# Diversion Project for People with Concurrent Disorders

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# Diversion Project for People with Concurrent Disorders

**Research Team Members**

Principal Investigator

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Co-Investigators

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# Advisory Panel Membership

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| Nancy Black | Manager Addiction Services and Community Mental Health Programs St. Joseph's Care Group ,Thunder Bay |
| Anne Bowlby | Ontario Ministry of Health & Long-Term Care |
| Vikki German | Ontario Ministry of Health & Long-Term Care |
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# Research Questions

1. What barriers to diversion have researchers and others identified for PCD? Conversely what conditions/strategies encourage optimal access?

2. What are the constituents of effective diversion programs, including skills and competencies of service providers?

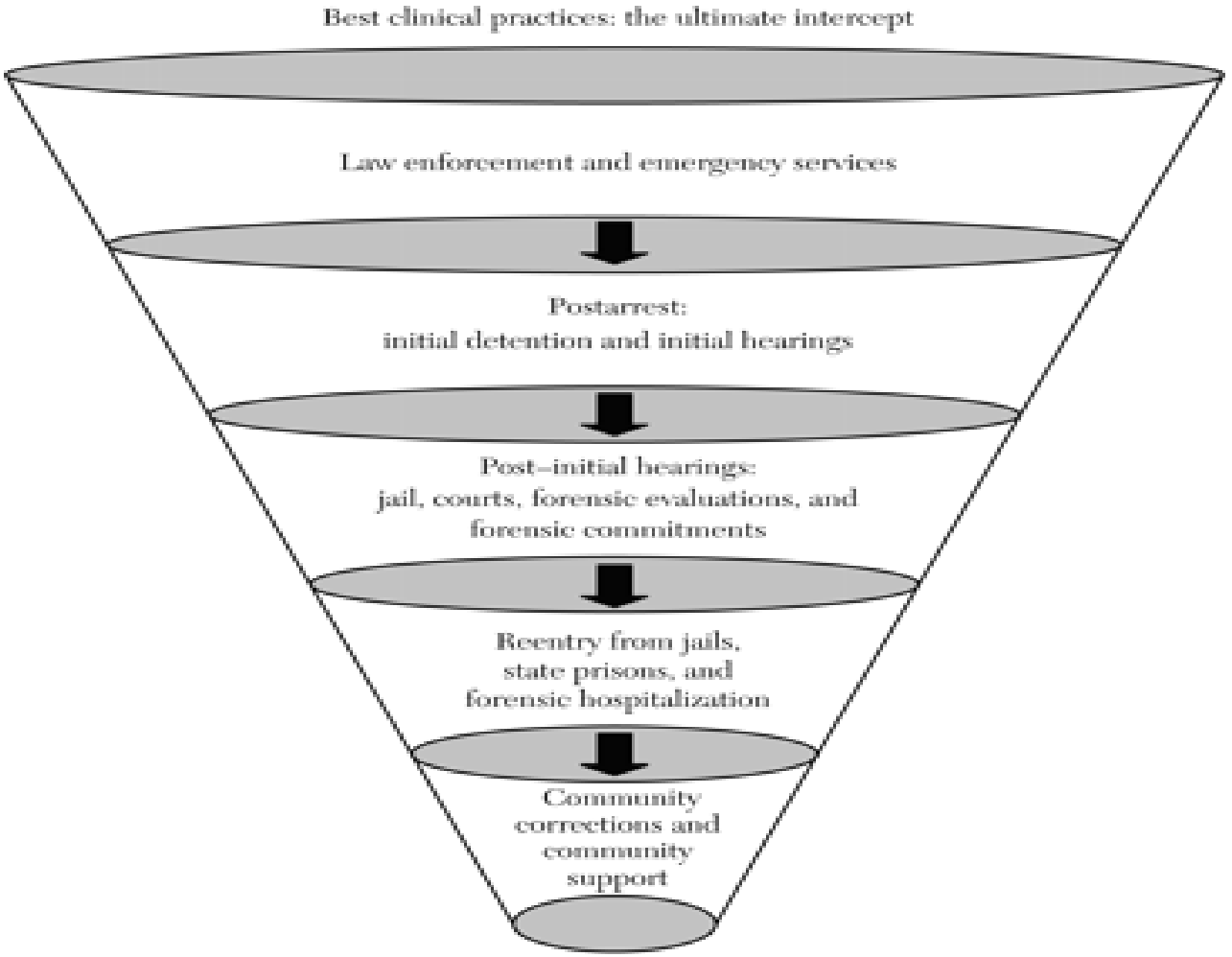
3. What criteria should be used to assess the appropriateness, effectiveness and outcomes?

# Methods

Sequential Intercept Model as a framework, From "Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness," by M. Munetz & P. Griffin, 2006, *Psychiatric Services,* 57, p. 544.

