2006) is another important principle in the

service delivery of MHD&CS services. Services within the mental health, criminal

justice, and broader social service sectors need to be linked and to collaborate with

clients, service providers, the government, and the community. The responsibility for this

service delivery to these clients is recognized as being the responsibility of all service sectors; therefore, formal partnerships are to be developed with service providers (MoHLTC, 2006).

The principle of education and support is to ensure that clients, families, other social supports, and service providers receive the information they request. This education and support provides public awareness and integrates back into the public those clients with mental health needs involved with the criminal justice system (MoHLTC, 2006).

The diversion of individuals within the criminal justice system occurs across a continuum of juncture points, which are considered the points of intervention (MoHLTC, 2006). The three intervention approaches identified are (a) pre-charge diversion, (b) court support, and (c) post-conviction.

The pre-charge diversion includes adults who seem to have mental health needs, who have come in contact with the police, or who are in conflict with the criminal justice system (MoHLTC, 2006). These individuals would benefit "from community or hospital-based mental health services as an alternative to incarceration" (MoHLTC, 2006, 2006, p. 9). At this point, the person is not charged with an offence, but the police may refer the person to mental health services, charge him or her with an offence, or take the individual to the emergency department for psychiatric assessment and possible hospitalization (MoHLTC, 2006).

The court support intervention juncture is the point of contact for adults who have mental health needs and who have been charged with a criminal offence (MoHLTC, 2006). These individuals would benefit from "community or hospital-based mental health

services and supports as an alternative to incarceration" (MoHLTC, 2006, p. 9). The

population that is of most priority at this juncture are those with a serious mental illness.

Other individuals who do not have a serious mental illness but who have been referred

for court support services are referred to other appropriate services and supports.

MHD&CS services are available to assist the members of the judiciary including the

court, crown attorney(s), defence counsel, and other court staff. These services focus on

screening and assessing individuals for possible diversion as well as linking clients to

their families or other support networks, and assisting the individual with the legal

process (MoHLTC, 2006). At this juncture, individuals are referred by various sources

that include the court, crown, defence counsel, probation officer, duty council,

community agencies, physicians, and psychiatrists, families, or even self-referral.

     The post-conviction juncture is the point of contact when individuals with mental

health needs who are convicted of a criminal offence are considered to benefit from

"community or hospital-based mental health services as an alternative to incarceration"

(MoHLTC, 2006, p. 9). At this juncture, there are several points when a person can

access community mental health services: when the person is in custody, when the person

is on community supervision, or when the person is involved in case management

services or other services, release planning, conditional release, and unconditional

release.

Health Care System Reform Within Mental Health Diversion Services

     Mental health policy framework. MHD&CS services have developed in the

broader context of health care system reform. Development of these services is consistent

with the current emphasis of Ontario's health system reform that is focused on

"delivering integrated, consumer-centred and appropriate health care through initiatives

such as Local Health Integration Networks, Primary Care Reform, and Family Health

Teams" (MoHLTC, 2006, p. 23). The MoHLTC's (1999) mental health policy

framework, *Making It Happen: Operational Framework for the Delivery of Mental*

Health Services and Supports, directed that clients with mental illness who become

involved with the criminal justice system need to be integrated into general mental health

services if their offending and risk is considered low (MoHLTC, 2006).

The *Making it Happen: Operational Framework for the Delivery of Mental*

Health Services and Supports Framework (MoHLTC, 1999) committed the ministry to

develop a hybrid system where mental health services assume greater responsibility for

low-risk clients, and the regional forensic services become fully integrated with the

current mental health system (MoHLTC, 2006). The regional forensic services through

the framework are expected to increase prevention of individuals with mental disorders,

cognitive impairments, or brain injuries within the forensic system, as well increase these

individuals' access to general mental health services. The treatment of these individuals

is to be delivered in the least restrictive manner and not be intrusive to the clients' needs.

The MoHLTC is also committed to providing a better link between mental health staff

and the criminal justice system. This link is meant to develop intervention and meet the

treatment needs of individuals who are continuously at one of the stages in the criminal

justice system (MoHLTC, 2006). The link with mental health services would continue

after the client is discharged from the jail setting.

        Human services and justice projects. In 1997, the

Human Services and Justice Coordination Project was sponsored by the (then)

Ministries of Health, Attorney General, Community and Social Services and

Solicitor General and Correctional Services to better co-ordinate, resource and

plan services for people with clinical needs who come into conflict with the law.

(MoHLTC, 2006, p. 24)

This project developed a blueprint for inter-ministerial and ministry-specific initiatives

as a joint responsibility for mentally disordered individuals in conflict with the law. This

project identified and defined key players and their roles and responsibilities as well as

the key juncture points between health, developmental services, and the criminal justice

system. Human Services and Justice Coordination Committees (HSJCC) were created at

the local, regional, and provincial levels as a result of the Human Services and Justice

Coordination Project, with the mandate to coordinate service planning and enforce

communications between players within the health, criminal justice, and developmental

service organizations (MoHLTC, 2006). HSJCCs developed strategies to address service

design and planning needs such as community intervention plans, court assessment plans,

and prevention plans.

Mental health task forces. In 1999, the MoHLTC established nine regional

Mental Health Implementation Task Forces. The mandate of these task forces was to

develop implementation recommendations for regional and local mental health services.

One of the recommendations from the task forces was to develop a policy framework for

populations with special needs, including those receiving forensic services, as well as a

policy framework for inter-ministerial linkages. These task forces recommended an

expert panel that was established in 2001.

Forensic advisory panel. The Forensic Mental Health Services Expert Advisory Panel was thus developed in 2001 to "advise the government on a provincial strategy for implementing a comprehensive forensic mental health system in the context of inter-ministerial co-ordination of forensic services" (MoHLTC, 2006, p. 24). The panel identified that guidelines needed to be established on standards of practice for accountability and evaluation for MHC support services. There was also an identified need for coordination between the provincial forensic system and the partnered ministries as well as a continuum of care that ranged from highly specialized inpatient services to community treatment for those in less structured settings (MoHLTC, 2006).

Service enhancement strategies. In 2004, the Ontario government identified the commitment to improving health care in Ontario by expanding community mental health services to serve an additional 78,600 clients annually by 2007 and 2008 by implementing intensive case management services, crisis response services, and early intervention services (MoHLTC, 2006).

In January 2005, the Service Enhancement Strategy was announced (MoHLTC, 2006). This strategy invested $27.5 million in annual funding for services that would divert individuals with mental illness away from the criminal justice system by providing them access to community mental health services (MoHLTC, 2006). This strategy is within the broader program framework for MHD&CS services but has a narrower focus with specified program deliverables.

Mental health courts. MHCs are intended to serve individuals who have been diagnosed with a serious and persistent mental illness who have found themselves

charged under the Criminal Code (Watson et al., 2001). The courts seek to link

individuals to appropriate mental health services based in the community.

In order to have people with mental disorders reduce their involvement within the

criminal justice system, many communities have created MHCs (McNiel & Binder,

2007). These courts function on therapeutic and rehabilitative principles that anticipate an

increase for individuals with mental disorders to gain access to treatment and reduce their

involvement with the criminal justice system (McNiel & Binder, 2007).

The principles of MHCs emerged out of inequalities faced by individuals with

mental illness within the criminal justice system (Watson et al., 2001). These principles

are therapeutic jurisprudence, rehabilitative principles, and restorative justice principles.

Therapeutic jurisprudence is "the study of the extent to which substantive rules,

legal procedures, and the roles of lawyers and judges produce therapeutic or anti-

therapeutic consequences for individuals involved in the legal process" (Watson et al.,

2001, p. 478). This lens examines how the traditional legal system affects individuals'

therapeutic outcomes (Watson et al., 2001). Therapeutic jurisprudence is a theory that

indicates that the law should be incorporated in a way that is therapeutic (Schneider,

2009) and use the justice system in a manner that addresses the underlying factors that

have contributed to the individual coming into contact with the law (Schneider, 2009).

MHCs are based on the drug court movement that believes that individuals'

mental health is a public health problem as well as a criminal justice problem, and

offenders should be receiving treatment and not incarceration (Watson et al., 2001). If

individuals relapse, this is not considered a failure but part of treatment (Watson et al.,

2001). The drug court is based on five elements: (a) immediate intervention, (b) non-

adversarial process, (c) hands-on judge, (d) treatment programs, and (e) team approach (Watson et al., 2001).

Restorative justice principles are a view of justice that focuses on repairing the "harm and relational disruption caused by criminal behaviour" (Schneider, 2009, p. 5). This principle focuses on having all stakeholders and the community involved in restoring offenders to being contributing members of society (Schneider, 2009). MHCs incorporate this principle as they look at rerouting the offender to treatment and the community by engaging stakeholders and community members in the individual's treatment. Restorative justice focuses on ensuring that offenders throughout the criminal process are "dealt with in a compassionate, humane and ultimately more social protective way" (Schneider, 2009, p. 5).

The primary goal of MHCs is to connect, reconnect, and reintegrate individuals with mental health needs to treatment and appropriate services (Schneider, 2009). These courts serve as a way for individuals to access services within the community for treatment or assessment. MHCs also seek to reduce recidivism rates of individuals with mental health needs involved within the criminal justice system (Schneider, 2009).

MHCs have been in existence in Canada since the mid-1990s when the first known program in Canada emerged in Toronto, Ontario (Schneider, 2009). This type of court was developed in order to continue to patch the broken system of mental health care for mentally disordered individuals (Schneider, 2009).

McNiel and Binder (2007) conducted a study that demonstrated that MHCs reduce the involvement of people with mental disorders within the criminal justice system. Kuehn (2007) also demonstrated that having MHCs benefited not only the

individual but also communities. Through further analysis, McNiel and Binder concluded

that individuals who elected to proceed through the MHC had a reduction in recidivism

related to their involvement with the criminal justice system. A further study conducted

in North Carolina in 2005 with 99 MHCs demonstrated that participation in MHCs was

associated with a reduction in recidivism (Hiday & Ray, 2010). This study also

concluded that 72% of offenders who were involved with a MHC were not rearrested,

and 81% of offenders who were ejected from the MHC were rearrested (Hiday & Ray,

2010). By examining the number of re-arrests of the participants in the study 2 years

later, this study also demonstrated individuals involved within the MHC were less

involved with the criminal justice system (Hiday & Ray, 2010).

Another major contribution of MHCs is their ability to identify service gaps in

communities (Watson et al., 2001). Identification of these service gaps allows for the

proactive approach of providing treatment to mentally disordered individuals within the

criminal justice system by examining the factors that contribute to these individuals being

involved with the justice system and how to reduce their further involvement (Watson et

al., 2001). There have been only a few studies on the effects of the MHCs in reducing the

number of individuals with mental disorders coming into conflict with the criminal

justice system (McNiel & Binder, 2007). More research in this area is needed to ensure

that treatment linkage and symptom reduction account for individuals with mental health

disorders being less involved in the criminal justice system (McNiel & Binder, 2007).

As populations of people with mental health disorders across the world are

unique, there is no single MHC model that fits everyone (Watson et al., 2001).

Historically, all parties involved with mentally disordered persons involved with the

criminal justice system would not collaborate with one another. Today, if all players are

not working collaboratively, the outcome for the individual involved with the criminal

justice system will not be successful (Watson et al., 2001). This team approach is

essential to ensure that individuals with mental health disorders have both their criminal

justice and mental health needs met (Hiday & Ray, 2010).

Individuals with mental health disorders may not have the capacity to make their

own decisions, and this will affect whether they participate within the MHC (Watson et

al., 2001). Therefore, it is critical to have experienced defence council that understand the

nature of the individuals' illnesses, as well as ensure that the individuals understand the

consequences of the options they choose (Watson et al., 2001).

Even if individuals agree to participate within the MHC, there needs to be

community mental health services, developmental services, and brain injury services

available for them to access. If these services are not available, the success of the MHC

will be jeopardized (Watson et al., 2001). Therefore, it is critical to ensure that

partnerships are formed between the MHCs and community mental health service

agencies to agree to service individuals within the MHC.

The process of the MHC in Kenora is that all parties of the court collaborate with

human service agencies in the Kenora Rainy River District to assist in implementing a

therapeutic intervention. This intervention ranges from "medication management,

substance abuse treatment, housing, job training, and psychosocial rehabilitation"

(Watson et al., 2001, p. 477). Individuals who are screened for MHC who have minor

charges are able to have their charges diverted if they participate in services. The MHC

will assist those individuals who do not have minor charges in structuring a sentence that fits their therapeutic needs.

The MHC in Kenora is faced with multiple challenges as the geographical area it serves is extremely large. The Kenora Rainy River District is comprised of many outlier courts, and having charges transferred to the Kenora MHC has been difficult. Training courtroom players in mental health and related forms has posed a difficulty as the outlier courts have not been exposed to the same training as the MHC in Kenora. There are also the challenges of delays in assessments and access to forensic psychiatric beds within the province, as well as the lack of psychiatric support for individuals when they return to their home communities. Another challenge is the ability to access treatment for these individuals within their community.

The intended impact of MHC is to have a dedicated court with specially trained crowns, justices, and staff working together to find timely and just resolutions for mentally disordered individuals who have committed crimes. This dedicated court focuses on a collaborative approach to prosecution as well as ensuring public safety. This court's intention is to have victims and family members see that the court recognizes and appropriately deals with the accused's unique issues. The court is committed to working with the accused and their families, the community, and mental health agencies as this will allow more cases to be diverted to the appropriate agencies.

As Justice Richard Schneider indicated in 2009 at The Canadian Institute's 9th Annual Conference, MHCs have specific objectives: (a) diversion (i.e., when an accused has been charged with a minor offence, there is an alternative that is offered to the accused); (b) expediting the pre-trial processes of being able to access assessments for

fitness to stand trial of the accused; (c) treatment of an individual's mental disorder; and

(d) slowing down of the revolving door situation that mentally disordered individuals

face within the criminal justice system.

Participation of individuals in MHC is voluntary. The accused agrees to follow a

treatment plan that is monitored by the court (McNiel & Binder, 2007). If the accused

follows through with the treatment plan, the expectation is that sentencing will be

reduced or will allow the individual to continue with therapeutic and rehabilitative

treatment.

The ultimate belief of the MHC is that the mental health services within the

Kenora Rainy River District will give the client access to mental health services and

allow the court to supervise this progress. The aim is to provide appropriate clinical

services to individuals who qualify for the MHC by also protecting the public (McNiel &

Binder, 2007). The MHC emphasizes the importance of acknowledging individuals'

successes in their participation in their treatment plans rather than looking at the

individuals' failures (McNiel & Binder, 2007).

Chapter 3: Methodology

In this study, the researcher examined the demographic characteristics of the clients involved in the MHD&CS program in CMHAK in 2005 versus 2010. The researcher then examined if there were different outcomes for individuals who were referred to the MHC that commenced in the year 2010 than for the clients in 2005 who received only MHD&CS services. By examining the different outcomes within the program in 2005 versus 2010, the researcher was able to answer the research question, "Does participation in the Mental Health Court reduce recidivism?"

Goals and Objectives of the Study

The researcher had two goals in examining recidivism rates: one was to establish if Kenora's MHD&CS program is effective in linking mentally disordered individuals to appropriate community supports; the second goal was to determine if diverting individuals into the criminal justice system reduced their involvement in the court system. Examining recidivism rates of this population allowed for the identification of effective risk management supports and community treatment supports for individuals identified within the MHD&CS program. This could allow for mentally disordered individuals to gain access to community services as well as live in communities by reducing the risk to themselves, to others, and to the community.

The definition of risk is general and is usually defined within the adverse consequences to individuals (Centre for Community Based Research [CCBR], 2009). Risk can be operationalized further through assessment; however, there is a long-standing debate on what are best practices in assessing risk. Are structural (actuarial) or unstructured (clinical) risk assessments better predictors of risk (CCBR, 2009)?

Forensic mental health clients are a unique population as these individuals are entering into both the criminal justice and mental health systems. Thus, individuals working in the Forensic Mental Health System must always ensure that the rights and needs of the accused person are balanced with the needs of the public (CAMH, 2012a). This balance of rights and needs of accused persons is achieved by examining the risk level of individuals, specifically attempting to predict whether the individual will reoffend. An accurate predictor of recidivism is a comprehensive understanding of the individual's biographic characteristics, historical factors (actuarial), as well as clinical factors that contribute to the criminal recidivism. Historical factors are characteristics of individuals that cannot be changed, such as age of first criminal offence and criminal history. Clinical factors are factors that are changeable and amenable to interventions, such as substance abuse and unemployment.

Some of the historical factors (actuarial) for understanding why there is a high proportion of individuals within the criminal justice system are related to the deinstitutionalization of individuals with mental disorders (Davis, 2006). As individuals with mental disorders were being transferred from large institutions into communities, support services and community treatment were insufficiently funded (Davis, 2006). Thus, mentally disordered individuals' lack of ability to access mental health services, basic needs, and treatment that was focused on individual needs led to these individuals committing crimes that resulted in them ending up in the criminal justice system in what is known as the post-deinstitutionalization era (Davis, 2006). Mentally ill offenders who become involved with the justice system are often individuals who have been suffering from a major mental illness that has gone unrecognized.

The researcher in the current project provides a descriptive analysis of the

biographic characteristics and historical factors (actuarial) of the individuals within the

MDH&CS program at the CMHAK for the two years of 2005 and 2010. The descriptive

analysis focused on the following variables for the individual:

- age
- gender
- service recipient area
- identification if Aboriginal
- preferred language
- baseline legal status upon intake
- current legal status
- presenting issues upon intake
- diagnosis
- home community
- if a concurrent disorder
- if a dual diagnosis
- if other chronic illnesses
- source of referral
- mental health history

- current legal status
- criminal history
- baseline living arrangement
- current living arrangement
- baseline residence type
- baseline level of residential support
- current residence type
- current level of support
- baseline employment status
- current employment status
- baseline education status
- current educational status
- primary income source
- baseline psychiatric hospitalizations
- current psychiatric hospitalizations

These variables, described as demographic and historical factors (actuarial), have greater

predictive validity, and are most often used in predicting behaviour for individuals over a

longer term, independent of any other variables (CCBR, 2009).

Clinical approaches address dynamic risk factors that are changeable and thus are

often the targets of intervention. Risk can vary among an individual's different personal

characteristics and environmental conditions such as their age, living conditions, socio-

economic status, family history, life events, and use of medications (Skeem & Mulvey,

2002). Also, the nature and extent of risk can increase or decrease depending on the

period of time in the individual's life. For example, someone who has been diagnosed

with schizophrenia may be at more risk in the prodromal stage than in the acute or

residual stage of their illness (Kapur, 2000; Snowden, 1997). Current research and theory

recommend that both clinical and actuarial approaches to risk should be integrated as this

will increase the likelihood of identifying short-term dynamic risk factors indicating areas

of need and support for the individual (CCBR, 2009).

Dynamic risk factors are statistically related to recidivism, and these variables

fluctuate over time (Barbaree & Goering, n.d.); therefore, risk needs to be assessed on a

continuous basis. Dynamic risk factors are important as they are targets for treatment, but

identifying these factors can also assist in developing more effective treatment programs

(Andrews & Bonta, 1998, as cited in Barbaree & Goering, n.d.; Quinsey, Coleman,

Jones, & Altrows, 1997, as cited in Barbaree & Goering, n.d.). As an individual's level of

risk fluctuates, these variables provide a measure to indicate when an offender is more

likely to reoffend violently (Barbaree & Goering, n.d.). The research indicates that as

dynamic risk increases, treatment providers can intervene to prevent future reoffending

by the offender (Barbaree & Goering, n.d.).

