Summary Report on the *Evidence-Based Practices in Forensic Mental Health Programs and Services Project:* The Development of Standards, Benchmarks, and Performance Indicators

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Executive Summary

The project has compiled a critical synthesis of the world literature on Forensic Mental Health Programs and Services (FMHPS). This synthesis has been used to address the following key objectives: (1) to develop a conceptual framework to identify the criteria and factors that should be considered in the development of standards for evidence-based practice in all aspects of Forensic Mental Health Programs and Services in Ontario, including policy, planning, evaluation, funding, training, and clinical interventions; (2) to identify and assess the evidence base for rehabilitation and treatment of mentally disordered offenders; (3) to develop appropriate standards and benchmarks (including staffing and funding levels) for FMHPS; and (4) to recommend performance indicators for FMHPS.

An experienced multi-disciplinary team of investigators participated in the project. The research design had four elements: (1) a comprehensive literature search including focused telephone interviews with acknowledged experts in Canada, Australia, the United States and the United Kingdom; (2) a critical review and analysis of the literature; (3) the development of a discussion paper with preliminary findings that was reviewed and discussed at a workshop by a specialized reference group including a number of Directors of Forensic Programs in Ontario; and (4) the completion of a final report incorporating input from the reference group. The project was undertaken with a clear understanding of the Ontario mental health and criminal justice systems to assist the MOHLTC in its further development of policy as it relates to persons with serious mental illness who are in conflict with the law.

Introduction

The present report is a summary of the *Evidence-based Practices in Forensic Mental Health Programs and Services Project*. This summary report describes the project's purpose, its methodology, findings and recommendations. The project has resulted in a number of products. The proposed standards and performance indicators are included as appendices to the summary report. The extensive literature review and annotated bibliography, also products of this project, are presented separately due to space limitations in the present report. The proposed benchmarks are presented in detail as part of the literature review.

Forensic Mental Health Programs and Services in Ontario

In Ontario, according to the Forensic Mental Health Services Expert Advisory Panel (Ontario Ministry of Health and Long-Term Care, 2002), a forensic patient is a person with a serious mental disorder who is involved in the criminal justice system under the Mental Disorder Provisions (Part XX.1) of the Criminal Code of Canada (CCC). These individuals are either facing charges before a court and the question of mental disorder has been raised (an assessment or treatment order has been made), or they have been before a court and have been found (1) Not Criminally Responsible on Account of their Mental Disorder (NCR), or (2) Unfit to Stand Trial. Canada adheres to the legal principle that persons cannot be held accountable or punished for a crime when their serious mental disorder rendered them incapable of appreciating the nature and quality of their actions and of knowing that it was wrong (Section 16(1); CCC), or if they are incapable of mounting a legal defence at trial (Section 672.31; CCC). The definition distinguishes forensic patients from (1) accused persons facing criminal charges who are diverted to appropriate mental health care in the community, (2) persons with a mental disorder who receive a criminal sentence at trial and who serve a term of probation or incarceration, (3) persons with a mental disorder who are brought to hospital by the police after a disturbance or altercation and who are subsequently detained in hospital under the (civil) Mental Health Act, and (4) persons involved with the law who suffer from a personality disorder and/or substance abuse disorder but who do not have a serious mental disorder. Forensic Mental Health Programs and Services (FMHPS) are defined as those dedicated mental health programs and services that are provided to forensic patients. This definition of FMHPS is consistent with the way such services are defined in Ontario, funded by the MOHLTC, and provided by designated facilities and regional forensic programs in Ontario.

Project Scope and Context

The current project did not focus on Assessments of Fitness to Stand Trial or Criminal Responsibility. These assessments contribute to the legal process whereby mentally disordered accused become designated as forensic mental health patients. Instead, the project focussed on evidence-based practices, standards, and benchmarks for the mental health services that are provided to forensic mental health patients after they have been designated by law as requiring such services.

Further, the project was not intended to identify evidence-based practice, standards or benchmarks in the treatment of criminally sentenced offenders. These individuals are not part of the forensic mental health system and do not receive FMHPS. However, the proposed work did review the literature on evidence-based practice in the treatment and risk management of sentenced offenders to determine the appropriateness and potential for extension of such practices to FMHPS, especially where the evidence base was lacking in FMHPS. Additionally, the project was not intended to cover attempts to prevent the criminalization of the mentally ill. While we strongly support the prevention of criminal justice involvement by the mentally ill, and while many interventions reviewed as part of the project would no doubt be effective in preventing further criminal involvement by the mentally ill, coverage of this issue is beyond the scope of the present project.

The current project does not attempt to replicate a consideration of best practices in mental health. Rather, it considers best practices for those aspects of mental health services that are particular to the forensic mental health system. By restricting the focus of the project in this way, we are not suggesting that general mental health treatment and rehabilitation are not important in treating the forensic patient. Psychiatric treatment of the serious mental disorder and general mental health care are central to the treatment of the forensic patient.

