Discussion Paper

Designated Mental Health Units in BC Correctional Facilities: Key Considerations for Planning Purposes Only

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Introduction

People with mental health and substance use disorders are over-represented in provincial and federal correctional populations across Canada, and it is not uncommon for offenders with mental illness to cycle in and out of the criminal justice system (Mental Health Commission of Canada, 2012; Ministry of Health Services and Ministry of Children and Family Development, 2010; Ministry of Justice, 2013; Office of the Correctional Investigator, 2012). Some people with severe mental health and substance use disorders who come into contact with the criminal justice system are required to undergo court-ordered assessments to determine their fitness to stand trial and/or criminal responsibility. And while there are special provisions for mentally disordered accused in the *Criminal Code of Canada*, the overwhelming majority of people with mental health and substance use disorders who come into conflict with the law do not fulfill the legal requirements for a determination of 'Not Criminally Responsible on Account of Mental Disorder' (NCRMD).

In BC, court-ordered assessments are conducted by the Forensic Psychiatric Services Commission (FPSC), and individuals who are adjudicated NCRMD are transferred to the authority of the BC Review Board and subject to treatment delivered by forensic psychiatric services. However, many more accused who have mental health and/or substance use problems are convicted in court and serve their sentences under the supervision of correctional services. Offenders sentenced to two or more years in custody are incarcerated in federal correctional facilities operated by the Correctional Service of Canada (CSC), whereas individuals sentenced to less than two years in custody are incarcerated in provincial correctional facilities. In BC, correctional services are delivered under the authority of the BC Corrections Branch of the Ministry of Justice. The Adult Custody Division operates nine provincial correctional facilities, including one correctional centre for women only[1], and two pretrial centres.

The majority of people in BC who come into contact with the criminal justice system have a diagnosed mental health and/or substance use disorder (Ministry of Health Services and Ministry of Children and Family Development, 2010). Substance use is especially common among provincial offenders, and concurrent mental health and substance use disorders are associated with an increased likelihood of involvement with corrections (Somers, Cartar, & Russo, 2008). Some researchers have suggested that "co-morbidity in the criminal justice system is perhaps the rule rather than the exception" (Ogloff, Davis, & Somers, 2004, p. 24). Data from a large cohort study of all individuals in contact with BC's provincial corrections system (n=95,797) over a 7-year period (April 1997 to March 2004) revealed that 56.4% of offenders had a diagnosed mental health and/or substance use disorder; specifically, 26.1% had a mental disorder, 6.7% had a substance use disorder, and 23.6% were dually diagnosed with both a mental health and substance use disorder (Somers et al., 2008). The study found that offenders with substance use disorders were over-represented among offenders in custody (Somers et al., 2008). Furthermore, although women represent only 15.2% of the BC correctional population, they represent 20.7% of offenders with mental disorders and 24.0% of offenders with concurrent disorders; and Aboriginal people, who are already disproportionately represented in the correctional population, are over-represented among offenders with substance use disorders (25.0%) and concurrent disorders (18.0%) (Somers et al., 2008).

Governments have an ethical and legal responsibility to provide quality mental health and substance use services to offenders (Livingston, 2008). Health care services in BC correctional centres are delivered by Sentry Correctional Health Services, a private health care provider contracted by the province, and mental health services are provided at all correctional centres. At present, all provincial correctional centres are staffed with nurses and a physician, or general practitioner. All correctional centres also have psychiatric resources, with a psychiatrist holding—at most—two clinics per week (Key informant consultation). Every inmate undergoes a mental health screening at the time of admission in order to identify further mental health and substance use assessment and treatment needs, and assess risk for suicide or other major adjustment issues associated with transition into the correctional system. Inmates may be referred to Mental Health Coordinators (mental health clinicians or psychiatric nurses) whose role is to triage referrals and provide counseling, psychologists, and addiction counselors.

Inmates who require psychiatric care are referred to on-site psychiatrists by the correctional centre's general practitioner. Once the psychiatrist sees an inmate, the psychiatrist's recommendations for treatment are shared with the general practitioner who, as the 'most responsible physician,' is responsible for implementing the recommended treatment plan (Key informant consultation). Internal policy dictates that, in the event that the psychiatrist and the physician disagree about the recommended treatment plan, they are required to discuss the plan and collaborate to develop a mutually agreed upon treatment plan for the inmate (Key informant consultation). Treatment interventions for voluntary inmate patients may include medication, appointments with the psychiatrist, sessions with a psychologist, or any combination of the above (Key informant consultation).

[1] Women are also housed in a second correctional centre, in separate areas from the men.

Of course, not all offenders with mental health and/or substance use disorders will agree to access mental health services on a voluntary basis, and some offenders who decline services may require involuntary treatment. BC correctional data from 2000/01 to 2004/05 revealed that the number of inmates in BC requiring acute psychiatric care in a designated mental health facility on an involuntary basis rose 18% (Olley, Nicholls, & Brink, 2009). Over the past several years, approximately 80 offenders per year have met the criteria for involuntary treatment under BC's *Mental Health Act;* however, because provincial correctional centres are not designated psychiatric facilities, involuntary treatment cannot be administered in custody. Waitlists for hospital beds mean that, until they can be transferred to a hospital facility for psychiatric care, individuals experiencing acute mental health symptoms may be placed in segregation. Although there is mixed evidence on the psychological impact of segregation in Canada, for some individuals with mental illness, segregation may exacerbate existing existing symptoms and generate a need for more acute psychiatric care in a hospital setting due to decompensation (Metzner & Fellner, 2010; Office of the Correctional Investigator, 2012).

Designated mental health units within BC correctional facilities could reduce wait times and practical difficulties associated with the transfer of offenders from provincial correctional facilities to provincial mental health care facilities. They could also relieve pressure on forensic psychiatric services to treat provincially sentenced offenders who meet the criteria for involuntary treatment under the *Mental Health Act*, as forensic services face increasing demands (Jansman-Hart, Seto, Crocker, Nicholls, & Côté, 2011). Designated mental health units within correctional centres could also be designed to treat individuals with acute symptoms who have not reached the threshold for involuntary treatment, and attempt to engage them in voluntary treatment. Finally, these units could support individuals who have chronic mental illness or engage in self-injurious behaviors to keep them out of segregation units and prevent deterioration in correctional settings. In order to support individuals with ongoing mental health and/or substance use problems, including self-injury, the units would need to offer a wider range of services on a voluntary basis.

Research has shown that people with mental health and/or substance use disorders often have difficulty adjusting to the prison environment, and have been found to commit more disciplinary infractions than non-mentally ill inmates (Metzner & Fellner, 2010). Correctional staff may consider them to be more difficult to manage due to behavioral issues associated with the symptoms of their mental illness (Ogloff, 2002). According to Holton (2003), "it is not uncommon for a mentally ill inmate to receive a conduct or disciplinary report for inappropriate behavior, even though the behavior demonstrated was actually the product of a mental illness." (p. 104). Offenders with mental illness may also be perceived as weak, and may be at greater risk of victimization and exploitation by other incarcerated individuals (Ogloff, 2002). The conditions of, and stress associated with, incarceration may further exacerbate pre-existing mental health conditions or trigger symptoms of mental illness (Ogloff, 2002). Offenders with mental health and/or substance use disorders are also at increased risk for self-harm and suicide (Ogloff, 2002).

According to Ogloff (2002), "one of the most pressing concerns identified in correctional services is the dilemma of how to treat and manage those inmates who are acutely mentally ill" (p. 10-11). Indeed, prisons may be the first place where many individuals with mental health and/or substance use disorders receive assessment and treatment services (Griffiths & Murdoch, 2009; Ogloff, 2002; Osher, D'Amora, Plotkin, Jarrett, & Eggleston, 2012). Ensuring timely access to inpatient psychiatric care for adults with mental health and/or substance use disorders in provincial correctional facilities is an ongoing challenge for BC Corrections, and "the lost opportunity to provide care when [a person with mental illness] is in custody is ultimately reflected in a risk to the security and safety of the individual and the community" (Olley, Nicholls, & Brink, 2009, p. 819).

Purpose

The BC Ministries of Health and Justice have partnered to undertake the 'Partners in Change: Enhancing Continuity of Care' initiative, which aims to improve the continuity of care for adult corrections clients experiencing mental health and/or substance use problems at key transition points between the correctional and healthcare systems. According to the Partners in Change Project Charter, the project has three key deliverables: (1) the development of a *provincial service framework* to guide planners and front-line health and corrections staff in providing services and support to offenders with mental health and substance use disorders, including information for staff aimed at reducing the stigma associated with mental illness and/or a history of criminal offending; (2) the development of *information sharing protocols* between health and corrections to improve continuity of care for inmates with mental health and substance use disorders; and (3) the development of *transition protocols* to guide the transitions of clients between the health and correctional systems.