The target behaviour the researcher addressed in this outcome evaluation was if

there was a difference in terms of recidivism for individuals who have gone through the

Kenora MHC who are involved with the MHD&CS program at CMHAK as compared to

individuals who were only involved in CMHAK's MHD&CS program. Some of these

individuals were found NCR or unfit to stand trial for a criminal offence, or were

conditionally discharged by the Ontario Review Board to communities in Northwestern

Ontario. This also included individuals who had been diverted into community programs

within Northwestern Ontario and individuals who had been sentenced to further

incarceration, placed on probation, received a conditional sentence, as well as had their

charges withdrawn from the criminal justice system who had been conditionally

discharged by the Ontario Review Board to communities in Northwestern Ontario.

In order to evaluate recidivism of clients, the researcher compared individuals

who have been through the MHD&CS program at the CMHAK in 2005 with individuals

who were part of the same program but who had also been through the MHC in Kenora

in 2010. In order to assess for recidivism, the researcher examined two variables: (a) new

charge under the Criminal Code (Government of Canada, 1985), and (b) readmission to a

designated forensic hospital in Ontario for revocation of Ontario Review Board

Disposition. The data for these two variables were examined by reviewing the

information entered in the Common Data Set from the beginning of each fiscal year in

both 2005 (April 1, 2005 – March 31, 2006) and 2010 (April 1, 2010 – March 31, 2011).

By examining the recidivism rates of individuals involved within the MHD&CS

program at CMHAK and those involved within the Kenora MHC, the researcher was able

to determine if being involved within the MHC reduced the incidents of mentally

disordered clients within both the criminal justice system and forensic mental health

system.

To complete the outcome evaluation, the researcher used the Common Data Set

(MoHLTC, 2007) that is intended for use by mental health agencies within the province

of Ontario. The use of the data was supported by the Local Health Integration Network

(see Appendix A). This data set includes both administrative and clinical data used to

capture the demographics of individuals using the mental health service, as well as

outcome measures for clients. Some examples of the outcome measures that the Common

Data Set contains are number of inpatient hospitalizations and length of stay during an

individual's program participation, as well as the number of admissions to jail during program participation.

As the Common Data Set information collected is limited to aggregate level data, the information collected does not include all of the elements required for service recipient classification, for funding (MoHLTC, 2007), or for research. The data collected within this data set is intended to address the accountability needs of the MoHLTC. Therefore, for research is to be conducted with the aggregate level data, the researcher needed to input additional variables into a separate statistical data package in order to capture other outcome measures.

The Common Data Set was developed after the publication of the *Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports* (MoHLTC, 1999) documents that indicated that the performance of programs should be measured against stated goals to ensure that the services and supports offered to individuals are achieving desired results (MoHLTC, 2007). The Common Data Set was also developed to ensure that organizations and programs are held accountable for both their funding and outcomes of their clients (MoHLTC, 2007). An internal working group was established within the MoHLTC in 2002 (MoHLTC, 2007) with the focus to develop a common data set within mental health. The Common Data Set is a program that includes both mandatory and optional elements. The professional employee is responsible for ensuring that the demographic, clinical, miscellaneous, and outcomes data are entered into the program.

Research Design

The researcher chose a quantitative research design for this study. This type of research design refers to observations that are fixed (York, 2009). Quantitative research is associated with outcome evaluations in which the researcher is testing whether a theory is in fact correct (York, 2009). As the researcher in the current study was testing if participation in MHCs reduces recidivism, quantitative research was an appropriate design for this study.

The research design that the researcher in the current study chose for the outcome evaluation was the Comparison Group Design (York, 2009), which for the current study would be:

O1   O2 (2005)

O1   X   O2 (2010)

The premise in the Comparison Group Design is to compare a treated group with a group that did not receive the treatment (York, 2009). When researchers use this design, they have a means of "measuring client progress and the basis for inferring causality to a limited degree" (York, 2009, p. 330). The O1 refers to the first group of individuals admitted to the MHD&CS program in 2005. This group did not receive the intervention, which is the MHC. The O2 for the first group refers to the individual's progress in 2005. This progress is measured by looking at how many times the individual was charged with a new offence under the Criminal Code (Government of Canada, 1985).

The O1 in the second group refers to the individuals admitted to the MHD&CS program in 2010. The X refers to the intervention, which is the individual's involvement

in the Kenora MHC. The O2 is the measurement of the client's progress in 2010, which is measured by looking at how many times the individual was charged with a new offence under the Criminal Code (Government of Canada, 1985).

The researcher conducted a descriptive analysis of the biographic characteristics and historical factors (actuarial) of variables and identified the level of measurement for each of these variables for the individual:

- age: interval level
- gender: nominal level
- service recipient area: nominal level
- identification aboriginal: nominal level
- preferred language: nominal level
- baseline legal status of individual upon intake: nominal variable
- current legal status: nominal variable
- presenting issues upon intake: nominal variable
- diagnosis: nominal level
- home community: nominal level
- if a concurrent disorder: nominal level
- if a dual diagnosis: nominal level
- if other chronic illnesses: nominal level
- source of referral: nominal level
- mental health history: nominal level
- current legal status: nominal level
- criminal history: nominal level
- baseline living arrangement: nominal level
- current living arrangement: nominal level
- baseline residence type: nominal level
- baseline level of residential support: nominal level
- current residence type: nominal level
- current level of support: nominal level
- baseline employment status: nominal level
- current employment status: nominal level
- baseline education status: nominal level
- current educational status: interval level
- primary income source: nominal level
- baseline psychiatric hospitalizations: ratio level
- current psychiatric hospitalizations: ratio level

The variables in the descriptive analysis that are measured at the nominal level are variables placed into categories with no particular order (York, 2009). For these variables, the descriptive statistics that the researcher used were basic measures: frequencies and mode.

The variables in the descriptive analysis that are at the interval level have a scale or score that has the same distance between each set of values (York, 2009). The variables in the descriptive analysis that are at the ratio level are the same as the interval level variables but have a fixed zero point (York, 2009). For all of these variables, the descriptive statistics that the researcher used are also the measures of central tendency: mean, median, mode; the measures of variability, including range, variance, and standard deviation; and summary tables, graphs, frequencies, and percentages.

The recidivism rates were examined by the researcher looking at the baseline legal status of participants upon intake to the MHD&CS program at CMHAK in 2005 and 2010 and comparing this to the individual's current legal status. The baseline legal status variable was measured at the nominal variable and is the independent variable that is believed to cause the dependent variable to be the way that it is (York, 2009). The dependent variable was the current legal status, which was measured at the nominal level. The scale for this variable was developed by examining two variables for both the 2005 and 2010 sample groups: (a) new charge under the Criminal Code (Government of Canada, 1985), and (b) readmission to a designated forensic hospital in Ontario for revocation of Ontario Review Board Disposition. This information is kept within a Common Data Set program (MoHLTC, 2007) at the CMHAK and was added into the Statistical Methods in Social Work Practice Program of the SPSS Statistical GradPack.[©]

By examining the sample's descriptive statistics, the researcher was able to compare the individuals within the program in 2005 and 2010 to examine if there is a relationship between the intervention of MHC and recidivism.

Data Collection Methods

Study sample. The study populations for this research project were individuals involved within MHD&CS programs at the CMHAK during 2005 and 2010. These individuals were referred by someone within the judiciary, a community member, client, or a family member within the Kenora Rainy River District. Each of the individuals was involved with the criminal courts in the Kenora Rainy River District and was identified with a mental disorder, developmental disability, or brain injury. The intake process to the MHD&CS program was conducted by a social worker who is employed at the CMHAK, has completed a Bachelor of Social Work degree from an accredited university, and who is registered under the College of Social Workers in Ontario.

The researcher examined 86 clients who were involved in the MHD&CS program at the CMHAK in 2005. All of these individuals were referred to the CMHAK program, and the researcher completed a formal intake and mental health status assessment of these clients. These clients were adjudicated by the courts, and the researcher examined the number of times the individuals had been involved with the criminal justice system since their adjudication, as well as the number of times the individual had been readmitted to a designated forensic hospital if they were under the Ontario Review Board system.

The researcher also examined 211 clients who were involved in the MHD&CS program at the CMHAK in 2010. A worker from the CMHAK program completed a formal intake, mental health status assessment, and recommended that these cases be

dealt with in the MHC. The researcher examined the number of times the individuals

have reoffended subsequent to appearance in MHC. Re-offence was defined as the

individual being charged with a new offence or placed back in the regular criminal justice

system due to noncompliance with the agreed treatment plan.

The size of the samples examined was 89 individuals in 2005 who were served

through the MHD&CS program at CMHAK and 211 individuals who were seen through

the MHC in Kenora in 2010. These individuals in both samples were diagnosed with

either a cognitive impairment, brain injury, or a major mental illness as defined in the

DSM-IV-R (APA, 2000) and received service through CMHAK's MHD&CS program.

These individuals were also involved with the criminal justice system.

Data. The researcher used secondary data that was available through the

CMHAK; mental health service agencies must report this data to the MoHLTC. All

participants within the study were informed at the point of assessment that the

information collected would be placed within the Common Data Set program (MoHLTC,

2007) at CMHAK, and their participation within the MHD&CS program at CMHAK

would be voluntary. At that time, each participant signed Consent to Service at CMHAK

that indicated that the individual was informed that their client information was included

in the database and would be used for secondary research analysis (see Appendix B). The

Common Data Set information is used by the Local Health Integration Network to

examine the demographics of clients served within the programs at CMHAK. The

variables identified within the research are all part of the Common Data Set.

The study sample for this outcome evaluation was a non-probability sample of 89

individuals in 2005 and 211 in 2010, since every person who received services during

these years was included. This was a purposive sample as 2005 is the last year that clients

in the MHD&CS program did not get referred to MHC, and 2010 is the most recent year

that clients were involved in MHC. All of the individuals in the sample were known to

have a major mental illness, cognitive impairment, or brain injury and had come into

conflict with the law. All of the 2010 individuals involved in the MHD&CS program

were examined in regard to the descriptive analysis as they were all involved in the

program.

The MHD&CS program provides services to the entire Kenora Rainy River

District, including courts in Red Lake, Sioux Lookout, Dryden, Ignace, First Nations

courts, and the Kenora court. However, only the Kenora court is currently the MHC.

Therefore, if clients' matters were not transferred to the MHC in Kenora, they were not

included with the comparison group design as the dispositions they received were not

provided within the principles of the current MHC. Not all participants in 2010 were

included in the analysis of the study therefore making the sample a non-probability

sample as the participants in 2010 were not drawn on a random basis. The 2005 sample

included everyone, as the Kenora MHC was only established in 2010.

Information about recidivism can be obtained from court records and from

forensic hospital admissions, and can be linked by selected staff members of the

CMHAK to the Common Data Set (MoHLTC, 2007) information. Once the researcher

obtained permission from the CMHAK Ethics Committee for this research, the researcher

became one of these selected staff members. The researcher met with the CMHAK Ethics

Committee members, who reviewed the CMHAK's Ethics Framework as well as its

Guiding Principles (see Appendix C).The researcher was then able to compare the

recidivism rates of people who received simple MHD&CS services in 2005 with those who went through MHC in 2010.

The data collected from these participants was used by the researcher only for professional purposes and was discussed only with other professionals concerned with the participants. As the participants in this study were considered vulnerable due to their mental disorders, cognitive disabilities, or brain injuries, the researcher obtained written permission from the CMHAK Ethics Committee as well as the University of Manitoba Research Ethics Committee to use the data collected to ensure that the benefits of the research outweighed the risks. The researcher met all ethics requirements as specified by the University of Manitoba while completing the study (see Appendix D).

Generalization. As the sample was not randomly selected, study results could not safely be generalized to the study population; however, it could be speculated that the results could be generalized to the study population in the Northwestern Ontario region.

Analysis

Mental health service agencies are required to report data semi-annually to the MoHLTC for entry into the Common Data Set (MoHLTC, 2007). The reporting periods for the two submissions are April 1 to September 30 (this is the first submission) and is called the semi-annual CDS report (MoHLTC, 2006). The final submission is done from April 1 to March 31 and is called the fiscal year CDS report (MoHLTC, 2006).

The Common Data Set (MoHLTC, 2007) program captures the demographics of individuals using mental health services. The program also captures outcome measures and was therefore able to identify the outcomes for clients within the MHD&CS program at CMHAK by providing the researcher the legal outcomes of each client. The Common

Data Set did not provide the researcher outcome measures that specifically examined associations between participation in MHC and recidivism of individuals in the criminal justice system. Therefore, the researcher added the descriptive data from the Common Data Set as well as the categories of recidivism to the Statistical Methods in Social Work Practice Program of the SPSS Statistical GradPack, so that non-parametric tests could be used. The researcher chose this program as it is the most widely used statistical program within both academic and professional organizations as it runs bivariate and multivariate statistics (Abu-Bader, 2006).

When the data was collected and ready to be analyzed, the researcher used non-parametric tests to determine associations between demographic variables and recidivism. The researcher chose to use non-parametric tests because the dependent variable and independent variables were measured at the nominal level. The dependent variable is recidivism as measured by re-offence, which can be measured with a nominal variable from 1 to 8 times. Therefore, the chi-square test was used to demonstrate if there was a significant statistical difference between the recidivism rates of the two sample groups from 2005 and 2010 due to the involvement of participants in the 2010 Kenora MHC.

Reliability and Validity of the Measurement Tool

The MoHLTC (2007) indicated that the Common Data Set for Mental Health is a reliable measurement tool within mental health system in Ontario used by many organizations: community and hospital sponsored community mental health programs (sponsorship is generally for specific program(s), not the whole agency); community-based functions sponsored by specialty psychiatric and divested provincial psychiatric hospital sites; and Assertive Community Treatment teams.

Limitations of the Research Design

This study was limited because the study sample was not selected on a random basis; therefore, the researcher could not generalize the findings of this study to the larger study population. Due to this lack of random assignment, there is a question around comparability of the two groups. This question is raised as individuals within the 2010 MHC group were asked if they wanted to participate within the MHC, whereas the 2005 group did not have the option of entering into the MHC as it did not exist. Therefore, when examining the current legal status of both groups, the researcher needed to consider that the MHC did not exist in 2005. When examining the current legal status, the researcher needed to consider the motivation of each group's members to enter into treatment, as being part of the MHC treatment is mandatory. Therefore, when examining if the intervention (MHC) caused the reduction in recidivism rates, the researcher needed to consider these differences.

Chapter 4: Results

This chapter discusses in detail the descriptive statistics and the recidivism results for both 2005 and 2010. Demographic characteristics are discussed first for each year; then a comparison of the 2005 and 2010 variables utilizing chi-square analysis of each variable are discussed. This is followed by analysis of the recidivism and readmission to hospital data by first discussing the descriptive statistics, and then a chi-square analysis of these variables.

Chi-square tests were conducted on all of the descriptive variables to compare participants in 2005 to participants in 2010 on each variable. Examining the chi-square of both sets of participants to one another in regard to each descriptive variable enabled the determination of the significant statistical associations, thus, which descriptive variables to use in determining predictability of involvement in the MHD&CS program at the CMHAK.

Part I: Descriptive Statistics

Demographic statistics for 2005. In 2005, a total of 67 participants received services in the MHD&CS program at the CMHAK. These 67 participants were all included in the descriptive analysis of the study as well as with the recidivism results.

Gender. Of the 67 participants in 2005, 53 (79%) identified themselves as male, and 14 (21%) identified themselves as female (see Table 1).

Table 1

Participant Gender in 2005

	2005	
Gender	Frequency	Percent
Male	53	79.1
Female	14	20.9
Total	67	100.0

Age. Of the 67 participants in 2005, 10 (15%) were between 1–20 years of age, 46

(69%) were between 21–40 years of age, 9 (13%) were between 41–60 years of age, and

2 (3%) were between 61–80 years of age (see Table 2).

Table 2

Participant Age in 2005

	2005	
Age	Frequency	Percent
1–30	38	56.7
31–60	27	40.3
61–80	2	3.0
Total	67	100.0

Marital status. Of the 67 participants in 2005, 52 (79%) were

single/divorced/widowed/separated/other, and 14 (21%) identified themselves as being

married or in a common-law relationship. One individual identified as being in another

type of relationship that was not listed, so this individual was omitted from the frequency

table (see Table 3).

Table 3

Participant Marital Status in 2005

	2005	
Marital status	Frequency	Percent
Single/divorced/widowed/separated/other	52	78.8
Married/common-law	14	21.2
Total	66	100.0

Participant community. There were 75 service recipient communities; therefore,

variables were recoded to three categories: First Nation community, Kenora Rainy River

District, and other communities. Table 4 illustrates the service recipient communities for

participants in 2005. As one individual did not identify the community, the outcome data

includes only 66 participants in 2005. Of the participants, 38 (58%) reported living in

Kenora Rainy River District, 24 (36%) reported living in a First Nation Community, and

4 (6%) were from other communities.

Table 4

Participant Communities in 2005

	2005	
Community name	Frequency	Percent
First Nation Community	24	36.4
Kenora Rainy River District	38	57.6
Other communities	4	6.1
Total	66	100.0

Ancestry. Of the 67 participants in the 2005, 44 (66%) identified themselves as

Aboriginal, and 21 (31%) identified themselves as non-Aboriginal (see Table 5). There

were two individuals within this sample group who did not identify their ancestry upon

intake.

Table 5

Participant Ancestry in 2005

	2005	
Ancestry	Frequency	Percent
Aboriginal	44	65.7
Non-Aboriginal	21	31.3
Unknown	2	3.0
Total	67	100.0

Language. Of the 67 participants in 2005, 48 (72%) identified themselves as

speaking only English, and 11, (16%) identified themselves as speaking other languages

identified as an Aboriginal dialect, either Ojibway or Oji-Cree. There were 7 (10%) who

identified themselves as speaking English and another language that was also identified

as an Aboriginal dialect, either Ojibway or Oji-Cree (see Table 6).

Table 6

Participant Preferred Language in 2005

	2005	
Language	Frequency	Percent
English	48	71.6
French		
English and French	1	1.5
English and other language	7	10.4
English, French, and other language	–	–
Other language	11	16.4
Total	67	100.0

Referral source. Of the 67 participants in 2005, the main referral source was the criminal justice system with 19 (28%). Defence council referred 17 (25%) of the participants, and 14 (21%) were self-referred or were referred by a family member or friend (see Table 7).

Table 7

Participant Referral Source in 2005

	2005	
Referral source	Frequency	Percent
CMHA/addiction organization	1	1.5
Criminal justice system	19	28.4
Family physicians	1	1.5
General hospital	_	_
Mental health worker	1	1.5
Other	2	3.0
Other community agencies	3	4.5
Psychiatrists	1	1.5
Self/family/friend	14	20.9
Defense council	17	25.4
Probation	4	6.0
Jail	2	3.0
Crown attorney	2	3.0
Total	67	100.0

Residence type. Table 8 shows that of the 67 participants in the year 2005, 46 (69%) were residing in their own home or apartment, and 8 (12%) were residing within a supportive-living environment that was staffed, or a congregate living environment that had staff for some period of time during the day. Three (5%) participants were missing

this information as the participants were non-communicative or did not want to respond.