A "Mental Health Accountability Framework" has been recently published in Ontario (Ontario Ministry of Health and Long Term Care, 2003), a document that provides valuable guidance with respect to appropriate performance domains and indicators in the evaluation of mental health services. While many aspects of the "Mental Health Accountability Framework" are applicable to FMHPS, this general accountability framework is incomplete as applied to FMHPS. Forensic programs differ from general mental health programs and services in the following aspect. Part XX.1 of the Criminal Code of Canada and subsequent case law point to forensic mental health patients as posing a threat to the safety of the public. In this regard, forensic mental health patients are distinguished from non-forensic mental health patients. While public safety concerns are present in general mental health services, they are not a central focus. In contrast, the assessment and management of the risk to public safety posed by forensic patients are defining features of FMHPS. Recidivism, whether it is of a general kind (e.g., theft) or of a more serious nature (e.g., sexual assault, murder), is of marked concern for those working in the forensic mental health system. There are implicit as well as explicit expectations that FMHPS will implement safeguards to prevent mentally disordered offenders from continuing to engage in criminal, especially violent, behaviour. According to Webster et al. (2000), 'risk management is the task of constructing social and physical environments that, in combination with knowledge of the individual's assets and liabilities, will likely lead to substantial reduction in violence potential.' (p. 127-128). Risk assessment and risk management principles will be integral in developing an appropriate accountability framework for FMHPS.

While risk management is central and critically important, FMHPS are also expected to provide a program of rehabilitation to the offender and to support their re-integration into the community. Such expectations are codified in the governing legislation. Section 672.54 of the CCC states that the court or board shall make the disposition that is the "least onerous and least restrictive to the accused" taking into account the four principles

enumerated in the section: (1) the need to protect the public from dangerous persons; (2) the mental condition of the accused; (3) the reintegration of the accused into society; and, (4) the other needs of the accused. In turn, the court or the Ontario Review Board (ORB) passes these expectations and directions on to the designated hospitals responsible for providing FMHPS. As part of ORB dispositions, the designated hospital is ordered to create a program for the detention in custody and rehabilitation of the accused person, taking into account the need to protect the public from dangerous persons, and the need to reintegrate the accused person into society.

Therefore, to be considered effective, FMHPS must balance the need to protect the public from the criminal acts of forensic patients on the one hand against the needs of the forensic patient for rehabilitation, community reintegration, and liberty on the other. FMHPS would be considered to be successful if they effectively rehabilitated the mentally disordered offender allowing for the person to be re-integrated into the community without recidivism or harm to the public. This suggests that performance indicators of FMHPS will include indicators of failure (criminal recidivism; violent re-offence) and indicators of success (patient release from in-patient custody to community living; discharges from the forensic mental health system).

The project focussed on the delivery of FMHPS. It did not discuss the merits of various forms of governance of FMHPS. However, where governance was seen to influence the delivery of FMHPS, relevant and appropriate comments concerning governance have been made. For example, a central issue in the governance issue has to do with whether or not FMHPS should be integrated into the more general (non-forensic) mental health system, or indeed, into the health care system considered more broadly, or whether FMHPS should be a stand alone system with little flow of patients from one set of services to another. Integration and co-ordination of health care services may be seen to have significant influence over the quality of care provided and received in FMHPS.

In January 2001, the Ontario Minister of Health and Long Term Care established the Forensic Mental Health Services Expert Advisory Panel. The Minister requested that the panel consider province-wide operational issues in the context of existing provincial and Ministry policies, and to advise government on a provincial strategy for the implementation of a comprehensive forensic mental health system. The advice was to cover: the inter-ministerial coordination of forensic services; the consolidation and clarification of existing provincial and Ministry forensic policies; and processes to improve services for forensic clients. The final report of the Expert Advisory Panel (Ontario Ministry of Health and Long-Term Care, 2002) has been released by the Minister of Health and Long Term Care, and is available on the MOHLTC website. The first author of the present project report (HB) was a member of this panel and a co-author of the report. The final report of the Panel has made 40 recommendations for the Minister's consideration. Although the final report and the panel's discussion made reference to evidence-based (best) practices and the establishment of standards and benchmarks in FMHPS, the final report did not go so far as to suggest what these practices and standards should be. The current project was not a duplication of the work of the panel but a logical extension of the panel's final report.

Method

The research project proceeded in 8 stages:
(1) Search of the published literature
(2) Identification of grey literature
(3) Preparation of an annotated bibliography
(4) Preparation of discussion document
(5) Expert Consultation
(6) Key Informant Interviews
(7) Preparation of "Evidence-based practices in FMHPS"
(8) Preparation of Final Summary with Recommendations

(1) Search of the published literature

The research team employed a systematic approach to identifying and appraising the international literature and research, both published and unpublished. A computer-assisted search of the various databases used in the formal academic literature in the mental health and criminal justice fields was conducted to identify evidence-based knowledge and policy reports related to FMHPS from 1990 to the present. The forensic mental health literature tends to be spread over a number of different disciplines and data bases. We included a search of the world's published literature using Medline (Medicine), PsychINFO (Psychology), the National Criminal Justice Reference Service (NCJRS) Abstracts (Criminology), and HMIC (a Health Management and Policy data base). This search was supplemented by a manual search of Reference Lists in the identified articles/reports. The literature survey was restricted to the English language literature and English documents. For each article identified, we rated its relevance to evidence-based practice in FMHPS and whether or not it provided empirical support for particular standards or practices.