***Figure 1***

The Sequential Intercept Model viewed as a series of filters



# Methods

1. Literature review including both published & grey literature;
2. Inquiries to provincial mental health departments,
3. Site visits, & key informant interviews with major organizations, & courts identified in literature as especially innovative or effective.

# Methods - Literature Review

Databases & internet resources searched. Investigators assigned literature corresponding to areas of expertise.

Standardized literature appraisal tool used to assess:

- research methods,
- number & measures of data,
- author's findings,
- intercept point and
- conceptual or methodological problems.

## Perspective of Co-investigator, P. Aharan - Personal

- - Initially, overwhelming. Wanted to contribute, but work as ED of St. Leonard's conflicted
- - Personally, I missed reading about jail and probation issues: out of scope
- + Awareness of prevalence of CD & treatment modalities
- + Awareness of policy implications …reallocation of funds to better address needs of PCD

## Perspective of Co-investigator, P. Aharan - Agency

- To introduce change in an organization need to change hiring practices and promote in-service, cross-training in CD
- Assess all clients for CD
- Position own agency at bail hearings where residential conditions, treatment conditions, medication compliance are part of bail and, if successful, could lead to adjournment & court diversion...stay of charges.

# Perspective of Co-investigator, P. Aharan – Chair HSJCC

- Disseminate finding of report widely
- Expand membership to SA providers
- Set goals to achieve consensus

# Methods - Site Visits, Phone Interviews Mail Contacts

- Based on literature, interview/observation guide developed
- Site visits to courts in Canada, U.S., queries to provincial governments, and phone interviews with major organizations, agencies & courts identified in literature as innovative or effective were conducted to obtain 'real world' practices & problems

# Methods - Qualitative Analyses

Site visits & phone interviews audio-taped, transcribed & qualitatively analyzed according to:

- Topics in the observation guide
- Interviewees perspective of three questions

# Findings

Prevalence of CD: High

- **General Population**: 29% substance use disorders in PMI, versus 16% (Reiger et al., 1990)
- OMHS, 18.6% of general population (Offord et al., 1996) CD.
- 55% with alcohol disorder had MI (Ross, 1995)

- **Criminal Justice Population:** 5% of jail detainees and 13% of prison inmates estimated (National Gains Centre, 1997)
- 80% of male detainees at Cook County (Abram & Teplin, 1991)
- 80% of probationers (Hiller et al., 1996)

# Findings

- The efficacy of integrated treatment for PCD is supported by the literature, yet integrated treatment is seriously deficient in the community.
- The lack of a formal system of integrated mental health and SA treatment in community-based treatment is a major barrier to the establishment and success of diversion programs.

# Integrated Treatment

- Same clinicians/teams working in one setting provide coordinated MH & SA interventions (Ridgely, Goldman & Willenbring, 1990).
- Integration accomplished through multidisciplinary teams: include both MH & SA specialists who share responsibility for treatment & cross-training (Carey 1996; Drake, Mercer-McFadden, Mueser, McHugo & Bond, 1998)
- Must be supported and sustained by a **common administrative structure** as well as **confluent funding streams** (Mercer, Mueser & Drake, 1998).
- Result for PCD: Services appear **seamless**, with consistent approach, philosophy & set of recommendations; the **need for PCDs to negotiate with separate systems, providers, or payers disappears** (Mueser & Drake, 2000).

# Barriers -Systemic

'Lack of coordination' between MH & CJ systems = access to treatment unavailable or not optimal

Treatment provided not integrated

Multiple funding streams, raising accountability issues & adding to infrastructure costs

Lack of funding for program sustainability = lack of long-term services

Staff attitudes & acceptance of ICDT

# Barriers - Situational

- Lack of Services (e.g. transportation, housing, employment opportunities, forensic MH professionals, etc.)
- Lack of Leadership, key to consensus building & streamlining of programming
- Lack of professional & public knowledge/awareness of CD; (generally) public's preference for jail over treatment
- Lack of evaluation data to track demographic, clinical & CJ variables

# Barriers - Personal/Familial

- Stigma/isolation
- Resistance/Denial/Recidivism ('revolving door' issues), all having implications for the development of outcome measures
- Lack of awareness
- Family Problems
- Dearth of culturally-based or gender-based services

# Barriers-Assessment/Identification

- Logistics of dual record keeping
- Confidentiality mandates/legislative 'limitations'
- Standards & Instruments:
  - develop program's own screening & assessment tools?
  - how/where to access those that already exist?
  - what to screen for & purposes and parameters of screening?
- Lack of on-going & cross-training of staff

# Key themes

| | |
|---|---|
| Systematic planning-inter agency government collaboration | Information sharing among agencies |
| Streamlined funding to support planning and evaluation | Culturally sensitive, gender-based services |
| Early case finding with standardized tools | Cross-training of staff |
| Availability of seamless range of integrated services | Assessment of program fidelity |
| Evaluation using uniform data elements | Expansion of diversion for felony offences |

# Recommendations -Overarching

1. Inter-ministerial, system-wide approach is necessary to develop & fund provincial-wide ICDT services.

Recognition that CDs are chronic, relapsing diseases be made operational:

(a) abstinence not eligibility criterion for admission;

(b) harm reduction is short & intermediate-term goals;

(c) consequences for using/abusing should be modified & matched to stages of change;

(d) relapse an opportunity to re-engage with services.