Two (3%) participants were unsure of their type of residence.

Table 8

Participant Current Residence Type in 2005

	2005	
Residence type	Frequency	Percent
Corrections/probation facility	1	1.5
Homeless	2	3.0
Hostel/shelter	_	_
Long term care/nursing home	_	_
Municipal non-profit housing	1	1.5
No fixed address	3	4.5
Other	_	_
Other/specialty care hospital	_	_
Private house/apt—owned/rent	46	69.7
Psychiatric hospital	_	_
Supportive housing—assisted living	_	_
Supportive housing—congregate living	8	12.1
Unknown	2	3.0
Missing	3	4.5
Total	66	98.5
System missing	1	1.5
Total	67	100.0

Living arrangements. Of the 67 participants in 2005, 15 (22%) were residing

with their parents prior to their involvement with the criminal justice system, 14 (21%)

were residing on their own, 13 (19%) were residing with relatives, and 10 (15%) were

residing with nonrelatives (see Table 9).

Table 9

Participant Living Situation in 2005

Living arrangement	2005	
	Frequency	Percent
Children	4	6.0
Non-relatives	10	14.9
Parents	15	22.4
Relatives	13	19.4
Self	14	20.9
Spouse/partner	5	7.5
Spouse/partner and others	6	9.0
Total	67	100.0

Residence support. As shown in Table 10, 53 of the 67 (79%) participants in

2005 had no support within their environment, 11(16%) resided in an assisted/supported

living environment, and 3 (5%) were in a supervised facility.

Table 10

Participant Residence Support in 2005

Residence support	2005	
	Frequency	Percent
Assisted/supported	11	16.4
Independent	53	79.1
Supervised facility	3	4.5
Total	67	100.0

Employment status. Some of the original employment variables with cell counts

of less than five were recoded in order to do the chi-square analyses. No employment

activity, no employment, other, and retired were recoded into unemployed; and

casual/sporadic and independent/competitive were recoded into employed. The original

frequencies of employment status are included in Table 11. Of the 67 participants in

2005, 45 (67%) had no employment, 13 (19%) worked at an independent/competitive

job, a full-time position; and 7 (10%) had a casual/sporadic job, a part-time position.

Table 11

Participant Employment Status in 2005

	2005	
Employment status	Frequency	Percent
Casual/sporadic	7	10.4
Independent/competitive	13	19.4
No employment—other activity	2	3.0
No employment of any kind	45	67.2
Unknown	–	–
Retired	–	–
Total	67	100.0

Education level. Some of the original education level variables with cell counts of

less than five were recoded in order to do the chi-square analyses. The categories that

were recoded were the following: no school at all, junior-kindergarten–Grade 3, Grades

4–6, and Grades 7–9 into less than Grade 9. Some college, university, trade school,

college, and adult education were recoded into Grade 10 or above. The original

frequencies of education status are included in Table 12. The variables of unknown,

other, and missing were excluded.

Of the 67 participants in 2005, 29 (43%) had a Grade 10–12 education, and 24

(36%) had a Grade 7–9 education. Four participants (6%) stated that their education

status was unknown as they did not know their educational achievement. Two

participants (3%) lacked educational information in the Common Data Set program, and

1 (2%) had another form of education.

Table 12

Participant Education Level in 2005

	2005	
Education level	Frequency	Percent
JK–Grade 3	1	1.5
Grade 4–6	2	3.0
Grade 7–9	24	35.8
Grade 10–12	29	43.3
Some college	1	1.5
College	–	–
University	2	3.0
Adult education	–	–
Trade school	1	1.5
Unknown	4	6.0
Other	1	1.5
Missing	2	3.0
Total	67	100.0

Income source. Some of the original income source variables with cell counts of

less than five were recoded in order to do the chi-square analyses. Ontario Disability

Support Program and pension, and employment insurance and Ontario Works Support

Program were recoded into government income. Employed was left as originally

reported. The variables of unknown, other, and missing were excluded for the chi-square

analysis.

Of the 67 participants in 2005, 17 (25%) were receiving funds from the Ontario

Disability Support Program, 17 (25%) were receiving from the Ontario Works Support

Program, 10 (15%) were employed, and 10 (15%) had no income. Three participants

(5%) could not indicate what income support they were receiving, if any (see Table 13).

Table 13

Participant Income Source in 2005

	2005	
Income source	Frequency	Percent
Employment	10	14.9
Employment Insurance	3	4.5
No Source of Income	10	14.9
Ontario Disability Support Program	17	25.4
Other	4	6.0
Pension	3	4.5
Ontario Works	17	25.4
Unknown	3	4.5
Total	67	100.0

Participants' psychiatric and diagnostic characteristics in 2005. In the next

sections, the original variables that were recorded on intake into the MHD&CS program

at CMHA are reported. These are followed by concurrent disorders and dual diagnosis.

Presenting issues. Table 14 shows that of the 67 participants in 2005, the most

frequent issues participants presented upon intake were legal issues, $N = 67$ (100%); and

substance abuse, $N = 46$ (69%). These were followed by psychiatric issues, $N = 26$,

38.8%, and suicide attempts, $N = 22$, 32.8%.

Table 14

Participant Presenting Issues Upon Intake in 2005

| Presenting issue | 2005 (*N* = 67) | | | |
| | Yes | | No | |
	Frequency	%	Frequency	%
Legal	67	100	0	0
Substance abuse	46	68.7	21	31.3
Anxiety disorder	6	9.0	61	91.0
Suicidal/homicidal	14	20.9	53	79.1
Crisis	5	7.5	62	92.5
Depression	7	10.4	60	89.6
Relationship difficulties	25	37.3	42	62.7
Aging difficulties	0	0	67	100
Eating disorders	0	0	67	100
Grief/ loss	1	1.5	66	98.5
Stress	6	9.0	61	91.0
Psychiatric symptoms	26	38.8	41	61.2
Abuse/violence perpetrator	13	19.4	54	80.6
Abuse/violence survivor	7	10.4	60	89.6
Sexual problems	3	4.5	64	95.5
Basic needs	20	29.9	47	70.1
Physical/medical	2	3.0	65	97.0
Suicide attempt	22	32.8	45	67.2

Primary diagnoses. Of the 67 participants in 2005, 14 (21%) had a substance-related disorder, 13 (19%) had a diagnosis of schizophrenia or other psychotic disorder, 9 (13%) had a mood disorder, and 6 (9%) had a personality disorder. Two individuals had an unknown diagnosis due to insufficient collateral to establish a diagnosis, or the participant did not undergo a psychiatric or psychological assessment for diagnostic clarification.

Some of the original primary diagnoses variables with cell counts of less than five were recoded in order to do the chi-square analyses: adjustment disorder and anxiety disorders were recoded into mood disorders. Schizophrenia, developmental handicap, and substance-related disorders remained as originally reported. Excluded variables for the chi-square analyses were delirium/dementia/amnestic/cognitive disorders, personality disorder, sexual and gender identity disorders, mental disorder due to general medical conditions, disorder of childhood/adolescence, eating disorder, unknown, and other. Table 15 reports the original category distributions of primary diagnoses.

Table 15

Participant Primary Diagnoses in 2005

Primary diagnosis	2005	
	Frequency	Percent
Adjustment disorders	2	3.0
Anxiety disorders	3	4.5
Delirium/dementia/ amnestic/cognitive disorders	2	3.0
Developmental handicap	5	7.5
Disorder of childhood/adolescence	2	3.0
Eating disorder	–	–
Mood disorder	9	13.4
Other	5	7.5
Personality disorder	6	9.0
Schizophrenia	13	19.4
Sexual and gender identity disorders	3	4.5
Substance related disorders	14	20.9
Unknown	2	3.0
Mental disorder due to general medical conditions	1	1.5
Total	67	100.0

Other illness information. Table 16 shows the variable distributions for 2005. For the chi-square analysis comparing these two years, the category 'other chronic

illnesses/disabilities' was excluded. Of the 51 participants in 2005, 33 (50%) had only

one diagnosis. There were 25 (37%) with a concurrent disorder (major mental illness with

a substance-abuse issue), 6 (9%) had a dual diagnosis (major mental illness with a

developmental disability), and 3 (5%) had a mental disorder along with a medical issue.

Table 16

Participant Other Illness Information in 2005

	2005	
Other illness information	Frequency	Percent
Concurrent disorder	25	37.3
Dual diagnosis	6	9.0
Other chronic illnesses/disabilities	3	4.5
None	33	49.3
Concurrent disorder and dual diagnosis	_	_
Total	67	100.0

Concurrent disorder. To be able to examine how many individuals had

concurrent disorders versus other disorders, all categories that were not concurrent

disorders were collapsed into the following category: dual diagnosis/other chronic

illnesses/ disabilities. Table 17 indicates that in 2005, there were 25 (37%) individuals

with concurrent disorders.

Table 17

Concurrent Disorder in 2005

Disorder category	Frequency	Percent
Concurrent disorder	25	37.3
Dual diagnosis / other / chronic illnesses / disabilities	42	62.7
Total	67	100.0

Previous psychiatric hospitalization. Table 18 shows the frequency distributions

of previous psychiatric hospitalizations for participants from 2005. Since the percentages

for both years appear to be quite similar, a chi-square analysis was not conducted. Of the

50 participants in 2005, 35 (52%) had previous hospitalizations for psychiatric reasons,

and 31 (46%) did not have any previous hospitalizations for psychiatric reasons. One

participant could not indicate if he or she had been hospitalized for psychiatric reasons.

Table 18

Participant Previous Psychiatric Hospitalization in 2005

	2005	
Previous hospitalization	Frequency	Percent
Yes	35	52
No	31	46
Unknown	1	2
Total	67	100.0

Participants' legal status in 2005

Legal charges upon intake. Of the 67 participants in 2005, 33 (49%) were

incarcerated, 10 (15%) were on an interim bail release order awaiting trial, and 11 (16%)

were on probation. The individuals who were on probation upon intake were referred to

the MHD&CS program as probation services was requesting a forensic assessment that is

coordinated by the MHD&CS program.

Some of the original categories of legal charges upon intake with cell counts of

less than five were recoded in order to do the chi-square analyses. The category

'incarcerated' remains as originally reported. Categories that were recoded into 'in

community' were the following: awaiting NCR assessment, awaiting sentencing, court

diversion, on bail awaiting trial, probation, awaiting fitness assessment, Ontario Review

Board detained – community access, stay of proceedings, and pre-sentence custody.

Table 19

Participant Legal Charges Upon Intake in 2005

	2005	
Legal charge	Frequency	Percent
Awaiting fitness assessment	–	–
Awaiting NCR assessment	1	1.5
Awaiting sentencing	6	9.0
Court diversion program	6	9.0
Incarcerated	33	49.3
On bail—awaiting trail	10	14.9
On probation	11	16.4
Ontario Review Board detained—community access	–	–
Stay of proceedings	–	–
Pre-sentence custody	–	–
Total	67	100.0

Legal status outcome. Table 20 reports the original category distributions of legal

status outcome. Of the 67 participants in 2005, 8 (12%) received a term of incarceration,

19 (28%) received a term of probation, and 9 (13%) were found to be unfit to stand trial.

The status of two individuals was missing due to their relocation outside of the program's

jurisdictional mandate; therefore, these charges were transferred to the new jurisdiction

with the outcome unknown.

Categories with a count of less than five were omitted in order to complete a chi-

square analyses on the variable of legal status outcome: awaiting fitness assessment,

awaiting sentencing, and on bail awaiting trial were recoded into awaiting sentence.

Conditional discharge, conditional sentence order, incarcerated, no criminal problems,

probation, Ontario Review Board detained – community access, stay of proceedings,

unfit to stand trial, presentence custody, suspended sentence, time served, in community

on own recognizance, charges withdrawn, court diversion, NCR, and Ontario Review

Board conditional discharge were recoded into sentence decided.

Table 20

Participant Legal Status Outcome in 2005

	2005	
Legal status outcome	Frequency	Percent
Awaiting fitness assessment	2	3.0
Awaiting NCR assessment	–	–
Awaiting sentencing	6	9.0
Charges withdrawn	–	–
Conditional discharge	3	4.5
Court diversion program	–	–
Conditional sentence	2	3.0
Incarcerated	8	11.9
NCR	–	–
No criminal problems	3	4.5
On bail—awaiting trial	2	3.0
On probation	19	28.4
Ontario Review Board conditional discharge	–	–
Ontario Review Board detained—community access	1	1.5
Stay of processing	3	4.5

Table 20 (continued)

Legal status outcome	2005	
	Frequency	Percent
Unfit to stand trial	9	13.4
Pre-sentence custody	1	1.5
Suspended sentence	2	3.0
Time served	3	4.5
In community on own recognizance	1	1.5
Missing	2	3.0
Unknown	–	–
Suspended sentence	–	–
Other criminal legal problems	–	–
Total	67	100.0

Demographic statistics for 2010. In 2010, a total of 210 participants received services in the MHD&CS program at the CMHAK. These 210 participants are all included in the descriptive analysis of the study. Of these 210 participants, 50 individuals participated in the MHC in Kenora. These 50 participants are included in the recidivism results. Tables have been added to aid in the interpretation of the results.

Gender. In 2010, 151 out of 210 participants (72%) identified themselves as male, and 59 (28%) identified themselves as female (see Table 21).

Table 21

Participant Gender in 2010

	2010	
Gender	Frequency	Percent
Male	151	71.9
Female	59	28.1
Total	210	100.0

Age. Of the 210 participants in 2010, 47 (22%) were between 1–20 years of age,

120 (57%) were between 21–40 years of age, 37 (18%) were between 41–60 years of age,

and 6 (3%) were between 61–80 years of age (see Table 22).

Table 22

Participant Age in 2010

	2010	
Age	Frequency	Percent
1–30	125	59.5
31–60	79	37.6
61–80	6	2.9
Total	210	100.0

Marital status. Of the 210 participants in 2010, 163 (78%) were

single/divorced/widowed/separated/other, and 47 (22%) were married or in a common-

law relationship (see Table 23).

Table 23

Participant Marital Status in 2010

	2010	
Marital status	Frequency	Percent
Single/divorced/widowed/separated/other	163	77.6
Married/common-law	47	22.4
Total	210	100.0

Participant communities. In 2010, there were 120 (57%) individuals who

reported living in the Kenora Rainy River District, 73 (35%) who reported being from a

First Nation community, and 17 (8%) who were from other communities (see Table 24).

These results indicate that the highest percentage of individuals using the MHD&CS

program is from the Kenora Rainy River District.

Table 24

Participant Communities in 2010

	2010	
Community name	Frequency	Percent
First Nation Community	73	34.8
Kenora Rainy River District	120	57.1
Other communities	17	8.1
Total	210	100.0

Participant ancestry. Of the 210 participants in the 2010, 146 (70%) identified

themselves as Aboriginal, and 63 (30%) identified themselves as non-Aboriginal. There

was one individual within this sample group who did not declare ancestry upon intake

(see Table 25). These results indicate that individuals who identify themselves as

Aboriginal represent the highest number of participants in the MHD&CS program.

Table 25

Participant Ancestry in 2010

	2010	
Ancestry	Frequency	Percent
Aboriginal	146	69.5
Non-Aboriginal	63	30.0
Unknown	1	0.5
Total	210	100.0

Preferred language. Of the 210 participants in 2010, 130 (62%) identified

themselves as speaking only English. There were 72 (34%) who identified themselves as

speaking another language that was identified as an Aboriginal dialect, either Ojibway or

Oji-Cree (see Table 26).

Table 26

Participant Preferred Language in 2010

	2010	
Language	Frequency	Percent
English	130	61.9
French	1	0.5
English and French	5	2.4
English and other language	72	34.3
English, French, and other language	1	0.5
Other language	–	–
Sign language, Spanish	1	0.5
Total	210	100.0

Referral source. Of the 210 participants in 2010, the main referral source was the criminal justice system with 57 (27%). Defence council referred 43 (21%) of the participants, and 25 (12%) were referred by the crown attorney (see Table 27).

Table 27

Participant Referral Source in 2010

	2010	
Referral source	Frequency	Percent
CMHA/addiction organization	11	5.2
Criminal justice system	57	27.1
Family physicians	1	0.5
General hospital	4	1.9
Mental health worker	6	2.9
Other	5	2.4
Other community agencies	21	10.0
Psychiatrists	5	2.4
Self/family/friend	13	6.2
Defense council	43	20.5
Probation	14	6.7
Jail	5	2.4
Crown attorney	25	11.9
Total	210	100.0

Current residence type. Table 28 shows that of the 210 participants in 2010, 182 (87%) were residing in their own home or apartment, and 6 (3%) were residing within a supportive-living environment that was staffed, or a congregate living environment that had staff for some period of time during the day. There were also 5 (2%) who had no fixed address.

Table 28

Participant Current Residence Type in 2010

Residence type	2010	
	Frequency	Percent
Corrections/probation facility	–	–
Homeless	1	0.5
Hostel/shelter	1	0.5
Long term care/nursing home	1	0.5
Municipal non-profit housing	1	0.5
No fixed address	5	2.4
Other	4	1.9
Other/specialty care hospital	1	0.5
Private house/apt—owned/rent	182	86.7
Psychiatric hospital	1	0.5
Supportive housing—assisted living	7	3.3
Supportive housing—congregate living	6	2.9
Unknown	–	–
Missing	–	–
Total	210	100.0
System missing	–	–
Total	210	100.0

Living situation. Of the 210 participants 2010, 60 (29%) were residing with relatives prior to their involvement with the criminal justice system, 51 (24%) were residing on their own, 33 (16%) were residing with their parents, and 25 (12%) were residing with nonrelatives (see Table 29).

Table 29

Participant Living Situation in 2010

	2010	
Living arrangement	Frequency	Percent
Children	6	2.9
Non-relatives	25	11.9
Parents	33	15.7
Relatives	60	28.6
Self	51	24.3
Spouse/partner	16	7.6
Spouse/partner and others	19	9.0
Total	210	100.0

Residence support. Of the 210 participants in 2010, 190 (91%) had no support

within their environment, 15(7%) resided in an assisted/supported living environment,

and 5 (2%) were in a supervised facility (see Table 30).

Table 30

Participant Residence Support in 2010

	2010	
Residence support	Frequency	Percent
Assisted/supported	15	7.1
Independent	190	90.5
Supervised facility	5	2.4
Total	210	100.0

Employment status. As shown in Table 31, of the 210 participants in 2010, 128

(61%) had no employment, 57 (27%) worked at an independent/competitive job

(meaning a full-time position), and 15 (7%) had a casual/sporadic job (meaning a part-

time position). One individual did not know how to respond to the question so the answer

was left as unknown.

Table 31

Participant Employment Status in 2010

	2010	
Employment status	Frequency	Percent
Casual/sporadic	15	7.1
Independent/competitive	57	27.1
No employment—other activity	6	2.9
No employment of any kind	128	61.0
Unknown	1	0.5
Retired	3	1.4
Total	210	100.0

Education level. Of the 210 participants in 2010, 83 (40%) had a Grade 10–12

education, 73 (34%) had a Grade 7–9 education, and 16 (8%) had a college education.

Nine participants (4%) had another form of education that was not included in the choices

listed, and 3 (2%) participants did not know this information (see Table 32).

