



ARCHIVED - Archiving Content

Archived Content

Information identified as archived is provided for reference, research or recordkeeping purposes. It is not subject to the Government of Canada Web Standards and has not been altered or updated since it was archived. Please contact us to request a format other than those available.

ARCHIVÉE - Contenu archivé

Contenu archivé

L'information dont il est indiqué qu'elle est archivée est fournie à des fins de référence, de recherche ou de tenue de documents. Elle n'est pas assujettie aux normes Web du gouvernement du Canada et elle n'a pas été modifiée ou mise à jour depuis son archivage. Pour obtenir cette information dans un autre format, veuillez communiquer avec nous.

This document is archival in nature and is intended for those who wish to consult archival documents made available from the collection of Public Safety Canada.

Some of these documents are available in only one official language. Translation, to be provided by Public Safety Canada, is available upon request.

Le présent document a une valeur archivistique et fait partie des documents d'archives rendus disponibles par Sécurité publique Canada à ceux qui souhaitent consulter ces documents issus de sa collection.

Certains de ces documents ne sont disponibles que dans une langue officielle. Sécurité publique Canada fournira une traduction sur demande.

Needs Assessment of Forensic Mental Health Programs and Services for Offenders in Saskatchewan:

Condensed Report

**Prepared by: Forensic Interdisciplinary
Research: Saskatchewan Team**

for the

**Centre for Forensic Behavioural
Science and Justice Studies**



**UNIVERSITY OF
SASKATCHEWAN**

December, 2012

The Centre for Forensic Behavioural Science and Justice Studies

The Centre for Forensic Behavioural Science and Justice Studies (CFBSJS) 'The Centre' was formally established at the University of Saskatchewan in 2011. For more information about the Centre including mandate of the Centre and sources of Centre funding see Website: <http://www.artsandscience.usask.ca/fbsjs/>

Project Funding

The needs assessment was commissioned by 'the Centre' at the University of Saskatchewan and undertaken from 2010 to 2012 by members of FIRST, the Forensic Interdisciplinary Research: Saskatchewan Team. FIRST is made up of a group of faculty members at the University of Saskatchewan and community researchers, specialists, experts, and practitioners representing diverse disciplines that work in the field and/or study forensic mental health in Saskatchewan.

Disclaimer

The views and opinions expressed in this study are those of the authors and do not represent any overarching official policy or opinion on the part of the University of Saskatchewan. The views and findings presented herein have not been reviewed by, nor are they meant to reflect the position of the Correctional Service of Canada (CSC), or the Government of Saskatchewan, Ministry of Justice, Corrections and Policing Division (formally the Ministry of Corrections, Public Safety, and Policing).

Acknowledgments

We would like to thank the families of offenders, frontline workers, and facility managers who participated in this research. Special thanks to: Ronda Appell, the Centre Coordinator; Christina Jones, Research Assistant, for her work on the EndNote data base; Lyndsay Hnatuk for helping with participant recruitment; and members of *FIRST for their input and editing on proposals, surveys, review of initial research findings, and final research reports. Study design and research coordinator for this project was S. Lee Sanders BAHon, MA, PhD student.

***First Members:** Olajide O. Adelugba, MBBS, FWACP, DPM; Arlene Kent-Wilkinson, RN, BSN, MN, PhD; Glen Luther, QC, LLB, LL.M.; Mansfield Mela, MBBS, FWACP, MRC (Psych), MSc Psych, FRCPC; Terry Nicholaichuk, PhD; Cindy Peternelj-Taylor, RN, BScN, MSc, DF-IAFN, PhD (c); Mark Olver, BA (Hons), PhD; Phil Woods, RMN, RPN, PhD; & Stephen Wormith, BA, MA, PhD.

For more information about the report contact:

Arlene Kent-Wilkinson: arlene.kent@usask.ca
S. Lee Sanders: lee.sanders@usask.ca

Citation for the Study

Kent-Wilkinson, A., & Sanders, S. L., Mela, M., Peternelj-Taylor, C., Adelugba, O, Luther, G., Woods, P., Olver, M., & Wormith, J. S. (2012). *Needs assessment and of forensic mental health services and programs for offenders in Saskatchewan*. Final Report (condensed). Conducted by Forensic Interdisciplinary Research: Saskatchewan Team (FIRST). Centre for Forensic Behavioural Sciences and Justice Studies, Saskatoon, SK: University of Saskatchewan.

December 2, 2012

FINAL REPORT (CONDENSED)

**Needs Assessment of Forensic Mental Health Services and Programs
for Offenders in Saskatchewan**

Arlene Kent-Wilkinson RN, CPMHN(c), BSN, MN, PhD
S. Lee Sanders BA (Honours), MA, PhD student
Mansfield Mela, MBBS, FWACP, MRC (Psych), MSc, Psych, FRCPC
Cindy Peternelj-Taylor, RN, BScN, MSc, DF-IAFN, PhD(c)
Olajide O. Adelugba, MBBS, FWACP, DPM
Glen Luther, QC, LLB, LLM
Phil Woods, RMN, RPN, PhD
Mark Olver, BA (Hons), PhD
J. Stephen Wormith, BA, MA, PhD

Members of:

Forensic Interdisciplinary Research: Saskatchewan Team (FIRST)

Research conducted for:

The Centre for Forensic Behavioural Sciences and Justice Studies
University of Saskatchewan
Saskatoon, Saskatchewan, Canada

EXECUTIVE SUMMARY (Condensed)

Although national and provincial initiatives are in place to address the needs of mentally disordered offenders (MDOs), Saskatchewan has unique demographic needs that are exacerbated among Aboriginal offenders in general, and Aboriginal women and youth in particular. A needs assessment of offenders with compromised mental health issues and an environmental scan of forensic mental health services and programs was undertaken in Saskatchewan from 2010 to 2012. This study was designed with three questions in mind: 1) What are the needs of offenders in Canada with compromised mental health including substance use disorders?; 2) What are the mental health needs of Saskatchewan offenders and how are they currently being met in the province?; and 3) What evidence-based forensic mental health services are needed in Saskatchewan? The study was carried out in three concurrent phases to capture the social, geopolitical, and cultural circumstances unique to the province of Saskatchewan. This included: 1) interviews with immediate family members of offenders; 2) an E-scan of correctional and community programming and services completed by facility managers; and 3) surveys with front line personnel who engage offenders in correctional environments and in the community. The triangulated methodology included a literature review of government documents and published literature, together with statistical and thematic analyses of the data from the three phases of the study.

A key finding from our study was that Aboriginal offenders with addictions, substance use disorders, and mental health issues are not accessing services equal to their level of need in Saskatchewan. Chronic substance abuse, addictions issues, and undiagnosed and untreated mental illness were found to be major problems identified for offenders represented in the study, as was a lack of pre-trial mental health and substance abuse screening, inadequate addictions/substance abuse programming, and failure to access culturally-relevant programs and services even where they do exist. Through scanning, we found that a menu of mental health and addictions programs and services exist at the correctional and urban community level, but that a few problematic areas exist in the northern health regions that service predominantly Aboriginal communities. Offenders are being released into some communities that are ill prepared to supervise, due to the high needs of the community itself.

Findings revealed major gaps in forensic mental health services in Saskatchewan compared to other provinces (e.g., insufficient inadequate forensic community outpatient services, and non-existent mental health court/diversion programs). Evidence suggests that decreased recidivism, and increased cost-effectiveness and mental health outcomes exist where therapeutic problem solving courts have been established. Both family members of offenders and frontline personnel felt there was a need for mental health courts, that it was the next logical step, a form of social justice, and a good intervention if cultural components could be built into the structure, and if mental health treatment orders could be enforced.

Respondents provided diverse opinions on the needs of Saskatchewan offenders and the contributing factors of criminal activity in their communities, and offered a snapshot in time of the ability of mental health programs and services currently available in our province to meet the needs of forensic clients with compromised mental health.

TABLE OF CONTENTS

Executive Summary	4.
TABLE of CONTENTS	5.
1.0 Introduction	8 .
Research Intent.....	8.
Definition of Terms	8.
Research Purpose and Objectives.....	9.
Research Questions	9.
Ethical Approval	9.
Report Overview.....	9.
2.0 LITERATURE REVIEW	11.
Search Strategy.....	11.
Database Search Limitations.....	11.
Sources of Information.....	11.
Review of Literature.....	12.
2.1 What are the issues of mentally disordered offenders generally?	12.
2.2 What are the needs of mentally disordered offenders generally?	18.
2.3 Mental Health Strategies and Initiatives	25.
3.0 METHODOLOGY	26.
Data Collection.....	26.
Data Analysis	29.
4.0 FINDINGS	32 .
Phase I - Interviews with Family Members of Offenders	32
Phase II – Surveys/Scans – Facility Manager	64
Phase III – Surveys – Frontline Staff	89
5.0 DISCUSSION	93 .
5.1 Defining Mental Illness and the Mentally Ill Offender	93.
5.2 Fiscal Responsibility of Forensic Mental Health Services	97.
5.3 Interventions/Best Practices - Mental Health Court.....	99.
6.0 RECOMMENDATIONS	103.
#1. Need for a Provincial Mental Health Strategy & Continuum of care	103.
#2. Need for a Consistent and Precise Definition of Mentally Ill Offender.....	103.
#3. Need for more Culturally-Relevant Forensic Programming.....	104.

#4. Need for Increased Funding.....	104.
#5. Need for Specialized Forensic Mental Health Services	105.
Limitations of the Study... ..	105.
Perceived Benefits of this Study and Implications for Research & Policy.....	105.

7.0 CONCLUSION **107.**

8.0 REFERENCES **110.**

Tables

Table 2.1.1: Mental Health Problems/Issues of MDOs.....	12.
Table 2.2.1: Criminogenic Needs of MDOs in SK	18.
Table 2.2.2: MDOs in Comparison to the General Population.....	19.
Table 2.2.3: Aboriginal Offenders in Comparison to non –Aboriginal Offenders.....	20.
Table 2.3.1: Correctional Mental Health Initiatives & Strategies in Canada	25.
Table 4.1.1: Correctional Facilities.....	33.
Table 4.2.1: Offender Mental Health Concerns	34.
Table 4.3.1: Respondent Attitudes toward Effectiveness of Mandatory and Conditional	36.
Forensic Programs and Services Received	41.
Table 4.3.2: Correctional Programming and Service Needs.....	41.
Table 4.4.1: Community Programming Needs.....	44.
Table 4.5.1: Outcome of Early Release	47.
Table 4.5.2: Outcomes of Police Diversion.....	47.
Table 4.5.3: Positive Outcomes of Police Diversion.....	48.
Table 4.5.4: Negative Outcomes of Police Diversion.....	48.
Table 4.5.5: Issues Facing MDOs in Custody.....	49.
Table 4.5.6: Issues Facing MDOs in the Community.....	52.
Table 4.6.1: Consequences of Not Getting a Program, Service/Treatment in the Community...54.	
Table 4.7.1: Programs and Services Needed in Saskatchewan.....	57.
Table 4.7.2: Programs and Services as Forms of Intervention.....	57.
Table 4.7.3: Views on Mental Health Court in Saskatchewan.....	62.

Acronyms

CHA	Canada Health Act
CCJS	Canadian Centre for Justice Statistics
CMHA	Canadian Mental Health Association
CPIC	Canadian Police Information Centre
CCC	Community Correctional Centre
CMHI	Community Mental Health Initiative
CNUs	Complex Needs Units
CoMHISS	Computerized Mental Health Intake Screening System
CCRA	<i>Corrections Conditional Release Act</i>
CPSP	Corrections, Public Safety and Policing (formerly until mid 2012) (now the Ministry of Justice, Corrections Division)
CSC	Correctional Services Canada
CJS	Criminal Justice System
DOJ	Department of Justice
FPT	Federal, Provincial, Territorial Partners
FASD	Fetal Alcohol Spectrum Disorder
FIRST	Forensic Interdisciplinary Research: Saskatchewan Team
IMHI	Institutional Mental Health Initiative
IMHCUs	Intermediate Mental Health Care Units
MDO	Mentally Disordered Offender
MHCC	Mental Health Commission of Canada
NGO	Non-Governmental Organization
OMS	Offender Management System
OCI	Office of the Correctional Investigator, Canada
WED	Warrant of Expiry Date
YCJA	<i>Youth Criminal Justice Act</i> (also Act)

**Needs Assessment of Forensic Mental Health Services and Programs
for Offenders in Saskatchewan
FINAL REPORT
(Condensed Version)**

1.0 INTRODUCTION

The criminalization of the mentally ill, over-representation of Aboriginal peoples in the criminal justice system, and increasing incarceration rates among young and female offenders are recognized as important social, and community health issues in Canada. The needs of offenders with compromised mental health and factors that affect criminal behaviour are increasingly complex, and require multi-faceted approaches to research and training. Institutions and communities providing mental health services and programs face insurmountable challenges due to a changing, aging, and increasingly more complex offender population in Saskatchewan. To identify and understand these needs, a province-wide study from 2010-2012 involved a needs assessment of forensic mental health programs and services for offenders in Saskatchewan. The study was commissioned by the Centre for Forensic Behavioural Studies and Justice Studies (CFBSJS) (the 'Centre') at the University of Saskatchewan and undertaken by the authors and members of the Forensic Interdisciplinary Research: Saskatchewan Team (FIRST).

Research Intent

The purpose of this study was to acquire a baseline of information on the needs of mentally disordered offenders (MDOs) in Saskatchewan and, to produce a document that identifies needs and issues unique to Saskatchewan to help to promote and sustain an effective and efficient criminal justice system. The objective of the study was to identify forensic mental health services and programming currently available in Saskatchewan in relation to the mental health needs of adult and young offenders resident in federal, provincial, or municipal correctional and detention facilities, within the court system, and/or engaged with post release/ supervision services in the community. Whether the needs of, and services for mentally disordered offenders in Saskatchewan were similar to, or different from the needs and services of their national counterparts, was a fundamental aim of this research.

Definitions of Key Terms

The importance of clear definitions became increasing evident throughout the process of the study. The key terms used in this study were defined as follows:

Mentally disordered offender. The Centre at the University of Saskatchewan, defined mentally ill in the criminal justice system as mentally disordered offenders including those dually diagnosed with addiction and substance abuse, and the relationship between mental health and corrections (University of Saskatchewan, 2010, 2012). For the purpose of this study, the term 'MDO' or offenders with compromised mental health' was used exclusively throughout this report to refer to adult and young offenders with mental disorders including substance abuse disorder, developmental disorders, cognitive disorders including FASD, and all co-occurring disorders who are involved at any stage of the process in the criminal justice system,

Forensic mental health system and services. “The forensic mental health system consists of an array of inpatient and community services providing mental health care to persons with co-occurring legal and mental health problems” (Livingston, 2006, p. 56). ‘Forensic’ is a term used in this report to describe the application of knowledge about mental health issues and services pertaining to the law or to the courts.

Needs assessment. A needs assessment is a systematic and ongoing process of providing information about the needs of a specific population to inform policy-making and programming decisions (Reviere, Berkowitz, Carter, & Ferguson, 1996). A needs assessment was engaged as a formal process of data collection and conveyance of results of the research on forensic mental health programs and services for offenders in Saskatchewan.

Criminogenic needs. Criminogenic needs are factors that can be changed, and when changed are associated with changes in recidivism among offenders (Bonta, 2000).

Environmental scan. The goal of scanning is to account for institutional and organizational factors and changes that can inform internal policy, program, and service development and decision-making practices that could result in the development of a strategic action plan informed by evidence-based research. The method is engaged in this study as a way to obtain information about forensic mental health services, gaps in services, and barriers to service provisions in the province based on offenders’ mental health and criminogenic needs.

Aboriginal peoples. Section 35(2) of Canada’s *Constitution Act, 1982* defined Aboriginal peoples as “including, Indian (First Nations), Inuit and Métis peoples (*Constitution Act, 1982*). The terms Aboriginal and Indigenous (which some now prefer) were used interchangeably in this report.

Research Questions

This study was designed with three questions in mind: 1). What are the needs of offenders with compromised mental health and how are they being met?; 2) What are the mental health needs of Saskatchewan offenders and how are they currently being met?; and 3) What evidence-based forensic mental health services are currently needed in the province?

Ethical Approval

This study was approved by the University of Saskatchewan Behavioural Research Ethics Board in August 2010 (BEH-1069b) and extended to August 2012 to allow for various clearances by participating agencies between August 2010 and May 2012.

Project Overview

It was not possible to provide a complete documentation of all issues that impact offenders with compromised mental health in Saskatchewan due to the breadth and complexity of the problem, limited access to institutional data, and scope of offender populations. Best efforts were made to ensure that this assessment contained meaningful and important information about factors unique to our province and what services are needed to alleviate gaps and barriers to provide the best practices or care.

Section I of this report contains the background and purpose of the study, research questions, and objectives; Section II provides a literature review of the research problem divided into five parts; The methodology of this study is reported in Section III which describes

data collection methods and phases of the study followed by the data analysis; Section IV presents our findings unique to Saskatchewan in the three phases of the study; Discussion topics with implications for future research needed are included in Section V; Section VI provides recommendations for strategic action to address the findings outlined in this report; Section VII concludes this report; and finally the Appendices include information about the recruitment process, participation criteria, consent, and debriefing materials used.

Sources of data. There are main three sources of data for this study: 1) interviews with family members of offenders; 2) survey of frontline personnel who interact with offenders; and, 3) scans, and survey with correctional and health facility managers.

Timeline of the study. The needs assessment and environmental scan project was undertaken from 2010 to 2012. During which time a literature review was completed, the survey tools were designed and implemented, data was collected and analyzed and the final report was written.

2.0 LITERATURE REVIEW

Literature Review

Our research questions were explored through a review of the published literature, government reports, and newspaper articles regarding mental health needs and related services for offenders including any publications relevant to Saskatchewan. We aimed to capture a synopsis of the most recent work that had been published with regard to the needs of and services for offenders with compromised mental health issues.

Search Strategy

EndNote software was used to identify academic literature on MDOs. The search engines included Academic Search Premier, LegalTrac, Medline, PsychInfo, Pubmed and Wiley. The key terms searched in the data bases included 'offender', 'mental disorder', 'mental illness', 'mentally disordered offender', 'substance use disorder', 'mental health courts', 'diversion programs', 'Aboriginal', 'addictions', 'mental health needs', 'mental health services', 'mental health treatment'; and 'mental health needs assessment'. A total of 47,814 articles were identified that directly related to offenders with compromised mental health. Of this number, 1,523 publications were Canadian content of which included 292 related research and clinical publications written in the last 20 years by the members of the FIRST team. There was noted to be a dearth of literature on MDOs in Saskatchewan specifically from beyond this research cohort.

Database Search Limitations

Database searches were limited to English language, although specific international journals translated into English were included. All database searches were restricted to articles written after 1990. Searches were also limited to journal articles with the exception of LegalTrac searches that included magazine articles, as this was the format of many law publications. Although the database searches were restricted to articles written post 1990, milestone commissions and reports significant to the rights of offenders with mental disorders, and the formation of forensic mental health services in Canada prior to 1990 were revisited (i.e., Archambault Commission, 1938; Fauteux Report, 1956; Chalke Report, 1972).

Sources of Information

Our review included significant government reports and major research and clinical publications after 1990 in addition to news articles from the Canadian media and press.

Concerns relating to the involvement of persons with mental health problems in the criminal justice system were not new. Various levels of governments and other interested organizations have examined this issue over the last few decades. As a result, we included a number of in-depth critiques, lay-studies, and valuable reports that had shed light on the issue in order to capture public sentiment about MDOs and the strengths of the institutions providing for their mental health care.

Government reports. Two primary sources of information included resources from the Correctional Services Canada (CSC) and the Office of the Correctional Investigator (OCI) (CSC, 2012d; OCI, 2012b). The needs and issues of MDOs have been well identified and researched

nationally by CSC, in addition to being monitored and critiqued by OCI. There were 204 CSC research reports and 39 OCI reports reviewed using our search criteria in this study. Government and media websites were also searched.

News articles. Newspaper articles were monitored from 2010-2012 for articles and press releases relative to MDOs. Issues relative to offenders with compromised mental disorders were released in the following publications: CBC News, the Canadian Press, the Globe and Mail, and the Star Phoenix. Key topics in the press included, but were not limited to: increasing numbers of mentally disordered offenders, overcrowding, mental health strategies, tough federal legislation on young criminals, fetal alcohol syndrome disorder (FASD), dangerous offender designation, the Omnibus crime bill, budget increases to keep mentally ill out of jail, gaps in mental health service delivery, segregation of elderly offenders, and issues of Aboriginal offender sentencing. The news articles provided another perspective of the current issues of concern being debated in the public forum.

Review of the Literature on Issues and Needs of MDO's

The literature was reviewed for the purpose of addressing the three research questions: What are the needs of offenders with compromised mental health and how are they being met?; 2) What are the mental health needs of Saskatchewan offenders and how are they currently being met?; and 3) What evidence-based forensic mental health services are currently needed in the province? A summary is provided here to address the first question only. See full Final Report for complete literature review. The review was divided into two parts: (1) Mental Health Problems/Issues of MDOs or barriers to mental health services; and (2) Mental Health (Criminogenic) Needs of MDOs.

2.1. What are the issues of mentally disordered offenders?

What are the issues of mentally disordered offenders?

Table 2.1.1 Mental Health Problems/Issues of MDOs

Mental Health Problems/Issues of MDOs (from the literature)
<p>A. Criminalization/involvement of mentally ill persons in the CJS</p> <p>B1. Increased numbers of Offenders with mental health issues B2. Increased numbers of Female offenders with mental health issues B3. Increased numbers of Young offenders with mental illness B4. Increased numbers of Aging offenders</p> <p>C1. Overrepresentation of Aboriginal offenders C2. Overrepresentation of Aboriginal woman offenders C3. Overrepresentation of Aboriginal young offenders</p> <p>D1. Offenders with complex mental health issues (Major mental illness) D2. Substance use disorders, D3. Co-occurring disorders,</p>

D4. Cognitive Disorders including FASD

D5. Suicide/Self Harm

E. Overcrowding

F. Stigmatization

G. Security/ Segregation /Safety

H. Recidivism of MDOs

I. Gang /Social Peer Associates

J. Abuse/ Aggression/Violence

A. Criminalization/involvement of mentally ill persons in the CJS

As a society, we are criminalizing, incarcerating and warehousing the mentally disordered in escalating numbers. The needs of mentally ill people are unfortunately not always being met in the community health and social welfare systems. As a result, the mentally ill are increasingly becoming deeply entangled in the criminal justice system and their problems are often compounded by substance abuse (OCI, 2010b; 2012a). Many argue that persons with mental illness who offend enter a cycle of criminalization where they are more likely to return to the criminal justice system than those who are not mentally ill (Statistics Canada, 2009c).

B1. Increased numbers of Offenders with mental health issues

Irrefutable evidence has existed for some time to show that the prevalence of mental disorder among those in the criminal justice system (prisoners and offenders or accused on community orders) is significantly greater than is found in the general population (CSC, 2009a, 2009i; OCI, 2012a; Ogloff, Davis, & Somers, 2004; 2005). More than one out of ten (13%) male offenders in federal custody have been identified at admission as presenting mental health problems and this proportion has almost doubled since 1996/97 (7% to 13%) (CSC, 2009i). “One consistent finding in the literature has been a higher prevalence of mental illness for remand prisoners than for sentenced prisoners” (Ogloff, Davis, & Somers, 2004, p. 18; 2005). Overall, these results indicate that not only are large numbers of prisoners suffering from mental illness, even larger numbers of mentally disordered offenders are being remanded prior to trial (Ogloff et al., 2004, p. 19; 2005).

B2. Increased numbers of Female offenders with mental health issues

In the last ten years, the number of women admitted to federal jurisdiction has increased by almost 40%. Women offenders now account for close to 5% of the total offender population. It is a growing and increasingly complex and diverse population (OCI, 2010a). It has been reported that 30.1 per cent of women offenders compared to 14.5% of male offenders had previously been hospitalized for psychiatric reasons (Public Safety Canada, 2008; OCI, 2012a). Twenty-nine percent of women offenders in federal custody were identified at admission as presenting mental health problems and this proportion has also risen more than two fold since 1996/97 (13% to 29%) (CSC, 2009i).

B2. Increased numbers of Young offenders with mental illness

Two thirds of youth in the juvenile justice system have one or more diagnosable mental disorders (Odgers, Burnette, Chauhan, Moretti, & Reppucci, 2005). Young offenders are often involved in gang activity (Odgers et al., 2005). Many end up in the juvenile court system, where they exhibit comorbid mental health problems that may remain untreated. Aboriginal male inmates are twice as likely to be affiliated with a gang (OCI, 2012a).

B4. Increased numbers of Aging offenders

The growing number of offenders aged 50 years and older behind bars now accounts for one-in-five federal inmates. Health care costs of managing the aging population of offenders has increased by 50% in the last ten years (OCI, 2012a). The health and safety concerns of aging inmates included victimization, mobility and assistive living needs, learning, correctional and vocational programming and palliative care. Many older inmates have concerns about their personal safety. The rising numbers of aging offenders are increasingly physically compromised. Quebec has the highest percentage of aging offenders (26 per cent), the Prairies have the lowest (11 per cent) (CBC News, 2012b). Although current statistics indicate lower numbers of older offenders in the Prairie provinces, these numbers are expected to increase as the offender population ages in Manitoba and Saskatchewan according to provincial projections of increases in Aboriginal offenders (OCI, 2009b; Public Safety Canada, 2008).

C1. Overrepresentation of Aboriginal offenders

Approximately 4% of the Canadian population is Aboriginal, while 21.4% of the federal incarcerated population is Aboriginal (OCI, 2012a). The Prairie Region accounted for 51% of all new net inmate growth between March 2010 and March 2012. Aboriginal offenders accounted for most of this increase and now represent 43% of the total offender population in the Prairie Region (OCI, 2012a). Over the last 10 years, while the overall non-Aboriginal inmate population has modestly increased by 2.4%, the Aboriginal inmate population has increased significantly by 37.3% (OCI, 2012a). The proportion of Aboriginal offenders presenting mental health problems at admission has increased from 5% in 1996/97 to 14% in 2006/07, but has settled at 9% in the 2008/09 fiscal year (Brink, Doherty & Boer, 2001).

C2. Overrepresentation of Aboriginal woman offenders

Aboriginal women offenders comprise 33 per cent of the total female inmate population under federal jurisdiction (OCI, 2010a). The number of federally incarcerated women has jumped by 40 per cent and aboriginal women by 80 per cent in the last five years. Incarceration rates for these two groups far exceed their representation rates in Canadian society at large (CBC news, 2012e; OCI, 2012a).

C3. Overrepresentation of Aboriginal young offenders

Aboriginal offenders tend to be younger, to be more likely to have served previous youth and/or adult sentences, to be incarcerated more often for a violent offence, to have higher risk ratings, to have higher need ratings, to be more inclined to have gang affiliations, and to have more health problems, including Fetal Alcohol Spectrum Disorder (FASD) and mental health issues (OCI, 2009b). With the Aboriginal population much younger than the

overall Canadian population and experiencing a higher growth rate, the problem of Aboriginal over-representation in corrections continues to worsen rather than improve (OCI, 2009b; Public Safety Canada, 2008).

D1. Offenders with complex mental health issues (Major mental illness)

The prevalence rates of a wide variety of “mental disorders” are disproportionately high in the criminal justice system. Rates of the major mental illnesses, such as schizophrenia and depression, are between three and five times higher than that expected in the general community” (Ogloff et al., 2004, p. 3; 2005). The high prevalence of mental disorders in Canada’s correctional system have been explained by various accounts: the developments in psychopharmacology, then de-institutionalization of psychiatric patients which followed, cuts in social services, the growing involvement of the justice system in social relations, the introduction of zero-tolerance policies with respect to drugs, and restrictions on committal practices (Standing Committee on Public Safety and National Security, 2010, p. 14).

D2. Substance use disorders

Substance use disorders are included among the mental disorders included in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000). Substance use disorders are endemic among prisoners, and among the most prevalent “mental disorders” in the criminal justice system (Ogloff et al., 2004, p. 24; 2005). In Canada, some 80% of offenders serving prison sentences of two years or more have problems with drugs and/or alcohol (CSC, 2009e; Standing Committee on Public Safety and National Security, 2010; OCI, 2012a). Almost two-thirds (63 per cent) of federal offenders report being under the influence of alcohol or other intoxicants when they committed the offence that led to their incarceration. Four out of five offenders arrive at a federal institution with a past history of substance abuse. Living with addiction or managing a substance abuse problem in a prison setting creates its own laws of supply and demand, which in turn is influenced by gang activity and other pressures (OCI, 2012a).

D3. Co-occurring disorders

The expression ‘concurrent disorders’ is applied to those who are suffering from a number of disorders at the same time. These may include “one or more mental health disorders, possibly combined with substance abuse problems, health problems, and intellectual deficiencies” (Standing Committee on Public Safety and National Security, 2010, p. 15). Offenders diagnosed with a mental illness are typically afflicted by more than one disorder, often a substance abuse problem, which affects 4 out of 5 offenders in federal custody (OCI, 2012a). A very high percentage of the offender population that abuses drugs is also concurrently struggling with mental illness. The interplay between addiction, substance abuse and mental health functioning is complex and dynamic (OCI, 2012). Dual diagnosis (comorbid major mental disorder and substance abuse) is the rule rather than the exception for mentally disordered offenders (Ogloff et al., 2004, p. 3; 2005).

D4. Cognitive Disorders including FASD

Cognitive deficits, also known as an intellectual disability is a condition in which people show significant limitations in their ability to learn and function. “The DSM-IV-TR subdivides individuals with intellectual disability into degrees of severity based on their level of impairment (mild, moderate, severe, or profound) in intellectual functioning” (FPT, 2012, p. 22).

The percentage of prison inmates with intellectual disabilities is at least twice as high as it is in the general population. People living with fetal alcohol syndrome disorder FASD represent about one per cent of Canada's overall population, but make up as much as a quarter of the prison population. Not only is FASD over-represented in the criminal justice system, there's a high level of repeat offenders (CBC News, 2010b). A CSC (2007b) Performance report noted an “increasing prevalence of offenders with learning disabilities as well as low functioning capacities” (p. 13).

D5. Suicide/Self Harm

Suicide is now the leading cause of death for Canadians in correctional facilities (CMHA, 2004). The suicide rate for federal offenders is more than seven times the Canadian average, while the number of serious self-harming incidents in prisons is rising (CMHA, 2010). Fifty percent of federally sentenced women self-report histories of self-harm (OCI, 2010a; OCI, 2012a). Aboriginal offenders account for 45% of all incidents of suicide attempts, self-harm rising in Canada's prisons, according to the federal ombudsman's report (CBCnews, 2012e; OCI, 2012a). Suicide is approximately three times more common among Aboriginal people than non-Aboriginal people (CSC, 2009g), and is also five to six times more prevalent among Aboriginal youth than non-Aboriginal youth (Canadian Association for Suicide Prevention, 2009; CSC, 2009g). In First Nations communities, the high prevalence of youth suicide usually is a result of feelings of hopelessness and despair (CSC, 2009a).

E. Overcrowding

Double-bunking (placing two inmates in a cell designed for one) has increased dramatically in the past two years. As of April 1, 2012, more than 17% of the incarcerated population was double-bunked. Experience in Canada and elsewhere shows that as prisons get more crowded, they often become more tense, volatile and violent places (CBC, 2012c). Inmate, staff and ultimately, public safety is compromised by prison crowding (OCI, 2012a). Cases of serious self-injury by federal inmates across Canada has nearly tripled in the last five years, a "dramatic" rise as prison conditions become more chaotic and overcrowded, according Canada's Correctional Investigator (CBC news, 2012c; OCI, 2012a).

F. Stigmatization challenge

Stigmatization with regard to mental illness is compounded in the criminal justice system. “Some offenders have the double stigmatization of mental illness and incarceration” (MHCC, 2009, p. 90). The higher rate of incarceration for Aboriginal peoples has been linked to systemic discrimination and attitudes based on racial or cultural prejudice, as well as economic and social deprivation, substance abuse and a cycle of violence across generations (OCI, 2006b).

G. Security/Segregation challenge

The extremely restricted conditions of confinement that prevail in segregation units can exacerbate symptoms of mental dysfunction. Of particular concern to OCI was that close to one-third of reported self-injury incidents occurred in segregation units (OCI, 2012a). In far too many cases, untreated mental health problems deteriorate to the point where they result in violations of institutional rules, altercations with staff and other offenders, and, often, self-harm. In too many instances, these offenders are placed in segregation or protective custody for their personal safety. Many complaints to the Office of the Correctional Investigator are concerned with segregation placements, transfers to higher security and use of force interventions, which all can be traced to behaviours rooted in unmet mental health needs (OCI, 2009b). Aboriginal offenders are often overrepresented among offenders in segregation (CSC, 2010a).

H. Recidivism of MDOs

The more needs an offender has, the higher the likelihood that he or she will return to prison more quickly (FPT Deputy Ministers Responsible for Justice, 2010; Juristat, 2005). Many argue that persons with mental illness who offend enter a cycle of criminalization where they are more likely to return to the criminal justice system than those who are not mentally ill (Statistics Canada, 2009c). The absence of an adequate transition from correctional services to community-based treatment or support programs perpetuates a cycle of reoffending (Standing Senate Committee on Social Affairs, Science and Technology, 2006). Aboriginal offenders: have a higher rate of recidivism than other offenders (OCI, 2009b).

I. Gang /Social Peer Associates

Gang members often inflict violence on others, including vandalism, theft, and aggression. Many end up in the juvenile court system, where they exhibit comorbid mental health problems that may remain untreated (OCI, 2012a). Aboriginal young male inmates are twice as likely to be affiliated with a gang (OCI, 2012a). According to the Royal Canadian Mounted Police (2006), it is estimated there are over 300 gangs and 7,000 members across Canada. Youth ages 11 to 13, a time of particular vulnerability, are primarily solicited to become gang members because decision- making capacities are limited, and they may look up to older peers for status and belonging. Certain risk factors seem to predispose a person to gang membership, including past trauma, learning disability, poor school performance, poverty, and family disorganization (Esbensen, Peterson, Taylor, & Freng, 2009).

J. Abuse/ Aggression/Violence

Eighty-five per cent of federally sentenced women report a history of physical abuse and 68% experienced sexual abuse at some point in their lives (CSC, 2010a; OCI, 2012a). Gang members often inflict violence on others, including vandalism, theft, and aggression. Many end up in the juvenile court system, where they exhibit comorbid mental health problems that may remain untreated (OCI 2012a). According to a 2003 Canadian Addiction Survey, over 35 per cent of Saskatchewan residents reported experiencing harm because of another person's use of alcohol. Problems included family and marital issues, arguments, verbal abuse and physical assault (Government of Saskatchewan, 2005b; 2005c).