As part of this larger initiative, the Canadian Mental Health Association, BC Division, is working closely with stakeholders to explore the use of designated mental health units within correctional facilities across jurisdictions as a potential strategy to provide more timely access to mental health and substance use services for offenders who meet the criteria for involuntary treatment under BC's *Mental Health Act*. This discussion paper has been prepared to support this work and the development of a broader mental health service delivery framework for people in contact with corrections. The findings and recommendations articulated in this discussion paper will be presented to and discussed with government, service providers, and other key stakeholders in the health and justice sectors at an upcoming planning day. A final paper will then be produced that integrates feedback from reviewers and stakeholders who participated in the planning day. The planning day will itself conclude with the development of an action plan.

Scope

The focus of the discussion paper is on the delivery of mental health and substance use services for inmates in BC's provincial correctional facilities who meet the criteria for involuntary treatment under the *Mental Health Act* and require acute psychiatric care in a hospital facility. However, the service models explored may also benefit people with mental health and/or substance use disorders who are seeking treatment on a voluntary basis or who are approaching, but have not yet reached, the threshold for involuntary treatment. The specific needs of people with Fetal Alcohol Spectrum Disorder (FASD), intellectual disabilities, and cognitive impairments are not included in this discussion paper, though the needs of these individuals warrant further attention. The unique needs of Aboriginal people, who are over-represented in correctional populations, and women, who are disproportionately represented among offenders with mental health and concurrent substance use disorders, are reflected in the paper but require further consideration in the planning of a designated mental health unit (Somers et al., 2008).

The review of designated mental health units in correctional facilities was limited to Canada, the United States, the United Kingdom, Australia, and New Zealand, with greater emphasis on mental health facilities and service delivery models in the Canadian context, given the similarities in legislative and policy frameworks. Designated mental health units in correctional facilities outside of the Canadian context that were described and/or evaluated in the literature were also included.[2]

Approach

The research involved a rapid review of the academic and grey literature (e.g., government reports, strategic plans, training manuals), focusing on the use of designated mental health units in correctional facilities, and was supplemented by consultations with key informants who have specialized knowledge of correctional and forensic mental health policy and service delivery, mental health and human rights legislation, and evidence-informed best practices relevant to correctional mental health and substance use services. Scholarly literature was identified through a keyword search of library databases, including Cumulative Index to Nursing and Allied Health Literature (CINAHL), Criminal Justice Abstracts, Medline, National Criminal Justice Reference Service (NCJRS), and PsycINFO. Internet search engines, including Google and Google Scholar, were also searched for relevant academic and grey literature. Keyword searchers combined 'correction* or prison or jail' with 'mental health unit,' 'psychiatric unit,' 'residential treatment unit,' crisis stabilization unit,' or 'acute psychiatric care.' The review focused on literature published since the year 2000,[3] with particular attention paid to models of correctional mental health service delivery, lessons learned from the implementation of designated mental health units in correctional facilities, and recommendations for the provision of efficient and effective psychiatric care to correctional populations.

[2] There are undoubtedly other examples of designated acute psychiatric care facilities within correctional services in other jurisdictions that did not come to the attention of this author or have not been described or evaluated in the published literature.

[3] Several articles in the scholarly literature, published between 1932 and 1985, that report on psychiatric inpatient units in correctional facilities were not included in this review because the facilities and models of service delivery were considered to be outdated and irrelevant to the current situation.

Consultations were also conducted with 10 key informants who were selected in consultation with the Canadian Mental Health Association, BC Division. These conversations were guided by the academic and grey literature, and questions identified by government in the short-term work plan for this project (see Appendix A). Key informant consultations were conducted via telephone and lasted approximately 30-60 minutes.

Language and Terminology

This paper uses the term *mental illness* to describe serious mental disorders, including schizophrenia spectrum and other psychotic disorders, bipolar and depressive disorders, and substance-related and addictive disorders, described in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013). The term *acute mental illness* is used to refer to the presence of active symptoms requiring intensive or emergency psychiatric care, whereas *chronic mental illness* is used to refer to persistent mental illness that may require less intensive services and ongoing supports. Co-occurring or co-morbid mental health and substance use disorders are referred to as *concurrent disorders*. The language of *mental health and substance use problems* is used to refer to mental health and substance use concerns that do not meet the criteria for a formal diagnosis, but are nonetheless important and signal a need for mental health services and supports.

Much of the literature on persons with mental illness in corrections refers to these individuals as 'mentally disordered offenders' or 'mentally ill inmates.' The language of 'offenders with mental illness' is used throughout this paper; however, given that the focus is on correctional populations, the term 'people with mental illness' is also used to emphasize that these individuals are *people* whose lives have been impacted by mental health and criminal justice involvement. The term 'mental illness' is used to refer to both mental health and substance use disorders. People with mental health and/or substance use disorders who are receiving correctional mental health services are also referred to as *patients* or *clients*, at times, to emphasize their mental health treatment status and the need to balance security with care.

Correctional mental health services refer to mental health and substance use programs and treatment services delivered in correctional settings, whereas *forensic mental health services* refer to specialized mental health services delivered in specialized forensic hospital settings. Please refer to the Glossary (Appendix B) for definitions of other key terms used throughout this paper.

Guiding Frameworks

Legal Framework

The *Canada Health Act* (1985) specifies that "the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (s.3). Individuals who are incarcerated in Canada are morally and legally entitled to essential health care services, but responsibility for providing health care services, including mental health and substance use services, to provincially sentenced offenders falls on the provinces and territories. In BC, the *Mental Health Act* (1996) indicates that an individual in a correctional centre who meets the criteria for involuntary treatment under the *Mental Health Act*, and receives two medical certificates completed by qualified physicians, may be transferred to a designated provincial mental health facility (see Appendix C). The Forensic Psychiatric Hospital (FPH) is one such institution, and admits most, if not all, inmates from BC correctional centres who meet the criteria for involuntary treatment under the *Mental Health Act*. Offenders must remain in the provincial mental health facility until they are well enough to be returned to the correctional centre from which they were transferred, or discharged. The *Forensic Psychiatry Act* (1996) specifies that one of the functions of the Forensic Psychiatric Services Commission is to provide psychiatric services to individuals in need of psychiatric care or assessment while in custody. Its core services thus include the involuntary treatment of offenders with mental illness who are serving sentences in provincial correctional centres. The *Correction Act* (2004) regulates the establishment of correctional centres in the province, security measures (e.g., use of force, restraints), movement of inmates between correctional centres, and absences, including Temporary Absences for medical or humanitarian reasons (s.22). The *Hospital Act* (1996) sets out requirements for, and duties of, hospitals in the province.

Policy Framework

BC Corrections (2010) is responsible for "reducing reoffending and protecting communities through adult offender management and control" (p. 2). The Adult Custody division is responsible for the management of offenders serving sentences of less than two years and individuals detained in remand centres awaiting trial.[4] Internal policies dictate the manner in which staff respond to the mental health needs of inmates, including the provision of mental health assessment and treatment services. BC Corrections (2012) played a key role in the development of a *Mental Health*

[4] The Adult Custody Division of BC Corrections also manages individuals in immigration detention.

Strategy for Corrections in Canada, which articulated a framework for mental health care in correctional facilities across Canada. The strategy envisions a continuum of care to ensure that offenders have "timely access to essential services and supports to achieve their best possible mental health and well-being" (p. 7), with the goal of improving community safety. The strategy is grounded in human rights principles, and emphasizes mental health recovery through the delivery of "client-centred, holistic, culturally sensitive, gender-appropriate, comprehensive, and sustainable" (p. 9) mental health services. Key components of the strategy include (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, and (7) community supports and partnerships. Furthermore, the strategy emphasizes the generation of evidence-based best and promising practices as one of four strategic priorities.

BC's ten-year mental health and substance use plan, *Healthy Minds, Healthy People* (Ministry of Health Services and Ministry of Children and Family Development, 2010), emphasizes the importance of partnerships between health and justice to improve access to supports for people with mental illness who are involved in the criminal justice system and enhance mental health services in correctional settings. Coordinated responses, and access to hospital beds or specialized treatment services, are identified as priorities for people with complex mental health and substance use problems (Ministry of Health Services and Ministry of Children and Family Development, 2010). The plan also emphasizes recovery and the importance of reducing the stigma associated with mental health and substance use problems.