(2) Identification of the grey (unpublished) literature

The literature search was further supplemented by focused telephone interviews with acknowledged experts in Canada, the United States, the United Kingdom, Australia and New Zealand, to elicit information about newer initiatives and studies or program manuals that may not yet have appeared in the literature. Our survey of the world's experts focussed on the English-speaking world (Canada, US, UK, Australia and New Zealand).

(3) Preparation of an annotated bibliography

Articles found to be relevant to the project were summarized and the article summaries were formatted in an annotated bibliography. The annotated bibliography is an important product of the current project. To our knowledge, there is no similar bibliography currently available. The bibliography will serve as an important resource for the MOHLTC and staff in the forensic system in carrying out recommendations made in the present report.

(4) Preparation of discussion document

The results of the review and analyses was synthesized and summarized in the form of a discussion paper that focussed on the following broad questions: (1) What qualities would

be desirable in a conceptual framework to guide the development of evidence-based best practices in FMHPS in Ontario? (2) What benchmarks, standards and performance indicators are appropriate and feasible to monitor and evaluate FMHPS? (3) What are the potential implementation challenges and what strategies are available to address them?

(5) Expert consultation

A small reference group of 20 individuals was convened to assist in further refining the findings. The members of the reference group were selected based on their knowledge of the current state of FMHPS in Ontario. The members were chosen from among the Forensic Program Directors in Ontario and members of the Forensic Expert Advisory Panel that had just previously submitted their report to the MOHLTC recommending changes to the forensic mental health system in Ontario, and members of the ORB. The reference group was asked to review the discussion paper and to attend a full-day workshop led by the project team.

(6) Key informant interviews

The expert consultation was further supplemented by focused telephone interviews with acknowledged experts in Canada, the United States, the United Kingdom, Australia and New Zealand, to elicit evaluative comments on the discussion paper that was subject of discussion by the reference group described above, and to review the recommendations made by the reference group at the conclusion of their day-long workshop, including draft statement of vision/mission/values/principles, standards and performance indicators.

(7) Preparation of document "Evidence Based Practices in FMHPS"

Information contained in the articles found in the literature search were carefully reviewed and analyzed, and a narrative literature review was written.

(8) Preparation of summary report with recommendations

The 7 steps described above were undertaken to inform the final summary (present) report. The final report incorporates feedback from the reference group and key informants. It includes a summary and discussion of our findings, conclusions, and assessment of the policy implications.

Findings

Our consideration and discussion of evidence-based practices in FMHPS was guided by two important frameworks. First, we required a conceptual framework to describe the elements of FMHPS and how they work together. Therefore, the project team developed a simple conceptual model to organize the concepts, processes and empirical evidence in FMHPS. Second, in the course of the project, it became apparent that best practices could not be determined entirely on the basis of the "objective" evidence-base. Evidence-based practices could not be discussed in a fully productive way without reference to subjective values and principles that guide, both explicitly and implicitly, varying approaches to clinical care and management of the forensic patient. This realization was made repeatedly as a result of questions and concerns posed by key informants, it arose in discussions with our local experts, and it became obvious during the development of performance indicators. The influence of values on evidence-based practices is widely recognized (APA Presidential Taskforce on Evidence-Based Practice, 2006). To meet this need, or to fill this gap, the project team wrote a draft statement of vision/mission/values/principles applicable to FMHPS. Then, the project team consulted our local panel of experts to further develop these draft statements. The international key informants were unanimously in favour of the final statement. With an appropriate process of consultation and confirmation, these statements could easily become the basis for official policy development in Ontario.

A Conceptual Framework for FMHPS

This project developed a conceptual model of FMHPS that captures the competing interests and concerns relating to risk management, rehabilitation, and community re-integration. The conceptual framework combines 4 dimensions, specifically: (1) static risk, (2) dynamic risk, (3) security restrictions, and (4) intervention/treatment.

The conceptual framework adopts the distinction between two general types of risk factors: static and dynamic. Static risk factors are variables statistically related to long-term recidivism that are either historical in nature (and thus cannot be changed with interventions) or else are features of the offender that are very unlikely to change over time. Static risk assessments are often accomplished using assessment instruments developed using an actuarial methodology. These actuarial assessments most often serve to identify high-risk individuals. The Violence Risk Appraisal Guide is perhaps the best known actuarial assessment instrument. It was developed in Ontario for this particular population (Quinsey, Harris, Rice, and Cormier, 1998).

Dynamic risk factors are also variables that are statistically related to recidivism but, importantly, these variables fluctuate over time. Dynamic risk factors are extremely important to FMHPS. First, they represent potential targets for treatment (Andrews & Bonta, 1998; Quinsey, Coleman, Jones & Altrows, 1997), and their identification can be used to design more effective treatment programs. Second, frequent assessments of dynamic predictors can be used to monitor offenders' fluctuating level of risk, particularly in the community where opportunities to re-offend are greatest. Changes in these measures may provide an indication of when an offender is more likely to re-offend violently. Vern

Quinsey and Brian Jones (Jones and Quinsey, 2002; Quinsey, Jones, Book and Barr (in press), in OMHF funded research, have developed a brief standardized Dynamic Risk Appraisal Scale for the detection of changes in level of risk for elopement and/or re-offending behaviour in the near-term for use in the context of FMHPS. On the basis of increased dynamic risk, treatment providers and caseworkers can intervene to prevent the patient's re-offence.