Table 32

Participant Education Level in 2010

	2010	
Education level	Frequency	Percent
JK–Grade 3	1	0.5
Grade 4–6	7	3.3
Grade 7–9	73	34.8
Grade 10–12	83	39.5
Some college	6	2.9
College	16	7.6
University	5	2.4
Adult education	2	1.0
Trade school	1	0.5
Unknown	3	1.4
Other	9	4.3
Missing	4	1.9
Total	210	100.0

Income source. Of the 210 participants in 2010, 54 (26%) received funds from

the Ontario Works Support Program, 53 (25%) were employed, 38 (18%) had no source

of income, and 33 (16%) were receiving support from the Ontario Disability Support

Program. One participant could not indicate what income support they were receiving, if

any (see Table 33).

Table 33

Participant Income Source in 2010

Income source	2010	
	Frequency	Percent
Employment	53	
Employment Insurance	7	3.3
No Source of Income	38	18.1
Ontario Disability Support Program	33	15.7
Other	13	6.2
Pension	11	5.2
Ontario Works Support Program	54	25.7
Unknown	1	0.5
Total	210	100.0

Participants' psychiatric and diagnostic characteristics in 2010

Presenting issues. Of the 210 participants in 2010, as shown in Table 34, the most frequent issues participants identified upon intake included suicide attempt, $N = 92$ (43.8%); anxiety, $N = 90$ (42.9%); depression, $N = 84$ (40%); psychiatric symptoms, $N = 79$ (37.6%); legal issues, $N = 67$ (100%); suicidal/homicidal tendencies, $N = 54$ (25.7%); and substance issues, $N = 46$ (69%).

Table 34

Participant Presenting Issues Upon Intake in 2010

| | 2010 (*N* = 210) | | | |
| | Yes | | No | |
Presenting issue	Frequency	%	Frequency	%
Legal	206	98.1	4	1.9
Substance abuse	154	73.3	56	26.7
Anxiety disorder	90	42.9	120	57.1
Suicidal/homicidal	54	25.7	156	74.3
Crisis	14	6.7	196	93.3
Depression	84	40.0	126	60.0
Relationship difficulties	75	35.7	135	64.3
Aging difficulties	2	1.0	208	99.0
Eating disorders	0	0	210	100
Grief/ loss	20	9.5	190	90.5
Stress	22	10.5	188	89.5
Psychiatric symptoms	79	37.6	131	62.4
Abuse/violence perpetrator	50	23.8	160	76.2
Abuse/violence survivor	22	10.5	188	89.5
Sexual problems	20	9.5	190	90.5
Basic needs	40	19.0	170	81.0
Physical/medical	27	12.9	183	87.1
Suicide attempt	92	43.8	118	56.2

Primary diagnosis. Of the 210 participants in 2010, 60 (29%) had a substance-related disorder, 43 (21%) had a mood disorder, 40 (19%) had a diagnosis of schizophrenia or other psychotic disorder, and 28 (13%) had a developmental disability (see Table 35).

Table 35

Participant Primary Diagnoses in 2010

	2010	
Primary diagnosis	Frequency	Percent
Adjustment disorders	4	1.9
Anxiety disorders	13	6.2
Delirium/dementia/ amnestic/cognitive disorders	3	1.4
Developmental handicap	28	13.3
Disorder of childhood/adolescence	7	3.3
Eating disorder	1	0.5
Mood disorder	43	20.5
Other	_	_
Personality disorder	6	2.9
Schizophrenia	40	19.0
Sexual and gender identity disorders	5	2.4
Substance related disorders	60	28.6
Unknown	_	_
Mental disorder due to general medical conditions	_	_
Total	210	100.0

Other illness information. In 2010, of the 210 participants, 53 (25%) had a concurrent disorder; and 26 (12%) had a dual diagnosis, while 120 (57%) had no other identified illness, dual diagnosis, or concurrent disorder (see Table 36).

Table 36

Participant Other Illness Information in 2010

	2010	
Other illness information	Frequency	Percent
Concurrent disorder	53	25.2
Dual diagnosis	26	12.4
Other chronic illnesses/disabilities	4	1.9
None	120	57.1
Concurrent disorder and dual diagnosis	7	3.3
Total	210	100.0

Concurrent disorder. Table 37 indicates that in 2010 there were 14 (21%) participants who had a concurrent disorder and 53 (79%) who had a dual diagnosis or other chronic illness or disability.

Table 37

Concurrent Disorder in 2010

Disorder category	Frequency	Percent
Concurrent disorder	14	20.9
Dual diagnosis/other/chronic illnesses/disabilities	53	79.1
Total	67	100.0

Previous psychiatric hospitalizations. Of the 210 participants in 2010, 86 (41%) did have previous hospitalizations for psychiatric reasons, while 123 (59%) did not have any previous hospitalizations for psychiatric reasons. There was also one participant in 2010 who could not indicate if he or she had been hospitalized for psychiatric reasons (see Table 38).

Table 38

Participant Previous Psychiatric Hospitalization in 2010

	2010	
Previous hospitalization	Frequency	Percent
Yes	86	41.0
No	123	58.6
Unknown	1	0.5
Total	210	100.0

Participants' legal status in 2010

Legal charges upon intake. Of the 210 participants in 2010, 47 (22%) were

awaiting sentence, 112 (53%) were incarcerated, and 27 (13%) were on interim bail

awaiting trial (see Table 39). These results indicate that the majority of participants in the

MHD&CS program were incarcerated upon intake.

Table 39

Participant Legal Charges Upon Intake in 2010

	2010	
Legal charge	Frequency	Percent
Awaiting fitness assessment	2	1.0
Awaiting NCR assessment	2	1.0
Awaiting sentencing	47	22.4
Court diversion program	3	1.4
Incarcerated	112	53.3
On bail—awaiting trail	27	12.9
On probation	11	5.2
Ontario Review Board detained—community access	2	1.0
Stay of proceedings	3	1.4
Pre-sentence custody	1	0.5
Total	210	100.0

Legal status outcome. Of the 210 participants in 2010, 19 (9%) were on interim release order still awaiting their trial, 96 (45%) received a term of probation, and 20 (10%) received a stay of proceedings, which meant entering into a Mental Health Diversion Agreement for 1 year. One individual whose status was unknown due to relocating outside of the program's jurisdictional mandate had these charges transferred to the new jurisdiction with the outcome unknown. Results are shown in Table 40.

Table 40

Participant Legal Status Outcome in 2010

Legal status outcome	2010	
	Frequency	Percent
Awaiting fitness assessment	1	0.5
Awaiting NCR assessment	5	2.4
Awaiting sentencing	11	5.2
Charges withdrawn	5	2.4
Conditional discharge	2	1.0
Court diversion program	4	1.9
Conditional sentence	–	–
Incarcerated	16	7.6
NCR	8	3.8
No criminal problems	12	5.7
On bail—awaiting trial	19	9.0
On probation	96	45.7
Ontario Review Board conditional discharge	2	1.0
Ontario Review Board detained—community access	5	2.4
Stay of processing	20	9.5
Unfit to stand trial	1	0.5
Pre-sentence custody	–	–
Suspended sentence	–	–
Time served	–	–
In community on own recognizance	–	–
Missing	–	–
Unknown	1	0.5
Suspended sentence	1	0.5
Other criminal legal problems	1	0.5
Total	210	100.0

Part II: Chi-Square Analyses of 2005 and 2010 Descriptive Variables

Gender. When the association between participant gender and involvement in the MHD&CS program was examined, 79% of participants in 2005 and 72% in 2010 were male (see Table 41). There were 21% in 2005 and 28% in 2010 who were female (see Table 41). It cannot be concluded that there is significant relationship between gender of participants involved in the MHD&CS program: x^2 (1, $N = 277$) = 1.36; p =.244. Pearson chi-square test results for gender are shown in Table E1, Appendix E.

Table 41

Gender Chi-Square

Gender	Variable	2005	2010
Male	Count	53	151
	% within year	79.1%	71.9%
Female	Count	14	59
	% within year	20.9%	28.1%
Total	Count	67	210

Age. Prior to being able to run the chi-square test, the variable of age was recoded to make fewer categories. The variables were collapsed into the following categories: ages 1–30 ($N = 38$, $N = 125$), 31–60 ($N = 27$, $N = 79$), and 61–80 ($N = 2$, $N = 6$). In order to run the chi-square, the categories with a count of less than 5 were removed, which was the cohort 61–80. Table 42 indicates that participant age is not related to involvement in the MHD&CS program. The results do not show a significant association between the variable of age for both years: x^2 (1, $N=269$) = .16; $p = .363$. Pearson test results are shown in Appendix E, Table E1.

Table 42

Age Chi-Square

Age	Variable	2005	2010
1–30	Count	38	125
	% within year	58.5%	61.3%
31–61	Count	27	79
	% within year	41.5%	38.7%
Total	Count	65	204

Marital status. Table 43 indicates that participant marital status is not related to involvement in the MHD&CS program. Prior to being able to calculate the chi-square test, the variable of marital status was recoded to make fewer categories. The variables were collapsed into the following categories: single/divorced/widowed/separated/other and married/common-law. The results do not show a significant association between 2005 and 2010 for the variable of marital status: x^2 (1, N =256) = .04; p = .842. This indicates that 78% (N = 52, N = 163) of individuals who were single/divorced/widowed/separated/other are not more than likely to be involved with the MHD&CS program than 22% (N = 14, N = 47) of individuals who are married/common-law. Therefore, it cannot be concluded that marital status is a predictor variable for individuals being involved with the criminal justice system (see Table E1, Appendix E, for Pearson chi-square test results).

Table 43

Marital Status Chi-Square

Marital status	Variable	2005	2010
Single/divorced/widowed/separated/other	Count	52	163
	% within year	24.2%	75.8%
Married / common-law	Count	14	47
	% within year	23.0%	77.0%
Total	Count	66	210

Participant community. Table 44 indicates that the service recipient

communities are not related to participant involvement in the MHD&CS program. The

results do not show a significant association between 2005 and 2010 for the variable of

service recipient community: x^2 (1, N = 252) = .05; p =.828.

Table 44

Participant Communities Chi-Square

Community	Variable	2005	2010
First Nation Community	Count	22	75
	% within year	37.3%	38.9%
Kenora Rainy River District	Count	37	118
	% within year	62.7%	61.1%
Total count	66	209	275

Ancestry. Table 45 illustrates that 70% participants in both 2005 and 2010

identified themselves as Aboriginal (N = 82) compared to 30% of individuals who

identified themselves as non-Aboriginal (N = 271). The results do not show a significant

association between the two variables: x^2 (1, N = 271) = .05; p = .481. Therefore, the

results indicate that there is no relation between participant ancestry and involvement in

the MHD&CS program.

Table 45

Ancestry Chi-Square

Ancestry	Variable	2005	2010
Aboriginal	Count	41	148
	% within year	66.1%	70.8%
Non-Aboriginal	Count	21	61
	% within year	33.9%	29.2%
Total count	59	193	252

Language. Table 46 illustrates that there is no significant association between

2005 and 2010 for the variable of language: x^2 (1, N = 251) = 2.2; p = .141. The

variables were collapsed into two categories so that the chi-square test could be

completed. The categories were English and other language. Therefore, the results

indicate that there is no relation between participant language and involvement in the

MHD&CS program (see Table 46 and Appendix E, Table E1).

Table 46

Language Chi-Square

		Year		
Language	Variable	2005	2010	Total
English	Count	43	114	157
	% within year	70.5%	60.0%	62.5%
	Count	18	76	94
Other language	% within year	29.5%	40.0%	37.5%
	% of total	7.2%	30.3%	37.5%
Total	Count	61	190	251

Referral source. These variables were collapsed into two categories so that the

chi-square test could be completed (see Table 47 and Table E1 in Appendix E). The

categories were criminal justice system and other community agencies. The criminal

justice category included defence council, probation, jail, and crown attorney; the other

community agencies included family, friends, mental health worker, psychiatrists, other,

family physicians, community organization, and general hospital. Table 47 illustrates that

there is no significant association between 2005 and 2010 for the variable of referral

source: x^2 (1, $N = 270$) $= .19$; $p = .661$. Therefore, the results indicate that there is no

relation between referral source and participant involvement in the MHD&CS program.

Table 47

Referral Source Chi-Square

		Year		
Referral source	Variable	2005	2010	Total
Criminal justice system	Count	42	146	188
	% within year	65.6%	68.5%	67.9%
Other community	Count	22	67	89
agencies	% within year	34.4%	31.5%	32.1%
Total	Count	64	213	277

Residence type. Table 48 illustrates that there is no significant association

between 2005 and 2010 for the variable of current type of residence: x^2 (1, $N = 253$) $=$

2.5; $p = .112$. The variables were collapsed into two categories so that the chi-square test

could be completed. The categories were supportive housing and private

house/apartment/own/rent. Categories with a count of less than five were excluded. The

categories that were omitted were corrections/probation facility, hostel/shelter, general

hospital, no fixed address, other, and psychiatric hospital. These categories were omitted as they had a count of less than five in one of the two years. Therefore, the results indicate that there is no relation between the current type of participant residence and involvement in the MHD&CS program (see Table 48; see also Table E1 in Appendix E for Pearson chi-square test results).

Table 48

Current Residence Type Chi-Square

		Year		
Residence type	Variable	2005	2010	Total
Supportive housing	Count	8	15	23
	% within year	14.5%	7.6%	9.1%
Private house / apt. / owned /	Count	47	183	230
rent	% within year	85.5%	92.4%	90.9%
Total	Count	55	198	253

Living situation. Table 49 illustrates that there is no significant association between 2005 and 2010 for variable of living situation: x^2 (1, $N = 271$) = 2.0; p = .160. The data were collapsed into two categories: living with relatives and self or nonrelatives. The following cohorts were placed within the category 'living with relatives': 'children and parents,' 'relatives,' 'spouse/partner,' and 'others.' The results indicate that there is no relation between participant living situation and involvement in the MHD&CS program (see Table 49 and Appendix E, Table E1).

Table 49

Living Situation Chi-Square

		Year		
Living situation	Variable	2005	2010	Total
Living with relatives	Count	17	40	57
	% within year	27.4%	19.1%	21.0%
Self or non-relatives	Count	45	169	214
	% within year	72.6%	80.9%	79.0%
Total	Count	62	209	271

Residence support. Table 50 illustrates that there is a significant association between 2005 and 2010 for the variable of level of support within participant living arrangement: x^2 (1, $N = 275$) = 5.2; $p = .022$. Categories that had a count of less than five were omitted. When the association between participant residence support and involvement in the MHD&CS program was examined, it was found that 81% of participants in 2005 and 91% in 2010 were independent. There were 19% of participants who had an assisted or supported residence in 2005 and 9% in 2010. It can be concluded that there is significant relationship between participant residence support and involvement in the MHD&CS program. These results indicate that there is relation between participant level of support in the living arrangement and involvement in the MHD&CS program (see Table 50 and Table E1, Appendix E).

Table 50

Residence Support Chi-Square

Residence support	Variable	Year		Total
		2005	2010	
Independent	Count	50	194	244
	% within year	80.6%	91.1%	88.7%
Assisted/ supported	Count	12	19	31
	% within year	19.4%	8.9%	11.3%
	% of total	4.4%	6.9%	11.3%
Total	Count	62	213	275

Employment status. Table 51 illustrates that there is no significant association between 2005 and 2010 for the variable of level of employment status: x^2 (1, N = 268) = .21; p =.644. In order to meet the test of assumption, the categories with a count of less than five were omitted. These categories were 'unknown' and 'missing.' The results indicate that there is no relation between participant employment status and involvement in the MHD&CS program (see also Table E1 in Appendix E).

Table 51

Employment Status Chi-Square

Employment status	Variable	Year		Total
		2005	2010	
Unemployed	Count	42	139	181
	% within year	70.0%	66.8%	67.5%
Employed	Count	18	69	87
	% within year	30.0%	33.2%	32.5%
Total	Count	60	208	268

Education. Table 52 illustrates that there is no significant association between 2005 and 2010 for the variable of level of education: x^2 (1, N = 251) = 2.0; p =.159. These results indicate that there is no relation between participant level of education and involvement in the MHD&CS program; see also Table E1, Appendix E.

Table 52

Education Level Chi-Square

Education level	Variable	Year 2005	2010	Total
Less than grade 9	Count	50	168	218
	% within year	92.6%	85.3%	86.9%
Grade 10 or above	Count	4	29	33
	% within year	7.4%	14.7%	13.1%
Total	Count	54	197	251

Income source. Table 53 illustrates that there is no significant association between 2005 and 2010 for the variable of participant income source: x^2 (2, N = 247) = 2.6; p = .274. These results indicate that there is no relation between participant income source and involvement in the MHD&CS program (see Table E1, Appendix E).

Table 53

Income Source Chi-Square

Income source	Variable	Year 2005	2010	Total
Employment	Count	10	49	59
	% within year	18.5%	25.4%	23.9%
No source of income	Count	8	39	47
	% within year	14.8%	20.2%	19.0%
Government income	Count	36	105	141
	% within year	66.7%	54.4%	57.1%
Total	Count	54	193	247

A number of the variables appeared on visual inspection to be almost identical in terms of their category distributions. Thus, chi-square analyses were not conducted on these variables. However, most clients reported having difficulties in the areas of substance abuse, anxiety symptoms, depressive symptoms, psychiatric symptoms, and past suicide attempts. These are areas where the agency may need to examine its approach to assisting clients in these areas in order to ensure that it is doing an adequate job. The only variables where there appeared to be differences in category distributions included anxiety disorder, depression, and suicide attempts. In the next topics, chi-square analyses are presented on these variables; see also Appendix E, Table E2.

Anxiety disorder. Table 54 illustrates that there is association between 2005 and 2010 for the variable of suspected or diagnosed anxiety disorder upon intake: x^2 (1, $N =$ 274) = 23.0; $p =$ .000. When the association between suspected or diagnosed anxiety disorder and participant involvement in the MHD&CS program was examined, 9% indicated yes in 2005, and 91% did not. There were 42% of participants who indicated yes in 2010, and 58% who did not. It can be concluded that there is a relation between suspected or diagnosed anxiety disorder upon intake and participant involvement in the MHD&CS program (see Table 54 and Appendix E, Table E2).

Table 54

Anxiety Disorder Chi-Square

| Anxiety disorder | Variable | Year | | Total |
		2005	2010	
Yes	Count	6	88	94
	% within year	9.4%	41.9%	34.3%
No	Count	58	122	180
	% within year	90.6%	58.1%	65.7%
Total	Count	64	210	274

Depression. Table 55 illustrates that there is an association between 2005 and 2010 for the variable of symptoms or diagnosis of depression upon intake. When the association between participant symptoms of depression or a diagnosis of depression and involvement in the MHD&CS program was examined, 11% indicated yes in 2005, and 89% did not. There were 39% of participants who indicated yes in 2010, and 61% who did not. It can be concluded that there is a relation between participant symptoms or diagnosis of depression upon intake and involvement in the MHD&CS program: x^2 (1, N =274) = 17.7; p =.000; see also Appendix E, Table E2. These results indicate that there is relation between participant level of suspected symptoms of depression or diagnosed depressive disorder and involvement in the MHD&CS program.

Table 55

Depression Chi-Square

Depression	Variable	Year		Total
		2005	2010	
Yes	Count	7	82	89
	% within year	10.9%	39.0%	32.5%
No	Count	57	128	185
	% within year	89.1%	61.0%	67.5%
Total	Count	64	210	274

Suicide attempts. Table 56 illustrates that there is no association between 2005 and 2010 for the variable of previous suicide attempts and participant involvement in the MHD&CS program. When the association between previous suicide attempts and participant involvement in the MHD&CS program was examined, 33% indicated yes in 2005, and 67% did not. There were 46% of participants who indicated yes in 2010, and 54% did not. As shown in Table 56 and Table E2, Appendix E, it can be concluded that

there is no relation between previous suicide attempts and participant involvement in the

MHD&CS program: x^2 (1, $N = 274$) = 3.6; p =.058.