2.2 What are the Criminogenic Needs of MDOs?

What are the Criminogenic Needs of MDOs?

The term “criminogenic needs” comes from the risk-needs-responsivity model of offender rehabilitation by Andrews and Bonta (2003). They state that in order to reduce recidivism, treatment must focus on the “criminogenic needs” of the individual. It is recognised that while all humans have a range of needs, some are related to offending (i.e., criminogenic needs) and some are not (i.e., non-criminogenic needs)” (Ogloff et al., 2004, p. 47; 2005).

This report attempts to define the needs in a way most amenable to further discussion. It is important to keep in mind that the needs identified by this scan are not all-inclusive. Many other important needs raised in the literature were dropped out along the way toward reaching a consensus on which ones were considered most important to SK. Some topics could have been defined or framed differently than how they came to be stated in this report. Other topics could rightly have been defined in a similar way, but with a different emphasis or focus.

Table 2.2.1 for Criminogenic Needs of MDOs in SK (findings from the literature).

Criminogenic Needs of MDOs (highlights from the literature)
<u>Criminogenic Needs of:</u> <ul style="list-style-type: none">a. At risk Women offendersb. At risk Young offendersc. At risk Aboriginal offendersd. At risk Aboriginal Women offenderse. At risk Aboriginal Young offendersf. Families of offenders (relationships, supports)
<u>Criminogenic Needs for:</u> <ul style="list-style-type: none">g. A precise and common definition of offenders with mental health issuesh. Culturally-relevant programmingi. Assessment and identification of mental health issuesj. Improvements in health determinants (housing/employment/socio-economic/welfare system)k. Effective mental health treatment and adjunct services (addictions)l. Access to services (community, mental health and addictions services)m. Diversion alternatives, problem-solving / therapeutic courtsn. Training in mental illness and recruitment of skilled professionals (police, security, health care)o. Continuity of care, information sharing, and quality of carep. Coordination of services/ partnershipsq. Fiscal responsibility of mental health sector and servicesr. Prevention

a. Women Offenders At Risk

CSC data indicates that the proportion of offenders with mental health needs identified at intake has doubled in the period between 1997 and 2008. Thirteen percent of male inmates and 29 per cent of women were identified at admission as presenting mental health problems

(CSC, 2009i); 30.1% of women offenders compared to 14.5 per cent of male offenders had previously been hospitalized for psychiatric reasons (Public Safety Canada, 2008; OCI, 2012a). Fifty percent of federally sentenced women self-report histories of self-harm, over half identify a current or previous addiction to drugs, 85 per cent report a history of physical abuse and 68 per cent experienced sexual abuse at some point in their lives (CSC, 2010a; OCI, 2012a). Women offenders accounted for one-third of self-injury incidents in 2010-11, including 15 attempted suicides. Three-quarters of all incidents occurred in multi-level institutions (regional treatment centres or the regional women's facilities) and maximum security facilities (OCI, 2012a).

b. Young Offenders At Risk

Two thirds of youth in the juvenile justice system have one or more diagnosable mental disorders (Odgers et al., 2005). Young offenders are often involved in gang activity (Odgers et al., 2005). Many end up in the juvenile court system, where they exhibit comorbid mental health problems that may remain untreated. Aboriginal male inmates are twice as likely to be affiliated with a gang (OCI, 2012a).

Table 2.2.2 MDOs in Comparison to the General Population

MDOs in Comparison to the General Population (from the literature)
<p><u>Female Offenders</u></p> <ul style="list-style-type: none"> • Twice as likely as male offenders to have a mental health diagnosis (CSC, 2009a). <p><u>Intellectual Disabilities</u></p> <ul style="list-style-type: none"> • Twice as high as general population (CBC News, 2010b). <p><u>Socioeconomic Measures</u></p> <ul style="list-style-type: none"> • Twice as likely to have not finished high school (Bouchard, 2004). • Nine times more likely to have been unemployed (Bouchard, 2004). <p><u>Suicide</u></p> <ul style="list-style-type: none"> • More than seven times the Canadian average (CMHAA, 2010; OCI, 2010a).

c. Aboriginal Offenders At Risk

Aboriginal offenders: have a higher rate of recidivism than other offenders (OCI, 2009b); are often overrepresented among offenders in segregation (CSC, 2010a); have a much higher incidence of mental disorders and addiction issues than non-Aboriginal offenders (Mann, 2009); have more health problems, including FASD and PTS syndrome (Mann, 2009); are younger upon admission into custody than non-Aboriginal offenders (Public Safety Canada, 2009b); account for 45 per cent of all incidents of suicide attempts (CBCnews, 2012e; Harris, 2012; OCI, 2012a); are disproportionately more involved in self-harm incidents (OCI, 2012a); serve more of their sentences in the institution before initial release, as compared with other offenders (OCI, 2009b); and, Aboriginal male inmates are twice as likely to be affiliated with a gang (OCI, 2012a).

An extremely high percentage of Aboriginal offenders report early drug and/or alcohol use (80 per cent), physical abuse (45 per cent), parental absence or neglect (41 per cent) and poverty (35 per cent) in their family backgrounds. Twenty-eight per cent of Aboriginal offenders had been raised as wards of the community, and 15 per cent had been sent to residential schools. Compared to non-Aboriginal offenders, Aboriginal offenders have demonstrated higher needs in the areas of personal/emotional orientation, substance abuse, employment, social interaction/associates, and marital/family needs (Trevethan, Moore, & Rastin, 2002; CSC, 2004). The higher crime rate among Aboriginal groups is associated with socio-economic problems such as poverty, poor education, unemployment, alcoholism, and family and marital difficulties (Statistics Canada, 2006b). Therefore, correctional programs that focus on education and employment have been shown to reduce recidivism.

d. Aboriginal Women Offenders At Risk

Findings of the needs assessment of federal Aboriginal women offenders (CSC, 2004) concluded that Aboriginal women offenders had clearly demonstrated needs in the areas of substance abuse, emotional issues, employment, and family. Aboriginal women offenders have also demonstrated higher needs in the marital/family domain than Aboriginal men offenders (Trevethan et al., 2002; CSC, 2004). Aboriginal inmates are disproportionately more involved in self-harm incidents, 104 Aboriginal offenders accounted for 45 per cent of all self-injury incidents (One Aboriginal woman accounted for 12 per cent of all reported self-injury incidents). Of particular concern to OCI, close to one-third of reported self-injury incidents occurred in segregation units (OCI, 2012a). Upon their return to the community, Aboriginal women offenders face numerous challenges including resuming childcare responsibilities, dealing with friends and family who are abusing substances, finding employment and gaining job skills, and locating affordable housing (CSC, 2004). Such difficulties may be similar to offenders in general, however, the approach for Aboriginal women must be unique. For example, Aboriginal women offenders stress the need for access to their spirituality and culture, and programs and services even in smaller communities (CSC, 2004).

e. Aboriginal Young Offenders At Risk

Aboriginal offenders tend to be younger, to be more likely to have served previous youth and/or adult sentences, to be incarcerated more often for a violent offence, to have higher risk ratings, to have higher need ratings, to be more inclined to have gang affiliations, and to have more health problems, including Fetal Alcohol Spectrum Disorder (FASD) and mental health issues (OCI, 2009b). Aboriginal young offenders have much higher needs relating to employment and education (OCI, 2006b).

Table 2.2.3 Aboriginal Offenders in Comparison to non –Aboriginal Offenders

Aboriginal Offenders in Comparison to non –Aboriginal Offenders (from the literature)
<ul style="list-style-type: none"> • Younger upon admission into custody (Public Safety Canada, 2009); • Higher rate of recidivism (OCI, 2009b); • Overrepresented in segregation (CSC, 2010a); • Higher incidence of mental disorders/addiction issues (Mann, 2009);

- More health problems, including FASD and PTS syndrome (Mann, 2009);
- 45 per cent of all incidents of suicide attempts (CBC news, 2012e; OCI, 2012a);
- More involved in self-harm incidents (OCI, 2012);
- Serve more of their sentences in the institution before initial release (OCI, 2009b);
- Twice as likely to be affiliated with a gang (OCI, 2012a).
- Higher needs in the areas of personal/emotional orientation, substance abuse, employment, social interaction/associates, and marital/family needs (Trevethan, et al., 2002; CSC, 2004).
- Five to six times higher suicide rates than non-Aboriginals youth offenders (CSC, 2009g).
- Three times higher suicide rates than non-Aboriginal adult offenders (CSC, 2009g).

f. Families of Offenders (relationships, supports):

Family is defined as a group of individuals who are related by affection, kinship, dependency or trust (CSC, 2009e). Inmates who are mentally ill are often estranged from their families, especially in cases where the family has been the victim, or simply because they are worn out from years spent on an emotional roller-coaster (CSC, 2007a). “Amazingly, there are families who do stay in contact,” Reverend Tervo added. “In lots of ways, when someone is mentally ill and in prison, the family can finally relax and know they’re safe; they don’t have to worry about their brother or son or father living on the street somewhere in downtown Vancouver” (CSC, 2007a, p. 18).

g. A Common Definition of Mental illness and Offenders with Mental Health Issues

Every Canadian province and territory has legislation to treat and protect people with severe mental ‘disorders’, and to protect the public as well. Each criminal justice sector approaches the issue of mental illness based on particular legal roles and obligations. As such, there are often differences in institutional definitions, ranging from observational and reportable behaviours to official diagnoses (Statistics Canada, 2009c). While most sectors prefer a broad definition, others may adhere to a narrow definition that does not include substance use disorders. There are many views and preferences for the term ‘mental illness’ as it emphasizes the seriousness of the conditions being experienced. Others prefer “mental health problem” because they see it as less stigmatizing or “mental disorder” as it can potentially encompass both “problems” and “illnesses” while also acknowledging the non-medical dimension (FPT, 2012, p. 23). [See Discussion Section]

h. Culturally-relevant programming

Aboriginal offenders have unique cultural and spirituals needs due to a history of colonization, residential schools and displacement. Aboriginal women offenders stress the need for access to their spirituality and culture, and programs and services even in smaller communities. Aboriginal women offenders have offered various perspectives on their needs upon release to the community, and as such, have important implications for reintegration strategies and community services (CSC, 2004). There are significant challenges in bridging the

gap between traditional correctional approaches, and Aboriginal methods of justice and reconciliation (OCI, 2006b).

i. Assessment and Identification of Mental Health Issues

CSC's use of computerized mental health screening at admission indicates that 62% of offenders entering a federal penitentiary are "flagged" as requiring a follow-up mental health assessment or service (CSC, 2012e; OCI, 2012a). Preliminary data from a computerized mental health screen indicate that approximately 38% of incoming male offenders showed symptoms associated with possible mental health problems that require follow-up assessment by a mental health professional (CSC, 2012e).

j. Improvements in Health Determinants (housing/employment/socio-economic/welfare system)

The World Health Organization (2010) identifies the social determinants of health as "poverty, gender inequality, ethnicity, unemployment, unsafe workplaces, urban slums, globalization, and lack of access to health systems" (para. 2). These interrelated conditions influence the health status of populations (Cohen, 2008); therefore it can be expected that if the determinants of health are negatively impacted, the health of the population will suffer. The higher crime rate among Aboriginal groups is associated with socio-economic problems such as poverty, poor education, unemployment, alcoholism, and family and marital difficulties (Statistics Canada, 2006b). Therefore, correctional programs that focus on education and employment have been shown to reduce recidivism.

k. Effective Mental Health Treatment and Adjunct Addiction Services

"In order to prevent people with mental health or addiction problems from committing crimes as a result of these problems and being incarcerated in provincial or federal correctional institutions, we also have to ensure that community mental health services are both available and effective" (Standing Committee on Public Safety and National Security, 2010, p. 20). Cooperation among the various levels of government is central to an integrated mental health system that will prevent those suffering from mental disorders and addiction problems from ending up in prison inappropriately because of lack of appropriate initiatives for community mental health and addiction prevention initiatives (Standing Committee on Public Safety and National Security, 2010, p. 19). Aboriginal offenders are referred to proportionately more programs than their non-Aboriginal counterparts of equivalent risk and need (CSC, 2012c; OCI, 2012a).

l. Access to Services (community, mental health and addictions services)

When people living with mental health problems and illnesses do end up in the criminal justice system, whether in remand, correctional or forensic facilities, they have a right to reasonable access to mental health services consistent with professionally accepted standards (*Corrections and Conditional Release Act*. In Statutes of Canada. (S.C. 1992, c. 20). On a consistent basis, delivery and access to health care remains the number one area of offender complaint to the Office of the Correctional Investigator. In 2010-2011, 700 offender complaints and inquiries were related to both physical and mental health care issues (OCI, 2010a). An

overall lack of accessible mental health services means offenders with an identified need for these services remain in settings ill-prepared to respond to their symptoms and behaviours. In far too many cases, their mental health problems deteriorate to the point where they result in violations of institutional rules, altercations with staff and other offenders, and, often, self-harm (OCI, 2009b). Lack of access to appropriate services, treatments and supports have also had a powerful influence on the situation of offenders with mental disorders being over represented in the criminal justice system (Arboleda-Florez, 2009).

m. Diversion Alternatives, Problem-Solving /Therapeutic Courts

An increasing number of mentally ill offenders in the criminal justice system tend to recidivate throughout the system. “The mental health court is a problem-solving court designed to address the underlying problems that can contribute to criminal behaviour and will result in better outcomes including a better quality of life for individuals experiencing mental-health problems and illnesses” (CBC News, 2011b). Sentencing options available to courts are often ineffective in changing the behaviour of those with FASD, and those with FASD are frequently repeat offenders,” according to the FASD association’s resolutions (CBC, 2010b). It urges “all levels of government to allocate additional resources for alternatives to the current practice of criminalizing individuals with FASD” (CBC, 2010b). The absence of an adequate transition from correctional services to community-based treatment or support programs perpetuates a cycle of reoffending (Standing Senate Committee on Social Affairs, Science and Technology, 2006).

n. Training in mental illness and recruitment of skilled professionals (police, security, health care)

According to sections 85 to 89 of the CCRA, health care for inmates is to be provided by registered healthcare professionals, in accordance with professionally recognized standards (Standing Committee on Public Safety and National Security, 2010, p. 6). Recruitment of skilled health care professionals is an issue within the federal and provincial systems. In addition there is a need for mental health training for frontline staff within the justice system specifically police, and correctional officers.

o. Continuity of Care, Information Sharing, and Quality of Care

‘Continuum of care’ is defined in the *Mental Health Strategy for Corrections in Canada* as “the integrated and seamless system of mental health services to meet the needs of individuals as they transition into the correctional system and back to the community” (FPT, 2012, p. 22). Under the Corrections Conditional Release Act (CCRA), the delivery of health care to offenders in federal institutions is a CSC responsibility. To ensure continuity of care when offenders are released into the community, CSC is also required to ensure that an offender has “a health insurance card upon release, and an adequate supply of medication for any physical problem and/or mental health disorder” (Standing Committee on Public Safety and National Security, 2010, p. 6).

A cycle is perpetuated by the absence of an adequate transition from correctional services to community-based treatment or support programs. The ‘lack of continuity’ often puts offenders, particularly released offenders, at risk of experiencing a number of problems. Not only do many released offenders with mental disorder come into (re) contact with the

criminal justice system, they also tend to look for other means to alleviate their problems, such as self-medication with illegal drugs. This is particularly the case in the absence of sufficient treatment and adequate access to community support and constant stigma and discrimination (Standing Senate Committee on Social Affairs, Science and Technology, 2006).

p. Coordination of Services/Partnerships

Partnerships and coordination are needed between correctional facilities, mental health facilities and the police, to care for the complex issues of offenders with compromised mental health issues (CMHA, 2008; OCI, 2009a). Provincial, territorial, and international correctional and forensic mental health services often face similar challenges, and many offenders transfer between systems (CSC, 2010e). At the end of the day both governments share the same commitment to public safety, to the principles of fair and humane treatment of offenders, and to the safe return of offenders to the community as law-abiding citizens (OCI, 2009a).

q. Fiscal responsibility of Mental Health Sector and Services

In reviewing the published literature and government reports, there were various figures of monetary amounts that were cited as to the cost of mental health services for offenders. Health care costs of managing the aging population of offenders has increased by 50% in the last ten years CSC's substance abuse programming budget fell from \$11M in 2008-09 to \$9M in 2010-11 (OCI, 2012a). The annual average cost of keeping a federal inmate behind bars has increased from \$88,000 in 2005-06 to over \$113,000 in 2009-10 (OCI, 2012a). In the three year period between 2006-07 and 2009-10, the average cost of maintaining a federally sentenced woman offender (without special needs) increased 26% from \$457 to \$578 per day (Public Safety Canada, 2011). While it costs \$578 per day to incarcerate a federally sentenced woman inmate, it is just over \$300 per day to maintain a male inmate, and in contrast, the annual average cost to keep an offender in the community is about \$29,500 (OCI, 2012a). At a time of wide-spread budgetary restraint, it seems prudent to use prison sparingly, and as the last resort it was intended to be (CBC News, 2012e).

r. Prevention

There is a need for rapid intervention, well before those concerned come into conflict with the law. When a crime is committed, there must be a capacity to assess the mental health of the accused in order to refer him or her to appropriate healthcare and support services and acquaint court officials with the accused's requirements (Standing Committee on Public Safety and National Security, 2010, p. 2). According to the Standing committee report on mental illness and addictions, "it is imperative that early detection of mental health and addiction issues be improved" (Standing Committee on Public Safety and National Security, 2010, p. 20).

Little Tx Prior to Incarceration. According to a comprehensive New Zealand study conducted by Brinded and colleagues (2001; Simpson, Brinded, Laidlaw, Fairley, & Malcolm, 1999), 58.2% of female inmates, 56.4% of remanded males, and 68.8% of sentenced males reported that they had received no treatment prior to entering prison. Most who had received treatment had attended a primary and community agency (21.6%, 20.4%, and 14.8% respectively). Prior specialist outpatient (9.9%, 7.8%, and 6.4%) and inpatient treatment usage

(9.9%, 15.3%, 9.9%) was quite a bit lower (Simpson et al., 1999) (Ogloff, Davis, & Somers, 2004, p. 53; 2005).

Summary of Literature on Issues and Needs of MDOs

As the literature suggests, the criminogenic and forensic (mental) health needs of forensic clients are vast. In Canada, mental health disorders are more common among inmates in correctional institutions than among the general population. Offenders are often poly-substance abusers and suffer from more than one mental health problem concurrently. This creates significant institutional challenges in the correctional facilities and organizations providing forensic programming and services in the community due to a changing, aging, and more complex offender population in Saskatchewan.

2.3. Mental Health Strategies and Initiatives

Mental Health Strategies and Initiatives

Forensic mental health initiatives and strategies in Canada from 2002-2012 were reviewed to inform our assessment of service provision in a Saskatchewan context. In reviewing the government documents the following timeline of mental health initiatives and strategies were identified.

Table 2.3.1 Correctional Mental Health Initiatives & Strategies in Canada.
See references for full reference citations.

Timeline of Mental Health Initiatives & Strategies in Canada, 2002-2012
2002 - Mental Health Strategy for Woman offenders (CSC, 2002)
2004 - Mental Health Strategy launched (CSC, 2004)
2005 - Community Mental Health Initiative (CSC, 2005)
2007 - Mental Health Commission incorporated (MHC, 2007)
2007 - Institutional Mental Health Initiative (CSC, 2007)
2007 - Mental Health Training package for Staff Implemented (CSC, 2007)
2007 - Computerized Mental Health Intake Screening System (CoMHISS) (CSC, 2007)
2007 - Primary Care (CSC, 2007)
2007 - Discharge and Integration planning (CSC, 2007)
2009 - National strategy to address needs of offenders who engage in self-injury (CSC, 2009)
2010 - Framework for a Corrections Mental Health Strategy for Canada (Federal, Provincial & Territorial [FPT] Partners, 2010)
2012 - Mental Health Strategy for Canada (MHC, 2012)
2012 - Mental Health Strategy for Corrections in Canada (FPT, 2012)

3.0 METHODOLOGY

Methodology

A mixed methods design was used of qualitative interviews and quantitative surveys. The study was carried out in three concurrent phases to capture the unique social, geopolitical, and cultural circumstances of offenders in Saskatchewan including: 1) interviews with immediate family members of offenders from all health regions in the province except for Athabasca (N=52); 2) an environmental scan of correctional and community programming and services in all health regions of the province (N=19); and 3) surveys with front line personnel who engage offenders in correctional environments and in the community (N=171).

3.1 Data Collection

Data Collection

Interviews, introductory meetings, and scans were undertaken between September 2010 and August 2011 as part of this assessment. Data collection was carried out in three concurrent phases to capture the unique social, geopolitical, and cultural circumstances of offenders in Saskatchewan.

Sample Selection

Phase I: Family members of offenders with compromised mental health were recruited through a province-wide campaign that included posters, agency recruitment, and word of mouth (see Appendix A). Family members were asked about their family members' needs and their opinions on the provision of forensic mental health programs and services in Saskatchewan.

Phase II: Letters of invitation were sent to various agencies and institutions engaging offenders and/or providing forensic mental health services in Saskatchewan including the ministries of mental/health, justice, corrections, policing, education, and community social services at municipal, provincial, and national levels. Advocacy groups, non-profit organizations (NGOs), First Nations' organizations, professional organizations were also invited to participate. (see Appendix B, C, E). Potential participants were provided with a research proposal for in-house ethics clearance and approval when required. Once approved, links to the online surveys were sent. Program and service managers and agency managers and directors were surveyed about the provision of programs services for offenders with compromised mental health including substance use disorders at their facility. Environmental scans were also performed to identify and gaps or barriers to services in the various mental/health regions.

Phase III: Letters of invitation were sent to various professionals and personnel engaging offenders with compromised mental health on the front lines. Frontline personnel were surveyed about their experiences and opinions on the provision of forensic mental health programs and services for offenders with compromised mental health including substance use disorders specific to Saskatchewan. Frontline respondents represent a diversity of professional perspectives at municipal, provincial, and federal levels including health, legal, justice, correctional, policing, public safety, social work, advocacy, NGOs, and First Nations government.

Methods of Data Collection - Techniques & Tools

Interview and survey questions and scans were based on the research questions for this study: 1) What are the needs of offenders in Canada with compromised mental health including substance use disorders?; 2) What are the mental health needs of Saskatchewan offenders and how are they currently being met?; and, (3) What evidence-based forensic mental health services are needed in Saskatchewan?

Information was collected using the needs assessment and periodic environmental scanning techniques articulated by Reviere et al (1996) and Fahey et al (1981; 1986) to assess available forensic mental health services and programming against the needs of mentally disordered offenders in Saskatchewan. Web-based scans and surveys were designed using University of Saskatchewan 'Survey Tools' software and hosted on the secure University of Saskatchewan server. Hyperlinks to the survey were included in the email for ease in disseminating information about the study to staff. Online surveys were completed by facility managers or directors with knowledge of the aims and objectives of the organization in the context of providing forensic mental health program and/or services for the scan.

Recruitment

Phase I. Recruitment of participants in Phase I included a poster campaign, agency referrals, and word of mouth. Participants were screened to meet the criterion of being an immediate family member of a Saskatchewan offender with a mental health issue(s) and/or substance use disorder(s) who was 1) currently in, or 2) had been in custody recently. Participants were given the choice of completing an online survey or meeting with an interviewer in person or by telephone to complete the survey. The same questions were asked in both methods. Participants were asked about the history of their family members in terms of their mental illness(es) and/or addiction(s). Participants were asked about their family members' access to programs and programming needs while in custody, on community release, and after warrant expiry. Participants were also asked for feedback on the appropriateness and effectiveness of forensic and community programming in reducing factors leading to criminality and recidivism.

Phase II. The environmental scan in Phase II was informed by family members' responses. Organizations, programs, and/or services of potential benefit to offenders and/or clients with mental health issues and addictions were identified. Facility managers were asked to provide information available to the public that was not easily found through documentary review. Questions included number of beds and/or inmates or clients served, staff training, source of funding, types of assessment, program or service offered, cost, and wait times, if any. Front line participants also (confusing as Frontline thought of phase III) provided additional information about their program or service including protocols for assessments as well as extraordinary services provided by front line personnel, for example, the procedures of emergency responders who must detain persons with known or suspected mental illness in communities where no mental health or addictions services currently exist. The scan also included reviews and evaluations of annual reports and publication arising from in-house research.

Phase III. Various methods were used to recruit frontline participants in Phase III. The most successful method was to engage service providers in the staff recruitment process. For example, once a scan had been completed by program or facility managers (or designates), introductory email messages were sent out to all frontline staff who worked with forensic clients and/or offenders with compromised mental health, informing them about the study. This email also presented an invitation to staff to complete an online survey, and included a link to the survey tool. Staff could decide whether or not to participate, and to do so anonymously if they wished. It was requested that staff be given adequate time and resources to complete the questions at work. The option of a telephone interview was also made available in the case that completion of a web-based self-administered survey was prohibitive. In addition, many of associations provided their members with information on the study via websites and newsletters and email links to the survey. Frontline personnel included health care professionals and advocates, correctional officers, and members from policing services and justice.

Incentives

Family members who participated in the study were given a cash honorarium in appreciation for their time and involvement. Family member interview participants in Phase I, were each given a \$30 monetary honorarium immediately following the interview. In one case, a translator was also provided with an honorarium for assisting in the interview process. Facility managers and front line personnel who participated in the online scan or surveys from Phase II and III were invited to enter a draw for a cash prize of \$300. Participants could use their first name, or an alias or other contact to identify themselves sufficiently for the draw. This information was separated from the data as soon as it was collected, and stored in a separate file offline. The winning participant was notified by the form of contact used to enter the draw. The prize was delivered after the data collection process was complete.

Ethics Approval

This study was approved by the University of Saskatchewan Behavioural Research Ethics Board in August 2010 (BEH-1069b) and extended to August 2012 to allow for various clearances by participating agencies between August 2010 and May 2012. The procedures for obtaining informed consent, confidentiality, and data storage were conducted in accordance with the ethical requirement of the study.

Informed Consent

Each participant was asked for their consent before the web-based or telephone environmental scan or survey began (see Appendix E, F, G, H, I in full Final Report). In the case of web-based scans and surveys, the consent form represented the opening page of the scan and survey. Written and verbal consent forms outlined the following: purpose of the study; duration of participation; the procedure; benefits and risks; confidentiality; researcher's name and contact information; voluntary nature of participation, and ability to withdraw without penalty. The opportunity for debriefing was given to the participants by the interviewer in person, or on the last page prior to exiting the online scan/survey along with the contacts

available for further information or crisis counseling should participants need either (see Appendix J, K, L, M in full final report).

Confidentiality

Participants were reminded of the voluntary nature of the scan and were given assurances about confidentiality. They were also informed as to how the information would be disseminated in a final report, academic publications and conference presentations. Potential participants for the web-based survey were sent an email hyperlink to the survey which could be completed anonymously using an alias. Confidentiality of the responses collected in the environmental scans and web-based surveys was guaranteed by the fact that they were not required to log in. Real names and contact information were not collected by recruiters and/or recorded in the collection of data. All correspondence with regard to any contact information of organization managers/directors was stored separately from the data. Any identifying information regarding staff and families were destroyed as soon as the interviews or survey questionnaires were complete.

Data Storage

Questionnaires were made inactive and taken offline once the study was complete. Completed surveys, tapes, transcripts, consent forms, etcetera were downloaded onto discs and stored in a filing cabinet located at the Center on campus and will be kept for a minimum of five years, after which time will be destroyed beyond recovery by data services. Names/aliases, contact information, and consent forms are filed separately from the transcripts of the interview sessions. All lists in hard copy that contained names, phone numbers, emails and/or any other identifying information was shredded upon completion of the study. In addition, emails from participants were deleted once the study was complete.

3.2 Data Analysis

Data Analysis

The methodology of the study was triangulated to include a review of literature on the needs of mentally disordered offenders, and statistical and thematic analyses of the responses of family members, facility managers, and frontline personnel. These quantitative and qualitative data were analyzed with the goal of highlighting useful information and making recommendations regarding how to best meet the needs of offenders with compromised mental health in Saskatchewan from a multidisciplinary perspective.

Methods of Data Analysis

The family and frontline data were analyzed using SPSS and NVivo statistical software. The purpose of the environmental scan was to identify correctional and community organizations, programs, and/or services of potential benefit to forensic clients with compromised mental health including substance use disorders and identify gaps and barriers to services as factors in their criminality and recidivism.

3.2.1 Family Interviews

Phase I: Family Interviews

Interviews with family members addressed the research problem through exploring offenders' needs and identifying how these needs were currently being met, or not being met, by correctional and community programs and services in Saskatchewan. It is important to offer a conceptualization of 'family' that captures the diversity of experiences within a population that includes indigenous peoples. We followed the Mental Health Commission of Canada's (2009) definition of 'family' member to include relatives, spouses, parents, siblings and/or people drawn from a person's broader circle of support which may include extended family, close friends, health care professionals, peer support workers, Elders, and other individuals within a person's social network and community.

Thematic analysis. A rich data set representative of various ethnicities, sexes, localities, and regions of the province was produced from the interviews that spoke of a variety of needs including mental health issues and/or substance use disorders, occurrence rates of criminal activity, and rate and length of incarceration. These needs helped to identify services and programs in the community and correctional environments in addition to court-ordered and/or intake assessment, programming, and/or treatment (if any), types of programming received, circumstances of early release, and the consequences of community programming and/or of not receiving a follow-up program as the case may be.

The interview data were analyzed using thematic analysis. This process compared and contrasted the data to the published literature (Braun & Clarke, 2006). In thematic analysis, themes or patterns within data can be identified in one of two primary ways: in an inductive or *bottom up* way, or in a theoretical or deductive or *top down* way. An inductive approach means the themes identified are strongly linked to the data themselves (Patton, 1988). "Inductive analysis is a process of coding the data without trying to fit it into a preexisting coding frame, or the researcher's analytic preconceptions; in this sense, this form of thematic analysis is data driven" (Braun & Clarke, 2006, p. 83). In our study, we believe our data were coded in an epistemological vacuum or without a theory of knowledge in mind. Braun and Clarke (2006) explained, "in contrast, a theoretical or 'deductive' thematic analysis is driven by the researcher's theoretical or analytic interest in the area, and is thus more explicitly analyst driven" (p. 84). In the case of our study we believe the specific research themes evolved through the coding process (which fits with the inductive approach).

3.2.2 Environmental Scan

Phase II, Environmental Scan

The environmental scan of correctional and community programming and services addressed our research questions by identifying the availability of forensic mental health programs and services in the province. This information was particularly useful in addressing the appropriateness and efficacy of services in meeting offenders' services and programming needs, and in assessing the availability of mental health services for offenders on community release and/or after warrant expiry. A focus of the environmental scan was to identify gaps and

barriers to service as factors in criminality and recidivism. Opinions on the need for mental health courts in Saskatchewan were also solicited. The scan was useful in identifying the availability of services, wait times, cost and other prohibitive factors that at-risk offenders face in the community.

3.2.3. Frontline Personnel

Phase III, Surveys with Frontline Personnel

The surveys with front line personnel addressed our research questions by providing a perspective on program and service delivery as well as current gaps in services from the perspective of people engaging offenders with compromised mental health in everyday practice. Two surveys were designed for this purpose including a series of questions for staff engaged in community service provision and a series of questions for institutional staff.

4.0 FINDINGS

Findings

The findings section was divided into the three phases of the research: Phase I, Interviews with Family Members of Offenders; Phase II - Surveys of Frontline Personnel; and Phase II - Surveys & Scans of Facility Managers.

Phase I - Interviews with Family Members of Offenders

Phase I consisted of interviews with immediate family members of offenders from all health regions in the province except for Athabasca (N=52). This assessment identified several characteristics of MDOs in Saskatchewan as seen in the responses of family members including 1) family of MDO population demographics; 2) the state of their mental health and mental health needs; 3) how these needs were currently being met through mental health programs and service; 4) issues affecting accessibility to service; 5) consequences of barriers to programs and services; and 6) what was needed in Saskatchewan.

4.1 Family Members of MDO Population Demographics of the Sample

Family Members of Offenders Population Demographics of the Sample

While federal and provincial initiatives are in place to address the needs of MDOs nationwide, Saskatchewan has unique demographic needs that must be considered. The number of Aboriginal offenders reaches critical levels in provinces where Aboriginal populations are prevalent including Saskatchewan, where indigenous peoples comprise up to 15% of the general population and up to 80% of provincial inmate populations (Government of Saskatchewan, 2012a). Nationally, Aboriginal peoples represent 4% of the general population but more than 60% of the inmate population in some prairie penitentiaries, compared to 21.4 per cent in national prison populations (OCI, 2012a).

Various ethnicities were captured in this cohort where the experiences and needs of Aboriginal offenders were represented by the majority (n=44; 84.61%; Non-status n=18; Treaty n=14; Métis n=11; Mixed [Dene and Caucasian n=1]. Non-Aboriginal perspectives also included in the cohort of family members by their disclosures about Caucasian (n=8; 15.4%) and African Black/East Asian n=1; 1.9%) perspectives were also included in this cohort.

All areas of Saskatchewan were represented by family members in this cohort who speak to the unique needs of our offender populations except for the far most northern region of Athabasca. While the majority of respondents represented offenders who lived in urban areas (n=38; 73%) with their families (n=27; 52%), respondents from First Nations, Métis, and Dene communities were included in this cohort (n=7; 13.46%). The majority of offenders represented in this cohort are male (n=37; 71.15%). The age range was between 17 and 65 years of age where the majority were between 21 and 29 years of age (n=18) and 30 and 39 years of age (n=16). Only 12% (n=6) of offenders completed high school where most respondents (n=25; 48.08%) reported having 'some elementary school' between grades 1 to 8.

Family members (N=52) embodied diverse relationships to offenders including siblings (n=16); children (n=13); parents (n=8); spouses and partners (n=9); and extended family members including cousins (n=9); nephews and niece (n=3); and grandparents, aunts, and uncles (n= 5). While key informants from the family cohort were often speaking to the experiences and needs of several family members in their interview, in several cases (n=3), they disclosed an ‘entire family of offenders’ with unique mental health needs. Several participants’ family members were also in custody or had court or sentencing pending at the time of their interviews (n=16; 31%). Offender experiences with facilities at the First Nations, municipal, provincial, and federal level in community, correctional, and forensic psychiatric settings around the provinces were represented in this study.