The conceptual framework combines risk assessment with security restrictions placed on forensic patients. Security restrictions are placed on forensic patients by hospitals and their staff with authority delegated to them by the jurisdictional authority (court or review board). These restrictions encompass the various levels of security in which FMHPS are provided, including in-patient (e.g., secure short-term assessment and treatment, medium-term rehabilitation, long-stay/maximum secure) and outpatient (e.g., day programs, family support, transitional community residential support, case management) programs and services. Within each level of security placement, security restrictions include the exercise of privileges provided by the ORB disposition, such as passes from the hospital unit to the community and the privilege to live in the community in approved accommodation. The conceptual framework posits a critical relationship between static and dynamic risk and restrictions placed on the forensic patient. For accused persons who are found to be higher in static risk, initial placement would normally be at higher levels of security and movement (cascading down) to lower levels of security would be slower and more carefully staged. Generally speaking, movements to lower levels of security would be keyed to reductions in dynamic risk.

Figure 1. Conceptual Framework Matrix

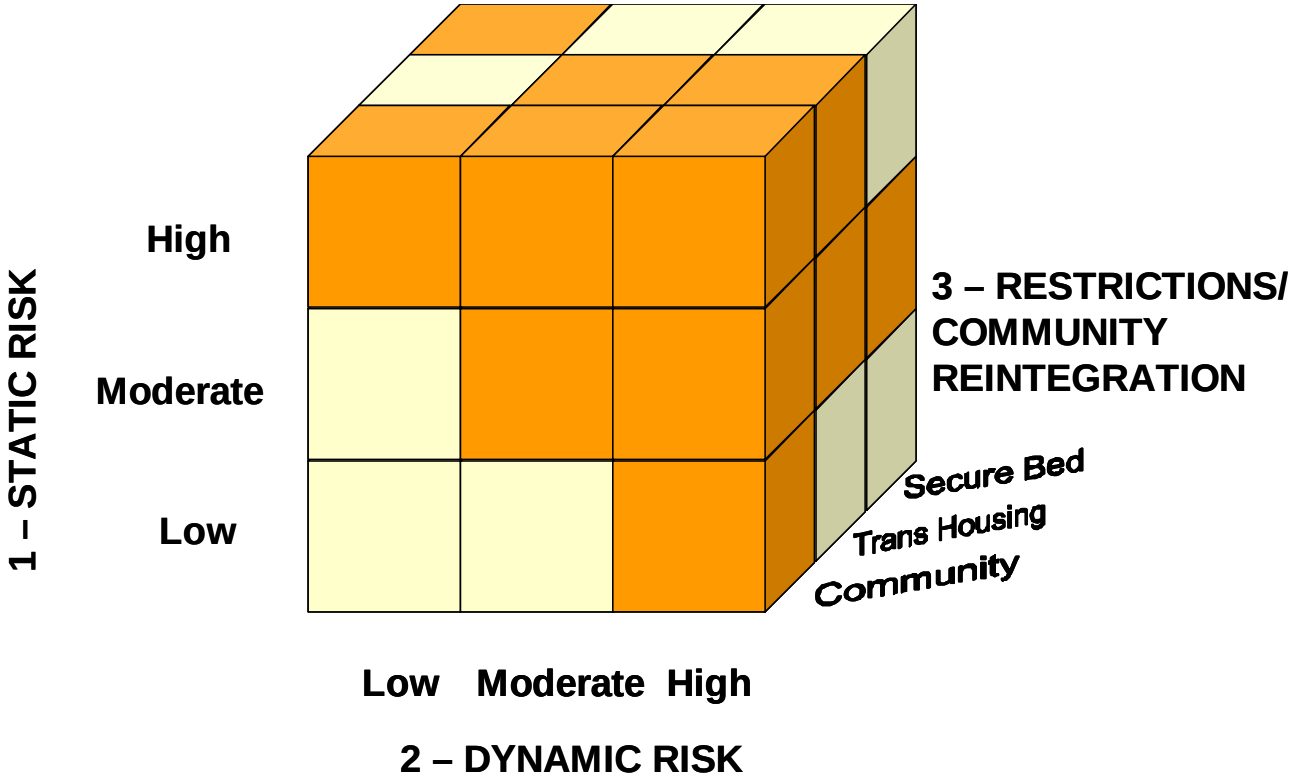

Figure 1 presents the first three dimensions of the conceptual framework in a matrix representation. Different shadings in the matrix illustrate when individuals of a particular risk may be detained or restricted. Low risk (static) individuals who are low-to-moderate risk in a dynamic sense, are maintained in the community. Low risk (static) individuals who are at high risk dynamically would be detained temporarily in transitional housing or on secure units in a hospital setting. When these individuals decrease in dynamic risk, they would be transferred back to community living. High risk individuals (static risk) who are also at high risk dynamically would be maintained in a secure hospital setting. When their dynamic risk is reduced, they may be transferred to transitional housing. As this model illustrates, generally speaking, when dynamic risk increases, greater restrictions are placed on the individual, and when dynamic risk decreases, restrictions are removed.