Table 56

Suicide Attempt Chi-Square

		Year		
Suicide attempt	Variable	2005	2010	Total
Yes	Count	21	97	118
	% within year	32.8%	46.2%	43.1%
No	Count	43	113	156
	% within year	67.2%	53.8%	56.9%
Total	Count	64	210	274

Primary diagnosis. Table 57 illustrates that there is no association between 2005

and 2010 for the variable of primary diagnosis: x^2 (3, $N = 231$) = 1.82; p =.058. These

results indicate that there is no relation between participant primary diagnosis and

involvement in the MHD&CS program; see also Table E3, Appendix E.

Table 57

Primary Diagnosis Chi-Square

		Year		
Primary diagnosis	Variable	2005	2010	Total
Developmental handicap	Count	5	27	32
	% within year	11.4%	14.4%	13.9%
Schizophrenia	Count	13	39	52
	% within year	29.5%	20.9%	22.5%
Substance-related disorders	Count	12	62	74
	% within year	27.3%	33.2%	32.0%
Mood disorders	Count	14	59	73
	% within year	31.8%	31.6%	31.6%
Total	Count	44	187	231

Developmental handicap. Table 58 illustrates that there is no association between 2005 and 2010 for the variable of primary diagnosis having a developmental handicap and involvement in the MHD&CS program: x^2 (1, $N = 274$) = 1.2; $p =$.271. See chi-square test results for this variable in Table E3, Appendix E.

Table 58

Participant Developmental Handicap Chi-Square

| Primary diagnosis | Variable | Year | | Total |
		2005	2010	
Developmental handicap	Count	5	27	32
	% within year	7.8%	12.9%	11.7%
All other	Count	59	183	242
	% within year	92.2%	87.1%	88.3%
Total	Count	64	210	274

Schizophrenia. Table 59 illustrates that there is no association between 2005 and 2010 for the variable of primary diagnosis being schizophrenia and involvement in the MHD&CS program: x^2 (1, $N = 274$) = .10 ;$p =$.756. See also Appendix E, Table E3.

Table 59

Schizophrenia Chi-Square

| Primary diagnosis | Variable | Year | | Total |
		2005	2010	
Schizophrenia	Count	13	39	52
	% within year	20.3%	18.6%	19.0%
All other diagnoses	Count	51	171	222
	% within year	79.7%	81.4%	81.0%
Total	Count	64	210	274

Substance-related disorder. Table 60 illustrates that there is no association between 2005 and 2010 for the variable of primary diagnosis being a substance-related disorder: x^2 (1, N = 274) = 2.9; p =.089. Thus, the results indicate that there is no relation between participant primary diagnosis being a substance-related disorder and involvement in the MHD&CS program. See chi-square test results for this variable in Table E3, Appendix E.

Table 60

Substance Related Disorders Chi-Square

Primary diagnosis	Variable	Year		Total
		2005	2010	
Substance-related	Count	12	62	74
disorders	% within year	18.8%	29.5%	27.0%
All other diagnoses	Count	52	148	200
	% within year	81.2%	70.5%	73.0%
Total	Count	64	210	274

Mood disorder. Table 61 illustrates that there is no association between 2005 and 2010 for the variable of primary diagnosis being a mood disorder: x^2 (1, N = 274) = 1.1; p = .285. Thus, the results indicate that there is no relation between participant primary diagnosis of mood disorder and involvement in the MHD&CS program; see also Table E3, Appendix E.

Table 61

Mood Disorder Chi-Square

Primary diagnosis	Variable	Year		Total
		2005	2010	
Mood disorder	Count	9	42	51
	% within year	14.1%	20.0%	18.6%
All other diagnoses	Count	55	168	223
	% within year	85.9%	80.0%	81.4%
Total	Count	64	210	274

Other illness. Table 62 illustrates that there is no association between 2005 and

2010 for the variable of other illnesses such as concurrent disorders (mental health

disorder and substance-abuse issue), dual diagnosis (mental illness and developmental

disability), or other medical illness: x^2 (2, $N = 268$) = 4.0; p =.134. In order to remove

the categories with a count of less than five in 1 of the 2 years, the categories of other

chronic/illness/disabilities were omitted. Thus, the results indicate that there is no relation

between other illnesses and participant involvement in the MHD&CS program. See

Pearson chi-test results in Table E3, Appendix E.

Table 62

Other Illness Information Chi-Square

Other illness information	Variable	Year		Total
		2005	2010	
Concurrent disorder	Count	24	54	78
	% within year	39.3%	26.1%	29.1%
Dual diagnosis	Count	6	26	32
	% within year	9.8%	12.6%	11.9%
None	Count	31	127	158
	% within year	50.8%	61.4%	59.0%
Total	Count	61	207	268

Concurrent disorder. Table 63 illustrates that there is no association between 2005 and 2010 for the variable of a concurrent disorder (mental health disorder and substance-abuse issue): x^2 (1, $N = 274$) = 3.3; $p = .067$. Thus, the results indicate that there is no relation between concurrent disorder and participant involvement in the MHD&CS program.

Table 63

Concurrent Disorder Chi-Square

Other illness information	Variable	Year		Total
		2005	2010	
Concurrent disorder	Count	24	54	78
	% within year	37.5%	25.7%	28.5%
Dual diagnosis / other	Count	40	156	196
chronic / illnesses / disabilities	% within year	62.5%	74.3%	71.5%
Total	Count	64	210	274

Legal status upon intake. Table 64 indicates that there is no association between 2005 and 2010 for the variable of legal status upon intake: x^2 (2, $N =219$) = 4.9; $p =088$. In order to reduce the variables with a sample size of five, the following categories were omitted: awaiting NCR assessment, court diversion program, on probation, awaiting fitness assessment, Ontario Review Board detained – community access, stay of proceedings, charges withdrawn, no criminal/legal charges, and missing. Therefore, the results indicate that there is a relation between participant legal status upon intake and involvement in the MHD&CS program; see chi-square test results for this variable in Table E4, Appendix E.

Table 64

Legal Status Upon Intake Chi-Square

		Year		
Legal status upon intake	Variable	2005	2010	Total
Awaiting sentencing	Count	6	47	53
	% within year	13.0%	27.2%	24.2%
Incarcerated	Count	29	100	129
	% within year	63.0%	57.8%	58.9%
On bail—awaiting trial	Count	11	26	37
	% within year	23.9%	15.0%	16.9%
Total	Count	46	173	219

Legal status outcome. Table 65 illustrates that there is no association between 2005 and 2010 for the variable of legal outcome: x^2 (1, N = 219) = 1.5; p =.232. Therefore, the results indicate that there is a relation between legal outcome and participant involvement within MHD&CS program; see also Table E4, Appendix E.

Table 65

Legal Status Outcome Chi-Square

		Year		
Legal status outcome	Variable	2005	2010	Total
Awaiting sentence	Count	4	27	31
	% within year	8.7%	15.6%	14.2%
Sentence decided	Count	42	146	188
	% within year	91.3%	84.4%	85.8%
Total	Count	46	173	219

Part III: Analysis of Recidivism and Readmission to Hospital in 2005 and 2010

Descriptive statistics. The data collected for recidivism was obtained from the

Common Data Set program at the CMHAK. The researcher obtained the recidivism data

from court records and dockets. The readmission to hospital data was obtained by the

mental health diversion worker and entered into the Common Data Set program if the

worker was alerted that individuals were readmitted to hospital because they had (a)

breached their Ontario Review Board Dispositions and were being admitted to a

designated forensic hospital; (b) been detained under the Mental Health Act; or (c)

voluntarily admitted themselves. The recidivism and readmission to hospital data was

then entered into the SPSS Program by the researcher. The researcher opened each

participant's file in the Common Data Set program and looked under the participant's

legal status and hospitalizations tab within the program and examined if there was a re-

offense under the Criminal Code (Government of Canada, 1985) or if there was a

readmission to designated forensic hospital within Ontario for revocation of Ontario

Review Board Disposition. This information was then entered into the Statistical

Methods in Social Work Practice Program of the SPSS Statistical GradPack. Both

variables were coded as 1 = yes and 2 = no and therefore were both nominal variables. As

the researcher was the only one entering the data, the information was examined three

times to ensure that it was verified and that there were no mistakes made in data entry.

All of the 67 participants in 2005 are included in the analysis. Of the 210

participants, there were 50 individuals who participated with the MHC in Kenora. These

50 participants are included in the recidivism and readmission to hospital results. Tables

will be added for aid in the interpretation of the results.

The results indicate (see Table 66) that in 2005, there were 34 (51%) participants who reoffended compared to 13 (26%) in 2010. There were 33 (49%) in 2005 who did not reoffend compared to 37 (74%) in 2010. These results indicate that those individuals in 2010 who were involved with the MHC reoffended less than those participants in 2005 who were in the regular court stream.

Table 66

Frequency and Percent of Re-offenses in 2005 and 2010

Variable	Frequency		Valid Percent	
	2005	2010	2005	2010
Yes	34	13	50.7	26.0
No	33	37	49.3	74.0
Total	67	50	100.0	100.0

Table 67 shows the frequencies for those individuals who were readmitted to hospital either through the civil mental health system or the forensic mental health system in Ontario. The results indicate that 25 (38%) of participants in 2005 had a readmission to hospital compared to 9 (18%) in 2010. There were 41 (62%) participants in 2005 who were not readmitted to hospital compared to 41 (80%) participants in 2010. These results indicate that there were a higher percentage of individuals in 2010 who were not readmitted to a hospital in Ontario compared to 2005.

Table 67

Frequency and Percent of Readmission to Hospital in 2005 and 2010

Variable	Frequency		Valid Percent	
	2005	2010	2005	2010
Yes	25	9	37.9	18.0
No	41	41	62.1	82.0
Total	66	50	100.0	100.0

Table 68 illustrates that there is an association between the 2005 sample that was involved with the MHC and the 2010 sample for the variable of re-offence. These results indicate there is an association between participants involved with the MHC and participants involved with the regular court system through the MHD&CS program: in 2005, 51% re-offended and 49% did not; in 2010, 26% of participants re-offended and 74% did not. It can be concluded that there is a relation between participants were involved with the MHC or involved with the regular court system in the MHD&CS program: x^2 (1, N =117) = 7.3; p =.007; see also Appendix E, Table E5.

Table 68

Re-offence Chi-Square

| Re-offence | Variable | Year | | Total |
		2005	2010	
Yes	Count	34	13	47
	% within year	50.7%	26.0%	40.2%
No	Count	33	37	70
	% within year	49.3%	74.0%	59.8%
Total	Count	67	50	117

Table 69 illustrates that there is an association between the sample of 2005 that was involved with the MHC and the 2010 sample for the variable of readmission to hospital. These results indicate there is an association between participants involved with the MHC and those participants involved with the regular court system through the MHD&CS program: 38% had a readmission to hospital in 2005, and 62% did not. There were 18% of participants who had a readmission to hospital in 2010, and 82% who did

not. It can be concluded that there is a relation between if participants are involved with

the MHC versus those involved with the regular court system through the MHD&CS

program: x^2 (1, N =116) = 5.4; p = .020; see also Appendix E, Table E5.

Table 69

Readmission to Hospital Chi-Square

Readmission to hospital	Variable	Year		Total
		2005	2010	
Yes	Count	25	9	34
	% within year	37.9%	18.0%	29.3%
No	Count	41	41	82
	% within year	62.1%	82.0%	70.7%
Total	Count	66	50	116

Three demographic characteristics of the clients in the MHD&CS program at the

CMHAK yielded statistically significant differences: residence support, if participants

were presenting with anxiety symptoms, and if participants were presenting with

depressive symptoms. Therefore, the researcher examined if these significant variables

had any association with the re-offense rates and readmission rates of participants in 2005

and those involved with the MHC in 2010.

Table 70 indicates that there is no association between re-offence rates of

participants in 2005 and their level of residence support: x^2 (2, N =65) = .51;

p =.512. The researcher omitted any missing variables. Therefore, the results indicate

that there is no relation between participant re-offence in the criminal justice system and

their level of support within 2005; see chi-square test results for this variable in Table E6,

Appendix E.

Table 70

2005 Re-offence and Residence Support Chi-Square

| Re-offence | Variable | Residence Support | | | |
		Assisted/ Supported	Independent	Supervised Facility	2005 Total
Yes	Count	6	26	1	33
	% within re-offence	18.2%	78.8%	3.0%	100.0%
No	Count	1	32	4	37
	% within re-offence	2.7%	86.5%	10.8%	100%
Total	Count	9	53	3	65
	% within re-offence	13.8%	81.5%	4.6%	100.0%
	% of total	13.8%	81.5%	4.6%	100.0%

Table 71 indicates that there is no association between re-offence rates of

participants 2010 and their level of residence support: x^2 (2, N =50) = .36; p =.360. The

researcher omitted any missing variables. Therefore, the results indicate that there is no

relation between participant re-offence in the criminal justice system and their level of

support within 2010; see chi-square test results for this variable in Table E7, Appendix E.

Table 71

2010 Re-offence and Residence Support Chi-Square

| Re-offence | Variable | Residence Support | | | 2010 Total |
		Assisted/ Supported	Independent	Supervised Facility	
Yes	Count	1	12	0	13
	% within re-offence	7.7%	92.3%	0.0%	100.0%
No	Count	1	32	4	37
	% within re-offence	2.7%	86.5%	10.8%	100.0%
Total	Count	2	44	4	50
	% within re-offence	4.0%	88.0%	8.0%	100.0%
	% of total	4.0%	88.0%	8.0%	100.0%

Table 72 indicates that there is no association between re-offence rates of

participants in 2005 and if they had symptoms of depression: x^2 (1, N =65) = .25;

p =.247. Therefore, the results indicate that there is no relation between participant re-

offence in the criminal justice system and if they experienced symptoms of depression

within 2005; see chi-square test results for this variable in Table E6, Appendix E.

Table 72

2005 Re-offence and Depression

		Depression		2005
Re-offence	Variable	Yes	No	Total
Yes	Count	5	28	33
	% within re-offence	15.2%	84.8%	100.0%
No	Count	2	30	32
	% within re-offence	6.2%	93.8%	100.0%
Total	Count	7	59	65
	% within re-offence	10.8%	89.2%	100.0%
	% of total	10.8%	89.2%	100.0%

Table 73 indicates that there is no association between re-offence rates of participants in 2010 and if they had symptoms of depression: x^2 (1, N =50) = .06; p =.058. Therefore, the results indicate that there is no relation between participant re-offence in the criminal justice system and if they experienced symptoms of depression within 2010; see chi-square test results for this variable in Table E7, Appendix E.

Table 73

2010 Re-offence and Depression

Re-offence	Variable	Depression		2010 Total
		Yes	No	
Yes	Count	1	12	13
	% within re-offence	7.7%	92.3%	100.0%
No	Count	13	24	37
	% within re-offence	35.1%	64.9%	100.0%
Total	Count	14	36	50
	% within re-offence	10.8%	89.2%	100.0%
	% of total	10.8%	89.2%	100.0%

Table 74 indicates that there is no association between re-offence rates of

participants in 2005 and if they had symptoms of anxiety: x^2 (1, N =65) = .41; $p =$

.414. Therefore, the results indicate that there is no relation between participants re-

offence in the criminal justice system and if they experienced symptoms of anxiety

within 2005; see chi-square test results for this variable in Table E6, Appendix E.

Table 74

2005 Re-offence and Anxiety Symptoms

Re-offence	Variable	Anxiety Symptoms		2005 Total
		Yes	No	
Yes	Count	4	29	33
	% within re-offence	12.1%	87.9%	100.0%
No	Count	2	30	32
	% within re-offence	6.2%	93.8%	100.0%
Total	Count	6	59	65
	% within re-offence	9.2%	90.8%	100.0%
	% of total	9.2%	90.8%	100.0%

Table 75 indicates that there is no association between re-offence rates of participants in 2010 and if they had symptoms of anxiety: x^2 (1, N =50) = .83; p =830. Therefore, the results indicate that there is no relation between participants re-offence in the criminal justice system and if they experienced symptoms of anxiety within 2010; see chi-square test results for this variable in Table E7, Appendix E.

Table 75

2010 Re-offence and Anxiety Symptoms

Re-offence	Variable	Anxiety Symptoms		2010
		Yes	No	Total
Yes	Count	5	8	13
	% within re-offence	38.5	61.5	100.0%
No	Count	13	24	37
	% within re-offence	35.1%	64.9%	100.0%
Total	Count	18	32	50
	% within re-offence	36.0%	64.0%	100.0%
	% of total	36.0%	64.0%	100.0%

Table 76 indicates that there is no association between readmission rates to hospital of participants 2005 and their level of residence support: x^2 (2, N =65) = .17; p =.173. Therefore, the results indicate that there is no relation between participants readmission to hospital and their level of support within 2005, see chi-square test results for this variable in Table E8, Appendix E.

Table 76

2005 Readmission Rates to Hospital and Residence Support Chi-Square

		Residence Support			
		Assisted/ Supported	Independent	Supervised Facility	2005 Total
Readmission	Variable				
Yes	Count	6	18	1	25
	% within readmission	24.0%	72.0%	4.0%	100.0%
No	Count	3	35	2	40
	% within readmission	7.5%	87.5%	5.0%	100.0%
Total	Count	9	53	3	65
	% within readmission	13.8%	81.5%	4.6%	100.0%
	% of total	13.8%	81.5%	4.6%	100.0%

Table 77 indicates that there is no association between readmission rates to hospital of participants 2010 and their level of residence support: x^2 (2, N =50) = .47; p =.473. Therefore, the results indicate that there is no relation between participants readmission to hospital and their level of support within 2010. See chi-square test results for this variable in Table E9, Appendix E.

Table 77

2010 Readmission Rates to Hospital and Residence Support Chi-Square

| Readmission | Variable | Residence Support | | | 2010 Total |
		Assisted/ Supported	Independent	Supervised Facility	
Yes	Count	0	9	0	9
	% within readmission	0.0%	100.0%	0.0%	100.0%
No	Count	2	35	4	41
	% within readmission	4.9%	85.4%	9.8%	100.0%
Total	Count	2	44	4	50
	% within readmission	4.0%	88.0%	8.0%	100.0%
	% of total	4.0%	88.0%	8.0%	100.0%

Table 78 indicates that there is no association between readmission rates to

hospital of participants 2005 and if they had symptoms of depression: x^2 (1, N =65) =

.06; p =.058. Therefore, the results indicate that there is no relation between participants

readmission to hospital and if they had symptoms of depression within 2005, see chi-

square test results for this variable in Table E8, Appendix E.

Table 78

2005 Readmission Rates to Hospital and Depression

| Readmission | Variable | Depression | | 2005 Total |
		Yes	No	
Yes	Count	5	20	25
	% within readmission	20.0%	80.0%	100.0%
No	Count	2	38	40
	% within readmission	5.0%	95.0%	100.0%
Total	Count	7	58	65
	% within readmission	10.8%	89.2%	100.0%
	% of total	10.8%	89.2%	100.0%

Table 79 indicates that there is an association between readmission rates to hospital of participants 2010 and if they had symptoms of depression: x^2 (1, N =50) = .04; p =.039. Therefore, the results indicate that there is a relation between participants' readmission to hospital and if they had symptoms of depression within 2010, see chi-square test results for this variable in Table E9, Appendix E. This therefore indicates that in 2010 that those individuals who had depression had a higher likelihood of being admitted to hospital in relation to their depressive symptoms.