Ethical Framework

Despite limitations on their liberty, people accused of, or convicted for, committing a criminal offence are morally and legally entitled to have access to quality health services, including mental health and substance use services delivered by qualified professionals (Livingston, 2008). The notion of *equivalence of care* underscores the rights of individuals in custody to be provided with mental health services that are comparable to those available to non-correctional populations in the community. That is, despite being incarcerated, prisoners should have equitable access to effective mental health services. These services should be provided in the *least restrictive* environment, and that environment should be therapeutic (Livingston, 2008). People with mental illness who are incarcerated should be treated with dignity and respect, and their gender- and culturally-specific needs should be met (Livingston, 2009; Ogloff, 2002). They also have a right to safety and protection from exploitation and abuse (Key informant consultation; Livingston, 2008).

Decisions concerning the delivery of mental health services within correctional facilities should be *evidence-based* and reflect *best practices*. A number of models exist for the delivery of psychiatric care for acutely mentally ill inmates in correctional facilities, all of which have benefits and drawbacks. Best practices include the screening and assessment of individuals in custody to identify those who may be experiencing acute psychiatric symptoms, or present a risk to themselves or others as a result of mental illness (Livingston, 2008). A comprehensive mental health assessment should then be conducted to determine the person's level of need and develop an individualized treatment plan (Livingston, 2008). A range of treatment options should be available to offenders during incarceration, including inpatient treatment in a hospital setting within the correctional system or in the community (Livingston, 2008).

Intersectionality Framework

People with mental illness are not homogeneous, and their mental health may be affected by a range of factors, such as gender, age, race, ethnicity, sexual orientation, etc. An intersectionality framework articulates how these intersecting factors not only shape their experiences of mental illness but may also compound their experiences of stigma and discrimination and impact their access to mental health services and supports (Mental Health Commission of Canada, 2012; Rossiter & Morrow, 2011). Aboriginal people, and Aboriginal women in particular, are disproportionately represented in the Canadian correctional system. In BC, Aboriginal people comprise approximately 25% of BC's correctional population. Women are the fastest growing prison population in Canada, and are more likely to be identified as having a mental health problem than their male counterparts (Office of the Correctional Investigator, 2012). These intersecting realities compel the need for gender- and culturally-specific programming and services in correctional settings, including mental health and substance use services.

It is well established that correctional populations have extremely high rates of physical and sexual victimization and trauma across the lifespan, and that these experiences shape people's pathways to crime and incarceration (Morrow, 2002; Rossiter, 2012). Rates of violence and trauma are especially high among women, Aboriginal people, and people with mental health and substance use disorders (Bombay, Matheson, & Anisman, 2009; Gearon, Kaltman, Brown, & Bellack, 2003; McDaniels-Wilson & Belknap, 2008). There is increasingly strong evidence that mental health and substance use disorders are linked to experiences of violence and trauma, and that correctional, mental health, and substance use services should be delivered using trauma-informed approaches (Clark & Power, 2005; Harris & Fallot, 2001; Miller & Najavits, 2012; Trauma-Informed Practice Project Team, 2013).

Current Challenges in the Delivery of Mental Health Services in BC Correctional Facilities

There are numerous challenges associated with mental health service delivery in correctional facilities, and the challenges faced in BC are similar to those faced in other jurisdictions. Indeed, prisons, by their very nature, are not always therapeutic environments, and are therefore not conducive to mental health treatment and recovery (Key informant consultation). Yet, correctional services often have difficulty ensuring timely access to inpatient psychiatric care for offenders with acute mental health and/or substance use disorders who require involuntary treatment in a hospital setting.

Individuals who decline psychiatric treatment, often by refusing to take medications, and demonstrate behavioural difficulties may be placed in segregation to ensure their own safety and the safety of others (Key informant consultation). BC correctional health policy requires inmates housed in segregation to be seen by a health care professional on a daily basis. As such, an inmate whose mental health is deteriorating in segregation may be assessed more closely in a health care unit to determine whether or not they meet the criteria for involuntary treatment under the *Mental Health Act*. However, if the inmate continues to decline treatment, it may take several days before the individual reaches the threshold for involuntary treatment (Key informant consultation). During this time, mental health staff may continue to try to engage the inmate and encourage them to accept voluntary mental health care. If the inmate continues to decline treatment but does not reach the threshold for involuntary treatment under the *Mental Health Act*, the offender will likely remain in segregation until he or she is stabilized. If the offender does eventually meet the threshold for involuntary treatment, Section 29(4) of the *Mental Health Act* requires that two medical certificates be completed by physicians.[5] As a result, offenders may have to wait several days for a second physician to attend the correctional centre to complete a second medical certificate, before they can be transferred to a designated mental health facility for involuntary treatment. Offenders awaiting transfer are typically housed in segregation due to disruptive, dangerous, and/or unpredictable behaviour. In this setting, offenders have limited access to programs, support, social engagement, and coping strategies, which may contribute to their deterioration as evidenced by increased distress, severity of psychiatric symptoms, and behavioural difficulties (Key informant consultation).

Offenders who meet the criteria for involuntary treatment under the *Mental Health Act* are granted a Temporary Absence (TA), which is approved by the Warden of the correctional centre, and may be transferred by the Sheriff to a facility that is designated as a provincial mental health facility under the *Mental Health Act*. As few such facilities have the appropriate level of expertise and security to provide involuntary treatment to provincial offenders, offenders are transferred to BC's only Forensic Psychiatric Hospital, operated by the FPSC, for specialized treatment (Olley et al., 2009). Delays may depend on the availability of beds at FPH and/or how soon the Sheriff is able to attend the facility. In some cases, offenders may be transferred the day their TA package is ready; however, if there is a waitlist at FPH, the inmate may be waiting in segregation for several more days before being transferred to the hospital. In the best-case scenario, transfer of an involuntary client would take place within one or two days; however, the wait could be more than a week (Key informant consultation).

Because FPH operates at, or nearly at, capacity, it is often unable to admit offenders requiring involuntary treatment in a timely manner. BC Corrections typically has 8-10 inmates admitted to FPH at any one time, with an additional 4-8 inmates waiting several days or weeks for admission. In 2011/12, FPH reported that the average wait time, after receiving and approving a referral, was 2.5 days. In 2012/13, the average wait time increased to 3.0 days, and for the 2013/14 year to date, the average wait time is 7.6 days. The challenges associated with the transfer of involuntary clients to FPH are often more amplified in smaller communities where physicians are not as readily available (Key informant consultation). It should also be noted that wait times are often shorter for women offenders because the women's ward at FPH is rarely at capacity and thus there are more often beds available for women offenders with mental illness (Key informant consultation).

When wait times are longer, offenders' medical certificates may expire while they are waiting for treatment, and the process of obtaining two medical certificates must start again. In some cases, offenders reach their release dates without having received the treatment they need and, upon release, must be escorted to hospital.

[5] Only one medical certificate is required for patients in the community, who are managed through Section 22 of the Mental Health Act, which may be seen as a double standard for patients in custody.

Competing Philosophies and Goals

Correctional mental health services are fraught with ongoing tensions related to conflicting philosophies, goals, milieu, professional roles, and relationships with mentally disordered offenders: "security vs. treatment; inmate vs. patient; assistance vs. control; prison vs. hospital" (Office of the Correctional Investigator, 2012, p. 11). According to Simpson (2003), "the difference in approach between the two systems is stark in theory and practice…" (p. 111). As a result, the behaviours of offenders with mental health and/or substance use disorders may be misinterpreted by correctional staff and met with punitive responses (Schizophrenia Society of Ontario, 2012). Indeed, "while security requirements are always a consideration in a prison setting, an escalation in the security response to meet a mental health need can be counter-productive" (Office of the Correctional Investigator, 2012, p. 11). On the other hand, "in a well-run forensic hospital, security comes from the strength of therapeutic engagement and assessment" (Simpson, 2003, p. 111). Finding ways of working together to ensure that the mental health needs of offenders with mental illness are met is critically important.

Treatment Options Within Correctional Facilities

Correctional facilities are not designated as mental health facilities under the *Mental Health Act*, which limits their ability to provide involuntary psychiatric treatment to inmates who decline services. If individuals deteriorate, they may be placed in segregation until they meet the threshold for involuntary treatment. Segregation units are generally used as a last resort for inmates exhibiting acute psychiatric symptoms, but for a minority of inmates who fail to respond to other responses, it may be used more commonly (Key informant consultation). Yet, it is well documented that the impact of segregation on mentally ill inmates is likely to be worse that for non-mentally ill inmates (Holton, 2003).