The fourth dimension of the model (not depicted in this figure) represents treatments and other interventions designed to facilitate the patient's community reintegration and safety. We distinguish between two kinds of treatment. First, treatment can be used in an attempt to reduce behaviors that threaten the safety of the public. These behaviors may include: aggression and problems in institutional management, criminal propensities, substance abuse, and sexual deviance. Second, treatment can be used to enhance protective factors. Protective factors include skills of daily living, social skills, vocational skills and leisure activities. Finally, when the patient have been discharged from hospital to community, FMHPS can intervene to enhance the community resources required to successfully re-integrate forensic patients into the community. These resources include: housing, income, employment, social support, and access to leisure activities.

For initial direction in the development of our conceptual model, we turned to conceptual models extant in the field of correctional psychology. Andrews, Bonta, and their colleagues (e.g., Andrews & Bonta, 1998; Andrews, Zinger, Hoge, Bonta, Gendreau and Cullen, 1990) proposed three central principles that will be useful for identifying relevant evidence-based practices in FMHPS: the Risk Principle, the Needs Principle, and the Responsivity Principle. The Risk Principle states that levels or intensity of intervention should be proportional to the level of risk of the offender in question. Higher risk individuals receive higher intensity intervention. The Needs Principle holds that in order to reduce the risk of re-offence, rehabilitative programs should concentrate on variables known to be associated with a higher probability of re-offence that could be changed with deliberate intervention (i.e., dynamic risk factors). The Responsivity Principle holds that treatment should be delivered in a form that is sensitive to the special strengths and weaknesses of the accused person. These principles link the assessment process with treatment and, in turn, with different outcomes. They have proved very important both for understanding criminal recidivism and for designing treatment programs for offenders within the correctional system that are effective in lowering recidivism rates. These three principles are central to our conceptualization of FMHPS. A more detailed description of our conceptual model will be found in *Evidence-based Practices in FMHPS.*

Vision, Mission, Values and Principles

The project team drafted these statements which were reviewed by our expert consultants and key informants. The final statements incorporate feedback and suggestions from these experts. The statement of vision, mission, values and principles (VMVP) is presented in Appendix I.

Annotated Bibliography and Literature Review

As a result of our development of a conceptual model to guide the work, as a result of our development of a statement of values to place practice in context, and owing to our consultation with experts, we are now in a position to present our findings. The findings are the foundation for a number of project products, including: (1) An annotated bibliography for FMHPS, (2) a review of the literature providing the evidence base for FMHPS. As a major effort related to this project, we have written a detailed review of the literature entitled, *Evidence-based Practices in Forensic Mental Health Programs and Services*. The world's literature (both published and unpublished) was reviewed searching for documents relating to program standards and evidence-based practices in FMHPS. All aspects of FMHPS were included in the review, including: policy, planning, evaluation, funding, training, and clinical interventions. The review searched for any documents relating to the development and/or evaluation of forensic mental health service benchmarks (including staffing and funding levels), including any mechanisms used to monitor and evaluate these initiatives including program standards, benchmarks and performance indicators.

The document contains the following chapters:

1. Introduction to Forensic Mental Health
2. The Legal Framework and Jurisdictional Authority
3. Risk Assessment and Management: From Prediction to Prevention
4. Hospital-Based Programs and Services
5. Community-Based Programs and Services
6. Forensic Mental Health Treatment and Rehabilitation

This literature review will serve as an important resource for the MOHLTC and staff in the forensic system in carrying out recommendations made in the present report. Based on the literature review, key informant interviews, and expert consultation, we are now in a position to present the additional essential project products relating to FMHPS, namely: (3) standards, (4) benchmarks and (5) performance indicators.

Standards

We have developed 8 standards in this project and they are presented in Appendix II. These standards rely heavily on the conceptual framework presented above. Three of the standards are relevant to risk assessment, 2 to risk management, and 3 to treatment.

Benchmarks

The project team has enlisted the help and assistance of Dr. John Hirdes from the University of Waterloo. Dr. Hirdes is one of the developers of the RAI-MH. Dr. Hirdes has collected substantial data using the RAI in Ontario mental health and hospital settings, including both forensic and non-forensic inpatient facilities. Dr. Hirdes and his colleagues have developed a case-mix model to account for costs relating to human resources in inpatient units. Dr. Hirdes has agreed to work with the project team to develop benchmarks for staffing and funding levels for forensic programs and services using his case-mix model. Dr. Hirdes is a co-author of Chapter 5 of the literature review on Hospital-based Programs and Services, which presents our proposed benchmarks.

Performance Indicators

Our proposed quality indicators are presented in tabular form in two formats. In Appendix III, we present our preferred format of presentation. In this table, indicators are organized in a matrix format in which indicator domains are presented along the vertical table axis and the measurement domain is presented along the horizontal axis. In Appendix IV, we present the indicators conforming to the Balanced Scorecard format. The indicators presented here were developed on the basis of the previously developed and presented products of this project (conceptual framework, standards, and VMVP) and reviewed and evaluated by our expert panel.

Project Recommendations

1. It is recommended that the Ministry of Health and Long-Term Care strike an implementation planning group comprised of the Directors of Forensic Programs in the province of Ontario together with selected other members with a wide range of expertise to conduct a strategic implementation exercise that will draw upon the findings and recommendations of this project. The task group would develop an implementation plan for the forensic mental health system in Ontario.