Table 79

2010 Readmission Rates to Hospital and Depression

| Readmission | Variable | Depression | | 2010 Total |
		Yes	No	
Yes	Count	0	9	9
	% within readmission	0.0%	100.0%	100.0%
No	Count	14	27	41
	% within readmission	34.1%	65.9%	100.0%
Total	Count	14	36	50
	% within readmission	28.0%	72.0%	100.0%
	% of total	28.0%	72.0%	100.0%

Table 80 indicates that there is no association between readmission rates to hospital of participants 2005 and if they had symptoms of anxiety: x^2 (1, N =65) = .14; p =.136. Therefore, the results indicate that there is no relation between participants readmission to hospital and if they had symptoms of anxiety within 2005, see chi-square test results for this variable in Table E8, Appendix E.

Table 80

2005 Readmission Rates to Hospital and Anxiety Symptoms

| Readmission | Variable | Anxiety Symptoms | | 2005 Total |
		Yes	No	
Yes	Count	4	21	25
	% within readmission	16.0%	84.0%	100.0%
No	Count	2	38	40
	% within readmission	5.0%	95.0%	100.0%
Total	Count	6	59	65
	% within readmission	9.2%	90.8%	100.0%
	% of total	9.2%	90.8%	100.0%

Table 81 indicates that there is no association between readmission rates to

hospital of participants 2010 and if they had symptoms of anxiety: x^2 (1, N =50) = .56;

p =.560. Therefore, the results indicate that there is no relation between participants

readmission to hospital and if they had symptoms of anxiety within 2010, see chi-square

test results for this variable in Table E9, Appendix E.

Table 81

2010 Readmission Rates to Hospital and Anxiety Symptoms

| Readmission | Variable | Anxiety Symptoms | | 2010 Total |
		Yes	No	
Yes	Count	4	5	9
	% within readmission	44.4%	55.6%	100.0%
No	Count	14	27	41
	% within readmission	34.1%	65.9%	100.0%
Total	Count	18	32	50
	% within readmission	36.0%	64.0%	100.0%
	% of total	36.0%	64.0%	100.0%

Chapter 5: Discussion

This chapter discusses the results of the research study and their implications. The research question that guided the study was "Does participation in the Mental Health Court reduce recidivism?" Implications of the findings, limitations of the study, and directions for future research are all discussed.

Descriptive Statistics

In order to understand the characteristics of the participants within the research study, the researcher examined and compared the demographic characteristics of the clients in the MHD&CS program in 2005 versus 2010 at the CMHAK. These demographic characteristics were compared by using descriptive statistics, cross-tabulation, and chi-square analysis.

The descriptive results for both years indicated that there were more males than females involved in the MHD&CS program at CMHAK. The typical user of the MHD&CS program was between 21 and 40 years of age, single/divorced/widowed/ separated, and spoke only English. They had their own residence and the level of support within the residence was either none (just themselves or support from their parents) prior to their involvement in the MHD&CS program, and they had no professional support within their living environment when admitted to the MHD&CS program. The majority of participants in the MHD&CS program had never had a job or were unemployed at the time of this study. Participants had an equivalent of a Grade 10–12 education, and the majority of participants were receiving assistance through the Ontario Disability Support Program. The majority of referrals for the MHD&CS program were from the criminal justice system or defence council. In 2005, 29% either worked at an

independent/competitive job (i.e., a full-time position) compared to 34% in 2010; this

indicates there was a 5% increase in participants who were employed. There was a 9%

decrease in individuals receiving assistance through the Ontario Disability Support

Program from 2005 to 2010. Having more individuals employed and not on the Ontario

Disability Support Program supports the 1999 MoHLTC mental health policy framework,

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and Supports that indicated that individuals with mental illness who become involved

with the criminal justice system need to be integrated into the community if their

offending risk is considered low. Employing individuals in the community promotes this

integration.

The descriptive results indicated that participants in the MHD&CS program most

frequently presented with the following issues for both 2005 and 2010: legal issues,

substance issues, relationship issues, psychiatric issues, abuse and violence as the

perpetrator, lack of basic needs being met, and suicide attempts. The highest number of

participants involved in the MHD&CS program had a diagnosis of a substance-related

disorder, schizophrenia or other psychotic disorder, or a mood disorder. These results

were congruent with the MoHLTC's (2006) findings from federal inmates in Canada that

indicated that there are a large number of inmates who have reported psychotic and

depressive disorders. The results also indicated that the number of individuals with a

diagnosis of a developmental disability was higher in 2010 compared to 2005. The

majority of individuals for both 2005 and 2010 did not have any other identified illness;

however, concurrent disorders were more frequent than individuals having a dual

diagnosis in both years for participants in the program. However, the rate of individuals

who had a concurrent disorder (mental health and addiction issues) within 2010 (25%)

was lower than in 2005 (37%), demonstrating a 12% decrease. The results also indicated

that there was an 11% decrease in the number of participants in the MHD&CS program

who had a previous psychiatric hospitalization upon intake in 2005 to 2010.

The results indicated that the majority of participants in the MHD&CS program

received a term of probation upon adjudication. There were more individuals found unfit

to stand trial in 2005 than in 2010 and more individuals in 2010 who were granted a stay

of proceedings and who entered into a Mental Health Diversion Agreement. These results

supported the MoHLTC's (2006) initiative to develop MHD&CS programs in Ontario, as

the programs' focus was to meet the needs of persons who were considered low risk by

managing their needs appropriately through community- or hospital-based services with

the use of Mental Health Diversion Agreements. Therefore, more individuals who had a

mental illness who were charged with a minor offence were being offered an alternative

to the correctional system. This supports the objective of the MoHLTC's (2006) initiative

and one of the assumptions of the MHD&CS program.

Chi-Square Analysis of Descriptive Statistics

The results from this analysis indicated that the following demographic

characteristics yielded statistically significant differences between 2005 and 2010: if

participants had residence support and to what level, if participants were presenting with

anxiety symptoms, and if participants were presenting with depressive symptoms. The

results of participants' level of residence support indicated that the majority of

participants in both years had no support within their environment upon intake (79%,

91%). These findings indicated that the participants in the MHD&CS program in both

years had no services within their residence. These results suggested that if individuals

who were coming before the MHD&CS program had no level of support within their

residence upon intake, the program was identifying those individuals with major mental

health disorders, cognitive disabilities, and brain injuries who had no professional

service. These results therefore were congruent with others' findings indicating that

individuals with mental health disorders are not receiving services and are at higher risk

to be involved in the criminal justice system (Gibbs, 2005; Schneider, 2009). This was

also similar to the MoHLTC's (2006) findings that individuals with mental illness are at

higher risk of isolation from community services. If these individuals are at a higher risk,

they will face higher risk of homelessness, isolation from community services, lack of

future access to treatment, and increased risk of experiencing symptoms of mental illness

(MoHLTC, 2006).

The descriptive variable of whether participants were exhibiting anxiety

symptoms upon intake was statistically significant when comparing 2005 to 2010. These

results indicated that there were more individuals in 2010 than in 2005 who identified as

having symptoms of anxiety or who had a diagnosis of an anxiety-related disorder (9%,

42%).

The descriptive variable of whether participants were exhibiting mood symptoms

upon intake was statistically significant. These results indicated that there was an increase

in 2010 over 2005 of individuals in the MHD&CS program who identified themselves as

having symptoms of or a diagnosis of a mood disorder (11%, 39%).

These results indicated that there was a 28% increase in 2010 of individuals who

were exhibiting mood or anxiety symptoms or who were diagnosed with either a mood or

anxiety-related disorder involved in the MHD&CS program. These results suggest that

the court personnel are better at identifying those individuals coming before the courts

who have mood or anxiety symptoms and therefore are identifying them to the

MHD&CS program. These results also suggest that those who did not receive mental

health services often found themselves involved in the criminal justice system, as Justice

Schneider stated in 2009. As involvement in the MHD&CS program requires obtaining

all previous hospitalization records of a participant, these results also indicated that

because individuals were not receiving psychiatric assessments through the civil system,

there was an increase of those individuals in prisons. This was congruent with Gibbs's

(2005) findings that individuals not receiving psychiatric assessment through the civil

system resulted in increased numbers of mentally ill individuals in prisons. This also

supported Gibbs's (2005) research that indicated the inadequacies of mental health

services within society as well as a huge gap in service for mentally disordered

individuals.

As indicated previously, all collateral from participants' past psychiatric

involvement was obtained, as well as information on participants' receipt of previous

mental health treatment. If participants had received previous treatment, the researcher

contacted those organizations, facilities, or treatment providers. As the results from the

study indicated that there was a 28% increase in 2010 of individuals who were exhibiting

mood or anxiety symptoms or who were diagnosed with either a mood or anxiety-related

disorder involved in the MHD&CS program. This finding supported other findings of

studies of individuals within Ontario (Steele et al., 2007). This was congruent with what

the Ontario CMHA (2014a) reported: if those individuals with mental health issues were

involved in the criminal justice system, their access to treatment was not being met. These results also demonstrated that there was an increase of those individuals within a provincial correction system who had a mental disorder that required a clinical intervention.

The MoHLTC (2006) reported that 15% to 20% of individuals within provincial correction systems have a mental disorder. This study indicated that within the 2010 sample, there were 42% of participants who had a mood disorder and 39 % who had an anxiety-related disorder; this was higher than the reported rate in 2006. This indicated, as the (2006) MoHLTC reported, that if there was an increase of individuals in correctional facilities in Ontario, there were concerns about the availability of resources, treatment, and assessment for mental health issues, the institutional capacity, and how policing and court services were delivered. This also indicated that different approaches to treatment of individuals with mental disorders involved in the criminal justice system need to be restructured, as correctional facilities in Canada are still the de facto psychiatric hospital for many individuals with mental illness (Watson et al., 2001).

Analysis of Recidivism and Readmission to Hospital

The researcher examined the data collected around participants' recidivism and readmission to a psychiatric hospital. This examination allowed the researcher to answer the guiding researcher question of the study: "Does participation in the Mental Health Court reduce recidivism?" This was done by examining descriptive statistics of participants within both 2005 and 2010 and then examining the chi-square analysis for each. However, as all participants in 2010 did not participate in the MHC, only those 50 participants who did were included in the recidivism and hospitalization results and

analysis for that year. Based on the examination of the results, the researcher was able to reject the null hypothesis and accept the hypothesis that participation in MHC reduces recidivism rates.

The results indicated those individuals within 2010 who were involved with the MHC reoffended less than those participants in 2005 who were in the regular court stream. In 2005, 51% of participants reoffended compared to 26% in 2010. There were 49% of participants in 2005 who did not reoffend compared to 74% in 2010. These results supported Kuehn's (2007) assertion that the purpose of the development of MHCs was to reduce the number of mentally ill individuals within correctional facilities. Since access to treatment and support within the community is a requirement of the MHC, improved services are leading to a decrease in individuals reoffending. As Justice Schneider in 2009 stated, the primary goal of MHCs is to connect, reconnect, and reintegrate individuals with mental health needs into treatment and appropriate services; therefore, these courts serve as a way for individuals to access services within the community for treatment or assessment. The results of this study demonstrated that MHCs also reduce recidivism rates of individuals with mental health needs involved in the criminal justice system.

As McNiel and Binder (2007) indicated, communities have created MHCs to help mentally disordered individuals reduce their involvement with the criminal justice system, and this is exactly what the community of Kenora has done. Kenora's MHC is based on therapeutic and rehabilitative principles that anticipate an increase in access to treatment for individuals with a mental disorder to assist in reducing their involvement with the criminal justice system (McNiel & Binder, 2007). McNiel and Binder (2007)

concluded that individuals who elected to proceed through an MHC had a reduction in recidivism with their involvement with the criminal justice system. This study's results, therefore, supported McNiel and Binder's results as well as Hiday and Ray's (2010) study that demonstrated that participation in MHCs was associated with a reduction in recidivism. McNiel and Binder's (2007) results concluded that 72% of offenders who were involved with an MHC were not rearrested, and the results of this research study were that 74% of participants who were involved in the MHC in 2010 did not reoffend.

The chi-square results of re-offence rates indicate that there is an association between the sample of 2005 who were involved with the MHC and the 2010 sample: x^2 $(1, N = 117) = 7.3; p = .007$. These results indicated that there are significant differences within both samples in regard to re-offence rates. This significant finding reflects that when individuals in 2010 were involved with the MHC that 74% did not reoffend and 26% did re-offend, whereas when individuals in 2005 were not involved with the MHC, the opposite was true (51% re-offended and 49% did not re-offend). Therefore, it could be concluded that individuals' participation in the MHC significantly influenced recidivism rates of individuals involved in the MHD&CS program. These results supported the evaluations made by Hiday and Ray (2010) and Watson et al. (2001) indicating that speciality courts such as MHCs reduce individuals' criminal behaviour. The results of the current study added to the growing number of reliable studies that support the slowing down of the revolving door situation that mentally disordered individuals face in the criminal justice system (Schneider, 2009).

The results for readmission to hospital indicated a lower percentage of participants in 2010 who were readmitted to hospital compared to participants in 2005. In

2005, 38% of participants were readmitted to hospital compared to 18% in 2010. Sixty-two percent (62%) of participants in 2005 were not readmitted to hospital compared to 80% in 2010. These results supported Kuehn's (2007) study that demonstrated that MHCs not only benefited the individual but also communities. A reduction in psychiatric hospital admissions indicated that participants were receiving treatment within the community, therefore reducing costly pressures on the hospital system.

The chi-square results of readmission rates to hospital indicated that there were significant differences between the sample of individuals in 2005 who were involved with the MHC and the 2010 sample in regard to readmission rates to hospital: x^2 (1, $N =$ 116) = 5.4; $p < .020$. This result reflected that when individuals were involved with the MHC, 82% were not readmitted to a hospital and 18% were readmitted to hospital, whereas when individuals were not involved with the MHC, 62% were not readmitted to hospital and 38% were readmitted to hospital. Therefore, it could be concluded that having individuals participate in the MHC significantly influenced individuals being readmitted to hospital. These results therefore supported the assumptions of the MHD&CS programs as laid out by the MoHLTC (2006) that indicated that individuals involved in the criminal justice system will have improved mental health functioning and better outcomes, and there will be a reduction in recidivism and hospitalizations, reduced pressures on the criminal justice system, and increased access to mental health services.

Chi-Square Analysis of Significant Descriptive Variables and Re-Offence and Readmission to Hospital

When examining which of the significant descriptive variables were statistically significant with either re-offence rates or readmission to hospital rates within their

prospective years, there was only one variable that was statistically significant. This was

the variable in the 2010 sample of if participants were experiencing symptoms of

depression and if they were readmitted to hospital. The chi-square results indicated that

there was an association between if participants were exhibiting signs of depression in

2010 and if they would be readmitted to hospital: x^2 (1, $N = 50$) = .04; $p = .039$.

Therefore, it could be concluded that individuals who came before the MHC with

symptoms of depression had a greater likelihood of being readmitted to hospital.

Individuals in the MHC with signs of depression are normally referred for psychotherapy

as a form of treatment; however, this raises the question whether this service is effective.

Steele et al.'s (2007) study indicated that only 32% of individuals with a mental disorder

will have spoken to a health professional, and that those individuals with a mental

disorder in Ontario report that they are dissatisfied with available services and those

services are not helpful. This finding therefore suggests that there should be an

examination of the perceptions of MHC clients and their involvement with psychotherapy

services within the Kenora Rainy River District to ensure that those who require these

supports do avoid accessing or utilizing the current mental health system that is in place

to prevent readmission to hospital.

Implications for Mental Health Courts

One of the benefits of conducting this research is that the results have direct

implications for how criminal courts should handle individuals with mental health issues,

cognitive disabilities, and brain injuries. The results suggest that if individuals with

mental health issues, cognitive disabilities, and brain injuries are offered access to a

speciality court, such as the MHC, based on therapeutic and restorative justice principles,

they would be less likely to re-offend and be involved in the criminal justice system. As

therapeutic jurisprudence is a theory that indicates that the law should be incorporated in

a way that is therapeutic (Schneider, 2009), this is contrary to the historical setup of the

justice system and how members of the judiciary are professionally trained. This theory

indicates that the law should use the justice system in a manner that addresses an

individual's underlying factors that have contributed to the individual coming into

contact with the law (Schneider, 2009) and therefore needs to have five elements: (a)

immediate intervention, (b) no adversarial process, (c) hands-on judge, (d) treatment

programs, and (e) team approach (Watson et al., 2001). The most important element is

the access to available treatment programs and resources, and the MHC in Kenora strives

to make these resources available to those individuals who participate within the court.

As individuals who are participating within the MHC access resources and case

management services have almost no vacancies within the district. Therefore, if

treatment programs and community-based services are what that MHC strives to make

available to those individuals who participate in the court, how will this be accomplished

if there are no vacancies in resources to divert individuals to? This suggests that further

resources need to be made available to support these courts but also the participants who

are accessing community-based treatment.

Additional resources are needed; thus, provincial structures such as the Human

Services and Justice Coordinating Committees (CMHA, 2014b) across the province need

to examine where to augment community services to meet the increasing service

demands and to support outcome evaluations such as in this research. These evaluations

should also be examining the services within the district and if those who are accessing

the services are matched with the appropriate level of service. This will ensure that the

level of support is matched to the participants' needs and will ensure a continuous flow

within services.

Another benefit of this research study is that it highlighted the increased number

of individuals who are not receiving effective service within the civil system. CMHA in

2014 indicated that due to this lack of access of service there is an increase in those who

are mentally ill being criminalized instead of accessing mental health services. Therefore,

the MoHLTC needs to consider re-investing in its mental health care system; if it does

not, MHCs will continue to be the "brave and innovative attempts to patch a broken

system" (Schneider, 2009, p. 1). Canadians should be able to access mental health care

and not have to be criminalized in order to receive treatment. As the Mental Health

Commission of Canada recently noted (as cited in National Criminal Justice Section,

Canadian Bar Association [NCJS, CBA], 2013), "The mentally ill are over represented in

the criminal justice system and that an urgent need exists for appropriate services and

treatment for these individuals" (p. 5).

This research also impacts those mentally disordered individuals involved within

the MHC as the federal government's introduction on February 8, 2013, of Bill C-54, the

Not Criminally Responsible Reform Act (NCJS, CBA, 2013). This bill will amend

Section XX.1 of the Criminal Code (Government of Canada, 1985) that deals with

individuals found NCR due to mental disorder. The purpose of Bill C-54 (NCJS, CBA,

2013) is to increase public safety and focus on the needs of victims by introducing a high-

risk category for those individuals found NCR. The Kenora MHC deals with all charges

under the Criminal Code. Under Canadian law, any charge under the Criminal Code can

have someone found NCR due to a mental disorder; that is, if the individual lacks the

capacity to know what they were doing when they committed an offence, they can be

found NCR. NCR individuals can therefore can be detained in a hospital and released

once they are no longer considered a significant threat to the public. Mackreal (2013), in

a *Globe and Mail* article, reported that this new legislation would allow judges to apply a

high-risk designation to a small number of violent offenders who have been found NCR.