Table 4.1.1: Correctional Facilities

Institution	N=115
ADULT CORRECTIONAL:	
North Battleford Correctional	n=3
Pinegrove (Women)	n=6
Prince Albert Correctional	n=5
Regina Correctional	n=10
Regional Psychiatric Centre	n=7
Saskatoon Correctional	n=29
Saskatchewan Penitentiary	n=10
POLICE CELLS:	
Rural Police Cells	n=10
Urban Police Cells	n=1
YOUTH DETENTION:	
Dojack (Regina)	n=4
Kilburn (Saskatoon)	n=16
North Battleford Youth Centre	n=1
Saskatoon Youth Detention	n=1
OTHER:	
Buffalo Narrows Work Camp	n=1
Community Corrections – Urban	n=1
Detox/Treatment Centre	n=1
First Nations Court Justice	n=2
MACSCI Centre	n=1
Provincial Healing Lodge	n=1
Out of Province Facility	n=3
Remand	n=2

4.2 Family Members - State of MDO Mental Health /Mental Health Needs in Saskatchewan

Family Members - State of MDO Mental Health /Mental Health Needs in Saskatchewan

Findings of this study indicated that the mental health needs of offenders in Saskatchewan were similar to those identified federally, however, certain mental health and criminogenic needs were exacerbated among increasing numbers of Aboriginal offenders in general, and Aboriginal women and youth in particular, including substance abuse, addictions, depression, and suicide ideation.

MDO Mental Health Needs

While only 8% of respondents report a family member with MDO status, a majority disclosed addictions (n=44; 85%), and violence (n=28; 54%) as mental health concerns. The majority of offenders represented in this cohort were classified as adult offenders (n=41; 79%) with primary needs as Aboriginal offenders (n=30; 58%); dangerous offenders (n=28); women (n=12; 23.07%); gang members and affiliates of organized crime (n=19; 37%); sex offenders (n=2); and young (n=9) and aging offenders (n=2). A number of adult offenders (n=20; 38.46%) in this cohort were also young offenders.

Substance abuse disorder. A major theme of family and frontline respondents was chronic substance abuse, addictions issues, and undiagnosed and untreated mental illness. The majority (81%) of family respondents disclosed histories of substance use disorders among offender populations represented in this cohort. Substance use disorder in addition to a mental health concern was reported by 97.7% of respondents. When asked about their family members' mental health, respondents disclosed a variety of addictions, mental illnesses, and disorders where addiction (N=168) to a host of illicit drugs (n=113), and substance abuse of alcohol (n=45), and prescription drugs (n=7) were most common. Addiction to injection needle drugs (n=44), cocaine (n=27); and cannabis (n=20) were most common among this cohort. Among injection needle drug users, Morphine (n=10); 'Ts and Rs' (Talwin and Ritalin; n=10); and 'Downs' and 'Dillies' (Dilaudid and/or plus Morphine (n=7) were most common. Among prescription drug users, Valium and Methadone were disclosed. Poly-substance abuse, chronic alcoholism, and co-morbidity of substance abuse disorder and/or addiction and other mental health issue including depression and suicide were common themes in the data. Using and/or selling high doses of prescription drugs like Talwin and Ritalin was also reported.

Table 4.2.1: Offender Mental Health Concerns

Addiction/Disorder/Illness/Issue	N=231
Addiction/Substance Abuse	n=168*
Alcohol	n=45
Drugs	n=113
Anxiety	n=1
Attention Deficit Disorder	n=3
Anti-social Personality Disorder	n=1
Bipolar Disorder	n=4*

Cutting/Self-harm	n=1
Depression	n=22*
DTs	n=1
Eating Disorder	n=3
FAS/E/D	n=3
Hyperactive ADHD	n=2
Mental Retardation	n=1
Mood Swings	n=2
Psychosis	n=1
Reactive Attachment Disorder	n=1
Schizophrenia	n=2
Self-medication	n=1
Sexual Abuse	n=1
Sexual Offending	n=1
Suicidal Ideation	n=7*
Suicide	n=1
Violence (Murder n=2)	n=4*

4.3. Family Members: The Provision of Forensic Mental Health Programs and Services in Saskatchewan

Family Members:

The Provision of Forensic Mental Health Programs/ Services in Saskatchewan

With regard to the provision of forensic mental health programs and services in Saskatchewan, this section looked at (1) Correctional Mental Health Programs and Services in Saskatchewan, and their effectiveness of many programs and identified specific service gaps; and (2) Community Mental Health Programs and Services;

Correctional Mental Health Programs and Services in Saskatchewan

Respondents reported that the majority of their family members received a mandatory or conditional mental health treatment and/or program while in custody (n=39), where the most commonly received program was for addictions and substance abuse (n=26). Interestingly, the majority of offenders represented in this cohort (n=42; 83%) were required to take part in a mandatory mental health and/or socio-cultural program and/or service as a condition of sentencing, however the majority of family members did not recall mental health assessments (n=32; 75%) or criminogenic needs assessments (n=35; 81%) being done to determine mental health or criminogenic programming needs.

Effectiveness of Correctional Programs and Services

The majority of respondents suggested that the correctional programs received were inadequate in meeting their family members' needs. The exceptions were cultural programs, pro-social programs, and employment and work-related programs. A major theme of this data was that mandatory correctional programs were ineffective in meeting offender's needs and

helping to change criminogenic attitudes and behaviours especially among offenders with addictions and/or substance abuse issues and/or unmet mental health needs who do not desire to change or cannot change 'their ways'.

Table 4.3.1. Respondent Attitudes toward Effectiveness of Mandatory and Conditional Forensic Programs and Services Received

Name of Program	Focus of Program	Effectiveness
Addictions/Substance Abuse (n=26)	Actual treatment services designed to educate about alcohol and other drug abuse, to help offenders abstain from the abuse of these substances, and to provide family members with tools to recognize and prevent relapse.	Inadequate (n=16; 64%)
Associates/Social Interaction (n=6) Explain what Associates is?	Understanding the consequences of anti-social peers or friends and their influence on behavior; understanding his or her role in the social interaction process (whether he or she is a predator or is too easily influenced by others); identification of an appropriate pro-social support network.	Inadequate (n=4; 67%)
Attitude / pro-social skills (n=5)	Development of non-criminal thinking, emphasis on victim awareness and empathy, and the fostering of pro-social values.	Adequate* (n=3; 75%)
Urban Camp/Bush Camp Firefighter Training (n=2)	Community service as a condition of sentence	Adequate*
Community functioning / life-skills (n=10)	Knowledge and skill including "life skills" programs and preparation for release.	Inadequate (n=5; 56%)
Employment / education (n=14)	GED and upgrading; completion of a trade apprenticeship; job training in a field suitable for post-release employment; assistance in looking for, applying for, and retaining a job after release	Inadequate (n=8; 62%)
Marital family relations (n=5)	Building family support; teaching parenting skills and reinforcing offender responsibility for dependent children.	Inadequate (n=3; 60%)

Native Spirituality/Culture (n=3)	Sweats, Sacred and healing ceremonies, drumming, singing, dancing, Native Brotherhood, circles, fasting/cleansing, Elders, day trips to reconnect indigenous person with Aboriginal culture as a form of intervention in offending behaviour	Adequate*
Personal / emotional management and orientation (n=11)	<p>Emotions and stress management, problem-solving, inter-personal relationship skills, inability to understand the feelings of others, and changing narrow, rigid thinking;</p> <p>* where the focus is on changing behavior that is likely to result in negative consequences such as impulsivity, risk-taking, aggression, anger, frustration tolerance and gambling;</p> <p>* where the focus is on addressing personal characteristics that increase the likelihood of criminal behavior including personality disorders and behavioural preferences such as inappropriate sexual attitudes or preferences.</p>	Inadequate (n=7; 64%)
Psychotherapeutic Medication (n=2)	Condition of Sentence	Unknown – just started
Sex Counseling (n=1)	Condition of Sentence	Unknown – just started
SGI Driving Without Impairment Course/Addictions Screening (n=1)	Driver education on the serious problems related to drinking and driving to help distinguish and separate the acts of drinking and driving. “Choosing to drive after drinking may be a sign of an alcohol abuse or addiction problem. If your driver's licence is suspended due to Criminal Code convictions, addiction screening and either an education or recovery program is mandatory”	Adequate

Native Spirituality and Cultural Programs. A majority of respondents (n=4) whose family members were required to attend mandatory Native Spirituality and Cultural programs while in custody found the program to be adequate overall in cultural and spiritual

development as a means of making correctional programming more effective. Respondents (n=4) found sweats, ceremonies, sweet grass and Elders, to be very helpful for their family members in a number of ways including changing attitudes toward violence:

For the first time she was able to get in touch with everything and make sense of what she did, who she was, and where she was going. They first took them to Wanuskewin for these sweats and then they changed it and they were not allowed to go anymore. Then everybody made a protest so they built a lodge in the Kilburn yard.

We don't practice native spirituality. His dad is Caucasian and he hates his dad so he enjoyed these programs and believed in it. He saw the Elder as a role model.

Attitude and Pro-social Skills Programming. A majority of respondents (n=3) whose family members were required to attend mandatory attitude and pro-social programming while in custody found the program to be adequate overall in changing the behaviours associated with the development of criminal thinking, victimization, and anti-social values. The main reason given for this rating is that their family member either learned alternatives to criminality and awareness of people's feelings, or that the experience with incarceration 'scared them straight'.

He has learned to be assertive rather than (sic) aggressive ...

It kind of helped as he was more aware of people's feelings.

Employment and Education Programming. A majority of respondents (n=8) whose family members were required to attend mandatory employment and education programming while in custody found the program to be inadequate overall in preparing their family member for gainful employment after release. Reasons given for this were that their family member fell back into old ways (substance use, addictions, gang associates, street life) upon release (n=11); that they either did not want to learn or could not learn due to a disability (n=2):

He [son] received GED training at the penitentiary. He felt belittled because it kept reminding him of his basic or lack of abilities. People like my son just need people to 'hang in there' and repeat the lessons and give encouragement: "Okay, we did it yesterday, let's do it again today!" But he's just being left to his own thoughts - put on ice - no books that were appropriate to his reading level; no cd's, no read-a-longs. So they stagnate and sink back. We need to keep them learning, but this approach keeps them dumb. He behaved better within the Regional Psychiatric Centre because he was given some individual attention. He received some training in how to think and plan; organization skills and planning into the future. The Elders did try to help him. {Mother]

If they [??]are in remand, there is no programming, nothing at all, no programs even when done your time, barely any programs at all just school and urban camp. That's when men go out and work for community, cutting wood, shovel walks for people out in

Pike Lake, one at City Hospital for domestic abuse. I am not even sure if they have them or not. You have to ask though. Very few programs and its all voluntary. And that's the problem plus the wait time.

Respondents disclosed feelings of shame that their family members felt by having barriers to learning and employment, including learning disabilities and lack of resources such as a driver's license or Grade 12/GED. Respondents (n=4) indicated that job training that led to employment upon release and other positive experiences such as working in the bush and learning a trade was a step in the right direction (n=4). Driver improvement programs and addictions screening was also found to be adequate in changing an offender's attitude towards drinking and driving offences that led to incarceration.

Addictions and Substance Abuse Programs and Services. A majority of respondents (n=16) whose family members were required to attend mandatory substance abuse programs while in custody found them to be inadequate overall in changing the behaviours associated with drug and alcohol addiction and preventing relapse. Reasons given for the inadequacy were that their family member 'went back to their old ways' (substance use, addictions, gang associates, street life) upon release (n=11); they were getting substances in jail (n=4); they did not want to change (n=3); and the program actually made the addiction worse (n=3). Reasons given for this are 1) lack of support and follow-up upon release; and 2) the availability of illicit drugs versus the unavailability of forensic methadone treatment programs in jail:

[The programs] kind of helped in jail but when he got out he had no programming and went back to it. He was trying to stay away from drugs in jail. He was trying to get off drugs but he traded his canteen for drugs. They are so easy to get in and out. He was able to get them on the inside.

He was a chronic alcoholic. He drank all of our money away. He would drink during the day, go to bed drunk, wake up drunk, and keep on drinking otherwise he'd get seizures. The [identifier omitted] court judge gave him addictions but the staff of the reserve did not make him follow through.

Respondents who found substance abuse programming to be effective indicated that their family members were now clean and sober, and using less (n=3), because of 1) caring networks in the correctional setting and community that 2) provided alternatives to using in circles of support and accountability:

His crimes were alcohol related to drinking and driving up north in the bush - Dene community. He has been in and out of voluntary treatment for most of his adult life - been to therapy, detox, counseling, Slim Thorpe in Lloyd. This was good education for getting to what he wants out of life and learning not to go there again. He's happy what he's doing now. He's evolving.

Associates and Social Interaction Programming. A majority of respondents (n=4) whose family members were required to attend mandatory associates, and social interaction programming while in custody found the program to be inadequate overall in changing the behaviours associated with the influence of anti-social peers. The main reason given for the inadequacy was that their family members was still in a gang (n=3), and they s/he either did not want to leave the gang or that s/he suffered violence when trying to leave. Respondents (n=2) who found associates programming to be effective suggested that their family members were trying to stay out of the gangs, trouble, and jail.

He's been out [of jail] a year and still in gang - active - but not as much since he met a girl and they are living together. They are expecting so he is settling down and growing up and getting mature. He realizes what he did was wrong especially now that a family is on the way. He is staying out so that he can protect them from gang life.

Community Functioning and Life-skills Programming. A majority of respondents (n=5) whose family members were required to attend mandatory community functioning and life-skills programming while in custody found the program to be inadequate overall in preparing their family member for release. The main reason given for this is that their family member 'went back to their old ways' (substance use, addictions, gang associates, street life) and ended up either back in jail with more time to serve, or on the streets, homeless. A common theme was that the desire to change was not there; that they learned how to take care for themselves but chose not to:

He was very dependent on me and my family. We had become very dependent on people so it was easier to live like that than get a job when he got out.

He has never done any of it. He is homeless, has no income and goes right back in. He did a home invasion last and that was what landed him in PA - lots of violence.

Marital and Family Relations. A majority of respondents (n=3) whose family members were required to attend mandatory Marital and Family Relations programming while in custody found the program to be inadequate overall in building family support, teaching parenting skills, and reinforcing responsibility for dependent children upon release. Reasons given for this were that the offender was still violent and did not want to change. Respondents (n=2) who found the program to be adequate remarked on the decrease of violence in the home.

They need parenting programs for our parents. They need to be taught how to take care of us.

Personal and Emotional Management and Orientation Programming. A majority of respondents (n=7) whose family members were required to attend mandatory Personal and Emotional (Anger) Management and Orientation programming while in custody found the program to be inadequate overall in managing stress, problem-solving, improving inter-personal skills, and changing narrow, rigid thinking that result in negative consequences and

criminality. Respondents (n=4) indicated that the program did not work because their family member was still abusive, angry, and/or violent. A common theme was that offenders had very little support as a coping mechanism when they got out.

Respondents who found Personal and Emotional Management and Orientation programming helpful indicated that it helped while their family member was incarcerated, but in the case where it led to early release, respondents felt that the program was not long enough to permanently change learned behavior that contributed to offending:

He was a spaz growing up, a very angry person. So everyone thought he would never change. His friends were partiers so he got back into that. He also used to spaz out if he did not get his own way. His parents would always enable him and get his drugs. It was really hard to deal with him when he was high. He had a very good life growing up. We grew up together. I was at his house every day and we were looked after, so I have no idea why he was so angry. But he had no family support in trying to get clean - none at all. He always listened to me instead of parents/bros/sisters.

Gaps in Correctional Services

A majority of respondents (N=46; 89%) reported that their family member needed a program and/or service while in custody but did not receive it. In addition to the need for mental health assessments identified by respondents above, a variety (n=98) of correctional programming needs were identified by this sample.

Table 4.3.2: Correctional Programming and Service Needs

Correctional Programming Need	N=98
Addictions treatment	n=41
Alcohol	n=26*
Drugs	n=15*
Gambling	n=1
Alternative measures (community programs)	n=2
Alternatives to gang life	n=5*
Alternatives to violence	n=1
Anger management	n=8*
Cultural programming	n=2
Education/job training/GED	n=4
Eating disorder programming	n=1
Eliminate drugs in prisons	n=1
Family programs (awareness and empathy)	n=2
Foster Care (adequate)	n=1
Individualized personal counselling	n=4
Mandatory programming	n=1
Medical assessment and supervision	n=4

Methadone	n=1
Money management	n=1
More beds/space	n=2
More programs for youth	n=1
Nutrition	n=1
Parenting	n=1
Psychiatric assessment and care	n=4
Physical therapy (injury)	n=1
Self-awareness/improvement/confidence building	n=4
Suicide intervention/prevention	n=1
Support network/group	n=3

Addictions Treatment Services. The majority of respondents (n=41) identified the need for correctional treatment programs and services for alcohol and drug addictions among young offenders and youth, and survivors of sexual abuse (n=3):

I think he should have been forced to go to school and get treatment too. They should have more opportunities for them when they are in when they are young - the only thing you get are religious based like AA and NA and the Healing Lodge and that's it - not enough, Need more options to keep busy and get better.

They [my children] are in and out of jail a lot and yes they sure did [need addictions treatment]. My youngest is in treatment now. They both go in voluntary, once to Calder and once to James Smith First Nation for a month. My oldest doesn't want programs because he thinks he can handle it on his own.

Alcohol and drugs played a really big role in his life. He was so addicted it wasn't even funny. He was so dope-sick - it was so bad. I never approved - he was so dependent. So zoned out.

“He needed treatment and programs while he was in Kilburn. That would have helped with the gangs, violence, and drugs. He would not be in the Penn now.

Addictions treatment. My uncle was also sexually abused when he was a boy.

Anger Management Programming. A number of respondents (n=11) also indicated a need for emotional (anger) management programming:

Before he died he was very violent - we were scared of him. He would yell. If he did not have his drug or alcohol he would become destructive to the house, break things, storm around. Talk loudly - never threaten or hit or hurt us but destroy his own things. He slashed himself one time in between Kilburn and when he was sent to North Battleford

... they sent him there because Kilburn was too crowded ... I never got to visit him there. The night he died, he hit me. I never told anybody that.

Psychiatric Treatment Services. The need for psychiatric treatment (n=4), sexual abuse counseling, and suicide intervention was also a common response in this cohort:

He tried to jump off a bridge and he tried to hang himself when he was on the phone with me. I wanted him to get help and I cannot believe that they took him to jail instead of the psych ward just to get the ticket money. He tried to kill himself, come on! I didn't know what to do. I didn't realize I had the power to get him committed.

Associates and Pro-social Programming. The need for programming alternatives to gang life was also a common theme:

She and I have been on our own since we were 12. She replaced our lack of family with gangs. She stayed alone at my mom's place for weeks at a time, and then months at a time. I would go and check on her and she was all alone without food and my mom was out partying. She wanted to be with her gang after that. She started that at about 12 and would do anything for them. It's a status thing now. She had no money or income back then and would beat people up. There used to be a lot of violence in our family. Our reserve tried to help her too. They held ceremonies and the Elders and medicine people talked to her but she ran away. I ran away too when I was 13. I went to my aunts because my mom was partying. She was only 15 when she started having us. I never did any of this because I left, but she stayed with my mom. I had role models and she didn't.

4.4 Community Mental Health Programs and Services

Community Mental Health Programs and Services

The majority of respondents (n=43; 93%) reported that their family member needed a program or service upon release but did not get it. A number of respondents (n=23) reported that their family member received a mental health program, service, and/or treatment after his or her release from custody where 87% (n=20) of these programs were required as a condition of release. The most common program, service, and/or treatment received was for addictions (n=15) to alcohol (n=11) and drugs (n=4). Psychiatric care (n=3), problem solving (n=3), emotional (anger) management (n=3), and job-readiness (n=3) were also regularly reported.

Effectiveness of Community Programs and Services

A majority of respondents (n=24; 77%) found community programs and services to be inadequate in meeting the needs of their family members.

Gaps in Community Programs and Services

A variety (n=80) of community program and service needs were identified by this cohort:

Table 4.4.1: Community Programming Needs

Community Programming Need	N=80
Addictions Treatment	Alcohol (n=24)*; Drugs (n-19)*
A better lawyer	1
Alternatives to gang life	1
Anger Management	10*
Cultural programming	3
Employment/Job Training	4
Family counselling	1
Individualized personal counselling	4
Life skills	2
Methadone	1
Preventive programs for young offenders	1
Programs based in home community	1
Programs for people with FASD	1
Psychiatric assessment/treatment/care	4* (n=3 childhood sexual abuse)
Sports and recreation	1
Support network/group	1
Victim empathy	1

While addictions treatment was identified as a primary need, respondents indicated that their family members required a combination of community treatments and socio-cultural services including rehabilitation and counseling, anger management, psychiatric treatment for childhood sexual abuse, job training, and cultural programming in their home communities. Mandatory treatment was a common theme in the family data:

They should have put him [my son] in a treatment center - he should have done a month in jail and a month in treatment and the court should have imposed that if it's a long sentence, that's what they should do.

He [my son] needed to get a skill so he could get a job. He has been bad all his life, the gangs are his family. He is with IP [Indian Possie] and he started a riot. So he's in lock down waiting to transfer out and is not getting any programs. He was the leader and he has to pay for that by getting more time on top of his sentence. He'll do anything for the gang and for this he will spend all his life in jail if necessary. His dad hung himself when he was 3 so no dad around to change that and get him out, the gang is all he knows.

Parents in this cohort felt very strongly that a lack of community resources for low income families was a contributing factor to criminality:

He [my son] was only assessed once at Kilburn and they said he was ok that he had ADD and ADHD and gave him meds and Ritalin which he used but mostly sold - he would

never take them. There are no rec programs for low income kids - no sports funding at school. We never had money to take them to these places. We sent them to school hoping they would get help there. They'd see other kids getting things like sports, clothes and shoes. So that's how it started, I couldn't afford to buy him nice clothes and so he stole them. My other two would wear clothes from Value Village but he would not. He was very proud and stubborn and I could not get him the things he needed, so he robbed people of theirs - bunny hugs and shoes, and he stole from stores, shoplifting and he got caught and charged.

Interestingly, the majority of respondents felt (n=44; 85%) 'safe' in their communities even though they identified them as being criminogenic:

Tons of addicts in my neighborhood and untreated mental health issues. Drug houses on my block. Self-medicated people with medical issues, mental health issues, very unpredictable, and lots of street people.

It's just not safe. The girls want to fight because the men want to bother you and they are jealous of that. I have brain tumors because I was jumped by 6 girls and a guy 7 times in one summer. It started over a cigarette paper - I asked for a paper from a guy and a girl got jealous and attacked me with a bunch of her friends. Then I got jumped by them when I refused to go drinking with them. They stomped on my head. I remember seeing blood coming out of my eyes and a girl coming at me with a butcher knife. Then I blacked out and they found five tumors in my head from that - one on my brain stem and two behind my eyes - all inoperable. I had surgery to try, but I am on constant pain meds now - that's all they can do.

4.5 Family Members Issues Affecting the Provision of Mental Health Programs and Service toward Desistance and Mental Health in Saskatchewan

Family Members Issues Affecting the Provision of Mental Health Programs and Service toward Desistance and Mental Health in Saskatchewan

The following Issues affecting the provision of mental health programs and service toward desistance and mental health in Saskatchewan were found:

Length of Illness

A major theme of the family data is a lifetime of undiagnosed and untreated mental health issues leading to criminality and recidivism among Aboriginal offenders (M/F). The majority of mental health issues are undiagnosed (n=29; 44%) in this cohort, and the most common response to length of illness is ten years (n=13), where a 'lifetime' of more than 20 years was reported a number of times (n=10). A common theme among children of offenders was "I grew up with it" and "I saw it my entire life." Half (n=26) of the offenders represented in

this cohort were being treated for their mental health issues before coming into contact with the criminal justice system.

Repeated Contact with the Criminal Justice System without Intervention

Total contact with the criminal justice system for this cohort is between 1 and 500 times [as stated by respondents] where less than 10 times is most common (n=15), which is only slightly lower than between 20 and 29 system contacts including police and courts (n=12). There are a number (n=10) of offenders with between 50 and 500 contacts. These contacts led to between 1 and 100 arrests, where the most common number reported was less than 10 arrests (n=22). A number of offenders are reported as having been arrested between 50 and 100 times (n=14). These arrests led to between 1 and 100 charges where the most common number of charges disclosed was less than 10 (n=31). A small number of offenders are reported as having 'lengthy' 'massive' and 'long' criminal records of between 50 and 100 charges (n= 6) for assault, violence, theft, and other substance-related issues including driving under the influence. These charges led to between 0 and 200 overnight incarcerations in cells, remand, and maximum security institutions. The most common number of incarcerations reported is less than 10 (n=33). A number of respondents reported a 'lifetime' of recidivism and repeat offences leading to between 20 and 200 separate adult incarcerations (n=4) of up to 25 years. The most common sentence for incarceration is under two years (n=34). However, respondents report a steady increase in time served of 'a few months' to several years' for escalating offences (from escaping to armed robbery, for example). A number of respondents reported that their family member's case was pending or before the courts and one believed that their family member "would never get out."

Offenders who did not serve their entire sentence (n=29; 56%) had conditions to follow upon their release. However, the majority (n=20; 69%) were unable to successfully complete their conditions. A common theme among this cohort was breach of conditions due to substance use that led to more time or in the case on one participant's spouse, a serious brain injury:

He was supposed to see a doctor and dry out because he was drinking himself to death. The amount he drank had lowered his platelets (red blood cells) to the point where it was being considered suicide. So the Dr's were going to have him committed in RPC I think but they didn't say where. He was supposed to see a counselor on the reserve but he never did. He was supposed to go to treatment - a native program on reserve - they were supposed to help him get into treatment. It was all court-ordered, but they were not making him go. They were all supposed to be trained and just ignored everything. They signed off on his fine option and never made him to ANY of his conditions. They never enforced them and he did not try. If they would have, he would not be in Parkridge. He had a seizure at home and then another one in emergency, then he fell off the bed at the hospital and hit his head. The blood clot was the size of a pancake and swelling in his brain led to a coma. He came out of it but they gave him 48 hours to live. He survived but now he is a vegetable - a baby. He has to have 24-hour care. He's got the mentality of a baby in adult diapers. My 16-month old has more intelligence than him. He can talk but he acts like a 2-year old. He has temper tantrums, he has to be

diapered and he is not able to change or feed himself - all of that. This was my opportunity to get out of an abusive relationship but sadly my 11-year old son lost a father.

Table 4.5.1: Outcome of Early Release

Outcome	N=68
Assaulted police officer	n=1
Breached	n=23*
Charges were dropped	n=2
Committed to care of family member	n=1
Committed to RPC	n=2
Court-ordered program	n=2
Court-ordered treatment	n=5
Fines	n=1
Got more time	n=5
Increase in violence	n=2
Nothing happened/let go	n=2
Ran away	n=1
Relapsed (drugs, alcohol)	n=9*
Sent to jail; sent back to jail	n=10*
Serious health conditions	n=1
Stole a car	n=1

Offenders who were diverted from the criminal justice system by police (n=32; 62%) also had conditions to follow. Conditions include heeding the warnings of police and staying away from alcohol and negative associates, to curfews and threats of arrest.

Table 4.5.2.: Outcomes of Police Diversion

Outcome	N=53
Banned from premises	n=1
Brought home by police/ambulance	n=15*
Court gave stricter conditions	n=3
Court gave probation	n=1
Police gave conditions	n=4
Police gave curfew	n=1
Police gave warning/lecture/scolding	n=5*
Police issued a fine	n=1
Police issued restraining order	n=2
Police let them go	n=8*

Police scared them with threat of future arrest	n=2
Police separated partners in domestic dispute	n=1
Police took person somewhere to sober up	n=2
Police took person to detox center	n=1
Police took person to drunk tank to sober up	n=2
Police put person on surveillance/monitoring	n=1
Person released on recognizance	n=3

The majority of respondents reported that their family member was able to meet his or her conditions (n=17; 53%) with favorable outcomes including reductions in charges and sentencing.

Table 4.5.3: Positive Outcomes of Police Diversion

Positive Outcome	N=18
Charges were dropped/sentence reduced	n=9*
Domestic/family violence stopped/decreased	n=1
Got needed program/counselling	n=2
Criminal behavior was reduced	n=5*
Sobered up	n=1

Those who failed to meet the conditions of police diversion returned to their 'old ways' (substance use, addictions, gang associates, street life) (n=7), contributed to domestic and family violence (n=7), and received additional charges and sentencing (n=6).

Table 4.5.4: Negative Outcomes of Police Diversion

Negative Outcome	N=30
Domestic/family violence	n=7*
Drinking/caused an accident	n=1
Got additional charges + time added after getting caught	n=6*
Got into trouble	n=2
In and out of jail	n=4
Lost custody of children	n=1
Refused to take medication	n=1
Returned to old ways (substance use, addictions, gang associates, street life)	n=7*
Was murdered by gang	n=1

Lack of Forensic Mental Health Assessments

The majority (n=37; 71%) of offenders represented in this cohort stated they have never had a mental health assessment done during their arrest, sentencing, hearing, and/or pre-trial procedures. Outcomes for offenders that received assessments (n=10) include counseling, medical and psychiatric treatment, detoxification and rehabilitation, fitness and state of mind tests, and programming. An important theme in the data on young offenders is that their parents had to educate themselves on matters of forensic mental health in order to plead for their children in court:

I had to beg the court for [an assessment for my son] at age 19. He was sent to RPC for one year but they 'did not understand why he was there for FASD'. I had to educate the staff about my son. For example, my son would go into class with his hoodie pulled tight around his face and only look down. He was written up for being 'defiant' but that was really 'fear' of not being able to learn. At the time, the staff doctor had not much understanding about it until he went to the FASD conference and THEN he got him numerous resources i.e. an Elder. He was doing good until he was released from RPC and went back to the streets.

Lack of Correctional Programs and Services

The majority of respondents (n=45; 87%) felt that the needs of offenders with compromised mental health were not being met by Saskatchewan correctional facilities. Respondents identified various issues facing offenders with mental health issues in correctional facilities based on the experiences of their family members.

Table 4.5.5: Issues Facing MDOs in Custody

Issues Facing MDOs in Custody	N=140
Availability of street drugs in jail	n=5
Depression	n=3
Forced into program/did not take seriously/took to get out	n=4
In jail when should be in psychiatric hospital	n=1
Job readiness	n=2
Lack of adequate family visitation	n=1
Lack of individualized counselling	n=13*
Lack of programming (including addictions treatment)	n=59*
Lack of proper medical supervision for meds	n=2
Lack of psychiatric assessments/treatment/care	n=11*
Lack of suicide intervention/prevention	n=1
Lack of supportive networks	n=15*
Lack of positive role models	n=8
Loss of freedom/feelings of hopelessness	n=3
Need for improved alternative measures/early release programs	n=1

Poverty/lack of affordable housing/poor bashing	n=6
Racism	n=5

Respondents felt that a lack of correctional programming (n=59) in general was a contributing factor in their family member’s criminality. Specific programming and services needs identified were alcohol (n=14), drug (n=6), and youth (n=7) addictions treatment and counseling; gang desistance (n=6); native spirituality and culture (n=5); and anger management toward domestic violence prevention (n=6). A common theme among respondents was that some of these programs should be mandatory in order to deal with underlying issues:

90% of the people I know in Saskatoon are on drugs and 40% are drinking. EVERYBODY from 20th to 22nd and Avenue H are all chronics. Its rank - I know this. I'm just out myself. I had to get away from the hood - away from the drugs - I'm on methadone pills, dose was 100, now 75. I was in and out from women's Pinegrove for stealing food and stuff that would go fast to get my drug. I knew I was an addict; I had to go get help myself. No one in jail gets help (methadone). I wanna quit this scene man, but they are all related, my family, so it's hard.

Respondents also felt that the current lack of individualized forensic psychiatric assessments, treatment, and care programs (n=26) was problematic.

People don't get proper help and guidance from counselors; there's not enough help. All you get is one person. I don't think they even ever offered them counseling. I was never ever offered it when I was in doing 8 years for my sentence. Not even once in the adult fed or provincial system. And I don't think it ever changed.

My brother was lost and confused ... somebody should have figured that out. ... He also used to write letters to himself asking the devil to leave him alone. He used to sleep walk too, he'd be fast asleep and he'd be playing with the stereo. I have seen a lot, man. I have 13 brothers and 14 sisters - all biological – half on my mom's side and half on my dad's side. We didn't stay too long in one place - my mom and dad were alcoholics. My mom's white, dad's native.

Parents in this cohort felt very strongly that a lack of mental health services in youth detention facilities was a contributing factor to criminality:

There is a lack of psych assessments at Kilburn. They need to get it together there. I was never asked to come in. I was always telling them they needed psychiatric help. I always told the police they needed them. Then I told the court that they needed psychiatric help. I would say my girls [daughters] need alcohol and drug treatment and I told them 'they talk about killing themselves all of the time'. I stood in front of all these people crying for my daughters and they did nothing. They never got the help.

A lack of supportive networks (n=15) was also a common theme among respondents in this cohort:

They need to help them more when they are in, to get them talking so they know where they are at. They have no one to talk to and they have no one. Then they do bad things to get attention because they are so lonely. They need someone who they can openly talk to. My son and others really have a lot of hurt inside and they need to get it out. The Elders are so busy with other clients that they have not enough time. The kids get attached to them and then they have no time for them so they get lonely and then act out.

Respondents also identified several socio-economic issues affecting offenders with compromised mental health including poverty, homelessness, racism, insensitivity, and unsafe neighborhoods.

Poverty. The mentally ill have nothing. All soup kitchens in Regina are closed; stress for the people - nowhere to go to eat. You have to pay \$4 to eat at Salvation Army. It's closed in the summer so this causes them to steal and boost to eat. There is only one place open at 5pm for free food - Soul's Harbour. The cause and effect is crime. People need to survive so they steal then they get caught. One of my friends used this method so he could get some food - he got caught and is in jail for panhandling to pay off his \$150 fine. You get one warning but you have to eat. Police do lots of poor bashing around our area.

Living arrangements. The rent is too high and people can't find housing. Can't get support without a house.

Racism. The 'dirty Indian' aspect is there. Life stops: life is put on hold and you're a number; you do your time, you try to survive; there's no purpose for life in there. So why bother getting up in the morning? Attitude? Deprivation = no freedom.

Hopelessness: the medical community sees up to the age of 26 as being hopeful to change poly-substance abuse, NOT AFTER. .

There is a huge race issue for white offenders because of so many Aboriginal people in jail. I mean come on there's so much they can get in there like TV, internet, good food. It is way different then when my dad was in back in the day compared to now. In fact this one guy asked for more time so he could get treatment. I heard that on CBC.

My uncle had a dog. He treated that dog like a kid, bought him treats, they had a house. The dog was his only companion. The cops kept picking him up about a year ago They took the dog to the SPCA or wherever the pound is and my uncle had no money to go get him out so they put him down. They totally affected him and he started to drink heavy and he got evicted and has been homeless ever since.