Community Hospitals

The *Mental Health Act* identifies three types of designated mental health facilities: provincial mental health facilities (e.g., FPH), psychiatric units within community hospitals, and designated observations units in smaller hospitals (Ministry of Health, 2013). Individuals who meet the criteria under the *Mental Health Act* for involuntary treatment and are transferred from custody must be treated in provincial mental health facilities. As such, individuals in provincial correctional facilities have traditionally been transferred to FPH for acute psychiatric care (Key informant consultation). Community hospitals designated as psychiatric and observation units under the *Mental Health Act* are often ill equipped to provide psychiatric services to individuals in custody due to the risk of violence and aggression, and the greater level of security required for this population[6] (Olley et al., 2009). Observation units, in particular, lack the resources to provide more than very short-term care to individuals requiring acute psychiatric care (Key informant consultation).

Waitlists for Hospital Beds and Transfer Delays

One of the greatest challenges in responding to the mental health needs of acutely mentally ill inmates is waitlists for transfer to designated mental health facilities (Olley et al., 2009; Neil, 2012). The Forensic Psychiatric Hospital operates at a high capacity, such that inmates awaiting transfer to the secure hospital on a Temporary Absence from a correctional facility may be waitlisted for several days. Due to high capacity at FPH, the average number of days on a waitlist rose to 12.3 in 2006/07 before dropping to 8.5 in 2007/08 (Olley et al., 2009). Since 2008, following the "imPROVE" initiative, the FPSC has managed to achieve the wait time target of 10 days for the admission of inmates from correctional facilities being transferred to FPH on a Temporary Absence for acute psychiatric care, with most inmates transferred to the secure hospital within 5 days of receipt of a TA referral (Olley et al., 2009). However, if forensic services are at capacity, people with mental illness requiring intensive inpatient treatment may still experience significant delays.

Stigma and Discrimination Associated with Mental Illness

People with mental illness often experience stigma and discrimination, which may be compounded for socially marginalized groups (e.g., women, Aboriginal people, individuals with disabilities, criminalized populations) and have significant implications for their mental health recovery (Rossiter & Morrow, 2011). Stigma associated with mental illness is not uncommon in correctional settings (Ray & Goldman, 2013). Similarly, the 'forensic' or 'criminal' label may lead to stigma and discrimination, and serve as a barrier to accessing mental health and social services, particularly in the community (Livingston, Rossiter, & Verdun-Jones, 2011).

[6] Increased security needs are associated with significant costs.

Designated Mental Health Units in Correctional Facilities: A Cross-Jurisdictional Review of Relevant Service Models

The correctional mental health service delivery models described below are drawn from Canada, the United States, Australia, and New Zealand. Prisons in the United Kingdom cannot be designated as hospitals under the Mental Health Act and, as such, prisoners who meet the criteria for involuntary treatment under the Mental Health Act must be transferred to hospital; they are not legally allowed to remain in prison (Bradley, 2009). Following treatment in a hospital setting, prisoners are transferred back to prison to serve the remainder of their sentences (Man, 2011). Lord Bradley (2009), in his review of people with mental illness in the criminal justice system, found that hospital transfer delays were associated with difficulties obtaining paperwork, lack of secure beds, disputes concerning the appropriate level of security, and the competing perspectives of correctional and mental heath staff.

Canada

The examples below include designated mental health units and other innovative forensic mental health service delivery models that address the needs of people with mental illness in correctional populations across Canada. They include psychiatric treatment centres that are designated mental health facilities under provincial mental health legislation (Regional Treatment Centres, Correctional Service of Canada), a co-located forensic psychiatric hospital and correctional centre (East Coast Forensic Hospital, Nova Scotia), a hybrid correctional and mental health facility (St. Lawrence Valley Correctional and Treatment Centre, Ontario), and forensic assessment and early intervention services (Forensic Early Intervention Service, Ontario; Forensic Assessment Unit, British Columbia).

Regional Treatment Centres, Correctional Service of Canada

Individuals serving sentences of two years or longer are under the management of the Correctional Service of Canada (CSC), and responsibility for the provision of health care services to federally sentenced men and women falls on the federal government, rather than provincial and territorial governments. There are approximately 675 psychiatric beds for federally sentenced offenders in Canada, the majority of which are designated hospital beds under provincial legislation. The CSC operates five Regional Treatment Centres (RTCs) and has agreements with other facilities, such as the Institut Philippe-Pinel in Québec. In the Pacific Region, CSC operates two 96-bed units, one of which is a designated mental health facility under BC's *Mental Health Act*. The Regional Treatment Centre is co-located with Pacific Institution in Abbotsford, BC, and serves federally sentenced men in the Pacific region.

Psychiatric units have fairly liberal admission and discharge criteria, and prisoners do not need to be acutely ill in order to gain access to these facilities (Key informant consultation). Rather, incarcerated people with serious mental illness, personality disorders, and cognitive impairment may be referred to psychiatric facilities on a voluntary basis, if they have an identified mental health need. Given the capacity of CSC to house individuals with mental health concerns, the average wait to be transferred to a psychiatric bed is three days (Key informant consultant).

In federal corrections, mental health services are delivered by 781 full-time staff. Each RTC employs a clinical director, usually a psychiatrist, an accreditation analyst, and a medical records clerk. Staff ratios for designated hospital beds are 1 clinical unit manager for every 20 patients, 1 nurse for every 4 patients, 1 social worker for every 10 patients, 1 psychologist for every 25 patients, and 1 psychiatrist for every 40 patients. All federal correctional staff (i.e., correctional and parole officers) receive a mandatory two-day training in 'fundamentals of mental health' which is customized for correctional settings and includes some training on the unique mental health needs of women and Aboriginal offenders. This scenario-based training is similar to mental health first aid, and teaches staff to recognize and interpret behaviours associated with mental illness. Additional training on self-injury, Borderline Personality Disorder, and Dialectical Behaviour Therapy (DBT) is offered on an on-demand basis, so that front-line staff are better able to support offenders with personality disorders who may be engaging in self-injurious behaviours (Key informant consultation).

Federally sentenced women who have acute mental health needs and require intensive residential treatment may be transferred to the Assiniboine Unit,[7] co-located with the Regional Psychiatric Centre (RPC) in Saskatoon, or to a 12-bed unit at the Institut Philippe-Pinel in Montreal. The Assiniboine Unit offers an Intensive Healing Program (IHP), developed in 1996 by the Correctional Service of Canada, for acutely mentally disordered women offenders, and provides individualized intensive psychiatric treatment within a therapeutic milieu on both a voluntary and involuntary basis. The assessment and treatment unit at the Institut Philippe-Pinel is located within a forensic psychiatric hospital, and offers crisis intervention for women with complex mental health needs, and voluntary treatment for federally sentenced women who have severe

[7] Previously the Churchill Unit.

personality disorders.[8] This treatment is based on a Dialectical Behaviour Therapy (DBT) model, the same model that has been adopted in Structured Living Environments (SLE) at each of the regional women's correctional facilities.[9] The SLEs provide intensive supports and services to mentally disordered women offenders, on a voluntary basis, in their regular institutions. Interdisciplinary teams with mental health training provide 24-hour support, and women residing in the SLEs benefit from having access to other programs in their institutions while receiving intensive mental health care. Intermediate psychiatric care for federally sentenced men who do not require more intensive care is offered through the Intermediate Mental Health Care Units (IMHCUs) and Complex Needs Units (CNUs).

The Correctional Investigator continues to identify problems in the provision of mental health services in federal correctional facilities. Relevant to this discussion paper is the concern that inmates with serious mental health needs are being transferred in and out of the RTCs (which are accredited and designated under provincial mental health legislation) and community hospitals not because of their changing mental health status and needs, but because of limited resources (e.g., lack of beds, understaffing) and staff fatigue (Office of the Correctional Investigator, 2012). The Correctional Investigator (2012) strongly encourages the transferring of acutely mentally disordered men and women offenders to institutions outside of the prison system that have specialized training and facilities to provide appropriate mental health care to those inmates with the highest psychiatric needs.