As part of the implementation planning process, it is recommended that:

2. The provincial forensic mental health system adopt a common statement of vision, mission, values and principles. The current project has developed a draft statement as a first phase for this exercise. See Appendix I.
3. The provincial forensic mental health system adopt a common set of standards covering the issues of risk assessment, risk management, and treatment/rehabilitation. The current project has developed a draft set of standards to inform this exercise. See Appendix II.
4. The provincial forensic mental health system adopt a common set of benchmarks with respect to bed numbers and staffing complements for all levels of inpatient security and outpatient services. Recommendations concerning these benchmarks are contained in the Literature Review produced as part of the current project.
5. The provincial forensic mental health system adopt a common set of performance indicators. A draft set of key indicators has been developed as part of the current project. These indicators are presented in Appendices III and IV. Appendix III presents a matrix of indicator domains combined with measurement domains, and Appendix IV presents the performance indicators in the format of the Balanced Scorecard.

Authors Note

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Additionally, the project team would like to express sincere gratitude to the Ontario experts who met for a one day workshop to provide advice and guidance and feedback on the discussion paper. The quality of the project was greatly enhanced by their thoughtful discussion and cogent arguments. The Ontario experts who contributed included: Jim Allin, Ron Ballantyne, Michael Chan, Jack Ellis, Russ Fleming, Ian Hector, Brian Jones, Peter Kennedy, Phil Klassen, Martin Lalumiere, Lynn Lightfoot, Richard Schneider, Michael Seto, Bob Sheppard, Steve Southmayd, Ruth Stoddart, Melody Upshaw, Janice Van de Vooren, and Chris Webster.

Finally, the project team would like to express its appreciation to various unnamed members of the Law and Mental Health Program at the Centre for Addiction and Mental Health who have participated in various project presentations and discussions. Their contributions are greatly appreciated.

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Appendix I: Statement of Vision, Mission, Values and Principles

Vision

FMHPS provide effective treatment and safe community re-integration of all forensic patients using evidence-based practices. FMHPS help patients to achieve and maintain optimal quality of life while protecting public safety.

Mission

Forensic mental health programs in Ontario will fulfill this vision and provide consistent, high quality services to all patients through the following activities:

Managing the Dual Responsibilities of Safe Management and Client-Centered Care

- Implementing best-practice assessment and clinical care of all forensic patients

- Providing evidence-based treatment of psychiatric, mental health and medical problems designed to meet the individual needs of each forensic patient

- Treating and managing all forensic patients at all times in the least restrictive and least onerous circumstances with respect to level of security, restrictions, and privileges considering the need to protect the safety of the public, the patient's current mental status, the need to re-integrate the patient into the community, and any other needs of the patient

- Offering interventions to support the forensic patient's community re-integration, including:

    a. assistance in obtaining housing
    b. encouragement of family support and involvement
    c. encouragement and support for vocational training and educational upgrading
    d. assistance in obtaining employment

- Ensuring re-integration of the forensic patient into the non-forensic mental health system at the earliest possible occasion

- Offering a core set of multi-disciplinary services (risk assessment, risk management, and treatment) at all levels of security (maximum security to community living)

- Providing state-of-the-art ongoing assessment and treatment of behaviours that threaten the safety of the public (substance abuse, anger, anti-social attitudes, beliefs and thinking, sexual deviance) of all forensic patients

- Ensuring day-to-day awareness of the level of risk posed by each forensic patient in the program informed by state-of-the-art risk assessment methodologies

- Implementing evidence-based risk management practices with all forensic patients

- Complying with all requirements set out in the Ontario Review Board dispositions of all forensic patients

- Implementing a quality improvement process that identifies opportunities for improvement in the delivery of services and evaluates outcomes using performance indicators relevant to the prevention of re-offence and quality of life of the forensic patient

- Providing services in a cost-effective and efficient manner

Community Service

- Partnering with other local and provincial forensic mental health services in the development of an optimally effective forensic mental health system

- Partnering with community, patient, family, legal and other advocate groups to continuously improve the quality of care and services provided to forensic patients

- Partnering with community agencies, non-forensic mental health care professionals and other advocate groups to prevent the criminalization of the mentally ill by promoting diversion of the mentally ill from the criminal justice system, where possible

Education and Training

- Recruiting and employing program staff in all of the mental health care disciplines (psychiatry, nursing, psychology, social work, occupational therapy, recreational therapy, and security) who have appropriate background and training to prepare them for work in the program and personal characteristics that make them suitable for work with forensic patients

- Providing in-house educational and training programs to support the vision and mission of the program

- Providing mentorship and supervision in all disciplines to support the vision and mission of the program

- Participating in public education (to police, courts, community mental health programs, family groups, etc.) on the relationship between mental disorder and criminal behaviour and violence in order to raise awareness about and reduce the stigma associated with forensic patients

Values

Forensic Mental Health Programs in Ontario will be guided by the following values in fulfilling this vision and mission:

- Respect and sensitivity to diversity in race, religion/faith, ethnicity, gender, gender identity, sexual orientation, age, family and socioeconomic status, language and communication ability, and physical and intellectual ability, and immigration and refugee status

- Responsibility to help reduce the stigma attached to forensic patients

- Respect for human worth and individual dignity

Principles

Forensic Mental Health Programs in Ontario will operate according to the following principles in fulfilling this vision and mission:

- Program resources will be allocated according to the Risk Principle (i.e. individuals assessed as being at the highest risk to re-offend will receive the highest concentration of resources)

- Treatment efforts will be guided by the Needs Principle (i.e. rehabilitative efforts will focus on known risk factors)

- Treatment efforts will be delivered according to the Responsivity Principle (i.e. programs will be offered in a manner that is consistent with the ability and learning style of the individual)

- The right to privacy limited by the need to protect the safety of the public and the safety of the forensic patient

- Research and evaluation are an important part of continuous quality improvement in forensic mental health

- Essential features of FMHP in Ontario are transparency and accountability
    - to the jurisdictional authority (ORB)
    - by submitting to a process of accreditation against (national and provincial) standards
    - by being open to a process of external and peer review

Appendix II: Standards in Evidence Based Practices in Forensic Mental Health Programs and Services

a. Risk Assessment Standard #1:
FMHPS in Ontario employ a uniform standard for the assessment of risk for violent and/or sexual offending. Risk assessments are based on complete information on each person assessed including a bio/psycho/social history, and an up-to-date criminal history (criminal charges and convictions) from a review of the Canadian Police Information Centre (CPIC) record.

b. Risk Assessment Standard #2:
FMHPS conduct assessments of long-term risk for violent recidivism on each offender for whom they are responsible. Such an assessment is based on an actuarial or structured methodology that has been validated in the empirical or scientific literature. Suggested instruments include the VRAG, the PCL-R, or the HCR-20. These assessments are conducted at least once for each offender and are to be completed (1) prior to any privileges being granted that involve the offender's unescorted access to the community or (2) within three months of the offender's admission to the program, whichever comes sooner. If such an assessment has been conducted previously at another FMHPS in the province, the current program has the option of adopting the previous long-term risk assessment, but such an adoption must be documented on the patient's chart.

c. Risk Assessment Standard #3:
FMHPS conduct regular assessments of dynamic or short-term risk on each offender for whom they are responsible. Such an assessment may be based on a mechanical/objective dynamic risk assessment methodology (e.g., HCR-20; SONAR for sex offenders; Dynamic Risk Appraisal Guide for violent offenders). Such regular dynamic risk assessments may be supplemented by guided clinical judgment. These assessments are updated frequently (i.e., kept current) to inform decisions concerning the granting of privileges, the restriction of liberty, and reporting to the ORB.

(All risk assessment standards are consistent with recommendation contained in the Forensic Mental Health Services Expert Advisory Panel Report)

d. Risk Management Standard #1:
Program resources (hospital units of different levels of security; unit staffing with different skill sets; and unit policies and procedures) are allocated and utilized according to the Risk Principle. Individuals assessed as being a high risk-to-re-offend violently and/or sexually are:

a. Initially placed in hospital units with higher levels of security,
b. Subject to higher levels of monitoring and scrutiny,
c. Subject to more gradual movement through the system through smaller incremental steps,
d. Provided with more intensive levels of treatment,

Compared with individuals assessed as being at lower risk.

e. Risk Management Standard #2

Privileges granted and restrictions placed on patients are based on continuous clinical assessments of dynamic risk. Decisions regarding the granting of (short-term) privileges or (short-term) imposition of restrictions are based on ongoing (continuous) assessments of dynamic risk. When the dynamic risk is assessed as high, privileges are not granted, and restrictions on behavior are imposed as appropriate. When dynamic risk is assessed as being low, privileges are granted, and restrictions on behavior are removed as appropriate.

f. Treatment Standard #1

Program treatment resources are directed according to the Need Principle. Treatment within FMHPS in Ontario is focused on reducing symptoms of mental disorder and behaviors that threaten the safety of the public. The Needs Principle states that in order to reduce the risk of re-offence, rehabilitative efforts must concentrate on variables known to be associated with a higher probability of re-offence (i.e., risk factors) that can be changed with deliberate intervention. The four most prevalent behaviors that threaten the safety of the public in this population are: aggression, problems in institutional management, criminal propensities, and substance abuse. Assessment of behaviors that threaten the safety of the public is conducted on an individual basis and treatment plans are tailored to meet the specific needs of individual patients.

g. Treatment Standard #2:

As a corollary to Treatment Standard #1, treatment should also focus on enhancing protective factors, or skills that once acquired, serve to protect the patent from further re-offense (i.e., protective factors). The salient protective factors are life skills, social skills, vocational skills, and leisure skills. Assessment of these skills is conducted on an individual basis and treatment plans are tailored to meet the specific deficits of individual patients.

h. Treatment Standard #3:

Program treatments are delivered according to the Responsivity Principle. The responsivity principle refers to delivering treatment programs in a style and mode that is consistent with the ability and learning style of the offender. The most effective styles of treatment are those matched with the needs, circumstances and learning styles of the offenders. In this population, the most effective styles and modes of treatment delivery are structured and active, such as social learning and cognitive-behavioral approaches. (Less effective styles are less structured, relationship-dependent, self-reflective, verbally interactive and insight-oriented approaches.)