Lack of Programs and Services in the Community

The majority (n=45; 87%) of respondents felt that the needs of offenders with compromised mental health were not being met by Saskatchewan communities after their

release from custody. Respondents identified various issues facing offenders with mental health issues in the community based on the experiences of their family members.

Table 4.5.6: Issues Facing MDOs in the Community

Issues Facing MDOs in the Community	N=104
Committing crimes of survival	n=1
Failure to recognize a problem (addiction)	n=3
Gang pressure	n=3
Going back to old ways	n=4
Inadequate role models	n=1
Lack of alternatives to making easy money from crime	n=2
Lack of counselling	n=11*
Lack of follow up	n=1
Lack of job skills and training leading to unemployment	n=1
Lack of options	n=1
Lack of programming (including addictions treatment)	n=29*
Lack of psychiatric assessments/treatment/care	n= 6*
Lack of supportive networks	n=24*
Need for stability and self-reliance	n=2
Poverty/lack of affordable housing/homelessness	n=7
Prevalence of street drugs in community	n=4
Too much freedom	n=3
Wait list for treatment	n=1

Respondents feel that a lack of community programming (n=29) in general was a contributing factor in their family member’s criminality. Specific programming and services needs identified were addictions treatment and counseling (n=8); reintegration planning (n=6); and native spirituality and culture (n=2). A common theme among respondents was that some of these programs should be a mandatory part of aftercare upon release.

Respondents also identified a lack of supportive networks (n=24) as an issues facing offenders upon release in that many family members had to rely on individual connections to indigenous communities to continue cultural practices started in jail:

There is no support after they get out. They are focused on their freedom and think they can do whatever they want. So we need to have mandatory classes for all of it. Just even group counseling or talking sessions.

They need someone to talk to once they get out too. They really need this so that they don't end up doing something worse. It’s like the residential school - keep everything inside. But this is not good because if it’s inside, you keep making the same mistakes. Like me, I was raised in a residential school and made the same mistakes with my kids.

Respondents also identified a lack of counseling (n=11) and psychiatric aftercare (n=6) to deal with sexual abuse, residential school abuse, and domestic violence as underlying causes and factors of criminality (n=5):

They need to have family support but if they are still mean the family breaks up. My mom was brutally abused by him for years before he went to jail. She stayed with him but after he got out they weren't together that long - 2 -3 months. But we were sent to live with him by the courts and social services because he had the money to support us. That was the worst. He was the meanest person I ever met. So I think they need to get them help or he should have been in there longer.

Socio-cultural issues such as poverty, homelessness, racism, and discrimination (also present in other categories previously addressed) were also identified by respondents as being underlying issues of criminality and to a greater degree for offenders once they were released from custody:

It's hard enough being First Nations - but there's lots of poor bashing on the outside: we're bums, trouble makers. They get no skills on the inside, so we need sensitivity training in this area for social services, police, and officers that deal with the mentally ill.

Length of Program

Length of correctional programs was also seen as prohibitive by the majority of respondents in this cohort (n=37; 71%) who thought that they were not long enough to be effective:

You need to finish what you start. My son tried to get into treatment when he was in Kilburn but he was not in there long enough. Then he got out and no one was making him go to treatment. The probation officer did not make him go - but he had to stay off drugs and alcohol. That does not make sense to kids - they need a little push to get themselves right from parents, corrections people and probation officers. They need a lot more programs in jail to start them off and then they will learn to follow the rules better.

Wait Times

Wait times were also seen as prohibitive by a number of respondents (n=24; 46%) who reported having to wait anywhere from between a week (n=3) to 2 years (n=2) for a treatment program or service for their family member. The most common response for wait time was one month (n=7).

There is a 2 month to 3-4 month wait to get methadone treatment. If they are on methadone they don't need hard drugs and don't do the crime. They also need methadone clinics in jail. They don't treat, or interview them. There is no doctor in there. They have to go through withdrawal all by themselves. So they are only in a short time and then when they get out they go and do the crime to get the drugs and it starts

again. So please, they need less wait time on the outside and methadone clinics on the inside. If they have methadone they would not need other drugs. It's a huge problem in Saskatoon with this. It's an easy fix - shorter wait list and set up clinics on the inside.

Travel

In the cases where travel was required to receive a program (n=13), the cost of the travel was seen as prohibitive unless paid for by government agencies including social services (n=4) and Indian Affairs / First Nations bands (n=3).

4.6 Consequences of Existing Issues and Barriers to Mental Health Programs and Services

Family Members

Consequences of Existing Issues and Barriers to Mental Health Programs and Services

Those respondents who identified gaps in service (n=40) reported a variety of consequences for family members who did not receive needed service(s) upon release. All of these respondents (n=46: 100%) reported that their family member faced various consequences and issues upon release because they needed a program while in custody but did not receive it.

Table 4.6.1: Consequences of Not Getting a Program, Service, or Treatment in the Community

Consequences	N=79
Abnormal/psychotic behavior	n=2
Abusive/violent	n=4
Addiction got worse	n=10*
Almost killed someone	n=1
Cannot find employment	n=1
Committed a murder*	n=3
Committed crimes to buy drugs	n=3
Crimes got worse/more frequent	n=4
Death*	n=2
Domestic abuse/violence increased	n=4
Goes in and out of jail (recidivism)	n=9*
Got angry	n=1
Got depressed/depression worsened	n=3
Got into trouble	n=3
Had to go on welfare/social assistance	n=1
Health deteriorated from alcoholism	n=1
Increased penalties/sentencing	n=5*
Isolation from home community	n=1
Joined a gang/interacted more with a gang than before	n=1
Loss of freedom	n=1

Lost custody of children	n=1
Lost driving license	n=1
Lost family/divorce/alienation	n=3
Lost job	n=3
Lost opportunities b/c of addictions	n=1
No job skills upon release	n=1
Poor diet	n=1
Refused to take medication	n=1
Suicide*	n=1
Victim of violence	n=3
Was ashamed	n=1
Was homeless	n=1
Withdrawal	n=1

Respondents reported a 'lifetime' of mental health issues and disorders and chronic alcoholism leading to family, inter-personal, and gang violence, criminality, recidivism, repeat offences, incarceration, increased penalties and sentencing, victimization, isolation, and death:

She picks on different races and was once stalking Roy Romanow. She called him 50 times citing love for him one minute and then was abusive toward him the next. That's why she was in the psych ward. Drugs made her more hyper. She was on anti-depressants and mood stabilizers but she was more abusive toward our mother and me. Once I was sitting on the floor in the yoga position lotus and she called me a 'fucking slut' and 'whore' because my legs were open.

My sister was always messed up. She used to kick holes in the walls and break down her door. She was always grounded for doing bad things - auto theft and assaulting police. She had a baby at 14, she lost her son, and my dad won't let her see him, so she's depressed.

My nephews separate themselves from this nephew. When they go play ball they leave him home, they don't want a sad-sack around. It's like my sister; she always got sad when she drinks, or, she drinks cuz she's sad. She's a bitch when she's drunk. So we don't want her around.

... she's in too deep with gangs. She's been in and out of the system so much. She meets the wrong people and she's afraid people won't like her so she goes around with these kinds of people - she's attracted to bad boys. She's doing hard drugs - I saw tracks. She started hanging around with this druggie and a pimp who got her hooked on drugs. She wasn't 'working', but he pushed her down once because they get them to steal for the gang to support their habits and she stole a razor kit and only got \$10 for it when he wanted \$20 so he freaked out and pushed her around. Next she was in an abusive relationship with a guy who raped her and beat her. He was a gang member who sold

coke to junkies. One time he stayed in the house for a while and would not let her out. He got other gang members to go to the store, run drugs, etc. so he could watch her.

[My son] has had to suffer withdrawal. I had to force him to go to psychiatrist. He is a very small boy 5' 7" or so and slim. He was assaulted twice by Saskatoon police downtown. I tried to get help but I am a single parent and I didn't know what to do. I was not allowed to see him. They quickly moved him to PA. He was 18. A member of my family was arrested around the same time and saw him. He told me his face was rearranged. Eventually he called me and told me he was okay and not to pursue it. He always got the longest time possible. They always picked him up as a known gang member with Native Syndicate. He had the tattoos and colors. Some guy from city police and parole already told me they were going to 'D.O.' him because he has had too many violent offender crimes like home invasions, robberies, and weapons. I have no money and no way to get him a lawyer. I don't think it's right, but who will listen to me?

My mom died and my dad was hanging out with street people - the lowest of the low - shifters and crackheads, abused kids. My dad was a good guy and wanted to help them. He was always helping young girls. Who knows what the exchange was. He was housing half of the west side and drove them to their reserve and stuff. He replaced my mom with food and me with them. But they used him. He was charged with having sex with a minor.

.....should see his record for violence ...

He committed a murder.

Alcohol addiction, addiction to crystal meth, taking everything he could get his hands on - pot, coke, whatever he could get. Also depression - started suffering from depression at about 16 - he met a girlfriend and then they broke up. He started using more drugs to deal with that and he turned violent. Then he committed suicide. He was found deceased with two mickeys of whiskey that he had drank straight.

4.7 Best Practices for Saskatchewan

Family Members Best Practices for Saskatchewan

Family members had a lot to say about the mental health programs and services that were working, those that were not, and those that are needed in Saskatchewan. More correctional programming and services (n=36), topped the list where cultural (n=8), jobs skills (n=5), anger management (n=5), and alternatives to gang life (n=3) were seen as key to changing behaviours associated with crime in combination with addictions and psychiatric care. Mandatory supervision (n=31) was also seen as a necessary service for Saskatchewan, as was the need for more community addictions services in the province (n=18).

Table 4.7.1: Programs and Services Needed in Saskatchewan

Program or Service Needed in Saskatchewan	N=113
Attention to needs of Caucasian inmates	n=2
Community services as alternative measure	n=1
Counselling in jail and community	n=2
Crisis line for offenders	n=1
Education about services/access to services	n=2
Less wait for treatment	n=2
Longer treatment programs	n=1
Mandatory/supervised/thorough assessment/treatment/programming/follow-up	n=31*
More correctional and community addictions treatment /counselling facilities	n=18*
More affordable addictions treatment	n=1
More healing lodges/access	n=1
More programming in correctional facilities	n=36*
More programming in general	n=1
More room in jails	n=1
Rehab in jail	n=3
Role models for youth	n=1
Suicide risk assessment/intervention/prevention in jails	n=1
Supportive networks	n=8

Mental Health Programs and Services as Interventions in Criminality and Recidivism

Respondents identified addictions services (n=29) and psychiatric treatment, counseling, supervision, and advocacy (n=14) as forms of intervention in the criminality of their family members. Respondents also identified a need for supportive networks (n=5) and socio-cultural programs in correctional facilities and in the community as being necessary to change the behaviours of their family members.

Table 4.7.2: Programs and Services as Forms of Intervention

Program and Service Interventions	N=68
Better role models	n=1
Employment	n=1
Housing	n=1
More room in jails	n=1
Programming	n=41*
Addictions	n=29
Drugs	n=12
Proper psychiatric assessment/treatment/counselling/supervision/advocacy	n=14*

Sensitivity training for staff/police	n=2
Suicide intervention/prevention	n=2
Supportive networks	n=5*

Respondents also saw intervention as being a holistic approach that included a variety of program and services based on individual need in combination with networks of support that included cultural role models and people who have ‘been there’. Because of the voluntary nature of many of the programs, respondents felt that having a cultural element would help convince people to get help:

You can't help people unless you have been there yourself so do they have people like that to talk to? No they don't so they have no clue what people need. I saw this documentary about kids huffing in the north. They just went in and picked them up and took them to rehab. Maybe that's what we need to do. A lot of people have no family and have a real bad life - their parents are druggies, gang members, hookers so they have no family and gangs replace them. They lie and convince them that they are their family. ... but if she had support or somebody then maybe she'd change.

My son needs a mentor; someone who has been there to say, it's okay - here's what it is. The public has no idea what goes on behind bars - they are not supposed to know. So when they get out, it's too overwhelming for them. They need people who have been there and can provide 24 hour support.

I have been in there myself and I know for a fact that it's easier to get help on the outside. Based on my experience it's all volunteer attendance even when it's court-ordered. It's good to have support from your community and First Nations culture. But they don't come to us tho. It's our choice. If we need to see an Elder or go to a sweat, we have to request it. So my cousin would never request it, he's not very traditional. Neither am I.

Methadone and Medical Detox

Some respondents felt very strongly about the addictions and mental disorders underlying their family members' criminality. The need for forensic psychiatric and addictions services was a common theme that ran through the responses of respondents with family members with FASD, schizophrenia, and addictions to opiates like Dilaudid:

What my sister needs - she is far too gone in her illness - is mandatory supervision and compulsory meds or they should treat her in jail to keep an eye on her.

Medical detox - look at why people steal a bottle of Listerine - they are not going to sell it, they are going to drink it. Or hairspray, rubbing alcohol, cough syrup, Gravol, Acetaminophen, downs, etcetera.

Rehab - really good rehab. I think it is best for him to be in a place other than our reserve where he doesn't know anyone.

Some respondents felt very strongly that more than just establishing more programs and services was needed to help their family members, calling for a social model of mental health care to address things like poverty, homelessness, and loss of culture as well as an examination of the criminal justice and mental health care systems in the province:

We need more space or extensions in jail to get people doing stuff in there. All people do is sit around and wait for the day to pass and that's it. The men's jail had space for 260 inmates and was supposed to be used for just 260 for their programming. It has over 1,000 - 1200 inmates and is being used to house them.

Their problems are not with the prisons. My mom has been committed 6 times. She is angry. I really think that the whole psychiatric system needs work. They need more doctors and nurses and less apathy. I could have done a better job of treating her. She has been diagnosed as borderline personality disorder – it's like a leftover bunch of symptoms so 'let's call it this.' She was schizophrenic at one point when she was 16 but only briefly. She has been diagnosed with everything actually, and all this times she's like, 'hey, I'm just a drug addict. She's been taking drugs (and meds) all her life. ... Now she doesn't try - just excuses everything with 'oh well, I am crazy'.

Breaking the Cycle

A number of respondents (n=25) stated that they and their family member needed help to get treatment for their mental health issues and addictions in order to break the (trans-generational) cycle of criminality and recidivism:

My oldest was scared straight by Kilburn but they are still suicidal and hurting themselves by cutting and drugs and alcohol. We need help. I would like to help my girls. I got no help from the courts or Kilburn. I don't know what to do. I have been at court every time and I have seen kids who have nobody there. They need support and help - then we would not have so many problems in or community. My girls always say you don't know what we're going through, but I do! I remember some nights sleeping in the park. I didn't want to go home. I was always threatened by my parents and I left home at 11. I ran around, I was in foster care, Kilburn. We had nobody. My mom's boyfriends were always in the PA Penn so me and my sister would spend our weekends up in the jail, waiting, instead of playing or hanging out with friends. I never wanted this for my girls. We really need help here.

Respondents repeatedly stated that they believed mental health issues including addictions were underlying factors in the criminality of their family members, but that their family members were not getting the help they needed in jail and/or in the community:

“People like my dad need to get help for the safety of others including their families and their kids. We were so abused by him - a lot - on a daily basis for years on and off. My mom had to leave and the only way for her to get out was to lose custody of us. I was 8 or 9 and he was psycho. He would beat us. He had a pellet gun and he would make us run around outside to practice his hunting. I was locked in a room and had to hide in the bushes. He used weapons on us, brooms, etc. and kicked us around with his cowboy boots. He would bring people over and we were forced to go out in the bush for days until they left. When he dried out after he got sick he tried to make amends but sometimes he would flip out again even though he can't remember it. He did awful things. When I was 12 he called me a whore because he said he saw me doing stuff - seeing things - the DT's? And he beat me black and blue in front of my little brother. We went into foster care when I was 6 but nothing ever happened and we were sent back to him. I never say it, but I am glad he's gone. He picked on me the most. He went to jail for abusing us, but they let him out and he abused us again and again. He definitely had something wrong with him - his mom and step dad did the same things to him - he was abused. A lot.”

A common theme among respondents was that they were worried about the affect of older children on younger children in the home in terms of role modeling substance use and gang involvement:

I know my son and he is not capable of hurting someone, no, never. He is a follower to his native friends. He is a gang leader, yes, he is very intelligent and talented so yes, he was made a leader but he would never hurt anybody, no. I asked him to leave so that my young son would not see him as a role model. I am starting to see that my young son is using gang language and writing down things after they talk on the phone so I am concerned. ... He is in the Penn and he will learn how it is to be really behind bars. He will get the help he needs. I would rather see him behind bars rather than on the streets.

Another theme was that many offenders suffer from emotional traumas associated with sexual, residential school, family, and institutional abuse that the criminal justice system does not currently understand the depth of the problem or know how to deal with it.

....a lot of young kids commit suicide because they have no one to talk to and they really need to get to talk to someone they could trust and open up to someone who will listen as soon as they go in. They get scared, they get recruited by gangs, they get jumped on and bullied, and they learn bad things like sexual favours and they have no other choice but to fight their way out because they are cornered. A lot of bad things go on in there. I know a lot of young boys this happens to. They learn to hate in there. This might be a good way if there were Aboriginal elders involved....

Another theme among family respondents was that they believed jail is not the place for people with mental health issues and addictions because of the effect it has on the family:

I don't think the needs of people like my dad are being met. People go to jail for underlying addictions and mental health issues and they are not being addressed. You are not helping the community by sending productive and non-violence or non-dangerous people to jail. It destroys families and they never can recover from it.

My husband has a good job and makes a lot of money working up north. He gets his pay cheque and in his weeks off, he stays up north and drinks in the FN community. He doesn't give us a cent. I am on social services and he has all of this income that he spends on booze and other women. When he comes home he is violent to me. He has had affairs with every single woman in the community up there. So I don't want him. The last time I saw him he broke my jaw and that got him 18 months in jail. I think it's too late for him now - he's a bad alcoholic.

I wish there was a support system for families of offenders. We feel so, so bad for the victims but my grandson also made US victims. We have to use caution at all times as we are known to his associates and rivals and sometimes I fear for my own safety. We have no one to talk to, nowhere to go. So we keep it inside and it is very hard to deal with sometimes. I am certainly not justifying or minimizing what happened. We have no way to bring back a life, but we also need help. His father has totally changed his life now and we have each other but we need to get well too. We all need to become healthy survivors. We need professional help to do this.

A further theme among respondents was the belief that that no matter how many programs and services currently exist in the province or will be established in the future, unless an offender is accountable, takes responsibility for their actions, and really wants to change, change will never happen:

People don't want to get up and get help because drugs are all around, right in their faces. They need to get out of the area - the hood - and they have to figure it out on their own. I did it. I was bad too, but I knew I had to move.

Mental Health Court

Respondents were asked directly for feedback on the need for a mental health court in Saskatchewan. A mental health court was conceptualized as follows:

A specialized court for mentally ill or disordered offenders (including those with addictions, substance abuse, and/or Fetal Alcohol Spectrum Disorder [FASD] which is as yet unclassified in the DSM-IV), where there is a consistent and informed team including a judge, psychiatrist, psychologist, nurse, and mental health court diversion worker and/or social worker present. ...

The majority of respondents (n=51; 98%) believed that such a court could help address the various addictions and psychiatric issues underlying the criminality of their family members, or,

help to prevent a lifetime of addiction and mental health issues leading to criminality for other people, especially youth.

Table 4.7.3: Views on Mental Health Court in Saskatchewan

Positive Views on Mental Health Court in Saskatchewan	N=143
Could get offenders help when they are young	n=3
Could order and enforce assessments/programming/supervision	n=39*
Court could help people open up and talk about problems	n=6
Court could help produce knowledge about mental health issues	n=1
Court could offer a form of tough love	n=1
Court could order treatment instead of jail (without treatment)	n=7
Court could provide options for a better life	n=8
Court could provide role models	n=4
Court staff would be relatable/trustworthy/empathetic/compassionate	n=20*
Court staff would be trained/experienced with mental health issues	n=11
Court staff would know where to find programs/services	n=20*
Court would address the illness as the reason for committing crime, then address the crime	n=11
It is another form of help/tool in the box/problem solving	n=11
Offender would be judged by a team of members of the community	n=1
Critical / Questions / Concerns About Mental Health Court in Saskatchewan	N=11
It already exists	n=1
Might be inclined to agree to treatment when not ready	n=1
Might end up doing more time in treatment than with regular sentencing	n=1
Most guys will work the system	n=3
People may not understand court lingo	n=1
Too much pressure all at once	n=1
Waiting list	n=1
Who decides which cases are heard?	n=1
Will court staff have proper training?	n=1

The majority of responses concerning the establishment of mental health court(s) were positive (n=143). Respondents (n=39) felt that such a court could impose an appropriate program or service for their family members. Court-ordered, enforced, and/or mandatory programs and services was a common theme among the data for this sample:

Assessment is necessary. Enforcement is necessary. It is too late for my ex but I have cousins who are in gangs. They get caught and go to jail where they do all the programs and say they will change to get out but they go right back to the life. My cousin's sister was also in jail there for selling drugs but she was also using alcohol and drugs too. She went and got programs and now she's right back to it. Now my nieces are all doing the

same. It's a pattern: they do this because of a bad life growing up, they join gangs and sell drugs for them. It's such a waste. These are all good people.

Respondents (n=40) also felt that the staff of mental health courts would be compassionate and trained to know the issues and know where to access services and resources:

Presently it works the other way around, they go to court and jail and then they get treatment. This is not good. My ex can talk better in this kind of court than the other kind because there are people there who understand what he is going through and he could trust them. Then he would open up and be able to heal.

Half the people [in regular court] are not trained to deal with it. In the jail, some counselors are recovered, but they are certainly not in the courtroom. It's good to have this. A provincial court never looks at your addictions, they just look at your charges and they judge you on your addictions as a person. All the people in jail are in there on drugs or alcohol related charged. These courts will address the problem - then the chance to treat them, then incarcerate them if they need it. The first step for people is to admit there's a problem, then deal with it. Or find someone to help you deal with it. Shame is a big thing, people are really ashamed to talk about it so we have to find a way to get people to open up then they can be helped and that's a known fact.

A common theme among this cohort was that mental health courts could be staffed with Aboriginal role models who had 'been there' and could help the court in understanding indigenous issues and world view:

My son has not been recognized in the court system. The judge looks blankly at him: 'Just another Indian, just one of those.' They don't understand. People who work with mentally ill know that there is a different thought process. So I am waiting for the day to come. I hope it's not too far off. They'd recognize the person and we could make a better society. It's like the Aboriginal Way - the COMPLETE circle. My son has been in the Penn for several years now. We go up and visit for Powwow. My husband has met so many young people - good people - at these events. You have to know that some of these people, in this context, do not belong in jail. They want to be normal; want to enjoy what we enjoy. They recall their pasts, cultures, poetry, songs, love of animals, etc. A mental health court would recognize this side and promote that.

A common theme among respondents was that mental health courts could help 'dig deep' to address the underlying issues that lead to addictions, substance abuse, and crime:

....That would be super-beneficial to people trapped in the cycle. There's been this eagerness to diagnose and prescribe shit. I've lied to get medicine when I was a coke-head. It's putting a band-aid on a broken arm. That's why people keep going back to

their old life of breaking the law and doing drugs. They need to be given the keys to break the cycle and find out what is broken inside and fix it.

Respondents also had questions and concerns about the form and function of mental health courts in Saskatchewan. A main concern was that offenders would ‘work the system’ and ‘ruin for people with legitimate concerns’ (n=3). Questions also arose over criteria for referrals into the mental health court process. Another issue was that if offenders were being diverted away from Cree court into mental health court, some individuals would ‘not understand the lingo’ and agree to things that they did not really understand. A further point was raised suggesting that mental health courts already existed in that lawyers can ask the court for assessments and treatment.

PHASE II - FINDINGS - ENVIRONMENTAL SCAN

4.0 FINDINGS - ENVIRONMENTAL SCAN

Environmental Scan

This assessment seeks to address some of the reasons why Aboriginal offenders in Saskatchewan are not receiving community mental health services equal to their level of need. The environmental scan outlines the provision of criminogenic needs programming and related forensic mental health care in Saskatchewan to address the effectiveness of institutional and local priorities that impact on MDO mental health and substance use relapse leading to recidivism, reoffending, and the commission of new offences. It also identifies the availability and accessibility of forensic assessments, programming, services, and referrals in order to eliminate a lack of community and correctional assessments, programming, services, and referrals as barriers to MDO mental health and desistance.

4.1 The State of Forensic Mental Health Programs and Services in Saskatchewan

The State of Forensic Mental Health Programs and Services in Saskatchewan

Over two hundred correctional and community mental health programs and service providers of benefit to MDOs were identified in the province. While only 19 scans were self-completed, a number of common themes emerged in regard to service provision. The bulk of information on forensic mental health and criminogenic needs assessments, programming, services, and referrals in the province was sourced online, through a variety of service directories, mini-focus groups, previous research, and from annual reports.

Responsibility for Mental Health Care in Saskatchewan

The regional health authorities (health regions) provide mental health services in Saskatchewan directly, through health care organizations including the Canadian Mental

Health` Association, or in partnership with other organizations including The Ministry of Justice, Corrections Division to provide health care to provincial inmates. The government of Saskatchewan is also responsible for mental health legislation and for the establishment, maintenance and administration of psychiatric hospitals. CSC is required by statute, “to provide essential health care, including medical, dental and mental health care, and reasonable access to nonessential mental health care that will contribute to the inmate’s rehabilitation and successful reintegration into the community” (*Corrections and Conditional Release Act [CCRA]*, 1992, c.20, s.86).

The Provision of Forensic Mental Health Care Provision in Saskatchewan

The forensic mental health care system in Saskatchewan consists of inpatient and community services for persons with co-occurring legal and mental health issues. Services are delivered through a number of institutional and community facilities.

4.2 Federal Corrections - Federal Correctional Facilities, Assessments, Programs, Services, and Referrals

Federal Corrections

Federal Correctional Facilities, Assessments, Programs, Services, and Referrals

Correctional Services of Canada participated in this scan. The Service owns, operates, manages, and/or partners with ___ institutions in Saskatchewan that house and/or provide services for federally-sentenced offenders. These facilities include a medium/maximum security penitentiary; a male-female custodial forensic psychiatry facility with multiple security levels; a minimum security men’s institution with two Aboriginal Pathways healing units; a multi-level minimum security healing lodge for women; a men’s healing lodge; a community correctional centre; and six (6) community residential facilities (CRFs). Federally-sentenced inmates have access to mental health assessment through Saskatchewan Hospital and addictions services through four treatment centers. Some federal facilities are managed in partnership with First Nations including the spiritual healing lodge with Prince Albert Grand Council. There are four parole offices in the province that oversee reintegration through community residential facilities and day parole.

Federal Correctional Facilities

There are a total of ___ forensic mental health beds available to federal offenders in Saskatchewan in addition to a host of institutional mental health treatment and counseling programs.

A focus of CSC’s institutions is on the successful reintegration of Aboriginal offenders into the community through a variety of programming and treatment services.

Saskatchewan Penitentiary. As of April 2010, there were 623 inmates resident at Saskatchewan Penitentiary. Saskatchewan Penitentiary is a medium and one maximum security institution capable of accommodating up to 659 inmates housed in four units, with one

designated unit for inmates with mental health issues who require constant supervision. The majority of inmates (41%) are serving sentences of forty months or more.

Regional Psychiatric Centre. As of April 2010, there were 191 inmates resident at the Regional Psychiatric Centre (RPC). RPC is a custodial forensic psychiatry facility with multiple security levels capable of accommodating 194 inmates, housed in four units for males and females. The majority of inmates (45%) are serving sentences of forty months or more.

Riverbend Institution. As of April 2010, there were 112 inmates resident at Riverbend Institution. Riverbend is a minimum security institution capable of accommodating 126 inmates housed in 20 self-contained units, including two Aboriginal Pathways healing units. The majority of inmates (50%) are serving sentences of less than forty months

Okimaw Ohci Healing Lodge. As of April 2010, there were 38 inmates resident at Okimaw Ohci Lodge. Okimaw Ohci is a multi-level women's facility located in the Necaneet First Nation and is capable of accommodating 40 inmates. The majority of inmates (61%) are serving sentences of less than forty months

Willow Cree Healing Lodge. Willow Cree is a men's healing lodge located in the Beardy's and Okemasis First Nation. Willow Cree is minimum-security institution capable of housing 40 inmates. As of 2007, various programs were being developed for implementation in keeping with The Aboriginal Corrections Continuum of Care including Brothers-by-Choice, CSC-core programming, emotional (anger) management, relapse prevention programs, sex offender maintenance, and substance abuse treatment in addition to psychological services.

Oskana Center. Oskana Centre is a men's community correctional centre (CCC) and CRF located in Regina capable of housing 42 inmates engaged in structured community release. Oskana provides a number of services, activities, and interventions including supervision aimed at helping inmates acquire the skills and supports necessary to successful reintegration. Oskana provides needs and risk-based programs to clients including substance abuse and cognitive/living skills, sex offender programs, and individual counseling services.

Prince Albert Grand Council Spiritual Healing Lodge. The Spiritual Healing Lodge is operated as a partnership between Prince Albert Grand Council, Saskatchewan Ministry of Justice, and CSC and is located in Prince Albert. The lodge is capable of housing 30 'Relatives' (inmates) in which 5 beds are designated for federally sentenced offenders. Programming is based on the medicine wheel in keeping with the Aboriginal Corrections Continuum of Care and deals with spiritual, mental, physical, and emotional dimensions of healing. Full-time resident Elders (and other teachers) deliver cultural programming in the form of sweat lodge ceremonies, talking/healing circles, and traditional medicines in addition to CSC-core programming that includes addictions, education, and job skills. Clients must be willing to work on their healing plans and participate in available programs to be eligible for admission.

Métis Addiction Council of Saskatchewan. The Métis Addiction Council of Saskatchewan is a community-based organization (CBO) that provides alcohol and drug recovery, reintegration, and healing programs to Métis and off-reserve Aboriginal peoples through its MACSI centres in Prince Albert, Saskatoon, and Regina. The Council operates a CRF in Prince Albert with 13 designated CSC beds for federal male offenders who have been released into the community on day parole, full parole, statutory release and statutory release with supervision. Clients must demonstrate willingness to pursue further education, employment, or training, and to accept responsibility for incarceration. Programs include

monthly, mandatory house meeting aimed at problem-solving; weekly (open and closed) in-house AA and NA meetings; Elder-run talking circles, smudging, and individual counseling; weekly H.A.W.K.S. programming which incorporates Aboriginal and cultural identity; weekly formal one to one individual, couples, and family counseling; and mental health program and service referrals.

The Council operates a treatment facility in Prince Albert with 16 beds available to federally-sentenced offenders. Addictions services include outpatient counselling, 28-day inpatient treatments, and a stabilization unit. Outpatient services are case-by-case. 28-day programs require clients to be alcohol/drug free for two weeks prior to their admission date. Stabilization units require clients to be drug/alcohol free for 72 hours before admission. The Council operates a treatment facility in Regina with 2 designated CSC beds for federally-sentenced male and female offenders needing 28-day treatment. The Council operates a treatment facility in Saskatoon with 12 beds available to federally-sentenced male and female offenders needing 28-day drug or alcohol treatment. Related community programs include substance abuse maintenance; AA/NA/GA meetings in the community; Choices for Men (for violence); Cognitive Skills Booster program; Community orientation; sex offender program; educational and skills training; access to reading, recreation, and sport; and outreach. The residence also visits Saskatchewan Penitentiary and Riverbend Institute. The Prince Albert facility accepts referrals from any institutions for men in Canada. The Regina and Saskatoon facilities accept referrals from any institutions for men and women in Canada. These facilities exclude violent inmates, dangerous sex offenders, and offenders with serious psychiatric disorders. The Centres will take non-Aboriginal peoples needing treatment.

YWCA. The YWCA of Prince Albert is a shared accommodation CRF that has 4 beds for federally-sentenced women on parole. Programs include 'Women Helping Women: A New Beginning' which is a one on one and group activity for women in conflict with the law. Group activities include self-esteem building, arts and crafts, circle sharing, and cultural programs co-facilitated by an Elder or Medicine Woman toward the goal of successful transition into the community. The program also offers resource outreach to other services in the community. Suitability is assessed by the parole officer.

The YWCA of Regina operates Kikinaw women's residence which has 4 designated beds for federally-sentenced women on parole. Staff members provide support with daily life skills and problem-solving and offer supportive counseling and community referrals for clients with mental health and addictions issues. Day Parole programs assist women with transitions between correction environments and the community. Supervised justice programs allow women convicted of an offence to serve their sentences at the YWCA on the weekends to allow them to continue working and/or parenting during the week.

The Salvation Army. The Salvation Army operates a CRF in Saskatoon that has 15 designated for federally-sentenced men on parole. New Frontiers offers one to one programming for a range of identified needs including chemical dependency; 12-Step Recovery, grief counseling, life management, budgeting, relapse prevention, planning, gambling, and community outings. The residence also visits Saskatchewan Penitentiary, Riverbend Institute, and RPC. Related community services include AA/NA/GA meetings in the community; clothing for those in need, and YMCA memberships. Offenders apply and are assessed for suitability. Offenders who have not taken part in programming, whose risk is considered too high for the

safety of the community, and whose behavior has been very problematic can be excluded. New Frontiers works with all POs at the Saskatoon Parole Office.

The Salvation Army operates a CRF in Regina that has 6 designated for federally-sentenced men on early release or parole. Waterston Centre offers one to one programming for a range of identified needs including casual employment opportunities; weekly on-site AA meetings; life skills programming; counseling services; medication monitoring and administration; assistance with financial management; on-site Pastoral services; and YMCA passes. The residence also visits Saskatchewan Penitentiary, Riverbend Institute, and RPC. Related community services include access to recovery programs (NA/AA); general counseling referral services; clothing; positive lifestyle workshop; and reintegration referral services. Admission is case by case. The Salvation Army is not obligated to accept all referrals made by CSC.

Meewasinota Aboriginal Healing Centre. Meewasinota Aboriginal Healing Centre is co-ed CRF in Saskatoon with 25 beds for male offenders and 10 beds for female offenders on parole or residency from various federal institutions. The focus of Meewasinota Centre is reintegration of offenders into their families and communities. Culturally-appropriate services include in-house weekly AA meetings; counseling services for a wide range of needs including life skills; substance abuse; relapse prevention; family counseling; problem solving; emotional, anger, and management; employment readiness, resumes, job searches; release planning; case plan management; goal setting; community service referral and outreach. Offenders are encouraged to participate in traditional, spiritual and cultural activities. Residents have access to the use of a Serenity Room on a 24hr basis. Related community programs include AA/NA meetings; cultural ceremonies programs; and YMCA passes to encourage structure and routine. Admission is case by case and the facility accepts offenders from other CSC institutions if they meet the criteria. The residence visits Saskatchewan federal institutions regularly. Offenders who have not taken part in institutional programming to address needs areas, are at risk of violence to staff, are not willing to continue to address needs areas in the community through programming, and whose mental or physical health needs are greater than the services offered may be excluded. Meewasinota works with all POs at the Saskatoon Parole Office.