The Correctional Investigator (2012) has argued that, like inmates in need of acute physical health care, offenders with acute or complex mental health needs may be better served by specialized services located in designated mental health facilities, such as secure psychiatric or forensic hospital settings. While many mentally disordered offenders may benefit from mental health treatment provided in the RTCs, ongoing challenges in responding to the needs of a minority of seriously mentally ill offenders necessitate the consideration of alternative options. According the Correctional Investigator (2012), these options should be reserved for those mentally disordered offenders who are considered 'highest risk/highest need' (Office of the Correctional Investigator, 2012).

Secure Treatment Unit, St. Lawrence Valley Correctional and Treatment Centre

The Ontario Ministry of Community Safety and Correctional Services operates four specialized treatment centres throughout the province: the Algoma Treatment and Remand Centre in Sault Ste. Marie, the Ontario Correctional Institute in Brampton, the Vanier Centre for Women in Milton, and the St. Lawrence Valley Correctional and Treatment Centre in Brockville (Schizophrenia Society of Ontario, 2012). The latter is the only correctional treatment centre in the province with a designated mental health unit.

The St. Lawrence Valley Correctional and Treatment Centre was opened in October 2003, as a partnership between the Ontario Ministry of Correctional Services and the Royal Ottawa Health Care Group. The facility is a hybrid correctional and mental health facility with a 100-bed Secure Treatment Unit (STU), which is designated as a Schedule 1 psychiatric facility under Ontario's *Mental Health Act.* The facility has four units, which are referred to as 'residences,' and each has a smaller four-bed 'diamond' for individuals who have difficulty in larger common areas. Each residence is also equipped with an observation unit. The unit was designed for provincially sentenced men, who are referred to as 'residents.' All men admitted to the unit have a serious mental illness; a substance use disorder would not be sufficient for admission unless the person has a co-occurring mental illness (Key informant consultation). Individuals who meet the criteria for involuntary treatment under the *Mental Health Act* would be transferred to the unit within 48-72 hours; those who do not yet meet the threshold for involuntary treatment are categorized as 'urgent' and would be transferred within 1-2 weeks; people with mental illness who do not, and are unlikely to, meet the criteria for involuntary treatment would only be admitted if they had five months or less left in their sentences (Key informant consultation). Approximately 10% of the offenders on the unit are treated involuntarily, while the overwhelming majority receive services on a voluntary basis. In light of the admission criteria for voluntary clients, it is not surprising that the average length of stay on the unit is 4.5 months.

Notably, correctional officers are not located on the units, and are instead involved in maintaining building security, while health care professionals are responsible for supervision and treatment on each residence. Staff receive a mandatory two-day training to orient them to the uniqueness of the facility (Key informant consultation). The absence of correctional staff on the units is believed to contribute to a more therapeutic milieu and the development of more trusting relationships between patients and treatment staff (Key informant consultation). However, staff face other challenges such as linking offenders to community mental health services, particularly in large urban centres. Recidivism data indicate that the two-year reoffending rate for people who received treatment services on the STU is approximately 50%, which management considers to be positive given the high risk of people with mental illness who access their services (Key informant consultation).

[8] http://www.pinel.qc.ca/ContentT.aspx?NavID=1475&CultureCode=en-CA

[9] http://www.csc-scc.gc.ca/text/prgrm/fsw/mhealth/8-eng.shtml

Mentally Ill Offender Unit, East Coast Forensic Hospital

Nova Scotia is unique in that it is the only province in Canada that has a provincial correctional institution co-located with a forensic psychiatric hospital. The East Coast Forensic Hospital was opened in 2001, and operates a Mentally Ill Offender Unit (MIOU), which provides treatment services to clients referred to the hospital for court-ordered assessments and offenders transferred from the correctional centre (Key informant consultation). The co-location of the two facilities has been advantageous in facilitating transfers from the correctional centre to the forensic hospital, with an average 1-2 day delay to move an offender to a hospital bed (Key informant consultation). The unit has 24 beds, half of which are used for court-ordered assessments and half of which are reserved for treatment, but there is a recognized need for flexibility in bed allocation in order to accommodate the needs of people with mental illness who come into conflict with the law (Government of Nova Scotia, 2011). Many people agree to treatment in the unit because it offers a more therapeutic environment than the correctional centre, but the unit treats people on both a voluntary and involuntary basis (Key informant consultation). Typically, approximately 15 beds on the unit are filled (Key informant consultation).

Nova Scotia is also one of only two provinces in Canada in which the provincial heath service delivers health services in both correctional and community settings.[10] Although there was strong leadership from corrections and health to make the unit possible, there have been challenges in integrating two different philosophies (Key informant consultation). Security staff is present 24/7, while three nurses are on the unit during the day and two nurses are on the unit overnight. Psychiatrists, psychologists, social workers, and occupational therapists also form part of the multi-disciplinary treatment team (Key informant consultation).

Forensic Early Intervention Service, Toronto South Detention Centre

The Forensic Early Intervention Service is an innovative service model developed by the Centre for Addiction and Mental Health (CAMH), in collaboration with Ontario corrections. The service will be implemented in late 2013 in the Toronto South Detention Centre, a new remand facility for men, and will add capacity within corrections to meet the mental health needs of remanded individuals. Health and justice partners explored several different models, including the development of an inpatient mental health unit within the remand centre, which would be designated as a Schedule 1 psychiatric facility under Ontario's *Mental Health Act.* However, they decided to implement a service based on an intensive assertive community mental health team model. One of the concerns with the implementation of a designated mental health unit within a correctional facility was who would be responsible for issues such as safety and security—health or justice. Decision-makers also felt that building an inpatient unit within corrections would be very resource-intensive, and would serve only a small minority of incarcerated individuals who need mental health services (Key informant consultation). The assertive community mental health team model was selected in part because it was thought that this model could better meet the mental health needs of all individuals in correctional settings (Key informant consultation).

Individuals admitted to the institution will be assessed by corrections health staff, using the Brief Jail Mental Health Screen (BJMHS). Individuals who screen positive will be triaged by the Forensic Early Intervention Service team, and a subsequent triage assessment, based on an adaptation of the Jail Screening Assessment Tool (JSAT), will determine their level of need. Remanded individuals will be assigned to one of three levels of need: (1) primary care, delivered by a physician and correctional mental health nurses, (2) secondary care, delivered by correctional mental health nurses and supplemented by a psychiatrist, similar to an outpatient treatment model, or (3) acute care, delivered by mental health professionals throughout the facility, similar to a home-based acute service model. Rather than placing these individuals in a specialized mental health unit within the facility, the Forensic Early Intervention Team will go to the units in which these individuals are housed. This group of individuals requiring acute care are those offenders with current active symptoms associated with a psychotic disorder, and remanded individuals who are acutely ill and may be unfit to stand trial or meet the criteria for an adjudication of NCRMD. Their placement in the detention centre will be determined by corrections staff, based on the individual's acuity, need for segregation or isolation, violence or suicide risk, and other factors, which may be informed by mental health assessments completed by the Forensic Early Intervention Service. All individuals seen by the Forensic Early Intervention Service will be treated on a voluntary basis; those who meet the criteria for involuntary treatment under Ontario's *Mental Health Act* will be transferred to designated mental health facilities in the community for acute psychiatric treatment (Key informant consultation).

The remand centre has a total of 1,650 beds, and is expected to receive 13,000-14,000 unique admissions annually. It is expected that 25-30% of individuals admitted to the centre will screen positive for mental health issues and receive a triage assessment. Approximately 25% of those receiving triage assessments, or 1,000 individuals, will then be referred to the Forensic Early Intervention Service. Ontario corrections currently employs physicians and nursing staff in all correctional institutions.

[10] Alberta is the only other province that has adopted this model for correctional health care delivery.

However, detention centres have only one mental health nurse on staff, and a psychiatrist who attends two or three half-days per week, so access to mental health services for remanded individuals is fairly limited (Key informant consultation). The Forensic Early Intervention Service staffing model is still being developed, but will include 2 full-time psychiatrists and approximately 12-13 multidisciplinary staff. CAMH is recruiting experienced community mental health practitioners, including social workers, nurses, occupational therapists, psychologists, and psychiatrists. Forensic Early Intervention Service staff will receive core training on the model of care and the adapted JSAT triage assessment tool; those who have no experience working with forensic or correctional populations may need additional training, but most of the initial staff will have extensive experience with this population. Nursing staff, hired by corrections to work in the detention centre, are also receiving training on the BJMHS assessment tool (Key informant consultation).