Appendix III: Proposed Forensic Mental Health Program Performance Indicators

	MEASUREMENT DOMAIN		
INDICATOR DOMAIN	PROGRAM/UNIT	STAFF	PATIENT/CLIENT
Risk assessment *Are scientifically valid structured risk assessment measures being used?*	Does the program have a policy that such measures are to be used regularly? Did the program sponsor training in the past year on the use of such measures?	Percentage of staff trained in the use of such measures.	Percentage of clients assessed using such measures Average time/client to perform assessment. Average cost/client to perform assessment. Percentage of interventions that are related to identified risk factors.
Risk Management/Safety *Are program resources allocated according to level of risk? Has the risk of harm to self and others (i.e., staff and the public) been adequately minimized?*	Does the program have protocols/ practices or policies that address the appropriate use of restraint? Are these based on best practices? Are there policies in place to allow staffing to acuity?	Is the staff mix on the unit optimal to maintain patient and staff safety? Are staff trained in the appropriate use of restraint? Do staff inform patients/clients upon admission about circum-stances that will lead to the use of restraint? Number of employee incidents resulting in lost time and/or staff injury.	Percentage of patients restrained. Percentage of reportable incidents; formal complaints; self harm; assaults. Percentage of absent without leave (AWOLs) while under supervision (distinguish between during privileges vs. escape from detention). Recidivism – while under and not under supervision; tenure in community to rehospitalization or rearrest. Patient perceptions of safety.
Treatment & Rehabilitation Are programs based on best practices and/or professional guidelines?	Availability of core services and programs. Are evidence-based treatment programs offered that target issues associated with risk for re-offence? Are treatment programs offered at a level that is accessible and understandable for most clients?	Is staff mix optimal? Are staff provided with professional development and educational opportunities?	Patient involvement in development of the treatment plan. Client/patient measures of participation.

INDICATOR DOMAIN	PROGRAM/UNIT	STAFF	PATIENT/CLIENT
Continuity of care/Accessibility *Are patients able to access services tailored to their needs in a timely fashion? Are relevant care providers integrated effectively across a client/patient's plan of care?*	Wait lists (e.g., to enter system, to move between security levels) Bed capacity and overflow. Average length of stay. Alternative level of care days. Availability of interpreters. Does the program have referral protocols with non-forensic mental health programs?	Number or percentage of staff involved in cross-program service delivery. Number or percentage of staff involved in cross-organization education about forensic services/patients.	Documented follow-up with non forensic mental health service providers after discharge? Patient perceptions of accessibility. Cost of maintaining "alternative level of care" (ALC) clients/patients (i.e., clients that no longer meet forensic mandate; clients that could be served on lower security levels)
Quality of Life *Does the program setting provide an acceptable quality of life for staff and clients/patients?*	Physical layout of the program setting – does the program meet accreditation standards? Does the program deliver culturally-appropriate services?	Measures of staff satisfaction. Staff turnover rates.	Do staff inform clients of their rights during their stay in program? Patient satisfaction and perceptions of care. Rate of formal complaints.

Appendix IV: Proposed Balanced Scorecard Quadrant

System Integration & Change (Learning & Growth)	Clinical utilization & Outcomes (Internal Processes)	Patient Perception of Care	Financial Performance & Condition
Dissemination of recent research/evidence based practices?	Number of clients/patients assessed for long-term risk for violent recidivism.	Patient/client awareness/understanding of risk assessment and involvement in setting treatment goals related to reduction of risk where possible.	Cost of utilization of structured risk assessment in staff hours per assessment.
Number of employee incidents resulting in lost time and/or staff injury.	Number of staff provided with training/education around structured risk assessment.	Client/patient perceptions of safety.	Staffing mix/complement
Is the staff mix on the unit optimal to maintain patient and staff safety?	Percentage of patients restrained.	Client/patient awareness of unit rules and consequences of breaking unit rules.	Are a greater proportion of program resources dedicated to higher risk clients?
Are staff trained in the appropriate use of restraint?	Percentage of reportable incidents; formal complaints; self harm; assaults.	Do staff inform patients/clients upon admission about circum-stances that will lead to the use of restraint?	Cost of replacement/missing staff.
Are evidence-based treatment programs that target behaviours that threaten public safety offered or accessible?	Percentage of AWOLs while under supervision (distinguish between during privileges vs. escape from detention).	Does participation in treatment and rehabilitation programs result in increased knowledge, functioning, or satisfaction?	Are the greatest resources in terms of treatment/rehabilitation programs offered to those with the greatest need?
Are evidence-based programs that target rehabilitation needs offered or accessible?	Recidivism – while under and not under supervision; tenure in community to rehospitalization or rearrest.	Are treatment programs offered at a level that is accessible and understandable for most clients?	Cost of maintaining clients/patients in a location that is of higher security than they require (or clients/patients who no longer meet the forensic mandate)
Proportion of appropriate forensic clients/patients referred out non-forensic programs.	Use of restraint protocols.	Are treatment/rehabilitation programs offered based on individual need?	Costs of legal expertise required for appeals and other issues.
Number or percentage of staff involved in cross-organization education about forensic services/clients.	Does participation in treatment and/or rehabilitation programs result in reduced risk?	Client/patient perception of rights.	
Does the program deliver culturally-appropriate services?	Wait lists (e.g. to enter system, to move between security levels).	Do staff inform clients/patients of their rights while in the program?	
Staff satisfaction.	Average length of stay (overall and within security levels).	Patient satisfaction with and perceptions of care, physical plant, etc.	
Staff turnover rates.		Rate/types of formal complaints.	