Sakwatamo Lodge –National Native Alcohol and Drug Addictions Program

. Sakwatamo Lodge is a 28-day alcohol and drug rehab and treatment centre for Aboriginal peoples with addiction located in Melfort. There are 20 beds available to male and female federal offenders. The focus of Meewasinota Centre is reintegration of offenders into their families and communities. Services include addictions treatment; mental health and holistic health services; family support; suicide prevention; youth suicide services; addictions; NNADAP workers; mental health therapists. Admissions are based on referrals and individual assessment at application. The lodge will take non-Aboriginal peoples needing treatment.

4.3 Federal Correctional Programs

Federal Correctional Programs

The scholarly and Service-based literature suggests that “targeting specific criminogenic needs is a relevant and effective means of enhancing public safety and reducing re-offending” (CSC, 2009). This scan identifies ____ programs of benefit to Aboriginal offenders in

Saskatchewan, as indicated by respondents in the family cohort. CSC programs are needs-based and target specific offender groups. Programs are research-based and designed to address the risk factors related to reoffending in order to contribute to the safe reintegration of offenders following release. The goal of the Reintegration Programs Division is to develop effective policies aimed at offender accountability for program completion through the integration of education, correctional, social, and employment programs. A major factor of success to this end is “the team of people who train, deliver, and support CSC Correctional Programs. They are the pro-social role models who transform the lives of the offenders they work with” (CSC, 2009c p.1). The results of internal program evaluation are presented in each program description and in Table _____ as well as program accreditation and/or review by panels of “internationally-recognized experts in the field who assess the design of the programs, and the manner in which they are delivered, in relation to eight criteria” (CSC, 2009c). These criteria speak to the effectiveness of programs based on theoretical explanations of how they should effect changes in behaviour through evidence-based research. They illustrate how effective programs target criminogenic needs to change behavior, and specify that programs involve teaching offenders the skills they need to help avoid criminal activities while engaging in legitimate pursuits. They also specify the duration and intensity of programming, and the need for aftercare. The final criteria concerns continuous program review and evaluation (CSC, 2009c).

Aboriginal Corrections Continuum of Care

The Aboriginal Corrections Continuum of Care model delivers culturally-appropriate and sensitive programming initiatives based on a holistic approach to meeting the specific criminogenic, cultural, and spiritual needs of Aboriginal offenders (CSC, 2009c). There are several components of this model that engage Elders, Aboriginal liaison and correctional program officers at the correctional level, and Aboriginal liaison and development officers at the community level (ACDOs). A goal of this model is to provide leadership and intervention to Aboriginal inmates wishing to follow a traditional healing path. Pathways healing units and stand alone healing lodges provide culturally-appropriate programs that incorporate Aboriginal peoples’ values, traditions, and beliefs. ACDOs develop reintegration plans in partnership with communities where Aboriginal offenders will be conditionally released. For Aboriginal women, this approach is considered to be central to the healing process by addressing mental health issues including sexual, physical, and emotional abuse, relationships, and substance abuse. Outreach programs facilitate reintegration through community-release preparation in the areas of education, vocational training, employment, and life skills. Women housed in healing lodge facilities are able to maintain contact with their children. Female staff members provide positive role models who assist in developing parenting skills. At the time of this scan culturally sensitive classification and assessment tools and needs-based programming for Aboriginal women were being proposed for development.

Assessments

A family of assessments is in place in the federal correctional system. Once a federal offender has been sentenced, s/he receives a Preliminary Assessment to assess immediate needs and the institution starts to collect important data and documents including police and

court records, and psychological assessments that inform programming needs assessments, interventions, and referrals. CSC uses various referral criteria including Canadian Police Information Centre (CPIC) and Offender Intake and Supplementary Assessments to determine programming needs.

Specialized supplementary assessments help to determine the program, level of intensity required for participation, and referral to a number of programs including substance abuse, family violence, violent offenders, and sex offender (CSC, 2009c). The bilingual Computerized Assessment of Substance Abuse (CASA) replaced the Computerized Lifestyle Assessment Instrument (CLAI) in 1999 to assess substance abuse in seven domains. The National Substance Abuse Program uses eight (8) assessment scales to assess offender progress toward treatment goals including 1) Beliefs About Substance Abuse; 2) Craving Beliefs Questionnaire; 3) Drinking and Drug Related Locus of Control; 4) Drug Avoidance Self Efficacy Scale; 5) Drug Taking Confidence Questionnaire; 6) Effectiveness of Coping Behaviours Inventory; 7) Inventory of Drug Taking Situations; and 8) Paulhus Deception Scales (CSC, 2009c).

The Spousal Assault Risk Assessment (SARA) is used to assess offender level of risk when screening criteria on the Family Violence Risk Assessment (FVRA) are met. The SARA is used to determine programming needs in terms of Family Violence Awareness for low risk offenders, or Family violence Treatment programs for offenders at moderate or high risk, in addition to private family visits, and release considerations (CSC, 2009c).

The Statistical Information on Recidivism (SIR) assesses probability of re-offending within three years of release. SIR assessments are used to guide referrals to the appropriate intensity level for Violent Offender programs. Specialized Sex Offender Assessments (SSOA) “must be completed for: (a) offenders whose current offence is a sex offence; (b) offenders who have a history of sex offences; and (c) offenders whose current or past offences involved sex offences, whether or not the latter resulted in conviction” (CSC, 2009c, p. 1). The SSOA guides referrals to a specific intensity of Sexual Offender Program. Mental health specialist assessments are critical to the formulation of an offender’s Correctional Plan as his or her ‘roadmap to intervention’. These assessments also inform offenders’ Correctional Plan Progress Report on level of change and integration of new skills and knowledge in the institution and/or community.

Mental Health Programs

CSC is legally mandated through the *Corrections and Conditional Release Act* to provide every inmate with ‘essential’ care and ‘reasonable’ access to non-essential care for the purpose of rehabilitation and successful reintegration into the community. Planning and policy is carried out by four branches: Clinical Services, Public Health, Mental Health, and Policy, Planning and Quality Improvement. CSC day-to-day mental health care is provided by health care professionals including social workers, nurses, pharmacists, physicians, and psychologists who are involved in the assessment, treatment, care, and rehabilitation of offenders with mental disorders where the focus is on the assessment and control of their risk to reoffend. CSC priorities include quality and consistency in the delivery of essential services; improved capacity to address the health needs of Aboriginal offenders; improved capacity to address the health needs of offenders with mental health disorders; strengthening internal and external partnerships. One in ten Aboriginal male offenders had a mental health issue in 2004 and the

proportion of offenders presenting with mental health is increasing (CSC, 2009d). Mental health issues may be barriers to correctional interventions in terms of responsivity and compliance to treatment. Unmet mental health needs can negatively affect the benefits of correctional interventions (CSC, 2009c). Participation in mental health programs is linked to positive community correctional outcomes (CSC, 2009c).

Substance Abuse Programs

Approximately 70% of federal offenders have been identified with substance abuse issues where 50% have a direct link between substance use and criminality (CSC, 2009c). Approximately 50% of the federal offender population is eligible for substance abuse maintenance (CSC, 2009c). In the Prairie region, 1,204 of Aboriginal males were referred to substance abuse programs with an enrolment rate of 57.39% (compared to 1,502 non-Aboriginal males [with a 67.58% enrolment rate], and 259 women [with a 64.48% enrolment rate]) (CSC, 2009d).

The National Substance Abuse program targets offenders who are assessed by the Computerized Assessment of Substance Abuse as being at a high, moderate, or low risk to reoffend. The High Intensity National Substance Abuse program targets offenders whose substance use is linked directly to crime. The moderate and low intensity modules target offenders whose substance use is linked to their criminal behavior. The primary objective of these programs is to assist offenders in coping with life situations without abusing drugs or alcohol that result in criminal behavior. Aboriginal male offenders meet the criteria for substance abuse programming more than any other program area where the majority meet the criteria for the high intensity program, followed by moderate intensity, and low intensity (CSC, 2009d).

The High Intensity Substance Abuse program is available at all CSC medium security institutions including those in Saskatchewan. This program was accredited in 2004. This program is effective in reducing recidivism and reoffending where 45% of offenders are less likely to return with a new offence and 63% less likely to return with a new violent offence (CSC, 2009c). This program is cost-effective at a rate of \$2.03 for every dollar spent on the program.

The Moderate and Low Intensity Substance program is available at most CSC institutions. The Moderate Intensity program was accredited in 2004. This program is effective in reducing recidivism and reoffending where 18% offenders in the Intent-to-Treat group were less likely to return to federal custody; 26% were less likely to return with a new offence; 45% were less likely to recidivate with a new violent offence (CSC, 2009c). This program is cost-effective at a rate of \$2.25 for every dollar spent on the program.

The National Substance Abuse Pre-release Booster program is provided to graduates of the high and moderate intensity programs who are within three months of release. The objective of the programs is to assist offenders with identifying some potential problems, harmful situations, and temptations in the community. This program is available at all CSC institutions including those in Saskatchewan. This program was accredited in 2004. This program was not yet evaluated at the time of this scan.

The National Substance Abuse Maintenance program is an aftercare program provided to graduates of high, moderate, low intensity, and Aboriginal Offender Substance Abuse programs after their release into the community. The goal of the program is to assist offenders

in the application of skills necessary to cope with daily life problems without the use and misuse of substances. Maintenance facilitators are expected to tailor the content to fit the needs of the group in order to address unique concerns (CSC, 2009c). This program was accredited in 2004. This program is not effective in decreasing recidivism among non-Aboriginal offenders (CSC, 2009c). This program was being phased out and replaced by the Community Maintenance Program at the time of this scan.

The Women Offender Substance Abuse program is designed to provide education and treatment to female offenders with substance abuse issues. This program is designed to address the needs of all female offenders. Interventions include mutual help to intensive treatment from intake to warrant expiry in the form of formal and cultural programming. A majority of women offenders meet the criteria for the Intensive Therapeutic Treatment model in the Women Offender Substance Abuse Program (CSC, 2009c). Approximately one-third of women offenders are eligible for high intensity programming. A smaller number also need high intensity violence prevention programs (CSC, 2009c). This program was not accredited at the time of the scan and had not been evaluated. This program is available at some CSC institutions in Canada including healing lodges and parole offices.

The Aboriginal Offender Substance Abuse program is a high intensity substance abuse program designed to reduce substance use relapse after release. The program targets Aboriginal offenders who have been assessed as having a high need for substance abuse programming. This program is delivered by two Aboriginal correctional program officers and an Elder who is responsible for 50% of the content. The impact of addictions is examined through a cultural lens to determine the emotional, mental, physical, and spiritual dimensions of healing in a safe environment (CSC, 2009c). This program is holistic in its approach to meeting the needs of First Nations, Métis, and Inuit male offenders through ceremonies, cognitive therapy, education, and relapse prevention. This program was not accredited at the time of the scan. This program is effective in reducing recidivism by 50% in the community (CSC, 2009c).

General Crime Prevention Programs

The Alternatives, Associates and Attitudes Program (AAA) targets high risk male offenders who have an offence pattern of crimes for gain and involve property, B&E, theft, fraud, or drug trafficking offences that are not associated directly with substance abuse. It focuses on antisocial peers, pro-criminal attitudes, and self-regulation deficits that are linked to criminal behaviour. This program is delivered at all CSC institutions and district offices including those in Saskatchewan and is also available to inmates on community release. The AAA Program was not accredited and had not been evaluated at the time of this scan.

The Basic Healing Program was developed to address intergenerational impact the residential school system. It targets male Aboriginal offenders with needs in the areas of attitude, relationships, problem-solving, conflict resolution, personal emotions management, critical reasoning, consequential thinking, and assertive communication. The objective of this program is to assist Aboriginal offenders in gaining insight into their criminal behavioural patterns through Elder and traditional Aboriginal teachings, and spiritual/ceremonial processes. This program is delivered at all CSC institutions, including those in Saskatchewan. The Basic Healing Program was not accredited and was under review at the time of this scan (CSC, 2009c).

The Circles of Change program targets Aboriginal women with moderate risk, and moderate to high criminogenic needs in an institutional setting. The objective of this program is to use Aboriginal teachings and Medicine Wheel concepts to support program material aimed at relapse prevention, changing attitudes, and emotional management in a culturally sensitive manner. Modules include attitude, marital and family, and personal and emotional management. Graduates of the program are recommended for the Aboriginal Women's Maintenance Program. This program is available at Okimaw Ohci Healing Lodge. At the time of this scan, this program was not accredited. The program was found to be effective in decreasing pro-criminal cognition among participants; helping in goal setting and achievement; helpful in bringing about healthier relationships skills; and helpful in increasing self-esteem (CSC, 2009d). The program was found to be problematic in terms of offender ability to complete material and modules on time. This program was being updated and modernized in preparation for accreditation (CSC, 2009c).

Violence Prevention Programs: High Intensity, Moderate Intensity, Maintenance, New Spirit of a Warrior Women's Program, and In Search of Your Warrior Program

Violence Prevention programs target male and female offenders who have committed violent crimes and are at a moderate to high risk for violence. The objective of this family of programs is to reduce violent re-offending through learning alternatives to violence in the form of emotional management and conflict resolution modules toward the development of standards that are incompatible with violence. In the Prairie region, 756 Aboriginal males were referred to violent offender programs with an enrolment rate of 61.90% (compared to 245 non-Aboriginal males [58.98%] and 90 [75.56] women – separate statistics are not available for Saskatchewan and/or women) (CSC, 2009d). Graduates of the High and Moderate Intensity programs for male offenders are provided with maintenance programs in the institution or community to monitor and cope with life's daily challenges. High Intensity Violence Prevention programs are available at all CSC medium and maximum security institutions in Saskatchewan. Moderate Intensity Violence Prevention programs are available at all CSC institutions and district offices. The Maintenance program is available at all CSC institutions in Saskatchewan. The High Intensity Violence Prevention program was accredited in 2000 and reaccredited in 2005. This program is effective in reducing recidivism among offenders in the Intent-to-Treat group (29%). Members in this group were also less likely to return to custody for a new (41%) or violent (52%) offence. Aboriginal offenders in this group were less likely to return to custody with a new violent offence (CSC, 2009d). This program is cost-effective at a rate of \$1.62 in savings for every dollar spent on the program (CSC, June 2009). At the time of this scan, the Moderate Intensity program was neither accredited or evaluated, however, the results of the Generic Program Performance measure indicate that Aboriginal male offenders enrolled in high and moderate intensity programs are achieving their treatment goals in both correctional facilities and post-release ($p < 0.0001$) (CSC, 2009d).

The Women's Violence Prevention program is available at all women offender institutions including Okimaw Ohci Healing Lodge in Saskatchewan (CSC, 2009c). Female offenders learn to recognize survival strategies that have negative consequences including drug trafficking and sex trade. Female graduates are recommended to participate in the Community Relapse Prevention and Maintenance Program for Women. The New Spirit of a Warrior is a high

intensity violence prevention program that was designed to address the needs of Aboriginal women specifically targeting substance abuse, gang association, and violence. The objective of the program is to reduce violent recidivism through Elder teachings and module delivery by a trained Aboriginal correctional program facilitator. Modules include anger, family of origin, self, cultural, and violence awareness. This program is available at specific CSC women offender institutions and women's healing lodges including Okimaw Ohci in Saskatchewan. At the time of this scan, this program was not accredited. There was no evidence that this program reduced criminality, violent offending, or recidivism in the Intent-to-Treat group (CSC, 2009d). There was insufficient data on whether the program reduced readmissions for a new violent offence (CSC, 2009d). This program is cost-effective at a rate of \$1.88 in savings for every dollar spent on the program (CSC, 2009c).

The In Search of Your Warrior Program is a high intensity intervention for male Aboriginal offenders with a history of violence. It is a culturally appropriate alternative to the general violence prevention programs offered by CSC. The objective of the program is to reduce violent recidivism through Aboriginal teachings and spiritually, and western approaches to treatment. Modules include anger, family of origin, self, cultural, awareness, and insight into how violence evolves and how it is passed from generation to generation (CSC, 2009d). This program is available at all CSC institutions in Saskatchewan. This program was not accredited at the time of this scan. This program is effective in reducing recidivism (19%; $p < .10$). This program is cost-effective at a rate of \$3.48 in savings for every dollar spent.

Family Violence Prevention Program

Family Violence Prevention programs include National High Intensity, Moderate Intensity, Aboriginal High Intensity, and Maintenance modules. The Family Violence Prevention programs provide interventions to male offenders who are assessed as being high and moderate risk to be violent in their intimate relationships. The objective of the program is to raise awareness of family violence and abuse and provide non-confrontational alternatives to violence between family members. The high intensity module is available at all CSC institutions including those in Saskatchewan. The moderate intensity module is available at all CSC institutions and community parole offices including those in Saskatchewan. A National Family Violence Maintenance program is offered to offenders who have successfully completed the high and moderate intensity programs. The goal of aftercare is to help offenders use the skills they learned in their Family Violence Prevention programs to cope with everyday problems. In the Prairie region, 514 Aboriginal males were referred to family violence prevention programs with an enrolment rate of 51.95% (compared to 427 non-Aboriginal males [48.01%] – separate statistics are not available for Saskatchewan) (CSC, 2009d). The High Intensity Family Violence Prevention program was accredited in 2001. This program is effective in reducing recidivism including technical revocations and in returning for new offences. This program is cost-effective at a rate of \$2.42 for every dollar spent on the program (CSC, 2009c). The Moderate Intensity Family Violence Prevention program was accredited at the time of this scan (2001). This program is effective in reducing recidivism including technical revocations and in returning for new offences. This program is cost-effective at a rate of \$2.31 for every dollar spent on the program (CSC, 2009c).

CSC also offers the High Intensity Aboriginal Family Violence program to male Aboriginal offenders assessed as being at a high risk for violence in their intimate relationships. The program is delivered by an Elder and trained correction program facilitators, one of who must be an Aboriginal correctional program officer. The program engages traditional culture spirituality including circle teachings, Wellness Wheels, and Sacred relationships to promote wellness and non-violence. This program is available at all CSC institutions including those in Saskatchewan. This program was not accredited at the time of this scan. There was no evidence to suggest that this program was effective at the time of this scan. Almost half of all Aboriginal offenders meet the criteria for the high intensity violence prevention programming (CSC, 2009d). More Aboriginal offenders meet the criteria to participate in the moderate intensity family violence prevention program than the high intensity (CSC, 2009d). *Roadways to Change* is a treatment primer that is offered to offenders who are assessed as being not ready to change. The objective of this program is to prepare offenders for the family violence treatment process

Education, Employment, and Skills Training Programs

CORCAN is a rehabilitation work program mandated to provide employment and employability skills training to federal offenders. Key employability skills learned in this framework are fundamental, personal management, and teamwork initiatives needed to get and keep a job upon release. This program is available at Saskatchewan Penitentiary and provides inmates with skills and experience in textiles; manufacturing, and construction. Research carried out by the Service has shown that this program is effective in reducing recidivism. Contracts help defray the operational costs of correctional centres and inmates use their earnings to pay restitution, support their families, or to support themselves while they are in custody.

Mental Health Assessments

The framework for a federal, provincial, and territorial partnership in addressing the mental health needs of offenders defines forensic mental health care as that which promotes wellness, prevents illness, and makes efforts to reduce stigma in keeping with community standards (FTP, 2012). Early identification and ongoing assessments of mental health needs is a priority of CSC and its provincial and territorial partners through mandatory assessments at intake where individuals are screened for risk and treatment needs. Comprehensive assessments are provided to offenders presenting with behaviours indicative of mental health problems, illness, or disorder. Individuals with mental health problems who are assessed as needing treatment or request treatment will receive appropriate service referrals in a timely manner.

Sex Offender Programs

Although Aboriginal sex offenders were not represented in our sample, one quarter of Aboriginal offenders meet the criteria for Sexual Offender Programs (CSC, 2009d). Federal sex offender programming includes the High Intensity, Moderate Intensity, and Low Intensity National Sex Offender Program; the Women's Sex Offender Program, the Tupiq Program for Aboriginal male offenders, and the Inuit Community Maintenance Program. The object of all

Sex Offender Programs is to contribute to the reduction of sexually-violent re-offending (CSC, 2009c). In the Prairie region, 603 Aboriginal male offenders were referred to the program and 72.97 were enrolled (compared to 740 non-Aboriginal male offenders (with 73.38% enrolment) (CSC, 2009d).

The National Sex Offender Program – High Intensity Program targets male offenders assessed at high need and risk to reoffend sexually. The goal of the program is to reduce recidivism through structured and standardized interventions (CSC, 2009c). This program was in its pilot phase at the time of scan and was not accredited or evaluated by CSC. This program is being implemented at all CSC medium security institutions including those in Saskatchewan.

The National Sex Offender Program – Moderate Intensity Program targets male offenders assessed at moderate need and risk to reoffend sexually. The goal of the program is to reduce recidivism through structured and standardized interventions (CSC, 2009c). This program was in its pilot phase at the time of scan and was not accredited or evaluated by CSC. This program is available at all CSC medium security institutions including those in Saskatchewan. This program is available at CSC institutions across Canada. This program was accredited in 2002. This program is effective in reducing the likelihood of readmission for non-Aboriginal males with non-child victims (but not in reducing the likelihood of new offenses of a sexual nature). This program is cost-effective at a rate of \$3.41 for every dollar spent on the program.

The National Sex Offender Program – targets Intensity Program targets male offenders assessed at low need and risk to reoffend sexually. The goal of the program is to reduce recidivism through structured and standardized interventions (CSC, 2009c). This program was in its pilot phase at the time of scan and was not accredited or evaluated by CSC. This program is available at all CSC medium security institutions including those in Saskatchewan. This program is available at CSC institutions and district offices across Canada. This program was accredited in 2002. This program is effective in reducing the likelihood of readmission for new non-violent offences for non-Aboriginal males with non-child and child victims.

There are a small number (0.3%) of women offenders who sexually offend. The Women’s Sexual Offender Program starts with a specialized assessment at intake and continues throughout the sentence and as maintenance in the community. This program targets women who have been convicted of a sexual offence or a non-sexual offender with sexual motivation, or admission for a sexual offence which they have not been convicted. This program does not include prostitution-related offences. The program is delivered by a psychologist with the goal of identifying contributing factors including past victimization and relationships. This program was not accredited or evaluated at the time of the scan. There are about 15-20 women sexual offenders nation-wide. This program is available at women’s facilities and community sites in Canada.

Community Based Correctional Programs

Community based correctional programs include the Community Maintenance Program, the Community Relapse Prevention/Maintenance Program for Women, and the Aboriginal Women Maintenance Program (CSC, 2009c).

The Community Maintenance Program was designed as a substitute for program-specific and booster programs in the community. The objective of the program is aftercare for

any offender who has completed a national correctional program or Aboriginal national correctional program with a priority for highest risk offenders (CSC, 2009c). This program is available at CSC community sites. While this program does not require accreditation, it was endorsed in 2005. This program is effective in reducing readmission and reoffending of Aboriginal offenders who participated.

The Community Maintenance Program was designed as a substitute for program-specific and booster programs in the community. The objective of the program is aftercare for any offender who has completed a national correctional program or Aboriginal national correctional program with a priority for highest risk offenders (CSC, 2009c). This program is available at CSC community sites. While this program does not require accreditation, it was endorsed in 2005. This program is effective in reducing readmission and reoffending of Aboriginal offenders who participated.

Community Relapse Prevention/Maintenance Program for Women is a component of aftercare. It is designed to help women strengthen their relapse prevention plans. This program is offered to women who have been recently released into the community, and to those women in the community identified as being at increased risk. The program is also available to provincially-sentenced women where agreements between CSC and the province are in place. This program was not accredited at the time of the scan and was under evaluation. This program is available at CSC institutions and community sites (CSC, 2009c).

The Aboriginal Women's Maintenance program was designed to provide and graduates of the New Spirit of a Warrior program with aftercare to maintain the skills and cultural/spiritual connection acquired in the correctional program. This program is also offered to women who have not completed a correctional program with the goal of helping them maintain crime-free lives outside of the institution through support, healing plans, and access to community resources. This program is delivered by an Aboriginal correctional program facilitator and assisted by an Elder in an institutional or community setting. This program was not accredited or evaluated at the time of this scan. The program is available at CSC institutions and district offices across the country (CSC, 2009c).

Restorative Justice Program

CSC supports the advancement of restorative justice as it contributes to CSC priorities and public safety through Restorative Opportunities that help meet the needs of offenders and victims toward justice, accountability, and reparation. The program is voluntary and aimed at healing and the involvement of citizens in creating safe and healthy communities.

4.4 Provincial Corrections: Provincial Correctional Facilities, Assessments, Programs, Services, and Referrals

Provincial Corrections

Provincial Correctional Facilities, Assessments, Programs, Services, and Referrals

The Ministry of Justice, Corrections Division (formally the Ministry of Corrections, Public Safety and Policing) was unable to participate in the scan. The bulk of information on provincial correctional forensic mental health and criminogenic needs assessments, programming, services, and referrals was sourced online, and through a variety of service directories, previous

research, and annual reports. While there is a dearth of public information about specific correctional programming outcomes in the province, we have made best efforts at locating this information and including it on our report. Major themes or focus in this literature is on Aboriginal corrections, community correctional programs for adult offenders and youth, and youth crime. Saskatchewan has one of the highest rates of the youth population appearing in youth court and the highest rate of youth in custody per youth population (Government of Saskatchewan, 2005). A core principle and value of the Division is that young offenders have individual rights and freedoms. A strategic priority for 2010-2024 is to increase program effectiveness toward the reduction of offending in youth with mental health needs including violence.

Provincial Correctional Facilities

There are a total of _____ forensic mental health beds available to provincial offenders in Saskatchewan in addition to a host of institutional mental health treatment and counseling programs. There are seven (7) adult community correctional centres and training residences in Saskatchewan.

Saskatoon, Regina, and Prince Albert each have a multi-level correctional centre for provincially sentenced and remanded male offenders including the new 90-bed dormitory for low-risk inmates in Saskatoon. At the time of this scan, plans were in place to add a 72-cell living unit within a secure perimeter of Prince Albert Correctional. Pinegrove Correctional in Prince Albert houses provincially-sentenced women and women on remand. At the time of this scan, plans were in place to add 30 beds to the women's facility to reduce the problems associated with overcrowding. There are two work camps for low to moderate risk offenders in the province: an urban work camp in Saskatoon and a northern camp in Besnard Lake to allow offenders in the north to remain closer to their home communities. The Division has a contract with Prince Albert Grand Council to operate Spiritual Healing Lodge which houses up to 25 provincial offenders. It also works in partnership with Saskatchewan Health to operate the Saskatchewan Impaired Driver Treatment Program in Prince Albert.

The Division oversees an open custody facility operated by the Salvation Army, a community training residence for women operated by the Elizabeth Fry Society, and a healing lodge operated by the Prince Albert Grand Council. There are 15 community supervision offices for offenders on conditional sentences, probation, or bail. Adult Corrections also works in partnership with the Ministry of Justice and Attorney General, and treatment, social service and community agencies to develop and implement Therapeutic Courts such as the Domestic Violence courts operating in North Battleford, Saskatoon and Regina. The Corrections Division also maintains an agreement with the federal government for the exchange of adult offenders between jurisdictions.

The average daily adult offender count in Saskatchewan in 2010 was 1,513 including offenders serving intermittent sentences, waiting for federal transfers, and fine default in addition to remand, parole suspension, and immigration hold. Status Indians (63%), Non-Status Indians (4%), and Métis (11%) represent 88% of the daily count. There were 2,915 new Aboriginal admissions to provincial sentences in 2010; 230 admissions for fine default (compared to 38 non-Aboriginal admissions) (Government of Saskatchewan, 2012a).

There are eight (8) young offender open, secure, and remand facilities in the province: Kilburn Hall Youth Centre, Saskatoon; Prince Albert Youth Residence; Drumming Hill Youth Centre, North Battleford; Paul Dojack Youth Centre, Regina; North Battleford Youth Centre; Orcadia Youth Residence, Yorkton; Yarrow Youth Farm, in rural Saskatchewan; and the Echo Valley Youth Centre, Echo Valley Provincial Park. Forensic psychiatric mental health services include one forensic psychiatric assessment unit at Saskatchewan Hospital. Offender daily counts were not available at the time of this scan.

Provincial Correctional Programs

A goal of the Division is reduction of recidivism through effective programs interventions for offenders that reflect current research and evidence-based practices. There is a 'wide range' of programs offered to adult offenders within secure institutions and communities around the province through the Institutional Operations Branch and the Community Operations Branch, administered by six regional offices of community corrections, the four major correctional centres, and seven reduced-custody facilities (Battleford and Buffalo Narrows Community Correctional Centres, Besnard Lake Camp and Saskatoon Urban Camp, and community training residences in Regina, Saskatoon and Prince Albert). Institutional and community services to the North, administered through the North West Community Operations office in North Battleford with sub-offices in Meadow Lake, Buffalo Narrows and La Loche, and the North East Community Operations office located in Prince Albert with a sub-office in Melfort.

The province's Adult Corrections Division administers the sentencing of offenders of up to two years less a day who are on remand, serving intermittent or weekend sentences, or who are under community supervision including probation, fine option or community service order. The focus of the 2011-12 Ministry of Justice Performance Plan is on the reduction of crime through effective law enforcement and responses to offending (Saskatchewan, 2011). Adult Corrections uses a balance of rehabilitation and supervision to reduce reoffending, new offences, and recidivism. A key action of the Ministry 2011-12 is the exploration of partnerships to deliver more anti-gang programming and interventions for adults and youth. This scan observes several of these partnerships including the FPT between the Ministry of Justice, Division of Corrections and Policing, the Heads of Corrections in 11 other jurisdictions, and CSC; the Ministry of Health; Prince Albert Grand Council; the RCMP; municipal police; First nations and Métis communities; community organizations, and local forms of government.

The Young Offenders Services division is responsible for ensuring the programs and services outlined in *The Youth Criminal Justice Act (Canada)*, are available. A main objective of young offender programs and services is to work with youth to reduce the likelihood they will re-offend. Sentences for youth can include Alternative Measures, Judicial Interim Release, Supervision of Community-based Orders and Secure and Open Custody. All programs and services are developed and delivered with community safety in mind. Programs and services for Young Offenders are also administered and delivered in custody facilities and through community programs across the province. The Division supports the ongoing crime-reduction and suppression strategies of the Prince Albert Community Mobilization Partnership through the Hub and Centre of Responsibility projects.

Aboriginal Correctional Continuum of Care. Aboriginal peoples are also over-represented in provincial correctional facilities accounting for 70 to 80% of the total offender population, compared to 15% of the general population (Government of Saskatchewan, 2011a). These numbers have not changed since 2001 (Government of Saskatchewan, 2005a). A focus of the Division is on the successful reintegration of Aboriginal offenders into the community through a variety of programming and treatment services. Another priority is on the implementation of culturally-appropriate programming as an effective rehabilitation intervention in reducing reoffending behavior. As with CSC, provincial corrections staff are seen as being integral to the reduction of recidivism among this offender population. Indigenous correctional staff contribute to the “overall organizational culture of diversity and its ability to support the holistic needs of the offender population,” including cultural ceremonies, traditions, and role models (Government of Saskatchewan, 2011a, p. 1).

The Ministry recognizes the ‘significant’ over-representation of Aboriginal peoples in the provincial criminal justice system (Government of Saskatchewan, 2010). A goal of the ministry is to ensure that correctional programs respect the cultural and spiritual needs of First Nations and Métis clients and have taken steps to develop Aboriginal correctional positions and hire aboriginal correctional staff. Recognition of the unique circumstances of the Aboriginal correctional client group is a goal of the Ministry as stated in the 2006-7 Saskatchewan Provincial Budget Performance Plan for Provincial Corrections. Culturally sensitive correctional programs developed and delivered in partnerships with Aboriginal peoples are seen as having better outcomes in providing a balance of rehabilitations with public safety and security (Government of Saskatchewan, 2011b).

A key action of the Division is to implement cultural programming for Aboriginal offenders in custody and the community. An objective of the Division is the retention of Elders, and Aboriginal staff and programs to respect the cultural and spiritual needs of Aboriginal clients. As the Division notes, many Aboriginal peoples in Saskatchewan “live under social conditions that are shown by research to contribute to criminal behaviour. Although there is no single cause of crime, risk factors, or vulnerabilities, work together over time to influence the likelihood of negative outcomes. Major risk factors are poverty, abuse, violence, education problems, employment problems and substance abuse” (Saskatchewan, 2005a, p. 14; 2011a, p. 8). The Division further notes that Saskatchewan “has a high percentage of at-risk youth, families and communities, and many Aboriginal youth, in particular, experience the conditions that contribute to misconduct and crime. Given the high numbers of Aboriginal people involved in the justice system, especially in custody programs, and with the Province’s Aboriginal population expected to increase by approximately 50 per cent between 1998 and 2016, effective programs need to be developed or the proportion of Aboriginal youths and adults in the correctional system will continue to grow” (Government of Saskatchewan, 2005a, p. 14). Service agreements with First Nations and Métis communities and Aboriginal Stakeholder groups in the delivery and review of alternative measures, reintegration and restitution programs and custody programs are key actions to assess the effectiveness of adult and youth programs aimed at the reduction of recidivism and the overrepresentation of Aboriginal peoples in the provincial system.

Assessments. The Division employs a case management process to identify the risks posed by offenders and provides rehabilitation and correctional programming to help reduce

risks and address the offender's needs. Adult Sentence Management evaluates offender risk and need and determines the combination of programs with the best likelihood of success in rehabilitation in the institution and community. A comprehensive model of structured and actuarial risk assessments is in place in the provincial correctional system. Primary and secondary risk assessments are used in Adult Corrections in Saskatchewan to identify the correctional services needed by an offender. Primary assessments are used to determine the probability of an offender committing any type of criminal offence in the future, which is referred to as generalized re-offending. Secondary risk assessments provide a likelihood of an offender committing future generalized offending. The Division follows a framework of Risk, Need and Responsivity and Professional Discretion Principles to use risk assessments to guide decisions about the type and intensity of correctional programs and services delivered to reduce risk.