Forensic Assessment Unit, Vancouver Pretrial Services Centre

The Forensic Assessment Unit (FAU) was a pilot project implemented in 1998 in a provincial pretrial facility. Its main purpose was to reduce wait times for accused individuals awaiting court-ordered forensic psychiatric assessments by moving the mental health services to the pretrial centre. The 39-bed unit at Vancouver Pretrial Services Centre was designated a mental health facility under the *Mental Health Act;* 13 beds were allocated to the FAU, with another 22 beds in the Segregation Special Handling Unit, and 4 beds in the Health Care Unit (Bond, Ogloff, & Tien, 1999). The FAU served clients who met the criteria for involuntary treatment under the MHA and required acute mental health services, as well as mentally disordered offenders seeking mental health services on a voluntary basis. The latter were only admitted to the FAU if beds were not being used by forensic clients, which meant that, in practice, only about 4 of the 13 beds were assigned to inmates from the correctional system.

The FAU was jointly staffed by correctional officers, forensic nurses, and psychiatrists (Olley et al., 2009). Psychiatric social workers and psychologists were also available as needed (Bond et al., 1999). Inmates from the provincial corrections population were treated by a pretrial centre physician, rather than the forensic psychiatrist, but were attended to by forensic nurses (Bond et al., 1999). Staffing on the unit was low, with one nurse per shift, one psychiatrist attending three days per week, and a part-time clinical coordinator for the unit (Bond et al., 1999). Correctional staff who were assigned to the FAU received a 3-day training program, and were considered valuable members of the team, even if their presence on the unit contributed to a more 'correctional' environment (Bond et al., 1999). The joint team model of correctional officers, forensic nurses, and psychiatrists worked well at the FAU; however, one of the greatest challenges identified in the FAU review was a shortage of staff, which was thought to impede the efficient delivery of mental health services (Bond et al., 1999; Olley et al., 2009). Key staffing needs identified in a review of the FAU included a full-time psychiatrist and a full-time, permanent, clinical coordinator for the unit (Bond et al., 1999). According to Olley et al., (2009), having a full-time coordinator improved communication at admission and discharge from the unit, and the continuity of care for inmates receiving hospital-based care (see p. 829). The FAU also faced ongoing challenges in creating a therapeutic milieu in a unit that operated more as a correctional rather than a mental health facility (Olley et al., 2009).

In December 2001, after approximately four years in operation, the FAU was closed, and its services and staff were moved back to the Forensic Psychiatric Hospital (Olley et al., 2009). This decision followed the opening of 25 new beds and a 'realignment of resources' that produced another 20 secure beds at the Forensic Psychiatric Hospital (Forensic Psychiatric Services Commission, 2002). According to FPSC, the "decision to centralize remand assessment services back at the Forensic Psychiatric Hospital is a reflection of the Forensic Psychiatric Services Commission's commitment to deliver the highest quality care and service within the most efficient and effective manner possible" (p. 5).

United States

The examples below include two State mental health institutions for correctional populations requiring acute inpatient care (Texas and Florida) and a Transitional Care Unit within a local detention centre that were identified in the literature. A Technical Assistance Report (Ray & Goldman, 2013) that was prepared in response to the growing population of people with mental illness at the McLean County Detention Facility, Illinois, explored 'options and opportunities' for jail-based mental health services, including the development of a mental health unit in the detention centre.

John Montford Unit, Texas Department of Criminal Justice

The John Montford Unit is a 550-bed hospital facility on a large acreage designed to provide inpatient psychiatric care to mentally ill male offenders in State correctional facilities throughout Texas. Offenders referred to the John Montford Unit are initially placed in a 'crisis management unit' where they receive psychiatric and psychological assessments to identify their mental health issues and determine their mental health service needs. Individuals who are admitted to the hospital are then transferred to the acute care unit, where they stay for an average of 10 to 14 days as they undergo further evaluation and

treatment planning (Thigpen et al., 2004). Once stabilized in the acute care unit, mentally ill offenders may be transferred to a subacute care unit, where they receive group therapy based on a biopsychosocial treatment model. According to Thigpen et al., (2004), the average length of stay on the subacute care unit is 90 to 180 days. As of August 31, 2012, the hospital had 775 employees: 457 security staff, 49 non-security staff, 3 staff from a correctional education institution, 158 contract medical staff, and 108 contract psychiatric staff.[11]

Corrections Mental Health Institution

The Corrections Mental Health Institution (CMHI), opened in 1985, is a 110-bed facility for male and female inmates in Florida who require acute psychiatric care (Bedard & DeVolentine, 2000). The CMHI is a four-floor building with two patient wings on each of three floors. Between 125 and 185 patients are admitted to the correctional mental health facility for treatment each year; most have chronic mental illness. In order to be admitted to the mental health facility, the warden of the inmate's home institution and two psychiatrists or psychologists must agree that the inmate is a danger to themselves or others due to mental illness. A court order for psychiatric care must then be made under the *Corrections Mental Health Act* before the 'inmate patient' is admitted as an involuntary patient.[12] The vast majority of inmate patients are transferred from Crisis Stabilization Units or Transitional Care Units in their home correctional institutions, with a minority (5-10% in 1995/6) admitted on an emergency basis due to self-injury or rapid mental health decompensation. Legislation mandates a review of inmate patient cases every 6 months. As many as 95% of inmate patients eventually return to their home correctional institutions, with approximately 80% of those offenders returning to Transitional Care Units in correctional facilities for intermediate follow-up treatment after they have been stabilized (Bedard & DeVolentine, 2000).

After 10 years, the CMHI adapted its treatment approach at no extra cost, and implemented an institutional case management model. This model consisted of four key elements: (1) inmate patients were assigned a case manager who stayed with the patient from admission to discharge,[13] and were re-assigned to that case manager if they were re-admitted to the mental health facility; (2) case managers worked with multiple treatment teams; (3) case managers reviewed treatment goals more frequently, between formal reviews of inmate patients' treatment plans; and (4) case managers advocated for inmate patients. This model facilitated the development of a therapeutic relationship with the case manager, which was believed to be a critical factor in improving the continuity of care for patients, stabilizing clients more quickly, reducing client manipulation, and reducing the time to develop a treatment plan upon re-admission (Bedard & DeVolentine, 2000). The implementation of the institutional case management model was met with positive feedback from both patients and staff, and reduced the average length of stay by 64 days (from 237 to 173 days) (Bedard & DeVolentine, 2000). This outcome is significant in light of the increased daily cost of housing one male at the CMHI ($84/day), compared to their home correctional facility ($46/day) (Bedard & DeVolentine, 2000). As well, returning clients to their home institutions frees up hospital beds for other inmates who are in need of acute psychiatric care. Bedard and DeVolentine (2000) cautioned about possible difficulties related to scheduling meetings between case management and treatment teams, and the potential for staff resistance and turnover. However, in the absence of empirical data comparing the traditional treatment model with the new institutional case management model, the authors conclude that the model has potential for improving client outcomes with no increase in costs.

Transitional Care Unit, North Broward Detention Centre

The mental health unit at North Broward Detention Centre (NBDC) holds up to 395 inmates (292 in dormitory units, 75 in segregation units, and 28 in special observation units). Approximately 25% of the mentally ill inmates on the unit are there due to severe decompensation and/or impairment, or significant behavioural problems (Hagar et al., 2008). The Transitional Care Unit was established "to provide more intensive mental health treatment to inmates in segregation" (p. 223) with the goals of improving socialization and treatment engagement, stabilizing inmates' mental health, and returning patients to a less restrictive environment (Hagar et al., 2008). Unlike the Corrections Mental Health Unit that provides more acute psychiatric care to mentally disordered offenders in the same State, the Transitional Care Program is a voluntary mental health treatment program. Inmates may be transferred to the unit from all security levels (minimum, medium, or maximum).

In 2008, a study was conducted to measure how well the Transitional Unit program met its goals of treatment engagement, socialization, and stabilization. The sample included 132 patients who were diagnosed with psychotic (73%), bipolar (14%), depressive (5%) or other (6%) disorders. The majority (59%) of patients was transferred to the mental health unit from medium security facilities, with 35% transferred from minimum security facilities, and 6% transferred from maximum security facilities. Their average stay in the unit was 26 days (range =

[11] http://www.tdcj.state.tx.us/unit_directory/jm.html

[12] This process is in place to avoid the possibility of malingering or admission for other reasons.

[13] That is, case managers were linked to inmate patients, rather than wings/floors in the institution.

1-169 days, median = 16 days). While a small proportion (5%) of patients were on the unit more than 100 days, 39% were on the unit for fewer than 10 days. Notably, patients are not transferred out of the unit for medication non-compliance, unless they become a danger to themselves or others due to mental health decompensation. A serious negative behavioural incident may be grounds for removal from the unit if mental health and correctional staff agree that the safety of staff and patients is at risk (Hagar et al., 2008).