Mackreal also reported that this bill would therefore increase the time between reviews of

those individuals' detention and prevent them from being considered for release until a

judge decides they are no longer a threat. Mackreal (2013) felt that this high-risk label

could be applied only to those who committed a violent offence and have either a

significant risk of re-offending or who might act after their release cause grave physical

or psychological harm to the public. Justice Schneider (as cited in Mackreal, 2013) stated,

"There is no evidence to suggest the current system isn't working" (para. 9). Justice

Schneider also indicated that the current rates of re-offending among those who go

through the NCR system have been lowered; therefore, there is no current issue around

public safety. Thus, Bill C-54's (NCJS, CBA, 2013) will impact the how MCHs deal with

offenders before the courts.

The Canadian Psychiatric Association (CPA) indicated that the government needs

to invest in restorative justice approaches for dealing with this population. Recidivism

rates of those individuals found NCR are five to six times lower than those NCR

individuals managed in the regular corrections system (Canadian Psychiatric Association

[CPA], 2013). The re-offence rates within this research supported this statement as these

rates were based on if individuals accumulated a new charge under the Criminal Code

(Government of Canada, 1985) or if they breached their Ontario Review Board

Disposition while in the community. The rates indicated that 74% of those individuals

involved with the MHC did not reoffend compared to 51% of those individuals who did

not reoffend when involved with the regular court. These results therefore support the

CPA's (2013) statements on the impact of Bill C-54 (NCJS, CBA, 2013). However, in

order for the continued success of MHCs in reducing recidivism rates, individuals need to

be identified within the criminal justice system, and, if this bill is passed, those

individuals with mental health needs will reluctantly plead guilty and remain silent about

their needs to avoid being labelled as a high-risk. This could result in an increase of

individuals with mental health needs within correctional facilities.

Finally, the researcher hopes that this study creates a discussion of how MHCs are

effective in not only reducing the pressures in the criminal justice system but also how

those involved with MHCs are gaining access to the mental health system within the

province of Ontario. As the research is specifically around Kenora's MHC, the hope

would be to advocate for development of such courts in different [additional]

jurisdictions within Northwestern Ontario.

Limitations

Since the MHC in Kenora was established only as of 2010, the size of the sample

is not large ($N = 50$); therefore, examining years after 2010 would be of benefit as there

would potentially be an increase in the number of individuals in the study. Therefore, as

there were a limited number of participants in the sample, the findings of the study have

limited generalizability. A larger sample could result in greater power to find significant

statistical results. Also, when examining the descriptive characteristics of both samples,

there were few clear population differences; therefore, the researcher cannot offer much insight into specific trends of both populations.

One of the limitations of this study was that the population consisted of only those individuals who were a part of the MHD&CS program through the CMHAK. As individuals with mental health issues, cognitive disabilities, and brain injuries who are involved in the criminal justice system are not always flagged and supported by the MHD&CS program, the results cannot be generalized to all individuals in the criminal justice system with mental health issues, cognitive disabilities, and brain injuries.

Information for this research was collected using the Common Dataset information (MoHLTC, 2007) within the computer system at CMHAK. The information for re-offence and readmission to hospital is entered into the dataset if the mental health diversion worker was made aware of this information and entered it into the Common Dataset. Information for individuals under the Forensic Mental Health System (CAMH, 2012a) can be obtained by the Ontario Review Board, as this information is made available to the public, if requested; the researcher was therefore able to obtain the readmission to hospital information. However, if individuals were readmitted to hospital under the Mental Health Act of Ontario (Government of Ontario, 2010), the regulations of the Personal Health Information Act (Cavoukian, 2004) apply. Therefore, obtaining admission information must be done with the client's informed and expressed consent. Thus, if the researcher was unable to obtain this consent, this information would not be entered into the Common Dataset. This is a limitation as individuals involved in the MHD&CS program could have had a readmission to a hospital, and the researcher would have been unaware and therefore the information would not have been entered into the

database. If it was not entered into the database, the current data sample is not accurate and thus not a true picture of those individuals involved in the MHD&CS program and their hospital readmission rates.

Other limitations included how the variables were measured within the Common Dataset and then coded within the SPSS analytics software program. As the majority of the variables are measured at the categorical level, this limited the researcher's ability to administer nonparametric tests that would allow the researcher to answer specific questions about the populations in question.

Recommendations for Future Research

Throughout the process of this research project, several ideas for future exploration were identified. One of these areas was the nature of the data collected. As the majority of the variables were categorical, the researcher was unable to conduct valuable parametric and nonparametric tests that would provide more insight into the populations. For example, if some of the variables were measured at the ordinal level, a regression analysis could be conducted. This would allow the researcher to predict which descriptive variables affect who is involved in the MHD&CS program.

Another area that could be examined is providing a larger sample of individuals involved with the MHC. This could be done by examining more than one year in a study. Having a larger sample base would assist in the results being generalized to larger populations.

Future researchers could also look at gaining access to the local hospital and regional forensic hospital records at the Lake of the Woods District Hospital as well as the Thunder Bay Regional Health Sciences Center; this would allow researchers to see

which individuals in the MHD&CS program were readmitted to hospital in relation to their mental health needs either through the civil system or the forensic system, providing a more accurate picture of participants' readmission to hospital rates.

Researchers could consider a research study on the participants in the MHD&CS program and their perceptions on psychotherapy services. This recommendation is based on the results of this study that indicate that those individuals involved in the MHD&CS program who have depressive symptoms will more than likely be readmitted to hospital for their symptoms.

In summary, this chapter has detailed the results and implications of the study. It has reviewed the research question and significant findings of the descriptive characteristics of participants, re-offence rates, and hospital readmission rates of those participants. Descriptive statistics of those participants involved in the MHD&CS program were also discussed, as well as how these descriptive statistics relate to re-offence rates and readmission rates to hospital. This chapter also provided a comparison of the results to previous research studies and concluded with the limitations of the study, implications of MHCs, as well as recommendations for future research.

Using the Common Dataset information on the computer system at CMHAK Branch (MoHLTC, 2007), the study examined whether participation within MHCs reduces recidivism rates. Data on the re-offence rates and readmission rates were entered into the Common Dataset and then transferred into the SPSS program for statistical review. After completion and analysis of the data, the results suggested that those individuals who were involved with the MHC were less likely to re-offend. Results also

suggested that those individuals who were involved with the MHC were also less likely to be readmitted to hospital for their mental health issues.

The results from this study were similar to past research that has been conducted on MHCs. It is the researcher's hope that the results provided from this study highlight the importance of the work being done by the MHC in Kenora and that courts within the province of Ontario will use this study to support their initiatives to start a speciality court within their own regions.

References

Abu-Bader, S. H. (2006). *Using statistical methods in social work practice: A complete SPSS guide*. Chicago, Illinois: Lyceum Books.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revised). Washington, DC: Author.

Barbaree, H., & Goering, P. (n.d.). *Summary report on the evidence-based practices in forensic mental health programs and services project: The development of standards, benchmarks, and performance indicators*. Toronto, ON: Ministry of Health and Long-Term Care.

Barsh, R. L. (n.d). *Canada's Aboriginal peoples: Social integration or disintegration?* Department of Native American Studies, University of Lethbridge. Retrieved from http://www3.brandonu.ca/library/cjns/14.1/barsh.pdf

Bettridege, S., & Barbaree, H. (2004). *The forensic mental health system in Ontario: An introduction guide*. Nation Library of Canada Cataloguing in Publication. Retrieved from http://knowledgex.camh.net/amhspecialists/resources_families /Documents/forencsic _guide_en.pdf

Canadian Mental Health Association. (2014a). *Canadian mental health association: Ontario division*. Retrieved from http://www.ontario.cmha.ca/branches .asp?fn=searchresults &BranchID=38&search=GO

Canadian Mental Health Association. (2014b). *Our work.* Retrieved from http://Ontario .cmha.ca/public-policy/capacity-building/human-services-and-justice-coordinating-committee/

Canadian Mental Health Association, Kenora Branch. (2008). *Forensic psychiatry protocol & procedures* [Internal document]. Kenora, ON: Author.

Canadian Psychiatric Association (2013, April 18). The consequences of Bill C-54 the, "Not Criminally Responsible Reform Act" [Information release]. Retrieved from http://www.cpa-apc.org/media.php?mid=1854

Carruthers, D. H. (2008). *Ontario review board: Annual report fiscal period April 1, 2007 to March 31, 2008*. Retrieved fromhttp://www.orb.on.ca/scripts/en /resources/Annual%20 Report%202007-2008.pdf

Cavoukian, A. (2004). *A guide to the personal health information protection act.* Information and Privacy Commissioner/Ontario. Retrieved from http://www .ipc.on.ca/images /resources/hguide-e.pdf

Centre for Addiction and Mental Health. (2012a). *Forensic mental health system: A program guide*. Retrieved from http://www.camh.ca/en/hospital /health _information/the_forensic _mental_health_system_in_ontario/Pages/the_forensic _mental_health_system_in_ontario.aspx

Centre for Addiction and Mental Health. (2012b). *Law and mental health.* Retrieved from http://www.camh.ca/en/research/research_areas/clinical_research/law-and-mental-health/Pages/default.aspx

Centre for Community Based Research. (2009). *Mental health risk assessment and management in community organizations: Region of Peel*. Retrieved from http:// www.hsjcc.on.ca /Resource%20Library/Risk%20Assessment/Mental%20Health %20Risk%20Assessment%20and%20Management%20in%20Community%20Or ganizations%20-%20Region %20of%20Peel%20-%202009.pdf

Corring, D. J. (2002). Quality of life: Perspectives of people with mental illnesses and family members. *Psychiatric Rehabilitation Journal, 25*, 350–358. Retrieved from the Ebscohost database.

Davis, S. (2006). *Community mental health in Canada*. Vancouver, BC: UBC Press.

Gibbs, W. (2005, Winter). Criminalization and mental illness. *Network*, 3–6. Retrieved from http://ontario.cmha.ca/files/2005/02/winter_2005.pdf

Gleeson, J., Nathan, P., & Bradley, G. (2006). The need for the development and evaluation of preventive psychosocial forensic interventions in mainstream adult community mental health services. *Community Psychiatry, 14*,180–185. Retrieved from the Ebsochost database.

Government of Canada. (1985). *Criminal code*. Retrieved from http://laws-lois.justice.gc.ca/eng /acts/c-46/page-1.html

Government of Ontario. (2010). *Mental health act*. Retrieved from http://www.e-laws .gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm

Government of Ontario, Health Force Ontario. (2013). *Specialist practice models.* Retrieved from http://www.healthforceontario.ca/en/Home/Physicians/Training _%7C _Practising_in_Ontario/Physician_Roles/Specialist_Practice_Models

Government of Ontario, Ministry of the Attorney General. (2005). *Crown policy manual.* Retrieved from http://www.attorneygeneral.jus.gov.on.ca/english/crim/cpm /default.asp

Greyhound killer believed man he beheaded was an alien. (2012, May 22). *CBC.ca.* Retrieved from http://www.cbc.ca/news/canada/ manitoba/greyhound-killer-believed-man-he-beheaded-was-an-alien-1.1131575

Hiday, V. A., & Ray, B. (2010). Arrests two years after exiting a well-established mental health court. *Psychiatric Services, 61*, 463–468. Retrieved from ps.psychiatryonline.org

Indian Act (1985, R.S.C., c. I-5). Retrieved from http://laws-lois.justice.gc.ca/eng/acts/i-5/page-1.html#h-1

Kapur, N. (2000). Evaluating risks. *Advances in Psychiatric Treatment*, *6*, 399–406. Retrieved from the Ebscohost database.

Kravitz, H. M., & Kelly, J. (1999). An outpatient psychiatry program for offenders with mental disorders found not guilty by reason of insanity. *Psychiatric Service*s, *50*, 1597–1605. Retrieved from the Ebscohost database.

Kuehn. B. M. (2007). Mental health courts show promise. *American Medical Association*, *297*(15). 1641–1643. Retrieved from jama.ama-assn.org

Lurie, S. (2008). Toward a mental health strategy for Canada. *The Journal of the Ontario Association of Social Workers, 34*(4). Retrieved from the Ebscohost database.

Mackreal, K. (2013). High-risk offender label – misses target,' says head of Ontario review board. *The Globe and Mail.* Retrieved from http://www.theglobeandmail .com /news /politics/high-risk-offender-label-misses-target-says-head-of-ontario-review-board /article9848889/

Major, J. L., & Davidson-Hunt, K. J. (2001). *Adult sex offender treatment program: Kenora-Rainy River District* [Internal document]. Kenora, ON: New Direction Counselling Centre.

McNiel, D. E., & Binder, R. L, (2007). Effectiveness of mental health court in reducing criminal recidivism and violence. *Psychiatric Services*, *164*(9), 1395–1403. Retrieved from ajp.psyhciatryonline.org

Ministry of Health and Long Term Care. (1999). *Making it happen: Operational framework for the delivery of mental health services and supports*. Retrieved from http://www.health.gov.on.ca/english/public/pub/mental/pdf/MOH-op.pdf

Ministry of Health and Long Term Care. (2006). *A program framework for: Mental health diversion / court support services*. Retrieved from http://www.hsjcc .on.ca/Uploads/A%20Program%20Framework%20for%20Mental%20Health%20 Diversion%202006.pdf

Ministry of Health and Long Term Care. (2007). *Community mental health: Common data set – mental health (CDS-MH*). Retrieved from http://www.mohltcfim.com /cms/upload/ a_6294/CDS-MH_Manual-er402Final26-Apr-07.pdf

National Criminal Justice Section, Canadian Bar Association. (2013). *Bill C-54 – not criminally responsible reform act*. Retrieved from http://www.cba.org/cba /submissions/pdf/13-20-eng.pdf

Northern Development Ministries. (n.d.). Northern Development Ministries. Retrieved from http://www.focusnorth.ca/ndmf_ontario.htm

Ontario Review Board. (2011a). *s.2 Unfit to stand trial.* Retrieved from http://www.orb.on.ca/scripts/en/legal/s2.asp

Ontario Review Board. (2011b). *s.16. Defence of mental disorder*. Retrieved from http://www.orb.on.ca/scripts/en/legal/s16.asp

Sapers, H. (2013). *Annual report of the office of the correctional investigator 2012–2013*. Retrieved from http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt /annrpt20122013-eng.pdf.

Sareen, J., Jagdeo, A., Cox, B. J., Clara, I., Have., M., Belik, S., Graff, R., & Stein, M. B. (2007). Perceived barriers to mental health service utilization in the United States, Ontario, and the Netherlands. *Psychiatric Services*, *58*, 357–364. Retrieved from ps.psychiatryonline.org

Schneider, R. (2009, April). *Mental health courts*. Paper presented at the Canadian Institute's 9th Annual Conference on Managing Legal Risks and Responsibilities in Mental Health Care, Toronto, ON.

Schizophrenia Society of Ontario. (2013). *What is stigma?* Retrieved from http://www .schizophrenia.on.ca /Schizophrenia-Psychosis/Stigma/What-is-Stigma

Skeem, J. L. & Mulvey, E. P. (2002). *Care of the mentally disordered offender in the community*. New York, NY: Oxford University Press.

Snowden, P. (1997). Practical aspects of clinical risk assessment and management. *British Journal of Psychiatry*, *170* (32), 32–34. Retrieved from the Ebscohost database.

Standing Senate Committee on Social Affairs, Science and Technology. (2005). *Out of the shadows at last: Part V: Federal leadership*. Retrieved from http://www .parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/pdf/rep02may06 part2-e.pdf

Steele, L, Dewa, C., & Lee, K. (2007). Socioeconomic status and self-reported barriers to mental health service use. *The Canadian Journal of Psychiatry*, *52*, 201–206. Retrieved from the Ebscohost database.

Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A. (2001). Mental health courts and the complex issue of mentally ill offenders. *Psychiatric Services*, *52*, 477–481. Retrieved from ps.psychiatryonline.org.

York, R. O., (2009). Evaluating human services: A practical approach for the human service professional. Wilmington, DE: Pearson Education.

Appendix A: Local Health Integration Network Data Use Approval

North West **LHIN**
RLISS du Nord-Ouest

975 Alloy Drive, Suite 201
Thunder Bay, ON P7B 5Z8
Tel: 807 684-9425 • Fax: 807 684-9533
Toll Free: 1 866 907-5446
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Télécopieur : 807 684-9533
www.northwestlhin.on.ca

August 22, 2012

Sara Dias
Canadian Mental Health Association, Kenora Branch
Box 1166, 721 Fifth Street
Keewatin, Ontario P0X 1C0

Dear Ms. Dias:

Re: Request for approval to access the Common Data Set at the Canadian Mental Health Association, Kenora Branch as part of your   Master of Social Work Thesis

I am writing to acknowledge receipt of your request for approval from the North West Local Health Integration Network to access the Common Data Set from your organization for the purpose of your research study titled "Does participation in Mental Health Court reduce recidivism?".

Based on our review of your planned approach to this research project, you have already received the approval directly from your employer at the Canadian Mental Health Association in Kenora (CMHAK) as per their requirements to adhere to the CMHAK policies and procedures which include the Personal Health Information Protection Act (PHIPA). The common data set is directly available through your organization and based on your internal approval process outlined in your email to us, you are able to proceed with your study accordingly.

I wish you success with your educational endeavors!

Sincerely

North West Local Health Integration Network

Appendix B: Informed Consents

Canadian Mental Health Association Kenora Branch Informed Consent to Service

Some important aspects of our services are discussed below.

Confidentiality:

- Information given to us by you is confidential. If it is determined that it is necessary to contact other persons in matters concerning you, your consent is implied within your "circle of care". This may include a family doctor, psychiatrist, previous counsellor, and/or other health professionals involved in your care.
- You may be asked to sign consent forms (express consent) for other professionals such as children's services workers, probation workers, lawyer or any other individual working with you that is not a health professional.
- You may express to us that you do not wish to have information shared with your "circle of care", you may refuse to sign consent, or you may withdraw your consent at any time.
- We will, whenever possible, notify you in advance of any situations where information is shared within your "circle of care".
- Please refer to the Ontario **Personal Health Information Protection Act** 2004
- Professionals have a responsibility to consult with a team about their work. This is done in a way that protects the anonymity of clients.
- **We collect information in a client information database. This database allows us to aggregate demographic information, report to our funders, and enable research efforts through the use of secondary data**.
- **In accordance with CMHA policies, generally client files will be kept a minimum of seven years after the end of the fiscal year during which the last contact with the client occurred**.

Exceptions to Confidentiality:

Situations may arise when we are unable to keep information confidential. These situations are:

- When we have reason to believe that a person under the age of 16 is at risk we are required by law to report the matter to Child and Family Services, or the police, giving all relevant information.
- When we believe that someone's life is at risk (either yours or another person's) and a reasonable plan for safety cannot be put into place, we will report the matter to the relevant services (police, hospital, doctor).
- When we receive a court subpoena for our records, or for your worker to appear in court we do not have the right to refuse to appear in court. Care will be taken in recording information for our records with this possibility in mind.
- In all situations where confidentiality is breached you will be informed in advance, if possible and your worker will discuss the matter with you.

Service Plans:

- You will be asked to assist your worker in determining your treatment plan's goals and objectives.
- We are required to keep a file of our contacts with you.
- Only CMHA Kenora Branch staff, and most particularly your worker will have access to your file.
- You have the right to see your file. If you wish to see your file, please make your request to your worker and arrangements will be made with the Privacy Officer to review your file.
- The file itself is the property of CMHA Kenora Branch.