Primary assessments are completed for offenders sentenced to probation, conditional sentence, and/or incarceration, when a court report has been ordered, and/or to inform the likelihood of future generalized offending. The Primary Risk Assessments (PRA) determines static and dynamic risk and are used to inform decisions about programming to reduce likelihood of recidivism. The Saskatchewan Primary Risk Assessment (SPRA) is an advanced assessment tool used to clearly articulate individual items. The PRA and SPRA are effective in predicting 1) breaches in community supervision order /probation; 2) conviction of a new offence; and 3) re-incarceration. Secondary Risk Assessments are more specific assessments that focus on the offender's risk of committing a certain kind of offence and are completed as required by the offender's needs and offense pattern. The Ontario Domestic Assault Risk Assessment (ODARA) is used to predict risk of spousal and family violence. The Static-99R is used to estimate the probability of sexual and violent recidivism among adult males who have already been convicted of at least one sexual offence against a child or non-consenting adult. The STABLE-2007 is used to assess treatment needs and help predict recidivism in sexual offenders. The ACUTE-2007 is used to help predict recidivism in sexual offenders.

The Division also provides supervision and services to youth based on a comprehensive assessment of the youth's needs.

Mental Health Programs

Saskatchewan is signatory to the Mental Health Strategy for Corrections in Canada. The Division recognizes the need for FASD screening and other interventions for unique offender populations with mental health care needs including youth, women, and violent offenders. The Division also recognizes the need for a continuum of programs services as effective rehabilitation interventions for offenders including offenders with mental health needs (Government of Saskatchewan, 2011b, p. 4). The effective delivery of mental health services along a continuum of care can only be realized in an environment that promotes wellness, prevents illness and makes active efforts to reduce stigma among offender populations in the institution and in the community. Forensic psychiatric assessments are conducted at the Regional Psychiatric Centre in Saskatoon.

Substance Abuse Programs

The Division operates The Dedicated Substance Abuse Treatment Unit at Regina Correctional. This program is delivered in partnership with the Ministry of Health and the Regina Qu'Appelle Health Region. A total of 500 offenders have been accepted into the treatment program and 467 offenders have completed it since 2004. This program is effective in the treatment of high risk offenders with significant needs in the area of substance abuse. The Division also offers a substance Abuse Pre-release program for offenders whose level of risk has been assessed as medium or high. A key action of the Division is to implement a relapse prevent programming for adults and youth supervised in community programs under Division case management. The Offender Substance Abuse Prevention Program is offered in the community to individuals assessed as requiring a moderate intensity substance abuse program. The goal of the program is reduction of offender risk for relapse to substance abuse and criminal behavior through the development of problem-solving and coping skills. This program targets Community Correction clients who are assessed to be within the moderate to substantial range of substance abuse, and whose criminal activity is directly related to substance abuse in the early stage of supervision.

The Choices program is a cognitive behavioral substance abuse program that focuses on relapse, prevention and maintenance. The goal of the program is reduction of offender risk for relapse to substance abuse and criminal behavior through the development of problem-solving and coping skills. This program targets probationers with a substance abuse problem ranging from low to moderate. It is also for clients who have had previous programs but are at high risk for relapse and would benefit from a refresher course or specific relapse prevention skills and planning.

Core Adult Correctional Crime Prevention Programs

Core adult correctional programs address issues such as substance abuse, sexual abuse, domestic abuse, anger management, violence, and aggression. The Cognitive Skills Program is designed to change offending behavior by introducing participants to a variety of alternative thinking and social skills. The goal of this program is to teach participants to think and consider the consequences before acting. This program targets offenders with cognitive deficits in the areas of problem solving, developing alternatives, considering consequences, impulsivity, and social skills.

The Anger Management Program is a general aggression control program and not specific to domestic violence. The goal of the program is reduce risk of aggression-based offences by reinforcing personal responsibility and emotional and conflict management. This program targets offenders with problems in managing anger and aggression, but whose offence patterns are not domestic violence.

Core Youth Correctional Crime Prevention Programs

The division offers a number of crime reduction interventions that focus on program interventions with a targeted group of offenders in certain communities. A goal of the Division is to continue to work with justice, health, culture, youth and recreation, and community resources and employment agencies to more effectively reintegrate young offenders in northern communities. Integrated human service initiatives such as SchoolPlus and the Youth

Services Model provide services across a wide spectrum of agencies in order to more adequately address the needs of offenders with a high risk to re-offend.

Specialized Adult Correctional Crime Prevention Programs

Specialized adult programs include language and literacy, planning, decision-making, employment, life and parenting skills. The Cognitive Skills program for offenders whose level of risk has been assessed as medium or high; the Help Eliminate Auto Theft (HEAT) program for offenders who re-offend for auto theft. An accountability process is in place for correctional programs and service to ensure that case plans in adult institutions are in compliance with case management standards. The Courage to Change (C2C) program is delivered on a one-on-one basis between case managers and offenders/high risk offenders. The C2C program targets behaviour change toward reduction in re-offending (Government of Saskatchewan, 2011b).

Violence Prevention Programs

The focus of the adult correctional system is on high-risk and high need individuals and the provision of a 'basic' level of service for low risk/low need offenders. The Division offers a combination of incarceration, risk and needs assessment, and delivery of appropriate programs to violent offenders including the proposed Serious Violent Offender Response Program. Correctional Violence Prevention Programs target individuals with indications of problems with anger and aggression management whose offence patterns are not for domestic abuse. The objective of the program is to reduce violent re-offending through individual learning and identification of the precursors and risk factors, thinking patterns, and relevance of stress and tension to violent behavior, and the impact of violence on self and others. The Division has also developed a Violence Reduction Initiative based on the identification of problematic communities and application of best correctional practices as part of an effort to enhance offender reintegration from custody into the community.

Family Violence Prevention Programs

Domestic Violence Programs are offered in rural and urban communities and range from five weeks to over one year in duration. These programs are facilitated by Mental Health Services, Probation Officers, or together on a co-facilitation basis. This program targets domestic violence clients with a range from first time offenders to offenders with extensive criminal pasts.

Education, Employment, and Skills Training Programs

The Division partners with community and government agencies to deliver and improve education and employment opportunities for offenders returning to the community. Prism Industries provides work-related experiences in three workshops at Saskatoon, Prince Albert (Pine Grove) and Regina Correctional Centres. Contracts help defray the operational costs of correctional centres and inmates use their earnings to pay restitution, support their families or to support themselves while they are in custody. The workshop at the Regina Provincial Correctional Centre focuses on woodworking. The Saskatoon Provincial Correctional Centre specializes in manufacturing and repair of metal products. The workshop at Pine Grove

Provincial Correctional Centre produces a range of sewn products including canvas goods. A goal at the time of this scan was to achieve accreditation of custody education programs.

Sexual Offender Programs

The Division offers institutional and community supervision treatment programs in partnership between Community Operations and Mental Health Services to provide a more enhanced delivery of services. These services include victim contact, encouragement and co-ordination of support persons, as well as education and community development. Specially-trained Community Operations staff members undertake court reports, risk assessment, case planning, and supervision. Private counselors offer programs in areas of the province where Mental Health Services do not operate.

Community Based Correctional Programs

An objective of the Division is the continued implementation of programs and services to support the appropriate use of diversion, alternatives to custody, and assistance in offender reintegration in partnership with Aboriginal organizations and other CBOs for adults and youth. CBOs that deliver youth extrajudicial sanctions include John Howard Society in Moose Jaw, Regina and Saskatoon; Tribal Councils in North Battleford, Prince Albert, Fort Qu'Appelle, Saskatoon, Meadow Lake and Yorkton and Friendship Centres in Fort Qu'Appelle, Ile-à-la-Crosse, La Ronge, and Prince Albert; and various CBOs in La Loche, Meadow Lake, North Battleford, Prince Albert, Regina, Swift Current, Estevan and Saskatoon.

Community operations target crime prevention initiatives in various communities to reduce crime and lower the risk of re-offending. These initiatives are developed in partnership with the Ministry of Justice, the RCMP, municipal police, First Nations and Métis communities, community organizations and other local government representatives. They involve a combination of measures including intervention and intensive supervision, and rehabilitation programs where appropriate.

The Division contracts with the Elizabeth Fry Society and the Prince Albert Grand Council for reduced-custody adult services for moderate risk offenders who work or receive education, training and/or specialized treatment in a community-based setting. The community training residences (CTR) offered by Elizabeth Fry provides female offenders with a period of transition to the community from custody by allowing them the opportunity to put into place those elements of their case plans that increase the likelihood of a successful reintegration. Adult community corrections programs include Journey to a Better Lifestyle program.

The Journey to a Better Lifestyle program is a holistic healing program delivered by the Prince Albert Grand Council. The program includes spiritual traditional teachings, life skills and anger management and is a pre-release program for low-risk offenders from the Prince Albert Correctional Centre. Various adult correctional programs are also delivered by Prince Albert Grand Council. Probation services are delivered by File Hills Qu'Appelle Tribal Council. Community-based agencies that deliver alternative measures programs for youth are John Howard Society in Regina, Moose Jaw and Saskatoon; Tribal Councils in Regina, Yorkton, Saskatoon, North Battleford and Prince Albert; Friendship Centres in Ile-à-la-Crosse, Prince Albert, La Ronge, Fort Qu'Appelle, Touchwood; various community-based organizations in La Loche, North Battleford, Regina, Meadow Lake, Saskatoon and Prince Albert. An accountability

process is in place for community correctional programs and service to ensure that case plans are in compliance with case management standards (Government of Saskatchewan, 2012b).

The Division also oversees the youth alternative measures program.

Restorative Justice Programs

The Division oversees the youth alternative measures program that provides alternatives to the formal court system by bringing the victim, the offender, and family and community representatives together to restore harmony in the community. A philosophy of the Division is that people are less likely to commit crime if they feel valued in their community and know what is expected of them. Restorative Justice Programs ensure that victims and offenders are appropriately reintegrated with their communities and receive support from the community in making positive changes in their lives to help prevent future offending and destructive behaviours. Restitution, education and employment/skills-based programs, and reintegration programs for young offenders are delivered by First Nations and Métis organizations in Prince Albert, Saskatoon, Regina, Yorkton, North Battleford, Fort Qu'Appelle and Ile-à-la Crosse; First Nations Bands at Onion Lake and Lac La Ronge; John Howard Society in Regina and Saskatoon; and other CBOs in Meadow Lake, North Battleford, Prince Albert, Saskatoon, Regina, and Sandy Bay.

Municipal Corrections and Forensic Services

Saskatchewan is serviced by 14 municipal police services and over 120 RCMP detachments (Government of Saskatchewan, 2012f; RCMP, 2012). A 20-year partnership between the province and the RCMP to provide services to Northern communities became effective on April 1, 2012 (Government of Saskatchewan, 2012f). The Royal University Hospital provides limited forensic community outpatient services. Saskatchewan has two drug courts, domestic violence courts in the largest cities, Cree Court in Meadow Lake, and a Dene Court in northern region of the province (Courts of Saskatchewan, 2012).

Community Based Organizations

Community based organizations provide intervention strategies and consultations to the Division by referral, and assist in the development and management of case plans. CBOs in Saskatchewan include the following:

- Local Health District, Alcohol and Drug Services
- Local Health District Mental Health
- Native Alcohol and Drug Addictions Program (NADAP)
- Department of Community Resources - Family Services
- Alcoholics Anonymous/Narcotics Anonymous
- Gambling Anonymous
- Salvation Army
- Local Hospital Social Worker
- Indian Métis Friendship Centre
- Indian Métis Christian Fellowship
- Churches
- Elders

E-Scan
Community Mental Health Programs and Services

4.5 Community Mental Health Facilities, Assessments, Programs, Services, and Referrals
(By Health Region)

Community Mental Health Facilities, Assessments, Programs, Services, and Referrals (By Health Region)

The commitment of federal and provincial corrections to providing evidenced-based and needs-based correctional programming to Aboriginal offenders is clear, as is the goal of sentencing Aboriginal offenders in their communities when possible. The relevance of mental health programs and services to improve offender responsiveness to correctional programming is central to this goal and is being addressed on a national scale. Of relevance to this study is the FTP partnership strategy toward continuity in client-centered, holistic, culturally-sensitive, gender-appropriate, comprehensive, and sustainable mental health programs and services to Aboriginal offenders with compromised mental health in keeping with community standards of mental health service delivery in Saskatchewan.

It is important to consider that after warrant expiry date, Saskatchewan offenders ‘must line up for services in the community like everybody else.’ There are currently no priority forensic services for offenders after warrant expiry date. This scan seeks to determine whether or not the seven elements of the national strategy are in place in the various health regions serving an offender’s community upon release: 1) mental health promotion; 2) screening and assessment; 3) treatment, services, and supports; 4) suicide and self-injury prevention and management; 5) transitional services and supports; 6) staff education, training, and support; 7) community supports and partnerships.

Saskatchewan Ministry of Health. The Ministry directs policies, establishes and monitors standards, provides funding, and ensures the provision of essential and appropriate services including mental health and addictions services in Saskatchewan. There are twelve (12) Regional Health Authorities (RHA) and one health authority in the province. Within these regions governmental, non-governmental, non-profit and for-profit CBOs provide mental health services throughout the various regions.

Canadian Mental Health Association. The Canadian Mental Health Association (CMHA) branches provide a wide range of tailor-made services to meet the need and resources of the communities in which they are based. CMHA branches receive financial support from the Saskatchewan Ministry of Health and works closely with stakeholders and other service providers to provide mental health services in the community. The goal of these services is to help people improve their mental health, integrate into the community, become resilient, and be supported in their recovery toward meaningful and productive lives. There are thirteen (13) CMHA branch offices in Saskatchewan.

Health Canada. Health Canada works with First Nations, Inuit, and government stakeholders and communities to support and improve the health of individuals and communities, and enable greater control of community health care by First Nations and Inuit.

peoples. Health Canada provides services to First Nations and Inuit peoples who are affected by substance use or abuse problems through the National Native Alcohol and Drug Abuse Program (NNADAP). There are ___ First Nations and Inuit Health Branch (FNIHBs) in Saskatchewan. NNADAP operates 10 treatment centers in Saskatchewan with a total of _____ beds. NNADAP also oversees the National Youth Solvency Program for youth 12 to 19 years which operates 10 centers in Canada providing 120 treatment beds in total. The youth centres follow a "continuum of care" approach that begins with pre-treatment, then treatment, and finally post-treatment care that involves families. The centres also provide information and training to community youth worker. Since the program began, the treatment centres have been used at maximum capacity where a minimum of 212 clients are treated each year.

Regional Scans

Each health region was scanned for evidence of the seven FTP indicators to determine the standard of community mental health service and delivery in Saskatchewan.

Athabasca Health Authority. The Athabasca Health Authority borders the North West Territories and covers the most northern regions of the province serving 4,500 residents with a high population of youth, according to the Authority (Athabasca Health Authority, 2011). This health authority includes the communities of Fond du Lac, Stony Rapids, Uranium City, Camsell Portage, Hatchett Lake, and Black Lake. There are two (2) First Nations communities in the region including Fond du Lac and Black Lake Denesuline First Nations, and the Métis communities of Camsell Portage, Stony Rapids, and Uranium City. There is an RCMP detachment in Stony Rapids (Athabasca Health Authority, 2011).

There is a CMHA branch office in Black Lake. There are outpatient drug and alcohol addiction services for youth, a mental health main clinic in Black Lake and eight (8) mental health therapists in the region. There are two addictions workers; one each for adult and youth. There is a mental health and addictions intake office in Stony Rapids. There is one visiting psychiatrist providing mental health clinics for 2 days every three months at Yutthé Dene Nakóhódí Health Facility and in the community of Fond Du Lac. Mental health and addictions services are also provided in Uranium City for four days every second month. A host of mental health issues were reported including addiction; substance abuse; depression; and suicide; family violence; sexual abuse; and residential school. There were 26 suicides in this region between 2004 and 2008 compared to 8 in the previous five years.

This region does not operate a mental health inpatient unit. There were 204 patient contacts for mental health related-issues in this region. There were 28 adult and 2 child and youth non-psychiatric ward separations and 856 patient days for clients from this region. There were 7 inpatient separations at inpatient facilities in other regions (n=5 Prince Albert; n=1 North Battleford; n=1 Saskatoon). There is a waiting period for some services in this health region. The Fetal Alcohol Spectrum Disorder Worker position has been vacant since Dec. 2010.

There is a First Nations and Inuit Health Branch (FNIHB) in Black Lake providing inpatient and outpatient mental health and addictions programs for community and court-ordered (forensic) clients. This FNIHB has a methadone program and also treats concurrent disorders, psychoactive drug patients, and residential abuse survivors. [See Table].

Keewatin Yatthé Health Region. The Keewatin Yatthé Health Region borders Alberta and serves 11,199 residents (as of 2010). This health authority includes the communities of La

Loche, Buffalo Narrows, Ile a La Cross, Beauval, and Green Lake. There are ___ First Nations communities including Canoe Lake, Churchill Lake, Dipper Rapids, Elak Dase, English River, Ile a La Cross, Knee Lake, La Loche, La Plonge, Peter Pond, Primeau Lake, Turnor Lake, and Wapachewanak, and the Métis communities in La Loche, Buffalo Narrows, Dillon (Green Lake), and Turnor Lake. There is a CMHA branch office in Buffalo Narrows. There are outpatient drug and alcohol addiction services in Beauval, Buffalo Narrows, and La Loche. There are detoxification services in La Loche and Ile a La Cross. There is a FNIHB in La Loche. There are mental health and addictions intake offices in Beauval, Ile a la Cross, Buffalo Narrows and La Loche. There is a family healing unit in Ile a la Cross.

Indicators

- Mental Health Promotion
- Screening and Assessment
- Treatment, Services, and Supports
- Suicide and Self-injury Prevention and Management
- Transitional Services and Supports
- Staff Education, Training, and Support
- Community Supports and Partnerships

Summary of Scan

This section spoke to our findings from the family surveys - that Aboriginal offenders are not accessing addictions and mental health services equal to their level of need, especially in the community. Through scanning, we found that a menu of mental health and addictions programs and services exist at the correctional and urban community level, but that a few problematic areas exist in the northern health regions that service predominantly Aboriginal communities this (i.e., lack of mental health and addictions services in La Loche and other Metis and Denesulin communities).

A brief synopsis from the scan of forensic mental health services in all the health regions revealed: Saskatoon had the highest rate of service utilization overall; Regina Qu'Appelle had the highest rate of forensic mental health service clients and admissions to addictions services; Prince Albert Parkland had the highest rate of non-resident forensic mental health clients, transfers from other RHA's, and pregnant clients using addictions services, but the least number of resident psychiatric and social work staff N=0; Northern regions had no residential rehabilitation services, and clients must travel extensively for service in Athabasca; and, finally the health regions of Keewatin had the highest suicide rates in the province, where rates are double that or southern RHA's and have continued to increase since 1999.



Phase III – FINDINGS - FRONT LINE SURVEYS

4.0 FINDINGS - FRONT LINE SURVEY

Front Line Surveys

This assessment seeks to address some of the reasons why Aboriginal offenders in Saskatchewan are not receiving community mental health services equal to their level of need from the perspective of front line personnel. The following is a summary of the key findings of the surveys with frontline personnel.

Surveys – Frontline Staff

Response from frontline responders who engage offenders with compromised mental health and addictions on a regular basis was overwhelming. Staff and professionals working in law enforcement, corrections, and justice participated readily and had a lot to say about the problems facing and caused by offenders with compromised mental health.

Criminalization of the Mentally Ill

A common theme of the frontline data is that criminalizing the mentally ill is not the answer; that the mentally ill are not criminals and do not belong in jail but currently there is no other system to deal with them. Frontline respondents noted that as police, they are often forced to look for criminal misconduct to get the person some help.

A common theme of the family and frontline data is the belief that the focus of the CJS is on the individual's crimes rather than on the whole person living with addictions and mental illness, and the relevance of compromised mental health to criminal behaviour. As previously discussed, correctional authorities recognize that there are several individual behavioural, mental, and social characteristics or criminogenic factors that contribute to recidivism including addictions (Government of Saskatchewan regarding Ministry of Corrections, Public Safety, and Policing, 2010). However, frontline respondents in this study spoke to the criminogenic needs of entire communities based on levels of dysfunction at a societal level. These needs include primary mental health care and addictions education and prevention. More than once, frontline responders addressed the astronomical amounts of proceeds from the sale of alcohol in certain northern and predominantly indigenous communities.

A common theme of the family, frontline, and institutional data is that jail is not the place for people with mental health issues because they get lost in the system and spend a lifetime in and out of corrections without proper diagnosis and treatment that could help change attitudes, thoughts, and behaviours leading to obedience, productivity, and a better quality of life.

Safety

A common theme of the frontline data was concerns about safety issues arising from interaction with mentally ill offenders with emotional management, substance abuse, and/or needle drug addictions.

Unhealthy Communities

Frontline respondents reported that many northern communities are not ready for the release of offenders for community-supervision. 'Dysfunction in the community' is a common theme reported by frontline respondents and family members to a lesser degree. In one case, a public safety professional suggested that the community in which s/he worked was 'so unhealthy that members could barely take of themselves, let alone an offender on strict conditions in the community'.

Access - Police

Respondents from policing domains felt 'too much responsibility' rested on them for meeting the needs of mentally disordered offenders in terms of accessing programs and services in northern community. Frontline respondents noted that police are often forced to look for criminal misconduct to get the person some help.

Continuum of Correctional Care (CCC)

Common responses given by family members and frontline personnel suggest a disconnect in the continuum of correctional care once an offender is released into the community: frontline respondents identified some communities as being 'unprepared' to supervise offenders; frontline respondents identified some northern communities as being 'dysfunctional' and leading to substance use underlining criminality; a majority of respondents reported: chronic substance use and addictions; undiagnosed and untreated mental illness; and lack of community resources

Coordination of Services/Partnerships

A common theme of frontline responders was the need for more partnerships between correctional facilities and the community to reduce reliance on the CJS for the provision of adult and youth programs and addictions services, and to bolster current initiatives for young offenders. Respondents saw a need for more community outreach or liaison officers* to connect offenders with mental health services upon release.

It was thought that partnerships between the CJS and First Nations should be expanded and/or nurtured to improve diversion and correctional outcomes for Aboriginal youth in particular. Plans are in place to increase mental health services in partnership with health agencies in the coming years and to supplement existing youth service partnerships with CPSP. Past initiatives include partnerships with Saskatchewan Justice, Saskatchewan Health, Saskatchewan Education, Sask Learning and SIAST, and FSIN,

Some First Nations respondents in this sample suggest that offender supervision and monitoring in certain First Nations communities was 'too lax' and therefore inadequate in terms of meeting their family member's addictions, substance abuse, and psychiatric needs.

Continued Focus on Improving Community Programs and Services in the North

Initiatives exist to provide correctional facilities and programming and community correctional programming in First Nations communities in the northern part of the province where services are unavailable to a delay in service exists because of the following: geography (i.e., the sheer size of the north compared to its number of inhabitants; weather; caseload; and lack of juridical staff including Aboriginal professionals

Some of these problems are being overcome through partnerships between justice, corrections, and First Nations agencies in the delivery of programs and services. Other initiatives include the hiring and training of local Aboriginal peoples as Justices of the Peace, and holding the accused in his or her home community until trial (rather than transporting them to other centers and away from their support systems). The sentencing of low to moderate risk offenders in their home community was seen as favourable for respondents living in rural, First Nations, and Métis communities.

Need for more Forensic Staff and Increased Mental Health Training and Support

A common theme in the frontline data is the need for more forensic staff and increased mental health training and support in correctional environments. Lack of resources and understaffing of mental health care teams has resulted in a focus on risk assessment and crisis management rather than primary mental health care. They states that plans to full-capacity develop mental health teams in federal institutions will minimize the reliance on referrals to treatment centers and provide better treatment options for the offender. The training of correctional officers to recognize the signs and symptoms of mental illness and make appropriate referrals to the mental health team is occurring at the federal level.

Mental Health Court as a Form of Social Justice

A common theme of frontline respondents suggests mental health court as a form of social justice (n=39) and a better alternative to incarceration (n=30). Frontline responders saw the merit of mental health court in addressing and reducing recidivism (n=44) through ordering referrals to help meet the offenders' needs: addressing the underlying issues of crime, focus on culturally-relevant treatment of the problem: addictions, disorders, culturally-relevant programming, holistic focus on rehabilitation of the individual. All of which would lead to mental wellness and community harmony, and a functional communities.

Frontline responders were of the view that mental health court was the next logical step in a court system that addresses systemic and social problems like drug addiction and domestic violence. They suggested that such a court could foster teamwork and inter-agency approaches to reintegration and knowledge transfer of best practices.

This sample of respondents was also of the view that trained professionals and a court staff of compassionate mentors would best know how to deal with offenders because "unless you've been there, you won't understand." While respondents were optimistic, a common critique was that some offenders would 'work the system' and ruin it for everyone else; that some offenders would feign mental illness and use it as a scapegoat.

On the other hand, respondents felt that court staff would have the knowledge and mental health training to weed out offenders without genuine mental health concerns.

Another common critique of mental health court was that it already exists; that the mentally ill do not need a separate or 'own' court. They felt that if in reality 90% of offenders have addictions, it would be unrealistic to take resources away from existing courts where there already is a shortage.

A further theme of this data is that there is lack of community supports and resources in the north and rural parts of Saskatchewan, and that there is nothing a mental health court can do for offenders without the necessary resources in place.

Frontline responders believed that a mental health court should be based on a system of careful monitoring to ensure compliance of treatment services and mental health programs that includes but is not reliant on police.

Summary of Front Line Surveys

This section further examined our findings of the scan and answered the questions, "What are the best practices, gaps, and innovations in service delivery in Saskatchewan?" and the final question, "What evidence based forensic mental health services are needed in Saskatchewan?" Frontline personnel who engage Saskatchewan offenders believed Aboriginal offenders are not accessing services equal to their level of need because Aboriginal offenders are being released into some communities that are ill equipped to supervise offenders. Specifically, they described "some northern communities as so 'dysfunctional', that this was actually leading to further substance use underlining criminality".

5.0 DISCUSSION

Discussion

The findings of this study generated many issues for discussion and reflection. Those identified here have specific implications for future research and policy development, as well as for challenges for Saskatchewan in providing forensic mental health services.

5.1 Defining Mental Illness and the Mentally Ill Offender

Definition of Mental Illness and Mentally Disordered Offender

The literature indicated that the definition of ‘mental illness’ and ‘mentally disordered offender’ (MDO) has been an important consideration in the provision of forensic mental health services, as services provided may depend on what mental health issues or problems are included or excluded in the definition of the term. In a feasibility study by M. Sinha on *collecting data on mental health issues in the criminal justice system* for Statistics Canada (2009c), warned that the definition of mental illness may prove to be the biggest challenge in data collection due to the varying definitions in the field. Each criminal justice sector approaches the issue of mental illness based on their particular roles and their legislated obligations. As such, there are often differences in the way mental illness is defined, ranging from observational and reportable behaviours to official diagnoses (Statistics Canada, 2009c).

The literature reviewed showed varying definitions from the different systems and services providing care for offenders with compromised mental health in primarily the Canadian context. An overview is provided here of definitions for ‘mental illness’ and ‘mentally disordered offender’, followed by a discussion in ‘Challenges for Saskatchewan.’

Defining Mental Illness

Every Canadian province and territory has legislation to treat and protect people with severe mental ‘disorders’, and to protect the public as well. Each criminal justice sector approaches the issue of mental illness based on particular legal roles and obligations. As such, there are often differences in institutional definitions, ranging from observational and reportable behaviours to official diagnoses (Statistics Canada, 2009a).

First, Frances, and Pincus (2004) suggest, there is no consistent operational definition of mental disorder to cover all situations or distinguish between normality and pathology and/or mental and physical illness. A broad definition includes any kind of mental suffering that is more than just ‘unpleasant’ (Cockerham, 2011) while a narrow definition involves only those behaviors that are ‘clearly’ undesirable and that no one wants to experience (Spitzer & Wilson, 1975). Spitzer and Wilson (1975) helped to define mental illness within psychiatry in the development of the *Diagnostic and Statistical Manual for Mental Health Disorders, 3rd Edition* (DSM-III) where mental disorder is defined as “a condition that is primarily psychological and that alters behavior” (p. 829). The condition must be a “clinically significant behavioural or psychological syndrome or pattern of dysfunction within the individual” (DSM-IV-TR, p. xxxi). This definition continues to be used in the current edition where clinically anything from substance abuse to psychopathic behaviour is included (Statistics Canada, 2009e).

The Mental Health Act of Saskatchewan, 1978. In the Act respecting mentally disordered persons, ‘mental disorder’ is defined as “mental illness, mental retardation, psychopathic disorder, or any other disorder or disability of mind. In this Act, “mentally disordered” and “mentally disordered person” have a corresponding meaning.

The Mental Health Services Act of Saskatchewan, 2004. In the Act respecting mental health services, ‘mental disorder’ is defined as “a disorder of thought, perception, feelings or behaviour that seriously impairs a person’s judgment, capacity to recognize reality, ability to associate with others or ability to meet the ordinary demands of life, in respect of which treatment is advisable.”

The Criminal Code of Canada, RSC, 1985. The definition of ‘mental disorder’ in a legal context in Canada is “a disease of the mind.” Persons who are deemed ‘unfit to stand trial’ (UST) are said to be “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, or (c) communicate with counsel. Section 16(1) of Code states that, “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.” Persons charged with an offence are, “presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility ... until the contrary is proved on the balance of probabilities” where “the burden of proof” is on the party that raises the issue.

Courts. At the court level, non-specialized criminal courts rely on the provisions within the *Criminal Code of Canada* relating to fitness to stand trial (FST) and not criminally responsible on account of mental disorder (NCRMD). Here a mental disorder is viewed as a "disease of the mind" (Statistics Canada, 2009c).

Police. Although no consistent definition exists across police services, the Canadian National Committee for Police/Mental Health Liaison (CNCMPHL), a subcommittee of the Canadian Association of Chiefs of Police, takes a broad view of mental illness as “individuals who are out of touch with reality and who may need help to keep themselves or others safe” (CNCMPHL, 2008). Since the police are often the first responders to situations involving individuals with mental illness and must react to situations, their own observations, as well as observations and information from family, friends, and neighbours are often used, rather than official psychiatric assessments or diagnoses. Policing decisions, however, must be in keeping with the *Criminal Code* and the relevant provincial/territorial mental health acts (Statistics Canada, 2009c).

Federal/Provincial/Territorial (FPT) Partners. ‘Mental health issues’ are defined as a generic term used to encompass any mental health concern (developmental disability, cognitive impairment, organic or acquired brain injury, mental disorder or illness, substance abuse disorder, etc.) that may be relevant (FPT Ministers Responsible for Justice, 2010). The FPT correctional partners prefer a broad definition of mental illness where ‘mental health issues’ indicate a generic term used to encompass any mental health concern. Their definition of compromised mental health or mental illness includes depression, suicide ideation, substance abuse, emotional disturbance, behavioural disorders, cognitive disorders, personality disorders,

and permanent brain damage (e.g., fetal alcohol spectrum disorder) (Statistics Canada, 2009d; FPT Ministers Responsible for Justice, 2010).

Mental Health Strategy for Canada, 2012. The *Mental Health Strategy for Canada (2012)* defines mental health problems and illnesses as patterns of behaviour, thinking or emotions that bring some level of distress, suffering or impairment in areas such as school, work, social and family interactions or the ability to live independently. They range from more common mental health problems and illnesses such as anxiety and depression to less common ones such as schizophrenia and bipolar disorder (Mental Health Commission of Canada, 2012),

Mental Health Strategy for Corrections, 2012. In the context of the *Mental Health Strategy for Corrections 2012*, the definition of mental health problems and/or mental illnesses followed the MHCC (2009) definition which refers to “clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering or impairment in one or more areas such as school, work, social and family interactions or the ability to live independently” (FTP, 2012, p.11).

Some sectors argue that given their differing roles and expectations, a definition should be customized for each sector. On the other hand, a few argue for a more uniform conceptualization of mental health issues across all criminal justice sectors (Statistics Canada, 2009b). While most sectors prefer a broad definition, others may adhere to a narrow definition that does not include substance use disorders. There are many views and preferences for the term ‘mental illness’ as it emphasizes the seriousness of the conditions being experienced. Others prefer ‘mental health problem’ because they see it as less stigmatizing or ‘mental disorder’ as it can potentially encompass both ‘problems’ and ‘illnesses’ while also acknowledging the non-medical dimension. There is also a preference for the term ‘mental health issue’ as it is broader and less connected to a purely ‘biomedical approach.’ There is also the view that symptoms are ‘gifts’ rather than ‘problems’, while others would reclaim the term ‘madness’. Still, some form of the term needs to be employed consistently to avoid confusion (FPT, 2012).

Defining Mentally Disordered Offender (MDO)

The literature also showed varying definitions of ‘offenders with mental disorders’ where (OMDs), and offenders with mental disorders (MDOs).

Corrections Service of Canada (CSC). Corrections Service Canada uses the term ‘offenders with mental disorders’ where “OMDs includes not only mental illnesses such as bipolar disorder or schizophrenia, but also disorders such as fetal alcohol spectrum disorders (FASD), Alzheimer’s disorder, attention deficit hyperactivity disorder (ADHD), personality disorders, as well as problems resulting from head injuries and other disorders that influence the functioning of an individual” (CSC, 2007, p. 19).

American Academy of Psychiatry and the Law. Mentally disordered offenders are those offenders who had been formally judged by the judicial system, both guilty of a crime and emotionally disturbed. MDOs do not include offenders whose mental illnesses have not been recognized by the courts (American Academy of Psychiatry and the Law, 2012).

MDO definition by Ogloff, Davis and Somers (2004; 2005). Ogloff et al., (2004; 2005) provided a comprehensive definition in their *Systematic review of the scholarly literature on mental disorder, substance use and criminal justice*. They defined the term ‘mentally disordered offender’ (MDO) as “those people who have a mental disorder and/or substance use disorder

(other than anti-social personality disorder), developmental disabilities (IQ below 70), low functioning (IQ above 70 with limited adaptive abilities), brain injury (organic or acquired) and Fetal Alcohol Effects or Fetal Alcohol Syndrome. In addition to the presence of a mental disorder, these people must be accused or convicted of committing offences or at high risk of involvement in the justice system” (p. 3). Ogloff et al., further clarified “although strictly speaking the term ‘mentally disordered offender’ (MDO) should refer to people who have been convicted of an offence, as we use the term, it applies to both those accused and convicted of committing offences. Some attention should be paid, as well, to those with a mental disorder who while not yet in the criminal justice system are at risk to offend” (p. 9).