Group programming is delivered three days per week by supervised psychology interns and is flexible so that it can be adjusted to the group's needs. Groups are capped at 10 patients, and programming focuses on developing skills that will assist with socialization, adjusting to the prison environment, and coping with mental illness (Hagar et al., 2008). Findings from the 2008 study showed that socialization, as measured by negative incident reports, improved during and after programming, but only for individuals who were discharged to open units. Those inmates who returned to closed units after residing in the Transitional Unit did not appear to benefit from the program, and were found to have low treatment engagement, as measured by group attendance and medication compliance (Hagar et al., 2008). The study found that although the number and type of symptoms, as measured by the Brief Symptom Inventory (BSI), did not decrease as a result of programming, the *intensity* of symptoms decreased significantly (Hagar et al., 2008). This change was attributed to coping and symptom management skills learned in the group, support from peers in the group, and medication compliance.

Australia

Mental Health Unit, Long Bay Hospital, Long Bay Correctional Complex

Long Bay Hospital[14] is located on the site of the Long Bay Correctional Complex, a multi-level security prison for men and women in New South Wales (NSW). The hospital was developed as a partnership among the Corrective Services NSW, the Justice & Forensic Mental Health Network, and a private consortium. Planning for the facility began in 1998, funding was allocated for its construction in 2006, and the facility was opened in 2008. Health and mental health services in the hospital are jointly administered by Corrective Services NSW and the NSW Ministry of Health.

The maximum-security facility has 85 beds, including a 40-bed Mental Health Unit. The hospital provides inpatient treatment to men and women with complex mental health needs who are in the NSW correctional system and meet the criteria for involuntary treatment under Australia's Mental Health Act or Mental Health (Forensic Provisions) Act. Health care services are delivered by multi-disciplinary treatment teams and reflect best practices. Inmates who are admitted to the Mental Health Unit may be transferred to the Justice Health Forensic Hospital, secure community-based mental health facilities, or returned to a correctional facility. No evaluations of the Mental Health Unit within the prison hospital could be located.

Marrmak Unit, Dame Phyllis Frost Correctional Centre

The Marrmak[15] Program is an integrated mental health service, which opened in August 2007 at the Dame Phyllis Frost Correctional Centre (a maximum security women's prison) in Victoria, Australia. The service includes a 20-bed inpatient unit, as well as outpatient services, outreach services, and a day program for women prisoners (Mistry & Bonett, no date). The goals of the program are to provide evidence-based services that reflect best practices in the community, a therapeutic environment that supports mental health recovery, and a continuum of care for incarcerated women with mental health problems. Program staff include a unit manager, a psychiatrist, two psychologists, 10 registered psychiatric nurses, a social worker, an occupational therapist, 8 prison officers, 4 senior prison officers, and a supervisor prison officer. All staff receive specialist training, and health and correctional staff work collaboratively to support women prisoners accessing mental health services through the Marrmak program.

The Marrmak inpatient unit serves women with acute mental illness, or women who are at high risk of self-injury or suicide, who are in need of intensive treatment in an inpatient setting (Mistry & Bonett, no date). Women with a wide range of mental health problems are seen on the unit. Admission to the unit is made by a psychiatrist, and can take anywhere from four to six weeks. The unit provides acute psychiatric care, with a focus on short-term stabilization, and step-down services for women who have been stabilized and are awaiting transfer out of the unit. Treatment is holistic and tailored to the needs of women depending on their age, culture, and ability. Release planning is an integral component of treatment, and women can receive aftercare through outpatient and outreach services. As of October 2012, no evaluations of the Marrmak Unit were available (Anderson, 2012).

[14] http://www.justicehealth.nsw.gov.au/long-bay-hospital

[15] Marrmak is in Indigenous word meaning 'keep safe.'

[16] Forensic inpatient care was previously delivered in the National Secure Unit at Lake Alice Hospital.

New Zealand

Regional Forensic Mental Health Centres, Forensic Mental Health Services

Forensic Mental Health Services (FMHS) were established in New Zealand following the recommendations of the Mason Report (1988). The philosophy of FMHS is based on several core principles, including that offenders with mental illness have the same right as non-offenders to access mental health services, and that offenders with mental illness should be the responsibility of health, rather than correctional, services (Simpson, 2003). Other principles of the forensic service delivery framework include that services should be client-focused, holistic, integrated, and culturally appropriate; match the individual's needs and be delivered in the least restrictive environment; balance individual rights and public protection; and minimize stigma associated with mental health and criminal justice system involvement (Fairley, 2007).

FMHS operates regional forensic psychiatric centres in Auckland, Wellington, Wanganui, Hamilton, Christchurch, and Dunedin (Ministry of Health, 2007).[16] Each forensic mental health centre offers court- and prison-liaison services, secure inpatient beds for assessment and treatment purposes, step-down beds within inpatient facilities, and outpatient mental health clinics within prisons to supplement primary healthcare services. Staffing ratios vary depending on the geographic location of the regional forensic mental health centre.

People with mental illness who are in prison may access acute mental health services in forensic inpatient settings. In 1999/2000, approximately one quarter of all referrals to inpatient forensic services in New Zealand were from corrections, and the overwhelming majority of clients were men (Ministry of Health, 2001). In these cases, offenders are transferred to the secure forensic mental health centre if they meet the criteria for involuntary treatment under the Mental Health Act and, once treated, are returned to prison. Courts may also sentence offenders with mental illness to prison, but require that they receive treatment in a hospital setting until they no longer require treatment, at which point they are transferred to prison to serve the remainder of their sentence.

Key Considerations for Designated Mental Health Units in Correctional Facilities

Leadership and Governance

In BC, mental health care for correctional populations is a joint responsibility of health and justice. Strong leadership is required to improve mental health services in correctional facilities and overcome differences in philosophies among professionals providing correctional (i.e., security) and mental health (i.e., treatment) services (Key informant consultation). Ogloff (2002) cites the need for strong leadership as one of the critical components in planning and designing correctional mental health services:

> Traditional boundaries that separate government ministries and agencies must be crossed to ensure that mental health services are provided to offenders in need, and to stop mentally ill offenders from cycling continuously through health, mental health, forensic and criminal justice systems. (p. 12)

BC is already leading the way in this regard, and has strong leadership as the only province in Canada with a Director of Mental Health Services in corrections (BC Corrections, 2013). The partnership between the Ministries of Justice and Health is further evidence of government's commitment to enhancing correctional mental health services for people with mental health and/or substance use disorders.

One of the challenges of decision-makers involved in these types of partnerships is to determine clear pathways between corrections and mental health services, and how best to work together without "tripping over each other" (Key informant consultation). In Ontario, Memoranda of Understanding have been developed between senior health and corrections decision-makers to guide how they will work together to serve the needs of mentally ill individuals in correctional centres. Mental health staff working in corrections in Ontario have also been actively involved in the development of mental health service delivery models in correctional facilities (Key informant consultation).

In some jurisdictions, mental health services in correctional settings are delivered by professionals who are employed by, and accountable to, health agencies rather than corrections. This governance model is thought to be beneficial because there is a more clear demarcation between health and corrections (Key informant consultation). Nova Scotia and Alberta are the only Canadian provinces in which mental health services are delivered by provincial health services that also provide community-based services (Key informant consultation). In Australia, mental health services in corrections must be delivered by a health agency that is independent of justice (ACT Health, 2008). The

Correctional Service of Canada is unable to adopt this type of model, but has recently reviewed its governance structure such that, by April 2014, clinicians working in the RTCs will report through a health chain of command rather than a correctional chain of command (Key informant consultation). This approach means that when conflict arises between mental health and corrections, these issues will be handled by decision-makers who have clinical training and expertise. This new governance model began in 2007 for physical health care, and 2013 for mental health in mainstream federal correctional institutions.

Another important consideration relates to the respectful sharing of information between corrections and mental health.

> For effective health care the bond of trust between a healthcare professional and their patient is essential to ensure improved health outcomes. […] If information were passed on to others without the consent of the patient then this trust would be broken. (ACT Health, 2008, p. 37)

If information-sharing is not carefully considered, correctional staff and legal professionals may well advise offenders and accused not to access mental health services (Key informant consultation). Having a mental illness may also have an impact on correctional decision-making, such as placement in, or release from, a correctional facility (Key informant interview). Individuals requiring mental health services may choose not to access these services if they believe doing so will have a negative impact on correctional or legal decision-making (Key informant consultation). In some jurisdictions, guidelines and training have been developed around information-sharing protocols that dictate when, how, and with whom health information is shared (Key informant consultation).