Appointments:

- CMHA Kenora Branch is dedicated to providing responsive services. You may not always need an appointment to access services.
- If an appointment has been scheduled for you and you are unable to attend, please phone and let us know and it can be rescheduled.
- On occasion, if your appointment needs to be rescheduled, we may need to contact you.
- If you do not wish us to contact you, please notify us and it will be recorded in the file.

Evaluation:

- We request that you let us know how we are doing. Your feedback is invaluable. To assist us in evaluating our services, you will be asked to complete an anonymous client satisfaction questionnaire. This questionnaire is only for our use the information is aggregated. It will in no way impact your access to future services.
- The client satisfaction questionnaire will be reviewed by the Executive Director and the Board of Directors in order to improve services.

Incidents, Adverse Events and Disclosure:
- CMHA Kenora Branch has a policy to report incidents and adverse incidents and follows the **Canadian Disclosure Guidelines** of the Canadian Patient Safety Institute.

I have read the above and Consent to Services provided by CMHA Kenora Branch

_____   _____

Signature   Date

Cmhak Jan 2013

New Directions Counselling Centre Informed Consent to Service

New Directions Counselling Centre's programs include individual counselling, case management, court diversion, assertive community treatment and supportive housing. Discussed below are some important aspects of our services.

Confidentiality:

· Information given to us by you is confidential. If it is determined that it is necessary to contact other persons in matters concerning you, you will be asked to sign a consent form giving us permission to discuss your information with a third party. This may include a family doctor, psychiatrist, previous counsellor, and/or other professionals involved in your care.
· You may be asked to sign consent forms at the initial meeting with the worker.
· You may refuse to sign a consent, or you may withdraw your consent at any time.
· In situations where you are unable to give your written consent due to personal or physical limitations, verbal consent may be considered and recorded in your file.
· Professionals have a responsibility to consult with a team about their work. This is done in a way that protects the anonymity of clients.

Exceptions to Confidentiality:

Situations may arise when we are unable to keep information confidential. These situations are:

· When we have reason to believe that a person under the age of 16 is at risk we are required by law to report the matter to Child and Family Services, or the police, giving all relevant information.
· When we believe that someone's life is at risk (either yours or another person's) and a reasonable plan for safety cannot be put into place, we will report the matter to the relevant services (police, hospital, doctor).
· When we receive a court subpoena for our records, or for your worker to appear in court we do not have the right to refuse to appear in court. Care will be taken in recording information for our records with this possibility in mind.

In all situations where confidentiality is breached you will be informed in advance, if possible and your worker will discuss the matter with you.

Service Plans:

· You will be asked to assist your worker in determining your treatment plan's goals and objectives.
· We are required to keep a file of our contacts with you.
· Only New Directions Counselling Centre or ACT Team staff, and most particularly your worker will have access to your file.
· You have the right to see your file. If you wish to see your file, please make your request to your worker and arrangements will be made for your to review your file.

·   The file itself is the property of New Directions Counselling Centre.

Appointments:

·   New Directions Counselling Centre is dedicated to providing responsive services. You may not always need an appointment to access services.

·   If an appointment has been scheduled for you and you are unable to attend, please phone and let us know and it can be rescheduled.
·   On occasion, if your appointment needs to be rescheduled, we may need to contact you.
·   If you do not wish us to contact you, please notify us and it will be recorded in the file.

Evaluation:

·   We request that you let us know how we are doing. Your feedback is invaluable. To assist us in evaluating our services, you will be asked to complete an anonymous client satisfaction questionnaire. This questionnaire is only for our use and will be kept confidential. It will in no way impact your access to future services.
·   The client satisfaction questionnaire will be reviewed by the Executive Director and the Board of Directors in order to improve services.

I have read the above and understand the limits of service as described.

_____   _____

Signature   Date

ndcc 0302

Appendix C: CMHAK Ethics Framework and Guiding Principles

Guiding Organizational Values
Fiscal Responsibility
Innovation
Safety
Holistic approach
Empowerment
Environmental Responsibility
Evidence informed decision making

Ethical principles: These include but are not limited to broad concepts such as respect for client autonomy, beneficence, duty to do no harm, justice and fairness, corporate responsibility, avoidance of conflict of interest, Codes of Ethics (professional and corporate).

Accountability
Accountable to legal requirements of PHIPA, HCCA, SDA, CRA, Professional Codes of Ethics

Resources available for decision making		
for use by staff to guide ethical decisions		
Clinical Guidelines	Organizational Guidelines	Research Guidelines
- Consent to services - Consent disclosure - Confidentiality	- CMHA Kenora Code of Ethics Policies: computer use, accessibility, client safety policies, Occupational Health & Safety, Employment Standards - Consent procedures, privileged reports procedures - Pandemic planning, infection control	Disclosure for research, education and/or quality assurance Policy & Procedure
Dr. Arthur Schafer, Ethicist, University of Manitoba		
Available on request		

Research Ethics:

Canadian Mental Health Association Kenora Branch follows policies and procedures for staff and students regarding their access to Personal Health Information for research, education and quality assurance purposes. These policies and procedures apply to all Personal Health Information compiled in the organization's records, regardless of the medium or storage location.

Research Policy Development and Ethical Practice:

We commit ourselves to live our organizational values in our teams and to support each other in our daily activities to demonstrate behaviours of 'honesty, objectivity, integrity, accuracy, transparency, respect for intellectual property, confidentiality, responsible mentoring, and respect for colleagues, social responsibility, non discrimination, competence, legality and protection of human subjects". (Shamoo and Resnick 2009. Responsible Conduct of Research, 2nd edition, Oxford University Press). We also abide by our Policy 2.1, Program Guidelines and Standards, a Statement Of Principles Guiding Participation in Research.

Framework for Accountable Ethical Decision Making

Is it a Clinical or Corporate Issue?

Clinical	Corporate

Stage 1. Problem
Questions: What is the problem? Who is responsible for taking action required to implement the solution?
Objectives: Clarify the question, narrow it down to manageable proportions.
Comments: Beware of questions that are too vague, too fuzzy or beyond your scope of control. Ensure you have the authority to solve the problem and implement your solution.

Process:
Does our process reflect accountability, fairness, transparency, relevant rationale, an avenue for appeals, and enforcement?
What is the problem? Who is responsible?

Directions:
Is the proposal consistent with?
1. The strategic plan
2. Our goals
3. Mission and vision
4. Current policies

Stage 3: Stakeholders
Questions: Who are the relevant stakeholders/stakeholder groups? What are their interests? Are there conflicting interests between stakeholders? Should they be represented in the decision making process? Who is not at the table and what would they say?
Objectives: Identify stakeholders, Assess stakeholder interest. Assess the need for stakeholder consultation. Identify conflicts
Comments: Sometimes ethical conflicts are conflicts between the legitimate interests of different groups. We need to identify those interests and assess their legitimacy. We are accountable to our stakeholders.

Stage 2: Issues
Questions: What are the ethical issues at play in the problem? What are the relevant agencies policies and procedures? What professional ethics are relevant? What are the relevant legal considerations?
Objectives: Formulate context: What is the ethical issue?
Comments: Get all of the relevant ideas onto the table regardless if they seem right or wrong.

Stage 5: Decision
State the favoured outcome from Stage 1. Explain reasons for preferring chosen outcome over the alternatives.
Objectives: Clearly identify decision. Clearly articulate reasons for choice.
Comments: This stage represents your public accountability. Apply the TV test: Would you be comfortable going on the 6 o'clock news and stating/explaining your decision?

Stage 4: Options and Assessments
Questions: What are the possible courses of action? How do they rank? What are the positive and negative consequences of each option? Why should we follow one course over another? Why is this value most important in this case? Do we have previous obligations we are bound to honour?
Objectives: Identify alternatives, Evaluate, Form judgment. Make decision.
Comments: IT is always possible that some pressing moral value will outweigh normal considerations. These values could arise from a number of sources and would include maximizing the good, autonomy, justice/fairness, caring/compassion, stewardship and privacy

Stage 6: Implementation
Questions: What steps are required to put the choice into action? Who is required to perform the relevant actions? What evaluation mechanism for follow up is required? What educational or informational strategies are required?
Objectives: Turn decisions into action. Provide evaluation mechanism. Inform and educate.
Comments: The best decisions are useless unless implemented. Part of our accountability is the ability to review decisions to check outcomes. Criticism of values-based strategies is often ill or misinformed. An explicit information or education strategy to get your decision, justification and reasons out can forestall a great deal of clean up later.

Canadian Mental Health Association, Kenora Branch
Program Policies and Procedures

Policy	Policy Title	Category	Approved	Revised
2.1	Statement of Principles Guiding Participation in Research	Program Guidelines and Standards	September 24, 2012	May 6, 2013

Policy

We believe that research and evaluation are opportunities for learning that will inform and improve the work we do with individuals and the communities we serve.

We will support and encourage research that will benefit the socially and economically vulnerable communities with which we work.

We believe that community participation improves the quality and relevance of research and evaluation.

We are committed to identifying and addressing the barriers that impede meaningful community participation in research.

We recognize that research has sometimes resulted in the effect of further marginalizing vulnerable communities. We will work to encourage and support research that:

- Empowers individuals and communities and addresses underlying systemic barriers to bring about social change
- Improves service delivery
- Improves the understanding of the determinants of health

We are accountable to the individuals and communities with which we work. We believe research and evaluation provide opportunities for demonstrating that accountability.

We believe that research findings should be shared with the individuals and communities who participated in the research and are committed to ensuring that any findings are made accessible to participants.

We believe that qualitative research is a valuable tool for documenting the knowledge, expertise, and experiences of our communities.

We recognize the quality and importance of the research and evaluation that is already being done by our CHCs. We are committed to increasing the skills of staff and community members to be involved in designing, conducting, interpreting and applying research.

This policy applies to all Canadian Mental Health Association Kenora Branch staff.

Procedure

1. All research proposals will require approval by the Ethics Committee, CMHA Kenora Branch.
2. Under PHIPA privacy legislation any investigator who is proposing to conduct research without explicit client consent must provide a research plan as outlined below. Please answer all questions fully.
   - The affiliation of each person involved in the research
   - The nature and objectives of the research and the public or scientific benefit of the research that the researcher anticipates
   - A description of the personal health information required and the potential sources
   - A description of how the personal health information will be used in the research, and if it will be linked to other information, a description of the other information as well as how the linkage will be done
   - An explanation as to why the research cannot reasonably be accomplished without the personal health information and, if it is to be linked to other information, an explanation as to why this linkage is required.
   - An explanation as to why consent to the disclosure of the personal health information is not being sought from the individuals to whom the information relates.
   - A description of the reasonably foreseeable harms and benefits that may arise from the use of the personal health information and how the researchers intend to address those harms
   - A description of all persons who will have access to the information, why their access is necessary, their roles in relation to the research, and their related qualifications.
   - The safeguards that the researcher will impose to protect the confidentiality and security of the personal health information,

including an estimate of how long information will be retained in an identifiable form and why.

- Information as to how and when the personal health information will be disposed of or returned to the health information custodian
- The funding source of the research.
- Whether the researcher has applied for the approval of another research ethics board and, if so the response to or status of the application.
- Whether the researcher's interest in the disclosure of the personal health information of the performance of the research would likely result in an actual or perceived conflict of interest with other duties of the researcher.

Appendix D: University of Manitoba Research Ethics and Compliance Approvals

UNIVERSITY
OF MANITOBA | Research Ethics
and Compliance
Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Fax +204-269-7173

RENEWAL APPROVAL

September 5, 2013

TO: Sara Patricia Garcia Dias
             Principal Investigator

FROM:
             Psychology/Sociology Research Ethics Board (PSREB)

Re: Protocol #P2012:056
             "Does participation in Mental Health Court reduce
             recidivism?"

Please be advised that your above-referenced protocol has received approval for
renewal by the **Psychology/Sociology Research Ethics Board**. This approval
is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be
reported to the Human Ethics Secretariat in advance of implementation of such
changes.

UNIVERSITY
OF MANITOBA | Research Ethics
and Compliance
Office of the Vice-President (Research and International)

Human Ethics
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APPROVAL CERTIFICATE

October 25, 2012

TO: **Sara Patricia Garcia Dias**
        Principal Investigator

FROM:

        Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2012:056**
        "Does participation in Mental Health Court reduce recidivism?"

Please be advised that your above-referenced protocol has received human ethics approval by the **Psychology/Sociology Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). It is the researcher's responsibility to comply with any copyright requirements. **This approval is valid for one year only**.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- If you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to the Office of Research Services, fax 261-0325 - please include the name of the funding agency and your UM Project number. This must be faxed before your account can be accessed.

- if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba Ethics of Research Involving Humans.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) in order to be in compliance with Tri-Council Guidelines.

UNIVERSITY OF MANITOBA | Research Ethics and Compliance

Office of the Vice-President (Research and International)

Human Ethics
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Canada R3T 2N2
Phone +204-474-8880
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September 25, 2012

TO: **Sara Patricia Garcia Dias**
Principal Investigator

FROM:

Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2012:056**
"Does Participation in Mental Health Court Reduce Recidivism?"

Thank you very much for your patience in waiting for this feedback on your application to the PSREB. This summer saw a surge of applications, and a change in committee membership which made prompt responses difficult. Still, I must extend my apologies for the delay in passing this feedback along to you. Further, I want to give you assurance that this delay is not a "new normal", and that future applications will be responded to more rapidly.

Thank you for your submission to the Psychology/Sociology Research Ethics Board. The review process has been completed, and some additional information, clarification and revision are required.

1. Clarify how the conflict of interest between the applicant's position as the Team Leader for the Courts Program at CMHAK, and the use of their clients as participants will be managed in terms of participants' right to refuse participation in this study.
2. Clarify how participants' rights to privacy are being protected given that the researcher plans to access information about their participants' recidivism (i.e., involvement in court proceedings or forensic hospitalizations) through their employment status.
3. Develop a form for Informed Consent where participants are informed about the voluntary nature of participation in this study and their rights to refuse participation without consequence, etc.

Approval is pending your response to the above items. Your written response, **including a cover letter which addresses each of the above items, and includes any revised forms (with revisions highlighted, if possible)**, should be sent to Maggie Bowman, Human Ethics Coordinator, 208 - 194 Dafoe Road (CTC Building), or by e-mail to _____ **(Please note that there is no need to re-submit the entire application, just those pertinent sections.)** If you have any questions you may contact me directly at

Certificate of Completion

This document certifies that

Sara Dias

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: 15 July, 2012

Appendix E: Pearson Chi-Square Test Results for Descriptive Statistics

Tables E1 to A8 show Pearson chi-square results for variables presented in

Chapter 4.

Table E1

Pearson Chi-Square Test Results for Demographic Variables

Pearson chi-square test variable	Value[a]	df	Asymp. Sig. (2-sided)	Minimum expected count	Number of valid cases
Gender	1.357	1	.244	17.66	277
Age	3.193	3	.363	13.06	277
Marital status	.040	1	.842	14.59	276
Participant community	.047	1	.828	22.71	252
Ancestry	.497	1	.481	18.76	271
Language	2.170	1	.141	22.84	251
Referral source	.192	1	.661	20.56	277
Current residence type	2.530	1	.112	5.00	253
Living situation	1.974	1	.160	13.04	271
Residence support	5.228	1	.022	6.99	275
Employment status	.214	1	.644	19.48	268
Education level	1.985	1	.159	7.10	251
Income source	2.590	2	.274	10.28	247

Note. a. 0 cells (0.0%) have expected count less than 5.

Table E2

Pearson Chi-Square Test Results for Psychiatric and Diagnostic Characteristics

Pearson chi-square test variable	Value[a]	df	Asymp. Sig. (2-sided)	Minimum expected count	Number of valid cases
Anxiety disorder	23.031	1	.000	21.96	274
Depression	17.673	1	.000	20.79	274
Suicide attempts	3.580	1	.058	27.56	274

Note. a. 0 cells (0.0%) have expected count less than 5.

Table E3

Pearson Chi-Square Test Results for Primary Diagnoses and Other Illness Information

Pearson chi-square test variable	Value[a]	df	Asymp. Sig. (2-sided)	Minimum expected count	Number of valid cases
Primary diagnoses	3.580	1	.058	27.56	274
Developmental handicap	1.210	1	.271	7.47	274
Schizophrenia	.097	1	.756	12.15	274
Substance-related disorder	2.888	1	.089	17.28	274
Mood disorder	1.142	1	.285	11.91	274
Other illness	4.025	2	.134	7.28	268
Concurrent disorder	3.346	1	.067	18.22	274

Note. a. 0 cells (0.0%) have expected count less than 5.

Table E4

Pearson Chi-Square Test Results for Legal Status

Pearson chi-square test variable	Value [a]	df	Asymp. Sig. (2-sided)	Minimum expected count	Number of valid cases
Legal status upon intake	4.862	2	.088	7.77	219
Legal status outcome	1.428	1	.232	6.51	219

Note. a. 0 cells (0.0%) have expected count less than 5.

Table E5

Pearson Chi-Square Test Results for Re-offence and Readmission to Hospital, 2005 and 2010

Pearson chi-square test variable	Value [a]	df	Asymp. Sig. (2-sided)	Minimum expected count	Number of valid cases
Re-offence	7.295	1	.007	20.09	117
Readmission to hospital	5.426	1	.020	14.66	116

Note. a. 0 cells (0.0%) have expected count less than 5.

Table E6

Pearson Chi-Square Test Results for Re-offence and Other Variables (2005)

Pearson chi-square test variable	Value [a]	df	Asymp. Sig. (2-sided)	Minimum expected count	Number of valid cases
Re-offence and residence support	1.377	2	.512	1.48	65
Re-offence and depression	1.340	2	.247	3.45	65
Re-offence and anxiety	.668	1	.414	2.95	65

Note. a. 4 cells (66.7%) have expected count less than 5.

Table E7

Pearson Chi-Square Test Results for Re-offence and Other Variables (2010)

Pearson chi-square test variable	Value [a]	df	Asymp. Sig. (2-sided)	Minimum expected count	Number of valid cases
Re-offence and residence support	2.041	2	.360	0.52	50
Re-offence and depression	3.594	2	.058	3.64	50
Re-offence and anxiety	.046	1	.830	4.68	50

Note. a. 4 cells (66.7%) have expected count less than 5.

Table E8

Pearson Chi-Square Test Results for Readmission to Hospital and Other Variables (2005)

Pearson chi-square test variable	Value [a]	df	Asymp. Sig. (2-sided)	Minimum expected count	Number of valid cases
Readmission to hospital and level of support	3.512	2	.173	1.15	65
Readmission to hospital and depression	3.602	1	.058	2.69	65
Readmission to hospital and anxiety	2.222	1	.136	2.31	65

Note. a. 3 cells (50.0%) have expected count less than 5.

Table E9

Pearson Chi-Square Test Results for Readmission to Hospital and Other Variables (2010)

Pearson chi-square test variable	Value [a]	df	Asymp. Sig. (2-sided)	Minimum expected count	Number of valid cases
Readmission to hospital and level of support	1.497	2	.473	0.36	50
Readmission to hospital and depression	4.268	1	.039	2.52	50
Readmission to hospital and anxiety	.340	1	.560	3.24	50

Note. a. 4 cells (66.7%) have expected count less than 5