Summary. The literature review revealed many different definitions for ‘mental illness’ and mentally disordered offender’ Some sectors argue that given the differing roles and expectations, a definition should be customized for each sector. On the other hand, a few argued for a more uniform conceptualization of mental health issues across all criminal justice sectors (Statistics Canada, 2009b). While most sectors prefer a broad definition, others may adhere to a narrow definition that does not include substance use disorders.

Challenges for Saskatchewan

Defining ‘mental illness’ or ‘mentally ill offender’ proved to be one of the biggest challenges in this study with regard to data collection and participation. The definition of mentally disordered offender revoked much discussion among the members of FIRST. We struggled with how best to define the term for the Centre, and for the Needs assessment study. We recognized that an initial definition offered in an early publication of the Centre (University of Saskatchewan, 2010) needed some additional work and thought.

In terms of forensic psychiatry, one of the members of FIRST, a forensic psychiatrist indicated that it is not enough to be suffering from mental illness and be in prison, additionally, the individual designated as MDOs must meet the definition of being formally judged, by the judicial system, both guilty of a crime and emotionally disturbed. However, for practical purposes as they relate to the provision of care, it’s often necessary to widen the definition to include individuals with major mental illness serving prison terms or under some kind of legal supervision [personal communication, Dr Olajide O. Adelugba, October 31, 2012].

Implications of not including substance use disorders. Recent statistics indicate that thirty-six per cent of offenders have been identified at admission as requiring some form of psychiatric or psychological follow-up. Given that Sixty-three per cent of offenders report using either alcohol or drugs on the day of their current offence (OCI, 2012) this causes a concern among provincial and federal administrators in allocating sufficient funds for treatment of this disorder. In Saskatchewan roughly 82% of the provincial offender population are said to be mentally-disordered when substance abuse disorder is included in the definition of MDO. A common definition of MDO is important to consider in Saskatchewan because of the prevalence of addictions and substance abuse issues underlying criminality and recidivism among Aboriginal offender populations observed in this sample

Research needed. A specific study on the definitions used to define mental health issues/illnesses /disorders may shed light on the reasons for each sector’s description and bring about policy changes if the reasons exclusions in the definition are monetary.

Working Definition

Members of FIRST developed a working definition for the term 'Mentally Disordered Offender' ('MDO') [See Recommendation #2]

5.2 Fiscal Responsibility of Forensic Mental Health Services

Fiscal Responsibility for Mental Health Care Services

What happens when the criminal justice system becomes, by default, the mental health care system? A common theme in the federal and provincial literature has been that jails and prisons are fast becoming our nation's largest psychiatric facilities and repositories for the mentally ill (Jacob, 2012; Kent-Wilkinson, 2010; OCI, 2010, 2012). If this is the case, then increased budgets are needed both within and outside of the system. Specifically, mental health promotion and prevention services are needed to keep people from entering the system; appropriate mental health treatment services for mental health and addictions issues are needed within the system; and, adequate community services for offenders are needed at the time of release to prevent relapse and reduce recidivism. Federal offenders are excluded from the *Canada Health Act* and are not covered by Health Canada or provincial health care systems (OCI, 2010) therefore CSC is responsible for mental health care services for federal offenders, however, mental health care for provincial offenders in Canada have come under differing ministries over the years.

Currently in Saskatchewan, mental health services are the responsibility of Correctional Service Canada for federal offenders; the Ministry of Justice, Corrections Division for provincial offenders; and the Ministry of Health provides general and specialized mental health services (including forensic) for provincial offenders. The Ministry of Health is responsible for the provision of appropriate and essential addictions services in Saskatchewan including forensic clients with addictions and mental health needs who have been released from correctional custody on a warrant of expiry date (WED).

What would happen if the Ministry of Health has the responsibility for mental health and health care services for provincial corrections overall. Would there be more funding for mental health care services? We have only to look to other provinces for these answers. Of note, the Ministry of Health in two provinces in Canada (Alberta and Nova Scotia), now has this responsibility. Although the reorganization in Nova Scotia is currently limited to Halifax (an urban centre), all provincial health and mental health services in Alberta are under the umbrella of Alberta Health Services. This authority also includes both the drug and alcohol addiction services, in addition to the forensic mental health services in Alberta. Will this restructuring be a trend across Canada? What reforms are needed in Saskatchewan in order to obtain the needed specialty forensic mental health care services?

Individuals with a mental health problem and/or illness often have previous points of contact with multiple systems, including provincial/territorial and federal correctional jurisdictions, health care institutions, and social services. All systems have a shared mandate to provide an integrated approach to a 'common client' to promote active client engagement, stability, successful community integration, and overall harm reduction in ways which are sensitive to diverse individual and group needs. Integrated efforts with the 'common client' will

result in fewer system contacts and ultimately fewer victims of crime (FPT Ministers Responsible for Justice, 2010).

The common client or patient (those with compromised mental health) often criss cross between federal and provincial corrections, revolve in and out of detox centres and homeless shelters, in addition to frequent admissions to emergency departments and stays on psychiatric units in acute care hospitals. Offenders with mental disorder are the same persons arbitrarily separated by the systems that care for them. It is indeed one of the faults of administrating not only an efficient system but a continuous care for those who need it. Protectionist tendencies regarding funding and financing only serve to hurt the offender and deny continuity of service, thus potentially elevating the risk. A fractured or compartmentalized service to the mentally ill (who for all intent and purposes do not stop having their difficulties when they cross these artificial boundaries) may only exist to serve administrators. Practically, organizations and systems who all care for the mentally ill need to engage one another in collaborative endeavors that are beneficial to the person affected.

Community supports and partnerships was a key element in the *Mental Health Strategy for Corrections* released in 2012. According to this strategy, "Outreach initiatives to build relationships with partners are essential to optimize individual mental health and well-being. enhance continuum of care, and contribute to the shared responsibility of public safety" (FPT, 2012, p. 16). Expected outcomes of the Strategy are that "Partnerships are developed between correctional jurisdictions, government partners (including regional health authorities), community service providers and non-government organizations (NGOs) to address factors that may affect individuals" mental health and well-being" (FPT, 2012, p. 16).

Partnerships and coordination are needed between correctional facilities, mental health facilities and the police, to care for the complex issues of offenders with compromised mental health issues (CIHI, 2008; OCI, 2009b). Provincial, territorial, and international correctional and forensic mental health services often face similar challenges, and many offenders transfer between systems (CSC, 2010e). At the end of the day both governments share the same commitment to public safety, to the principles of fair and humane treatment of offenders, and to the safe return of offenders to the community as law-abiding citizens (OCI, 2009b).

Governments must make a "serious investment" in the mental-health system to prevent the vulnerable from ending up in prison. Co-ordinated action is needed for this complex set of problems. All levels of government must work together and, along with community partners, invest in a system based on mental health promotion, prevention and early detection and access to care and treatment (Standing Senate Committee on Social Affairs, Science and Technology, 2006). According to the *Standing Committee Report on Mental Illness and Addictions* (2010), it is also imperative that provincial funding be increased for services and programs to tackle the structural and social determinants of mental health including access to adequate housing, gainful employment, and income stability. The Committee also recommended partnerships and capacity-building between public health and social services networks to meet community mental health needs by facilitating access to treatment and support services, and strengthening early detection of mental health and addiction issues (Standing Committee on Public Safety and National Security, 2010, p. 20).

The many challenges associated with the mental health and the justice systems are recognized nationally and worldwide, and a number of reforms are underway in different

jurisdictions. Invariably, these reforms reflect a combination of local needs, resources, legislation and a consideration of available evidence.

Challenges for Saskatchewan

Respondents in this study indicated that a lack of adequate institutional and community resources were a contributing factor to relapse and recidivism in the province. Future research is needed to look at fiscal responsibility for mental health services for offenders provincially and nationally. To date, no single study has been able to calculate the full costs of mental illness to the family, cultural, and/or political systems of Canadian society, or the loss of income and quality of life for victims of mental illness. We do know that the average cost of federal incarceration per inmate has increased from \$88,000 in 2006 to more than \$113,000 in 2010. In contrast, the annual average cost to keep an offender in the community is about \$29,500. At a time of wide-spread budgetary restraint, it seems prudent to use prison sparingly, and as the last resort it was intended to be (CBC News, 2012e; OCI, 2012a).

We agree with the *Mental Health Strategy for Canada* that society will never be able to adequately reduce the impact of mental health problems and illnesses through reactive treatment programs and services alone. We must pay greater attention to the promotion of mental health and wellness for the entire population in order to prevent mental illness wherever possible. Compelling evidence for the effectiveness of promotion and prevention programs has been accumulating in Canada and internationally for many years, and we cannot afford to wait any longer to implement these programs on a national scale (Mental Health Commission, 2012).

Support from the private sector and philanthropic organizations are required as well. To meet the needs of a service economy dependent on social capital and ‘brain power’, Saskatchewan must be prepared to invest in the future mental health and well-being of its population. This means allocating resources to mental health priorities identified through evidence-based research that is needed to explore fiscal responsibility for mental health services for MDOs in our province and nation-wide. Mental health advocates argue that there will be limited success in decriminalization of the mentally ill if mental health resources and other social supports including housing and income stability are inadequate or do not exist. Like with most social problems, the solution for decriminalization of the mentally ill lies with government and Saskatchewan must make the necessary investments in these areas.

5.3 Interventions/Best Practices for Forensic Mental Health Services - Mental Health Court

Interventions/Best Practices for Forensic Mental Health Services: Mental Health Court

The feasibility of mental health court to alleviate systemic challenges in the delivery of forensic community mental health and addictions services to offenders needs further discussion. While frontline respondents in this study were mixed in their views offering logistical and critical feedback, family respondents were overwhelmingly positive and in support of the creation of problem solving courts in the province as a form of intervention. This was especially so for Aboriginal respondents if they thought cultural components could be built into the structure.

Specialty Courts

The advent of mental health courts and other specialty courts, including drug courts, has been one of the most dramatic developments in the area of mentally disordered offenders in recent times” (Ogloff et al., 2004, p. 4-5; 2005). Mental health courts are problem-solving courts designed to address the underlying problems that can contribute to criminal behaviour, and have resulted in better outcomes including a better quality of life for individuals experiencing mental-health problems and illnesses.

Objectives and Goals of Mental Health Courts

Mental health courts have recently emerged to address the issue of accused persons with mental health issues charged with minor offenses. Mental health courts engage a rehabilitative response over legal sanctions and have four main objectives: 1) diversion away from the criminal justice system and into treatment and psychiatric rehabilitation; 2) expedition of the assessment of fitness to stand trial (FST); 3) treatment of any mental disorder(s); and 4) reduction of recidivism among persons with mental illness (Schneider, Bloom, & Heerema, 2007). Mental health courts operate differently based on the needs and resources available in the context in which they are established (Schneider et al., 2007). Mental health courts sit either on a full-time basis or on a regularly scheduled part-time basis for the exclusive purpose of addressing the disposition of cases involving mentally ill or developmentally disabled offenders. The courts provide a wide range of service including expedited forensic assessments, collaborative dispositions, and as outreach to services in the community (FPT, 2010, October).

The overarching goal is to minimize the MDOs re-contact with the criminal justice system (McGuire, 2000). This is accomplished by making use of psychiatric, legal, and community resources and diversion programs that provide low-level MDOs the opportunity to agree to better quality of life through treatment and stable housing, and the opportunity to have their charges decreased or dropped. Upon discharge into the community, the court provides offenders with information and contacts to facilitate access to the necessities of life including community psychiatric care (Ontario Court of Justice, 2006; Statistics Canada, 2009c).

Development of Mental Health Courts

Mental health courts have become established practice for dispensing mentally disordered accused. There are currently at least 125 operational courts in 36 states (Council of State Governments [CSG], 2005). The development of the mental health courts in Canada have been influenced by proponents, changes in mental health laws, tragedy, and availability of funds. The first mental health court in Canada was established in Toronto in 1998 (Ontario Courts 2007; Schneider, 2010). Subsequent mental health courts and pilot court projects emerged in St. John’s in 2003 (Brien, 2004) and Newfoundland and Labrador in 2007 (Moulton, 2007); London in 2007 (Cooper & Neary, 2007); Montreal in 2008; and Halifax/Dartmouth in 2009. In Ontario, mental health courts operate in Ottawa, Newmarket, Peel, Sault Ste. Marie, Walkerton, Owen Sound, Kitchener, Sarnia-Lambton, and Windsor (FPT, 2010; CMHA, 2010b). Mental health courts are in various stages of development in other jurisdictions.

A court diversion program was developed in Calgary in 2000 and a mental health court was established in Winnipeg in 2012 (CBC News, 2010a; 2011b, 2012d; Government of Manitoba, 2012). The establishment of mental health courts have been dependent upon need rather than population and courts have been established in cities with populations well under

100,000 (i.e., Owen Sound and Sault Ste. Marie). Mental health care professionals and representatives from justice have been key in championing the cause.

Barriers to Establishment of Mental Health Courts

The Standing Senate Committee on *Mental health and drug and alcohol addiction in the federal correctional system* was disappointed to learn that a lack of funds was hampering the establishment of drug treatment and mental health courts across the country, and believed that the use of specialized courts should be increased, and that sufficient funding be provided in order to ensure that offenders with drug addiction and mental health issues receive the appropriate treatment at the right time (Standing Committee on Public Safety and National Security, 2010, p. 24). The recommendation of the Standing Committee was that the federal government “to support the creation and funding of more drug treatment courts to divert offenders with addictions to treatment centres and mental health courts to divert those with mental health needs to appropriate services” (Standing Committee on Public Safety and National Security, 2010, p. 23).

Challenges for Saskatchewan

With regard to solutions or interventions to the problems experienced by offenders with compromised mental health, Wormith and Luong (2007) noted that although there are specialized drug courts in Regina and North Battleford, a recent review of specialized court services across Canadian provinces and territories revealed that Saskatchewan was not among the country’s leaders. The update from our study/scan in 2012 revealed that Saskatchewan has some specialty courts to deal with some of the issues unique to the province (i.e., Regina Drug Treatment Court; Moose Jaw Drug Treatment Court; Domestic Violence Courts in North Battleford, Regina, and Saskatoon; a Cree Court in North East Saskatchewan; and, a Dene Court in Meadow Lake), but to date Saskatchewan is still one of the only provinces that does not have mental health courts or diversion programs. Without these and other community resources, more mentally ill people end up in the criminal justice system as the police may have no other recourse but to lay charges for even the most minor public disturbances.

Specialized Forensic Mental Health Services Needed

Various FIRST members advocate for a mental health court as a form of intervention to reduce the criminality and recidivism of our unique MDO populations in the province. There is a need for specialized forensic psychiatric services in Saskatchewan, specifically a mental health court with joint forensic ‘outpatient’ services. Future research is needed to further investigate the type of mental health or therapeutic problem solving courts needed for Saskatchewan, as well as the location for outpatient and court diversion services. Research is underway by members of FIRST to investigate the type of cultural therapeutic problems solving courts, diversion programs, and outpatient services needed for Saskatchewan. Evidence-based research indicates recidivism rates decrease in provinces with joint mental health court and forensic outpatient programs. Calgary, Edmonton, and Winnipeg are good examples with the establishment of Forensic Assessment and Outpatient Services (FAOS) in Calgary, Forensic Assessment and Community Services (FACS) in Edmonton, Alberta, and Forensic Community Services (FCS) in Winnipeg, Manitoba. Saskatchewan is a province without adequate outpatient services for federal and provincial offenders. This is problematic in that courts must be able to

dispense MDOs to adequate, appropriate, effective, and culturally appropriate treatment programs and services.

6.0 RECOMMENDATIONS

Recommendations

The inclusion of a 'need' in the recommendations was not to imply that the criminal justice system currently is not taking steps to address that specific need, or imply criticism of the steps that are being taken. Rather, it represented the views of participants and illustrates the major themes identified in their responses in relation to issues that underlined criminality, addiction or mental health relapse, or recidivism from repeat offences.

Members of the Forensic Behavioural Sciences and Justice Studies (FIRST) team concluded that to meet the needs of, and to improve the outcomes for mentally disordered offenders, the following five recommendations are needed and should be immediately implemented.

Recommendation 1:

Need for a Provincial Mental Health Strategy and Continuum of Care

The members of FIRST concluded that a 'provincial continuum of care' consisting of interdisciplinary and inter-sector collaborations, along with a 'mental health strategy' is needed for Saskatchewan. 'Continuum of care' was defined in the *Mental Health Strategy for Corrections in Canada* (Federal-Provincial-Territorial [FPT] Partnership, 2012) as the integrated and seamless system of mental health services to meet the needs of individuals as they transition into the correctional system and back to the community. According to their vision statement, "Individuals in the correctional system experiencing mental health problems and/or mental illnesses will have timely access to essential services and supports to achieve their best possible mental health and well-being. A focus on 'continuity of care' will enhance the effectiveness of services accessed prior to, during, and after being in the care and custody of a correctional system. This will improve individual health outcomes and ultimately contribute to safe communities" (FTP Partners, 2012, p. 7). A 'provincial mental health strategy' including a framework for a 'continuum of care' for offenders with compromised mental health in Saskatchewan is needed not only to improve psychological, physical and social wellbeing, but also for better legal outcomes for offenders, their families, and society.

Recommendation 2:

Need for a Consistent and Precise Definition of Mental illness and of the Mentally Disordered Offender (MDO)

Members of FIRST recommend that a consistent definition of mentally disordered offender inclusive of substance use disorders is needed at all levels of corrections in the province. Just as the study by Statistics Canada (2009) entitled *An investigation into the feasibility of collecting data on the involvement of adults and youth with mental health issues in the criminal justice system* warned that defining 'mental health issues' and/or 'mental illness' would and did prove to be one of the biggest challenges with respect to data collection, because of the potentially vast scope of a definition.

Members of FIRST recognize that including substance use disorders in definitions of 'mental illness' and/or the 'mentally disordered offender (MDO)' would have implications for funding allocations, however we believe that the exclusion of substance use disorders, a

prominent contributory factor of criminality, is not only a disservice to those with the problem, but is a guaranteed feature for an unsafe community. A common theme found in the literature and in the participant responses of this study was the belief that substance use disorders underline criminality.

Although many criminal justice and mental health care sectors have included substance abuse in their definitions of mental disorders, the authors of this study noted that neither the Mental Health Commission of Canada (2012) nor the FPT Partners (2012) were explicit enough in their definitions of mental health problems in their respective *mental health strategies*. Both *mental health strategies* defined mental health disorders according to the areas of life impacted by mental health problems or issues, rather than by specific diagnostic attributes (i.e., identification of specific illnesses).

Working definition. Members of FIRST recommended the term ‘Mentally Disordered Offender’ (‘MDO’) be defined as offenders with compromised mental health including those offenders diagnosed with a major mental disorder(s), substance use disorder(s), learning/developmental/cognitive disorder(s) including FASD, and all co-occurring disorder(s). While alcohol and drug dependence is recognized in DSM-IV, we acknowledge that FASD as yet, is unclassified. This definition would apply to adult and young persons at any stage of the criminal justice process in the forensic or legal context of being at risk, accused or convicted of a crime.

For the purpose of this study, the term of ‘MDO’ and/or ‘offenders with compromised mental health’ was used exclusively throughout this report.

Recommendation 3:

Need For Culturally-Relevant Forensic Programming

Members of FIRST recommend the ongoing and increased need for culturally-relevant forensic programming. Family and frontline respondents disclosed a lack of culturally-relevant forensic programming as a factor in the criminality or recidivism of Aboriginal offenders. Continued focus on cultural elements in relevant forensic services and community programming for indigenous offenders is needed to reduce recidivism and crime in the province. Cultural programming and the ongoing support and involvement of Elders, Aboriginal liaison officers, community representatives and Aboriginal organizations is viewed as key to closing the outcome gaps for First Nations, Métis and Inuit offenders (OCI, 2006b).

Recommendation 4:

Need for Increased Funding for Mental Health Promotion and Forensic Prevention, Intervention, and Treatment Services

Members of FIRST recommend that increased provincial funding is necessary, as correctional institutions are assuming a major role as ‘the healthcare provider’ for both mental health and physical health related conditions. Provincially, Saskatchewan has yet to make mental health a priority by allocating equitable financial resources from the health budget to address mental health concerns (Department of Health, 2002; Jacobs et al., 2008; 2010). A major theme that emerged from the interviews with family respondents was the lack of addictions or substance abuse treatment services for offenders upon release. In Saskatchewan, offenders have to ‘line up for services like everybody else.’ This points to the need for funding for adequate forensic mental health outpatient adult services in our province, which can only

be provided by a full team of forensic health care professionals, rather than relying solely on individual mental health professionals working on their own.

Therefore, funding for recruitment and retention of forensic mental health professionals is needed to support forensic specialty services as interventions in reducing recidivism and crime in the province, as well as to help improve the quality of care for offenders. Prevention of mental illness and mental health promotion is needed for at risk groups of those identified with mental health and substance use disorders prior to entering the criminal justice system. As indicated in the *Mental Health Strategy for Canada* (MHCC, 2012) treatment alone is not the total solution for better outcomes, society must also pay greater attention to the prevention and promotion of mental health and wellness on a national scale for all populations.

Recommendation 5

Need for Specialized Forensic Services in Saskatchewan

Members of FIRST advocate for specific specialized forensic mental health services needed in Saskatchewan. Therapeutic problem-solving courts established in other jurisdictions to address the disposition needs of offenders with mental health and substance use disorders have shown positive results (Schneider, 2010). Evidence-based research supports decreased recidivism and increased cost effectiveness (Rutherford & Duggan, 2007) in provinces with mental health courts, especially when combined with joint forensic outpatient programs to address the various placement needs of MDOs. The *Mental Health Strategy for Canada* (MHCC, 2012) addressed the “over-representation of people living with mental health illness and problems in the criminal justice system” (p. 46) as a priority with the following recommendation for action: “Increase the availability of programs to divert people living with mental health problems and illnesses from the corrections system, including mental health courts and other services and supports for youth and adults” (MHCC, 2012, p. 49, rec. 2.4.1). Prairies provinces to the east and west have either diversion mental health programs or mental health courts, and both Alberta and Manitoba have well established forensic outpatient service teams to address the needs of persons with compromised mental health involved in the criminal justice system. To date, Saskatchewan may be the only province without these specialized forensic mental health services.

Limitations of the Study

Missing in this research was input from offenders themselves. Due to the difficulty of interviewing offenders while in custody, it was determined that family members could provide the next best alternative. However, some of family member participants in their responses revealed they had themselves been in custody in the past, and provided rich data from both perspectives. Another limitation of this study was that survey data from some invited stakeholders was not attainable in the time limits of this study. Although some ministries were willing to participate, the project had timelines of data collection over a 12-18 month period to which to adhere.

Perceived Benefits of this Study and Implications for Social Policy

This needs assessment and E-scan of the provision of forensic mental health programming and service domains in Saskatchewan based on the criminogenic needs of a

diverse mentally disordered offender population in Saskatchewan, was a necessary first step. We anticipate the report of this study will contribute to the general knowledge of forensic mental health and societal issues that are relevant to Saskatchewan and to the prairies with its unique set of social, geo-political, and cultural circumstances that constitute the region. Quality of service, gaps, barriers, and the need for programming and services were identified, the implications of which we hope will inform social policy to enable the maintenance, improvement, and addition of specialty services and programming toward aiding the social welfare of mentally disordered offenders. The benefits of which will ultimately accrue to the safety of public at large.

Conclusion

Our needs assessment study provided a broad description of the current status of the services and needs of the mentally disordered offender in Saskatchewan based on the needs identified by the participants in the study. Our three research questions were answered through the needs assessment and environmental scan of forensic mental health programs and services for offenders in Saskatchewan completed in 2012. Our research interviewed family members of offenders with compromised mental health and surveyed facility managers and frontline personnel to assess how mental health needs were being met by correctional facilities and forensic mental health services in Saskatchewan. The responses from some groups were overwhelming. Participants were eager to provide information based on their interaction with forensic clients with compromised mental health including addictions and substance use disorders. Front line personnel were forthright in expressing what they believed was needed to reduce crimes being committed by persons with mental health issues and addictions, alleviate the strain on mental health resources, provide better services to forensic clients, improve the quality of life for offenders and their families, and make their jobs easier and more rewarding as mental health, and justice professionals and staff. Interviews with family members of offenders comprised an additional rich data set concerning the issues affecting offenders with mental health issues and addictions throughout Saskatchewan. All respondents provided diverse opinions on what they saw as the contributing factors of criminal activity in their communities. They offered a snapshot in time of the ability of mental health programs and services currently available in our province to meet the needs of forensic clients with compromised mental health.

The first question asked: What are the needs of offenders with compromised mental health and how are they being met? Irrefutable evidence for some time has confirmed that increased numbers of mentally ill people are becoming involved in the criminal justice system (CSC, 2012; OCI, 2012) into a system that is neither conducive to their needs, nor is it providing adequate or timely assessment or treatment. The needs of the mentally ill were unfortunately not always being met in the community health and social welfare systems. As a result, the mentally ill are increasingly becoming deeply entangled in the criminal justice system and their problems are often compounded by substance abuse. Women and young offenders occupy the highest increases in prevalence rates and Aboriginal offenders are over represented in incarceration rates.

The second question asked: What are the mental health needs of Saskatchewan offenders and how are they currently being met? Our study found that the needs and issues of MDOs in Saskatchewan are similar to MDOs nationally, that identify increased numbers of Aboriginal women and Aboriginal youth. Although federal and provincial initiatives are in place to address the needs of MDOs, those multiple needs are exacerbated among Aboriginal offenders in general and Aboriginal women and youth in particular whose numbers in Saskatchewan are overrepresented in the criminal Justice system.

Family members of offender in our study stated that Aboriginal offenders with addictions, substance use disorders, and mental health issues are not accessing services equal

to their level of need in Saskatchewan. Through scanning, we found that a menu of mental health and addictions programs and services exist at the correctional and urban community level, but that a few problematic areas exist in the northern health regions that service predominantly Aboriginal communities this (i.e., lack of mental health and addictions services in La Loche and other Metis and Denesulin communities). In addition, Prince Albert Parkland was found to be severely lacking in professional resources (i.e., no permanent forensic psychiatrist or social workers).

Frontline personnel who engage Saskatchewan offenders believed Aboriginal offenders are not accessing services equal to their level of need because Aboriginal offenders are being released into some communities that are ill equipped to supervise offenders. Specifically, they described some northern communities as so 'dysfunctional', that this was actually leading to further substance use disorders and underlining criminality. Family members of offenders told us that upon release if all programs were made mandatory, their family members would have more success at following through.

The third and final question asked: What evidence-based forensic mental health services are currently needed in the province?

Our study identified gaps in services that need immediate action, as the needs of offenders with compromised mental are critical. Specialized forensic mental health services were identified as needed to meet the needs of MDOs in Saskatchewan. Specifically forensic outpatient services and therapeutic problem solving courts have been found to be effective in other Canadian provinces. Both family members of offenders and frontline personnel felt there was a need for mental health courts, that it was the next logical step, a form of social justice, and a good intervention if cultural components could be built into the structure, and if mental health treatment orders could be enforced.

The first question asked: What are the needs of offenders with compromised mental health and how are they being met? Irrefutable evidence for some time has confirmed that increased numbers of mentally ill people are becoming involved in the criminal justice system (CSC, 2012; OCI, 2012) into a system that is neither conducive to their needs, nor is it providing adequate or timely assessment or treatment. The needs of the mentally ill were unfortunately not always being met in the community health and social welfare systems. As a result, the mentally ill are increasingly becoming deeply entangled in the criminal justice system and their problems are often compounded by substance abuse. Women and young offenders occupy the highest increases in prevalence rates and Aboriginal offenders are over represented in incarceration rates.

The second question asked: What are the mental health needs of Saskatchewan offenders and how are they currently being met? Our study found that the needs and issues of MDOs in Saskatchewan are similar to MDOs nationally, that identify increased numbers of Aboriginal women and Aboriginal youth. Although federal and provincial initiatives are in place to address the needs of MDOs, those multiple needs are exacerbated among Aboriginal offenders in general and Aboriginal women and youth in particular whose numbers in Saskatchewan are overrepresented in the criminal Justice system at rates of 35 times that of the general population.

Family members of offender in our study stated that Aboriginal offenders with addictions, substance use disorders, and mental health issues are not accessing services equal

to their level of need in Saskatchewan. Through scanning, we found that a menu of mental health and addictions programs and services exist at the correctional and urban community level, but that a few problematic areas exist in the northern health regions that service predominantly Aboriginal communities this (i.e., lack of mental health and addictions services in La Loche and other Metis and Denesulin communities). In addition, Prince Albert Parkland was found to be severely lacking in professional resources (i.e., no permanent forensic psychiatrist or social workers).

Frontline personnel who engage Saskatchewan offenders indicated that Aboriginal offenders are not accessing services equal to their level of need because Aboriginal offenders are being released into some communities that are not adequately prepared to help them. Family members of offenders told us that upon release if all programs were made mandatory, their family members would have more success at following through. Both family members of offenders and Frontline staff felt there was a need for a mental health court.

The third and final question asked: What evidence-based forensic mental health services are currently needed in the province?

Our study identified gaps in services that need immediate action, as the needs of offenders with compromised mental are critical. Specialized forensic mental health services were identified as needed to meet the needs of MDOs in Saskatchewan. Specifically forensic outpatient services and mental health courts have been found to be effective in other Canadian provinces.

Members of FIRST recognized that every effort must be made to prevent the criminalization and incarceration of persons who commit offences due to mental health issues and addictions. Resolving this problem goes far beyond provincial and federal mandates; it requires significant investments in prevention and diversion. Provincial and federal governments must work together and invest in, together with community partners, a system based on mental health promotion, prevention and early detection and access to care and quality treatment in the community. This approach recognizes that the correctional environment is not ideal for treating offenders with mental health issues and addictions. However, when incarceration is considered the appropriate response to the crime and as necessary for ensuring public safety, FIRST firmly believes that action must be taken for the rehabilitation of offenders with compromised mental health and for the implementation of a range of programs to ensure their successful reintegration in the community.

8.0 REFERENCES

References

- American Academy of Psychiatry and the Law. (2012). *Definition of mentally disordered offender*. Retrieved from <http://www.aapl.org>
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm-iv-tr>
- Andrews, D. A., & Bonta, J. (2003). *The psychology of criminal conduct* (3rd ed.). Cincinnati, OH: Anderson Publishing.
- Arboleda-Florez, J. (2009). Mental patients in prisons. *World Psychiatry, 8*(3), 187-189. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2755284/>
- Athabasca Health Authority. (2011). *Athabasca health authority: Healthy people, healthy land, annual report 2011*. Black Lake: Athabasca Health Authority. Retrieved from http://www.athabascahealth.ca/images/reports/AHA2011_Web.pdf and <http://www.athabascahealth.ca/>
- Bonta, J. (2000). Offender Assessment: General issues and considerations. *Forum on Corrections Research, 12*(2), 14-18.
- Bouchard, F. (2004). A health care needs assessment of federal inmates in Canada. *Canadian Journal of Public Health, 95*(Suppl. 1), S49.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101. Retrieved January 11, 2007, from http://science.uwe.ac.uk/psychology/DrVictoriaClarke_files/ThematicAnalysis%20.pdf.
- Brien, A. H. (2004, Dec 10). *Saint John mental health court: A program of the Provincial Court of New Brunswick*. Annual Report (with Cumulative Summary for 4year period ending November 19, 2004). Retrieved from <http://www.mentalhealthcourt-sj.com/annualreport1.html>
- Brink, J. H., Doherty, D., Boer, A. (2001). Mental disorder in federal offenders: A Canadian prevalence study. *International Journal of Law & Psychiatry, 4*(5), 339-356.

Bronskill, J. (2010, Dec 15). MPs urge 'serious' money for mental health to keep ill people out of prison. *The Canadian Press Dec 15, 2010*. Retrieved from <http://www.680news.com/news/national/article/157192--mps-urge-serious-money-for-mental-health-to-keep-ill-people-out-of-prison>

Canadian Association for Suicide Prevention. (2009). *The CASP National Suicide Prevention Strategy*. Retrieved from <http://www.suicideprevention.ca/blueprint>

Canadian Broadcasting Corporation News. (2010a, November 10). *Judge amplifies mental health court call*. CBC News. Manitoba. Retrieved from <http://www.cbc.ca/news/canada/manitoba/story/2010/11/10/mb-mental-health-court-winnipeg.html>

Canadian Broadcasting Corporation News. (2010b, October 12). *No jail for fetal alcohol sufferers: Lawyers*. Retrieved from http://www.cbc.ca/canada/british-columbia/story/2010/10/12/bc-fsa-bar-association-resolution.html?ref=rss&loomia_si=t0:a16:g2:r1:c0.0683389:b38304852

Canadian Broadcasting Corporation News. (2011a, August 31). *John Howard worker no longer at Saskatoon jail*. Retrieved from <http://www.cbc.ca/news/canada/saskatchewan/story/2011/08/31/sk-john-howard-1108.html>

Canadian Broadcasting Corporation News. (2011b, June 7). *Manitoba creates mental health court*. With files from the Canadian Press. Retrieved from <http://www.cbc.ca/news/canada/manitoba/story/2011/06/07/mb-mental-health-court-manitoba.html>

Canadian Broadcasting Corporation News. (2012a, Mar 23). Aboriginal history must factor in sentences, Supreme Court says. *The Canadian Press*.

Canadian Broadcasting Corporation News. (2012b, March 19). Canada urged to segregate elderly prisoners By Alison Crawford, *CBC News*. Retrieved from <http://www.cbc.ca/news/world/story/2012/03/19/f-crawford-aginginmates.html>

Canadian Broadcasting Corporation News. (2012c, April 30). *Jail overcrowding could get worse, warns Sask. Ombudsman*. *CBC News*.

Canadian Broadcasting Corporation News. (2012d, May 9). *Mental health court set to open in*

Winnipeg. Files from the Canadian Press. Retrieved from <http://www.cbc.ca/news/canada/manitoba/story/2012/05/09/mb-mental-health-court-manitoba.html>

Canadian Broadcasting Corporation News (2012e, October 23). *Suicide attempts, self-harm rising in Canada's prisons: Aboriginal offenders account for 45% of all incidents, ombudsman's report finds* (by Kathleen Harris). CBC News. Retrieved from <http://www.cbc.ca/news/politics/story/2012/10/23/pol-prisoner-self-injury-ombudsman.html>

Canadian Institute for Health Information (CIHI) (2008). *Improving the health of Canadians: Mental health, delinquency and criminal activity*. Ottawa: Author. Retrieved from http://www.cmha.ca/data/1/rec_docs/1771_mh_crime_full_report_apr11_08_e.pdf

Canadian Institute for Health Information. (2009). *Mentally healthy communities: Aboriginal perspectives*. Ottawa: CIHI.