## Recommendations - Overarching

2. Policy frameworks be developed by OMHLTC in which required elements of diversion for PCD are articulated & technical assistance is provided to facilitate implementation.

3. Consensus on identification & definition of outcomes of pre-charge and post-charge diversion programs is required for research studies & for monitoring programs.

## Recommendations - Overarching

4. Planning grants established by OMHLTC to enable local agencies to develop partnerships & that pre-established criteria which include sustained evaluation activities be used to evaluate the grant applications.

5. Boundaries for local HSJCCs, regional forensic programs, court jurisdictions, police services, etc. should be reviewed & plans for alignment be developed in PCD diversion programming.

## Recommendations - Overarching

6. OMHLTC CD diversion policy frameworks should include the constituent elements of culturally- and gender-based programming.

7. Synthesis reports of diversion for PCDs in jails, probation and post-release, and diversion for juveniles be commissioned.

## Recommendations - Pre-Arrest/Charge

1. Capacity for community-based withdrawal management beds be addressed to ensure that police cells are **not** used for PCDs in withdrawal.

2. That using planning grants, local police services & community MH agencies be encouraged to develop jail diversion plans for PCD; smaller detachments encouraged to forge regional partnerships. MOA required to formalize responsibilities, fiscal arrangements, monitoring, etc. between partners.

# Recommendations - Pre-Arrest/Charge

3. Police & diversion partners have regular meetings for case conferences from a systems' improvement enhancement viewpoint.

4. That planning grants to establish **monitored safe beds with priority for police** required in each community. PCD should be assessed, stabilized & linked with community services. The time that people with CD are allowed to stay in safe beds needs to be specified, e.g., 24-48 hours. Inclusion & exclusion criteria should be developed as well as staffing plans.

# Recommendations - Pre-Arrest/Charge

5. That changes to Section 33 of *The Mental Health Act* be made to allow deputizing of all hospital security personnel in Schedule I facilities for the purposes of retaining custody of PCD.

6. That the Janofsky & Tamburello study be replicated in Canada as it may have implications for police training & use of safe beds.

# Recommendations - Pre-Arrest/Charge

7. Signing of Advanced Directives for consent to release of information in specific circumstances, pending changes to privacy legislation, by PCDs be encouraged so that sharing of information between health & criminal justice systems can be enhanced.

# Recommendations - Post Charge Court Diversion

1. Public records of arrests released daily by police to community CD agencies. When client identified, agency should immediately visit with a view to ascertaining eligibility for court diversion.

2. That active case finding be supported by ensuring that court support workers have access to collateral information such as records of arrest, synopsis of alleged offense and other court documents.

## Recommendations - Post Charge Court Diversion

3. Cross training of CD court & community staff be conducted about eligibility criteria, process for court diversion, & liaison with diversion personnel.

4. Case finding by court support workers be encouraged by attendance at mental health docket bail hearings, through access to cells, liaison with duty and defence counsel, and liaison with remand centres, etc.

# Recommendations - Post Charge Court Diversion

5. Court diversion programs should develop bulletins /brochures that outline program for PCD (eligibility, services, etc.) & send to all lawyers & relevant court personnel.

6. Cross training for legal profession & court personnel on symptoms of CDs and pre-screening procedures be conducted to enhance the case ascertainment of PCDs eligible for diversion.

# Recommendations - Post-Charge Mental Health Court/Dockets

1. Planning grants & technical assistance available for courts to establish a MH docket in which dedicated judges & JPs preside, the frequency of which be based on volume of cases.

2. Cross training in mental illness for dedicated judges, JPs & court personnel be developed & delivered though basic workshops & web-based continuing education.

# Recommendations - Post-Charge Mental Health Court/Dockets

3. Ministry of Attorney General develop practice memorandum for establishment of serious indictable offence felony MH courts for PCD.

4. Planning grants & technical assistance be provided to courts & agencies for the establishment of MH courts for PCD.

5. All drug court clients be screened for CDs and those so diagnosed be referred to the Mental Health Court for integrated treatment of CDs.

# The End

- For full text of the report see:
- lhrionhealth.ca/research/hohsr/
- Or contact:
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