Canadian Institute for Health Information (CIHI). (2011). *Health Indicators Interactive Tool 1996-2011*. Retrieved from <http://www.cihi.ca/CIHI-ext-portal/internet/en/applicationfull/health+system+performance/indicators/health/cihi011641>

Canadian Mental Health Association. (2004). Backgrounder: Justice and mental health. Citizens for Mental Health. Retrieved from <http://www.cmha.ca/citizens/justice.pdf>

Canadian Mental Health Association (Ontario). (2008, September). *Police and mental illness*. Retrieved from <http://www.ontario.cmha.ca/justice.asp?CID=5441>

Canadian Mental Health Association (CMHA). (2010a, October 28). *OCI reviews CSC's mental health strategy*. Mental Health Notes

Canadian Mental Health Association. (2010b). *New mental health court in Sault Ste. Marie*. Retrieved from http://www.ontario.cmha.ca/mental_health_notes_story.asp?CID=562206

Canadian National Committee for Police/Mental Health Liaison. (2008.). *How would you know?* Retrieved from <http://www.pmhl.ca/en/how.html>

Cockerham, W. (2011). *Sociology of mental disorder*. Upper Saddle River, NJ: Pearson

Cohen, B. (2008). Population health promotion models and strategies. In L. Leeseberg Stamler, & L. Yiu (Eds.), *Community health nursing: A Canadian perspective* (2nd ed., pp. 93-110). Toronto, ON: Pearson Prentice Hall.

- Calverly, D. (2010). Adult correctional services in Canada: Component of Statistics Canada catalogue no. 85-002-X. *Juristat*, 3, 3. Ottawa: Statistics Canada.
- Chaimowitz, G. (2012). The criminalization of people with mental illness. Position paper of the Canadian Psychiatric Association. *Canadian Journal of Psychiatry*, 57(2), Insert 1-6. Retrieved from <http://publications.cpa-apc.org/media.php?mid=1268>.
- Conway, J. (2003). *Executive summary Saskatchewan mental health sector study final report. Prepared for the mental health workforce in Saskatchewan*. Saskatoon: Saskatchewan Health.
- Constitution Act, 1982, section 35(2)*. Section 2 of the Canadian Constitution.
- Constitution Act, s.92*
- Cooper, T., & Neary, C. (2007, December 6). London's mental health court: An unfortunate necessity. Crime and Therapy: London's Mental Health Court. *News Media Journalism. Faculty of Information and Media Studies [FIMS]*, University of Western Ontario. Retrieved from <http://www.fims.uwo.ca/NewMedia2008/group1.aspx>
- Corrections and Conditional Release Act (CCRA)*. In Statutes of Canada. (S.C. 1992, c. 20). Retrieved from <http://laws.justice.gc.ca/en/C-44.6>.
- Correctional Service Canada. (2002). *The 2002 Mental health strategy for women offenders*. Ottawa: Author. Prepared by J. Laishes. Retrieved from <http://www.csc-scc.gc.ca/text/prgrm/fsw/mhealth/toc-eng.shtml>.
- Correctional Service Canada. (2004, July). *A needs assessment of federal Aboriginal women offenders*. Retrieved from <http://www.csc-scc.gc.ca/text/rsrch/reports/r156/r156-eng.shtml>
- Correctional Service Canada. (2006). *The Corrections and Conditional Release Statistical Overview - Annual report for 2006*. Ottawa: Author.
- Correctional Service Canada. (2007a, August 7). Addressing mental health needs of offenders. *Let's Talk*. 32(1). Retrieved from http://www.csc-scc.gc.ca/text/pblct/lt-en/2007/32-1/pdf/32-1_e.pdf
- Correctional Service of Canada. (2007b). *Correctional Service of Canada 2006 – 2007 performance report*. Ottawa, ON: Author.
- Correctional Service Canada. (2007c). CSC launches a comprehensive mental health strategy. A continuum of care. *Lets Talk*, 32(1). Retrieved from <http://www.csc-scc.gc.ca/text/pblct/lt-en/2007/32-1/2-eng.shtml>

- Correctional Service Canada. (2007d). *Strategic plan for human resource management, 2007-2010*. Retrieved from http://www.csc-scc.gc.ca/text/pblct/sphrm07_10/message-eng.shtml
- Correctional Service Canada. (2009a, July 2). *Aboriginal community development in corrections. Demographic overview of Aboriginal peoples in Canada and Aboriginal offenders in federal corrections*. Retrieved from <http://www.csc-scc.gc.ca/text/prgrm/abinit/know/10-eng.shtml>
- Correctional Service Canada. (2009b). *Computerized mental health intake screening system (CoMHISS): National guidelines*. Ottawa: Author.
- Correctional Service Canada. (2009c, June). *Correctional programs: Correctional program descriptions*. Reintegration Programs Division: Ottawa. Retrieved from http://www.csc-scc.gc.ca/text/prgrm/cor-pro-2009-eng.shtml#_Toc231830444
- Correctional Service Canada. (2009d, January). *Evaluation report: Correctional Service Canada's correctional programs*. Evaluation Branch, Retrieved from <http://www.csc-scc.gc.ca/text/pa/cop-prog/cop-prog-eng.pdf>
- Correctional Service Canada. (2009e, July 13). *Families of offenders*. Retrieved from <http://www.csc-scc.gc.ca/text/fami/definition-eng.shtml>
- Correctional Service Canada. (2009f). *Institutional mental health service (Primary Care) Guidelines*. Ottawa: Author.
- Correctional Service Canada. (2009g, August 13). Investigating suicide. *FORUM on Corrections Research*. Retrieved from <http://www.csc-scc.gc.ca/text/pblct/forum/e043/e043e-eng.shtml>
- Correctional Service Canada. (2009h). *National strategy to address the needs of offenders who engage in self-injury*. Ottawa: Author.
- Correctional Service Canada. (2009i). *The changing federal offender population: Highlights 2009*. Research Branch. Ottawa: CSC.
- Correctional Service Canada. (2010a, January). *Aboriginal corrections*. Quick facts. Retrieved from www.csc-scc.gc.ca/text/pblct/qf/pdf/01-eng.pdf
- Correctional Service Canada. (2010b, November). *Mental health strategy*. Quick Facts. Ottawa: CSC. Retrieved from <http://www.csc-scc.gc.ca/text/pblct/qf/11-eng.shtml>
- Correctional Service Canada. (2010c, July). *Preliminary results from the women's self-*

- injurious behaviour study*. Ottawa: CSC.
- Correctional Service Canada. (2010d, December). *Self-injury incidents in CSC Institutions over a thirty-month period* (December, 2010). Ottawa: CSC.
- Correctional Service Canada. (2010e, December). *Towards a continuum of care: Correctional Service Canada Mental Health Strategy*. Retrieved from http://www.csc-scc.gc.ca/text/pblct/health/tcc-eng.shtml#_Toc267041272
- Correctional Service Canada. (2010f, July) *Twenty years later: Revisiting the task force on federally sentenced women* (July, 2010). Ottawa: CSC.
- Correctional Service Canada. (2011a, October). *Health services sector 2010-2011 Performance measurement report* (October, 2011). Ottawa: CSC Ottawa: CSC.
- Correctional Service of Canada. (2011b). *History of the Canadian Correctional System*. Retrieved from www.csc-scc.gc.ca/education/media/pdf/ha-student-etudiant-eng.pdf
- Correctional Service of Canada. (2011c, April 15). *National facility directory*. Retrieved from <http://www.csc-scc.gc.ca/text/region/nat-fac-dir-eng.shtml#p1>
- Correctional Service Canada. (2011d, July). *Preliminary results from the men's self-injurious behaviour study*, (July, 2011). Ottawa: CSC.
- Correctional Service Canada. (2011e). *Significant findings from national investigations into inmate suicides 2006-2010*. Ottawa: Author.
- Correctional Service Canada. (2012a, April) *Aboriginal offenders – A statistical analysis* (Program referrals comparing offenders by risk and need, April 2011). Ottawa: Author.
- Correctional Service of Canada. (2012b, April). *Monthly population count* (April 2012). Ottawa: Corporate Reporting System.
- Correctional Service Canada. (2012c, April). *National report on exemptions to Commissioner's directive 550* (covering period April 1, 2012 to July 31, 2012), (dated April 2012). Ottawa: CSC.
- Correctional Service of Canada. (2012d). *Reports*. Retrieved from <http://www.csc-scc.gc.ca/text/rsrch/reports/rprts-eng.shtml>
- Correctional Service Canada. (2012e, February). *Review of mental health screening at intake – internal audit* (February, 2012). Ottawa: CSC.
- Council of State Governments (CSG). (2005, May). *A guide to mental health court*

design and implementation. New York: Author. Retrieved from <http://www.consensusproject.org/mhcourts/Guide-MHC-Design.pdf>

Courts of Saskatchewan. (2012). Retrieved from <http://www.sasklawcourts.ca/>

Department of Health. (2002). *Business plan. Priorities of 2002-03*. Retrieved from http://www.gov.ns.ca/health/reports/.../DOH_Business_Plan_2002_03.pdf

Esbensen, F. A., Peterson, D., Taylor, T. J., & Freng, A. (2009). Similarities and differences in risk factors for violent offending and gang membership. *Australian and New Zealand Journal of Criminology*, 42,1–26.

Fahey, L., King, W. R., & Narayanan, V. K. (1981). Environmental scanning and forecasting in strategic planning: The state of the art. *Long Range Planning*, 14(1), 32-39.

Fahey, L., & Narayanan, V. K. (1986). *Macroenvironmental analysis for strategic management (The West Series in Strategic Management)*. St. Paul, MN: West Publishing Company.

Federal-Provincial-Territorial Partners. (2007, June). *Working group on chronic offenders Final Report*. Ottawa: Department of Justice.

Federal-Provincial-Territorial (FPT) Ministers Responsible for Justice. (2010, December). *A Framework for a Corrections Mental Health Strategy for Canada*. Building Wellness Along the Continuum of C.A.R.E.: Creating Access to Resources for Everyone.

Federal-Provincial-Territorial (FPT) Partnership. (2012). *Mental health strategy for corrections in Canada*. Retrieved from www2.gnb.ca/.../corrections/MentalHealthStrategyForCorrectionsInC...

Findlay, I. M., & Wier, W. (2004). *Aboriginal justice in Saskatchewan: 2002-2021: The benefits of change. A report presented to the commission on First Nations and Métis peoples and justice reform*. Saskatoon.

First, M. B., Frances, A., & Pincus, H. A. (2004). *DSM-IV-TR guidebook*. Washington, DC: American Psychiatric Pub.

Friedli, L. I., & Parsonage, M. (2009). *Promoting mental health and preventing mental illness: The economic case for investment in Wales*. Cardiff, Wales: All Wales Mental Health Promotion Network. Retrieved from <http://www.publicmentalhealth.org/Documents/749/Promoting%20Mental%20Health%20Report%20%28English%29.pdf>.

Government of Manitoba. (2012, April 10). Province announces mental health court to begin in

May: Expanded mental-health services help make problem-solving court possible: Ministers. *News Release – Manitoba*. Retrieved from <http://news.gov.mb.ca/news/index.html?archive=2012-04-01&item=13634>

Government of Saskatchewan. (1995). *North Battleford forensic unit opens*. News release March 16, 1995. Retrieved from <http://www.gov.sk.ca/news?newsId=aa63639c-c311-4f30-804f-467aef7047ca>

Government of Saskatchewan. (2003). *Response to the provincial ombudsman special report: Inmate services and conditions of custody in Saskatchewan correctional centres*. Corrections and Public Safety. Regina.

Government of Saskatchewan (2005a). *2006–2007 Saskatchewan provincial budget performance plan: Saskatchewan corrections and public safety*. Regina: Queen's Printer. Retrieved from <http://www.finance.gov.sk.ca/performance-planning/2006-07/CorrectionsAndPublicSafetyPerformancePlan0607>

Government of Saskatchewan. (2005b, June). *Healthy choices in a healthy community: A report on substance abuse, prevention and treatment services in Saskatchewan* by Graham Addley. Retrieved from http://www.health.gov.sk.ca/fs_substanceabuse_addley.pdf.

Government of Saskatchewan. (2005c, August). *Premier's project hope: Saskatchewan's action plan for substance abuse*. Saskatchewan Health. Retrieved from http://www.health.gov.sk.ca/fs_090205_projecthope.htm

Government of Saskatchewan. (2010). *Community program profile 2009-2010*. Ministry of Health. Regina: Queen's Printer.

Government of Saskatchewan. (2011a). *Aboriginal peoples*. Retrieved from <http://www.gov.sk.ca/Default.aspx?DN=d35c114d-b058-49db-896a-4f657f5fd66e>

Government of Saskatchewan. (2011b). *Annual report 2011-2012*. Ministry of Correction, Public Safety, and Policing. Regina: Queen's Printer. Retrieved from <http://finance.gov.sk.ca/PlanningAndReporting/2011-12/201112CPSPAnnualReport.pdf>

Government of Saskatchewan. (2011c). *Plan for 2011-2012*. Ministry of Correction, Public Safety, and Policing. Regina: Queen's Printer. Retrieved from <http://finance.gov.sk.ca/Default.aspx?DN=69e7c0ed-6e18-4090-8420-35c670e97d17>

Government of Saskatchewan. (2012a). *Adult correctional facilities*. Ministry of Justice, Corrections. Retrieved from <http://www.justice.gov.sk.ca/Default.aspx?DN=60b466f2-9a2f-4562-a56b-77854dc2a160>

- Government of Saskatchewan. (2012b). *Adult corrections services*. Ministry of Justice, Corrections. Retrieved from <http://www.justice.gov.sk.ca/adultcorrections>
- Government of Saskatchewan. (2012c). *Correctional centres*. Ministry of Justice, Corrections. Retrieved from <http://www.justice.gov.sk.ca/Default.aspx?DN=dcd54f68-a604-4c08-aa5b-c393c8dcc20a>
- Government of Saskatchewan. (2012d). *List of municipal police services in Saskatchewan*. Ministry of Justice, Policing and Community Safety Division. Retrieved from <http://www.justice.gov.sk.ca/PCS-List>
- Government of Saskatchewan (2012e). *Institutional operations*. Ministry of Correction, Public Safety, and Policing. Regina: Queen's Printer. Retrieved from <http://www.justice.gov.sk.ca/Default.aspx?DN=9ccc19a2-c504-4cfe-ae2-478891a82ff8>
- Government of Saskatchewan. (2012f). *Plan for 2012-2013. Ministry of corrections, public safety, policing*: Regina: Queen's Printer. Retrieved from <http://finance.gov.sk.ca/PlanningAndReporting/2012-13/CSPPlan1213.pdf> and <http://finance.gov.sk.ca/PlanningAndReporting>
- Government of Saskatchewan. (2012g). *Young offenders*. Ministry of Justice, Corrections. Retrieved from <http://www.cpsp.gov.sk.ca/default.aspx?DN=156e0094-39b6-4c95-90e0-32f6fca0c81b>
- Government of Saskatchewan. (2012h). *Young offenders services*. Ministry of Justice, Corrections. Retrieved from <http://www.justice.gov.sk.ca/Default.aspx?DN=2d8dceb5-7363-4edb-a230-6002a75fad3d>
- Government of Saskatchewan. (2012i). *Young offender services strategic plan*. Ministry of Justice, Corrections. Retrieved from <http://www.justice.gov.sk.ca/YO-Stratplan>
- Harris, K. (2012, October 23). Suicide attempts, self-harm rising in Canada's prisons: Aboriginal offenders account for 45% of all incidents, ombudsman's report finds. *CBC News*. Retrieved from <http://www.cbc.ca/news/politics/story/2012/10/23/pol-prisoner-self-injury-ombudsman.html>
- Hartford, K., Carey, R., & Mendonca, J. (2007). Pretrial court diversion of people with mental illness: Literature review. *The Journal of Behavioral Health Services & Research*, 34(2), 198-205.

- Health Canada. (2011). *Drug and alcohol use statistics: Highlights from the 2011 report: Major findings from the Canadian alcohol and drug use monitoring survey (CADUMS) 2011*. Ottawa: Queens Printer. Retrieved from <http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/index-eng.php>
- Jacob, J. D. (2012). The rhetoric of therapy in forensic psychiatric nursing. *Journal of Forensic Nursing*, (epub ahead of print)
Doi 10.1111/j.1939-3938.2012.011
- Jacobs, P., Dewa, C., Lesage, A., Vasiliadis, H., Escobar, C., Mulvale, G., & Yim, R. (2010). *The cost of mental health and substance abuse services in Canada*. Edmonton, AB: Institute of Health Economics. Retrieved from <http://www.ihe.ca/documents/Cost%20of%20Mental%20Health%20Services%20in%20Canada%20Report%20June%202010.pdf>.
- Jacobs, P., Yim, R., Ohinmaa, A., Eng, K., Dewa, C., Bland, R. ... Slomp, M. (2008). Expenditures on mental health and addictions for Canadian provinces in 2003/04. *Canadian Journal of Psychiatry*, 53(5), 306-313. Retrieved from <http://publications.cpa-apc.org/browse/documents/339>
- Juristat (2005). Returning to correctional services after release: A profile of Aboriginal and non-Aboriginal adults involved in Saskatchewan Corrections from 1999/00 to 2003/04. Canadian Centre for Justice Statistics. Statistics Canada.
- Kent-Wilkinson, A. (2010). Psychiatric mental health forensic nursing: Responding to social need. *Issues in Mental Health Nursing*, 31, 425-431.
DOI: 10.3109/01612840903506444
- Latimer, J., & Lawrence, A. (2006). *The Review Board Systems in Canada: An overview of results from the mentally disordered accused data collection study*. Report rr06-1e. Ottawa, Justice Canada, Research and Statistics Division. Retrieved from http://www.justice.gc.ca/eng/pi/rs/rep-rap/2006/rr06_1/rr06_1.pdf
- Leschied, A. (2011). The treatment of incarcerated mentally disordered women offenders: A synthesis of current research. *Corrections Research: User Report* (August, 2011). Ottawa: Government of Canada Publications. Retrieved from http://publications.gc.ca/collections/collection_2011/sp-ps/PS3-1-2011-3-eng.pdf
- Lightfoot, L. O., & Hodgins, D. (1988). A survey of alcohol and drug problems in incarcerated Canadian offenders. *International Journal of the Addictions*, 23(7), 687-706.
- Lightfoot, L. O., & Hodgins, D. (1993). Characteristics of substance abusing offenders: Implications for treatment programming. *International Journal of Offender Therapy & Comparative Criminology*, 37(3), 239-250.

- Livingston, J. D. (2006). A statistical survey of Canadian forensic mental health inpatient programs. *Healthcare Quarterly*, 6(2), 56–61. Retrieved from <http://www.longwoods.com/publications/healthcarequarterly>
- Livingston, J. D. (2009, March). *Mental health and substance use services in correctional settings: A review of minimum standards and best practices*. Vancouver: International Centre for Criminal Law Reform and Criminal Justice Policy. Retrieved from http://www.icclr.law.ubc.ca/files/2009/Mental_Health.pdf
- Makin, K. (2010, November 17). Mentally ill offenders swamping prisons. *Globe and Mail*.
- Mann, M. (2009, November 13). *Good intentions, disappointing results: A progress report on federal Aboriginal corrections*. Ottawa: Office of the Correctional Investigator. Retrieved from <http://www.oci-bec.gc.ca/rpt/oth-aut/oth-aut20091113-eng.aspx>
- McGuire, J. (2000). Can the criminal law ever be therapeutic? *Behavioral Sciences & the Law*, 18(4), 413-426.
- Mental Health Commission of Canada. (2009). *Toward recovery and well-being: A framework for a mental health strategy for Canada*. Retrieved from http://www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507_MHCC_EN_final.pdf
- Mental Health Commission of Canada (MHCC). (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Calgary, AB: Author. Retrieved from <http://www.mentalhealthcommission.ca/English/Pages/Strategy.aspx>
- Motiuk, L. & Nafekh, M. (2000). Aboriginal offenders in federal corrections: A profile. *Forum on Corrections Research* 12, 10-15.
- Moulton, D. (2007, June 1). *Mental health courts gain popularity across Canada*. [The Lawyers Weekly](http://www.lawyersweekly.ca/index.php?section=article&articleid=484). ZAA Legal Recruitment. Retrieved from <http://www.lawyersweekly.ca/index.php?section=article&articleid=484>
- Odgers, C. L., Burnette, M. L., & Chauhan, P., & Reppucci, N. D. (2005). Misdiagnosing the problem: Mental health profiles of juvenile offenders. *Canadian Academy of Child and Adolescent Psychiatry Review*, 14, 26-29.
- Office of the Correctional Investigator. (2006a, June 30). *33th Annual report 2005/06*. Ottawa: Author. Retrieved from <http://www.oci-bec.gc.ca/rpt/annrpt/annrpt20052006-eng.aspx>

Office of the Correctional Investigator. (2006b, June 30). *Backgrounder: Aboriginal Inmates - The numbers reveal a critical situation*. Retrieved from <http://www.oci-bec.gc.ca/rpt/annrpt/annrpt20052006info-eng.aspx>

Office of the Correctional Investigator (OCI). (2008, June 26). *Annual Report 2007-2008. 35th Anniversary Office of the Correctional Investigator 1973-2008*. The Correctional Investigator Canada. Retrieved from <http://www.ocibec.gc.ca/rpt/annrpt/annrpt20072008-eng.aspx>

Office of the Correctional Investigator, (2009a, November 7). *Annual report 2008-09*. Ottawa: Author. Retrieved from <http://www.oci-bec.gc.ca/rpt/annrpt/annrpt20082009-eng.aspx>

Office of the Correctional Investigator. (2009b, November 13). *Good intentions, disappointing results: A progress report on federal Aboriginal corrections*. Ottawa: Author. Retrieved from <http://www.oci-bec.gc.ca/rpt/oth-aut/oth-aut20091113-eng.aspx>

Office of the Correctional Investigator. (2010a, November 5). *Annual report 2009-10*. Ottawa: OCI. Retrieved from <http://www.oci-bec.gc.ca/rpt/annrpt/annrpt20092010-eng.aspx>

Office of the Correctional Investigator. (2010b, September 23). *Report finds serious gaps in the planning and delivery of mental health services for federally sentenced offenders*. Retrieved from <http://www.oci-bec.gc.ca/comm/press/press20100923-eng.aspx>

Office of the Correctional Investigator. (2010c, September 23). *Under warrant: A review of the implementation of the Correctional Service of Canada's 'mental health strategy'*. Prepared by John Service. Retrieved from <http://www.oci-bec.gc.ca/rpt/oth-aut/oth-aut20100923-eng.aspx>

Office of the Correctional Investigator. (2012a, June 26). *Annual Report of the Office of the Correctional Investigator 2011-2012*. Ottawa: OCI. Retrieved from <http://www.oci-bec.gc.ca/rpt/annrpt/annrpt20112012-eng.aspx>

Office of the Correctional Investigator. (2012b, November 29). *Index of annual reports*. Retrieved from <http://www.oci-bec.gc.ca/rpt/index-eng.aspx>

- Ogloff, J. R. P., Davis, M. R., & Somers, J. M. (2004). *Mental disorder, substance use, and criminal justice contact: A systematic review of the scholarly literature*. For Ministry of Health Services, Government of British Columbia. Retrieved from http://www.google.ca/search?q=Mental+disorder%2C+substance+use%2C+andcriminal+justice+contact%3A++A+systematic+review+of+the+scholarly+literature&sourceid=ie7&rls=com.microsoft:en-us:IE-SearchBox&ie=&oe=&redir_esc=&ei=zkiYULiUG-fziQKUoIG4Dg
- Ogloff, J. R. P., Davis, M. R., & Somers J. M. (2005). *Mental disorders, substance use, and criminal justice contact: A systematic review of the literature*. British Columbia Ministry of Health Services.
- Ombudsman Saskatchewan. (2002). *Locked out: Inmate services and conditions of custody in Saskatchewan correctional centres*. Regina: Provincial Ombudsman. Retrieved from <http://www.ombudsman.sk.ca/uploads/document/files/lockedout-en.pdf>
- Ontario Court of Justice. (2006). *Ontario Court of Justice: Annual Report*. Retrieved from <http://www.ontariocourts.on.ca/ocj/en/annualreport/2005.pdf>
- Ontario Courts. (2007). *Mental Health Court Toronto, Old City Hall*. Retrieved from http://www.ontariocourts.on.ca/ontario_court_justice/mentalhealth/index.htm
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.
- Public Safety Canada. (2008). *Corrections and conditional release statistical overview, 2008*. Retrieved from <http://www.securitepublique.gc.ca/res/cor/rep/2008-04-ccrso-eng.aspx#b6>
- Public Safety Canada. (2009). *Corrections and conditional release statistical overview: Annual Report 2009*. Portfolio Corrections Statistics Committee. Ottawa: Author. Retrieved from http://www.publicsafety.gc.ca/res/cor/rep/_fl/2009-ccrso-eng.pdf
- Public Safety Canada. (2011). *Corrections and conditional release statistical overview: Annual Report 2011*. Corrections Statistics Committee. Ottawa: Author.
- Reviere, R., Berkowitz, S., Carter, C.C., & Ferguson, C.G. (1996). *Needs assessment: A creative and practical approach for social scientists*. Washington, DC: Taylor & Francis.
- Royal Canadian Mounted Police. (2011). *About the RCMP*. Retrieved from <http://www.rcmp-grc.gc.ca/about-ausujet/index-eng.htm>

- Royal Canadian Mounted Police. (2012). *Saskatchewan detachments*. Retrieved from <http://www.rcmp-grc.gc.ca/sk/detachs/index-eng.htm>
- Rutherford, M., & Duggan, S. (2007, September). Forensic Mental Health Services: Facts and figures on current provision. *The Sainsbury Centre for Mental Health*. London: The Sainsbury Centre for Mental Health.
- Saskatchewan Learning & Saskatchewan Health. (2003, January). *Saskatchewan mental health sector study final report*. Retrieved from <http://www.health.gov.sk.ca/mental-health-sector-study>.
- Schneider, R. D. (2010). Mental health courts and diversion programs: A global survey. *International Journal of Law and Psychiatry*, 33, 201-206.
- Schneider, R. D., Bloom, H., & Heerema, M. (2007). *Mental health courts*. Toronto: Irwin Law.
- Service, J. (2010). *Under warrant: A review of the implementation of the Correctional Service of Canada's 'Mental Health Strategy.'* Ottawa: Office of the Correctional Investigator of Canada. Retrieved from <http://www.oci-bec.gc.ca/rpt/oth-aut/oth-aut20100923-eng.aspx>.
- Smetanin, P., Stiff, D., Briante, C., Adair, C., Ahmad, S., & Khan, M. (2011). *The life and economic impact of major mental illnesses in Canada: 2011 to 2041*. Risk analytica, on behalf of the Mental Health Commission of Canada.
- Spitzer, R. L., & Wilson, P. T. (1975). Nosology and the official psychiatric nomenclature. In A. Freedman & H. Kaplan (Eds.), *Comprehensive textbook of psychiatry*. New York: Williams & Wilkins.
- Standing Committee on Public Safety and National Security. (2010). *Mental health and drug and alcohol addiction in the federal correctional system*. K. Sorenson (Chair). 40th Parl., 3rd sess. Parliament of Canada, House of Commons. Retrieved from <http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=4864852&Language=E&Mode=1&Parl=40&Ses=3>
- Standing Senate Committee on Social Affairs, Science and Technology.. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Report of the Standing Senate Committee on Social Affairs, Science and Technology. M. J. L. Kirby (Chair) & W.J. Keon (Deputy Chair). 38th Parl., 1st sess. Parliament of Canada, Senate. Retrieved from <http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/rep02may06-e.htm>

- Statistics Canada. (2003a, January 21). Aboriginal peoples of Canada: A demographic profile. 2001 Census: Analysis series. Census of population data released January 21, 2003. Retrieved from <http://www.statcan.ca>
- Statistics Canada. (2003b). *Special study on mentally disordered accused and the criminal justice system*. Canadian Centre for Justice Statistics. (No. 85-559-XIE).
- Statistics Canada. (2005). *Projections of the Aboriginal populations, Canada, provinces and territories 2001 to 2017*. Ottawa, Statistics Canada.
- Statistics Canada. (2006a). 2006 Census: Aboriginal peoples in Canada in 2006: Inuit, Métis and First Nations, *2006 Census: Findings*. Retrieved from <http://www12.statcan.gc.ca/census-recensement/2006/as-sa/97-558/index-eng.cfm>
- Statistics Canada. (2006b). *Aboriginal people over-represented in Saskatchewan's prisons*. Retrieved from http://www41.statcan.ca/2006/2693/ceb2693_002-eng.htm
- Statistics Canada. (2008). *Aboriginal peoples in Canada in 2006: Inuit, Metis and First Nations, 2006 Census*. Ottawa, Statistics Canada.
- Statistics Canada. (2009a). *An investigation into the feasibility of collecting data on the involvement of adults and youth with mental health issues in the criminal justice system*. [By M. Sinha]. *Crime and Justice Research Paper Series 85-561-M Vol. 2009 no. 16*. Canadian Centre for Justice Statistics, Retrieved from <http://www.statcan.gc.ca/pub/85-561-m/85-561-m2009016-eng.htm>
- Statistics Canada. (2009b). Executive Summary. *An investigation into the feasibility of Collecting data on the involvement of adults and youth with mental health issues in the criminal justice system*. [By M. Sinha]. *Crime and Justice Research Paper Series 85-561-M Vol.2009 no. 16*. Canadian Centre for Justice Statistics. Retrieved from <http://www.statcan.gc.ca/pub/85-561-m/2009016/summary-sommaire-eng.htm>
- Statistics Canada. (2009c). Section A: Overview of issues - Mental health and the criminal justice system: *An investigation into the feasibility of collecting data on the involvement of adults and youth with mental health issues in the criminal justice system*. [By M. Sinha]. *Crime and Justice Research Paper Series 85-561-M Vol. 2009 no. 16*. Canadian Centre for Justice Statistics. Retrieved from <http://www.statcan.gc.ca/pub/85-561-m/2009016/section-a-eng.htm>
- Statistics Canada. (2009d). Section B: Results of consultations and options for future data collection. *An investigation into the feasibility of collecting data on the involvement of adults and youth with mental health issues in the criminal justice system*. [By M. Sinha]. *Crime and Justice Research Paper Series 85-561-M Vol. 2009 no. 16*. Canadian

Centre for Justice Statistics. Retrieved from <http://www.statcan.gc.ca/pub/85-561-m/2009016/section-b-eng.htm>

Statistics Canada. (2009e). Appendix 3 Feasibility study- Consultation document. *An investigation into the feasibility of collecting data on the involvement of adults and youth with mental health issues in the criminal justice system*. [By M. Sinha]. *Crime and Justice Research Paper Series 85-561-MVol. 2009 no. 16*. Canadian Centre for Justice Statistics. Retrieved from <http://www.statcan.gc.ca/pub/85-561-m/2009016/app-ann/app-ann3-eng.htm>

Statistics Canada. (2011a). *Canada population estimates*. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/110622/t110622a2-eng.htm>

Statistics Canada. (2011b). *Mortality, summary list of causes: 2008*. (Statistics Canada catalogue No. 84F0209X). Retrieved from <http://www.statcan.gc.ca/pub/84f0209x/84f0209x2008000-eng.pdf>.

Statistics Canada. (2012). *Census profile, 2011 Census- Population and growth rates*. Retrieved from <http://www12.statcan.gc.ca/census-recensement/2011/rt-td/index-eng.cfm>

Statistics Canada (2012, March). *Population projections by Aboriginal Identity in Canada 91-552-X*. Ottawa: Author. <http://www.statcan.gc.ca/pub/91-552-x/2011001/meth-eng.htm>

Teplin, L. A. (1990). The prevalence of severe mental disorder among urban jail detainees: Comparison with the epidemiologic catchment area program. *American Journal of Public Health, 80*, 663 -669.

Teplin, L. A., Abram, K. M. & McClelland, G. M. (1994). Does psychiatric disorder predict violent crime among released jail detainees? A six-year longitudinal study. *American Psychologist, 49*, 335-342.

Trevethan, S., Moore, J.P., & Rastin, C.J. (2002). A profile of Aboriginal offenders in federal facilities and serving time in the community. *Forum on Corrections Research, 14*(3), 17-19.

United Nations. (2007). *The millennium development goals report - the United Nations*. Retrieved from www.un.org/millenniumgoals/pdf/mdg2007.pdf

University of Saskatchewan. (2010). *Forensic centre proposal*. Forensic Behavioural Sciences and Justice Studies (FBSJS) Initiative. Saskatoon, SK.

University of Saskatchewan. (2011a). *Annual report 2010-2011*. Centre for Forensic Behavioural Sciences and Justice Studies (CFBSJS). Saskatoon, SK: U of S.

- University of Saskatchewan. (2011b). *Centre for Forensic Behavioural Sciences and Justice Studies, Centre website*. Saskatoon, SK: U of S. Retrieved from <http://www.artsandscience.usask.ca/fbsjs/>
- University of Saskatchewan. (2012). *Annual report 2011-2012*. Centre for Forensic Behavioural Sciences and Justice Studies (CFBSJS). Saskatoon, SK: U of S
- Vogel, L. (2010). Pan-Canadian strategy being developed to tackle mental health in prisons. *CMAJ*, 182(18). doi: 10.1503/cmaj.109-3722. Retrieved from <http://www.cmaj.ca/content/182/18/E819.full>
- Wexler, D. B. (2000). Therapeutic jurisprudence: An overview. *Thomas M. Cooley Law Review*, 17, 125-134,
- Wexler, D. B. (2008). *Rehabilitating lawyers: Principles of therapeutic jurisprudence for criminal law practice*. Durham, NC: Carolina Academic Press.
- Whonnock, K. (2008, April). *Aboriginal courts in Canada*. Scow Institute. Retrieved from http://www.scowinstitute.ca/library/documents/Aboriginal_Courts_Fact_Sheet.pdf
- Wilson-Bates, F. (2008). *Lost in transition: How lack of capacity in the mental health system is failing Vancouver's mentally ill and draining police resources*. Vancouver, Vancouver Police Department.
- Woods, J. (2011, August 22). Sask. jails 'recipe for disaster': Crowded facilities get worse. *The Star Phoenix*, A1-A2. Retrieved from <http://www.thestarphoenix.com/news/saskatoon/Sask+jails+recipe+disaster/5287245/story.html>
- World Health Organization. (2010). *Social determinants of health*. Retrieved from http://www.wpro.who.int/health_topics/social_determinants/
- Wormith, J. S. & Luong, D. (2007). Legal and psychological contributions to the development of corrections in Canada. In R. Ax and Fagan, T. (Eds.), *Corrections, mental health, and social policy: International Perspectives* (pp. 129-173). Springfield, IL: Charles C. Thomas & Ltd.