Populations Served

Designated mental health units in correctional centres may serve the needs of two populations: (1) remanded individuals awaiting a court-ordered forensic psychiatric assessment, and (2) sentenced offenders who are seeking voluntary treatment or who meet the criteria for involuntary treatment under the *Mental Health Act* and can be treated in a psychiatric hospital on an involuntary basis (Ogloff, 2002). It is important, when considering the mental health needs of individuals in correctional settings, to conceptualize mental health on a continuum and recognize that inmates have varying mental health needs (Key informant consultation). The majority of specialized mental health treatment units are designed for inmates with acute mental illness or chronic mental health concerns, particularly those with psychotic and major mood disorders (Holton, 2003). However, in federal correctional facilities, people with acute mental illness can be treated and managed fairly easily in hospitals, whereas meeting the needs of individuals with personality disorders presents the greatest challenge for corrections (Key informant consultation).

Research evidence suggests that the mental health needs of women, elderly, ethnic minority, and other minority offenders are often not met (Brooker et al., 2009). It is important that a designated mental health facility is able to meet the needs of women and men in need of acute psychiatric care, and that these services are gender-specific, culturally sensitive or culturally safe, and trauma-informed, recognizing the strong links between trauma, mental illness, and substance use. In New South Wales, Australia, the over-representation of Aboriginal people in correctional settings led to the development of an 'indigenous specific health unit' and discussions about the need for a Indigenous health program that is culturally safe and employs Aboriginal health workers (ACT Health, 2008).

Location and Milieu

According to the *Mental Health Strategy for Corrections in Canada* (BC Corrections, 2012), an expected outcome of effective mental health treatment services is that "individuals with acute or chronic mental health problems and/or mental illnesses are placed in an environment that offers a therapeutic milieu with the appropriate level of support" (p. 13). Mental health units in prison environments should be designed to be low-stress, with a focus on support and treatment and a goal of stabilizing mentally ill offenders and returning them to the prison population with improved coping skills (Lovell, Johnson, et al., 2001). Ideally, the unit should have multiple wings that allow patients to step-down to a less restrictive environment as their mental health status improves, and before they return to the correctional centre from which they were transferred, or are discharged to the community. The inclusion of 'transitional care units' could be developed for this purpose. Evidence suggests that smaller units, with private rooms for 8-10 patients each, are likely to be more therapeutic than larger units for this population (Ray & Goldman, 2013).

The presence of correctional officers in designated mental health units within correctional facilities means that these units resemble 'correctional' facilities more than 'mental health' facilities (Olley et al., 2009). Security measures, including 'lockdowns,' can make the environment appear to be more punitive than therapeutic, thereby interfering with psychiatric treatment (Bond et al., 1999). A review of the FAU found that space was important in the delivery of mental health care. For example, the interview room was too small, given that individuals were experiencing acute symptoms. The nursing station on that unit doubled as the location where correctional officers were situated, which had implications for patient confidentiality. Multiple interview and examination rooms are required to ensure that multiple patients may be seen by mental health professionals concurrently, and that patients' privacy is maintained at all times (Bond, et al., 1999). Staff meeting rooms and washrooms should be available on the unit, and the physical design should allow for natural light and access to the outdoors,

which would benefit both staff and clients on the unit by reducing stress, tension, and aggression, and improving mental health (Bond et al., 1999; Ray & Goldman, 2013).

Correctional services in some jurisdictions are considering models similar to the Forensic Early Intervention Service model in Ontario, where mental health services go to where the individuals in need are being housed, rather than transferring those people to units where mental health services are centralized. For example, the Correctional Service of Canada recognizes that not all people will do well in a hospital setting, and that people with a diagnosis of Borderline Personality Disorder tend to cycle rapidly in and out of designated mental health facilities.

Staffing Model and Roles

Mental health units in prisons are typically staffed by multi-disciplinary treatment teams, including nurses, social workers, psychologists, psychiatrists, occupational therapists, who work closely with correctional officers (Holton, 2003). One of the greatest challenges identified by key informants in the delivery of mental health services within correctional facilities was overcoming the differences in philosophies and priorities of mental health and correctional staff. For example, correctional staff may feel threatened by the involvement of mental health staff, and tensions between the two are likely to emerge (Key informant consultation). Strong collaboration among leadership is important so that this mutual respect trickles down to front-line mental health and correctional staff (Holton, 2003). Indeed, "…without collaboration, any correctional [mental health] treatment program is destined to fail" (Holton, 2003, p. 120). Collaboration can be enhanced through dialogue and the development of guidelines for working together.

Staffing issues exist in provincial correctional centres today, with a shortage of psychiatrists creating ongoing challenges for mental health service delivery (Key informant consultation). Correctional officers are key members of the team, but the team should have more mental health staff than correctional staff. For example, correctional staff may not need to be present at all times, but more than one nurse should be on duty during day shifts (Bond et al., 1999). Psychologists play an important role in BC correctional facilities, currently, and psychology should continue to be a core aspect of mental health treatment (Key informant consultation). In federal corrections, the 'circle of care' around a person with mental illness includes mental health and correctional staff, as well as other staff involved in supporting the individual (Key informant consultation).

Staff Selection and Training

Correctional officers' attitudes towards mentally ill inmates, and desire to support the treatment of mental illness in correctional settings, are important in that they may be more attentive to subtle changes in an inmate's mental health status and better able to identify opportunities for early intervention (Holton, 2003). As such, correctional officers should be carefully selected based on their knowledge of mental health issues, and their experience and interest in working with people with mental illness. Indeed, it is critical that staff develop constructive and respectful relationships with offenders who have mental illness (Key informant consultation).

Another critical component of mental health service delivery in correctional facilities is training for mental health, correctional, and administrative staff (Holton, 2003). All staff working in the designated mental health units should receive training specific to the operation of the unit and the needs of people with mental illness who will be served (Brooker et al., 2009). Training should aim to increase awareness of mental health issues, provide skills related to the identification of individuals in need of psychiatric care, teach crisis intervention and de-escalation techniques, and familiarize staff with relevant laws, policies, procedures, and information-sharing protocols (Government of Nova Scotia, 2011). Training should be delivered by mental health professionals who are bound by a set of professional ethics and, like mental health training for police officers, should dispel myths about mental illness and increase understanding of how mental illness may affect behavior, particularly in the correctional setting (Key informant interview). Identified training gaps include the need for continuing education or follow-up training (Key informant consultation). Training on gender-specific needs, cultural sensitivity and safety, and trauma-informed practice should also be offered to assist staff in working with different groups who have unique mental health needs.

Cross-training of mental health and correctional staff, where both groups of staff attend training workshops together, has been identified as good practice to ensure collaboration among staff working with people with mental illness in custody (Key informant consultation). Interdisciplinary training has been identified by correctional services as a promising approach in facilitating dialogue and encouraging collaboration among correctional and mental health staff that often have competing philosophies and goals (Key informant consultation). In addition to training, all staff working with offenders who have mental illness should be well managed and supervised to ensure that they are supported in doing this work (Key informant consultation).

Release Planning and Aftercare

Release planning for individuals with mental illness is an essential component of mental health service delivery in correctional settings (Livingston, 2008; Schizophrenia Society of Ontario, 2012). Given the relatively short time that individuals may be incarcerated in the provincial correctional system (i.e., less than two years and, on average, significantly shorter lengths of time[17]), connecting people with mental illness to community-based mental health services while they are incarcerated is essential to ensuring continuity of care post-incarceration. Indeed, attending to the unique needs of people with mental illness when planning for release will be critical to their community reintegration and mental health (Livingston, 2008). Ensuring that offenders are connected to a general practitioner upon release from a correctional facility would significantly enhance the continuity of care and improve ongoing engagement with mental health services in the community (Neil, 2012).

When considering the implementation of designated mental health units in correctional facilities, it is important to ensure that individuals are provided with ongoing support for their inevitable re-integration into the general prison population, and eventually into the community. Discharge planning prior to transfer back to the correctional centre from which the person came, or to the community, must be a central component of inpatient care, given that transfer into and out of an acute psychiatric unit may be stressful for individuals experiencing mental illness (Thigpen et al., 2004). Stepped care and aftercare are important to "prevent rapid cycling between acute psychiatric care and prison" (Brooker et al., 2009, p. S109), particularly if the length of stay on the mental health unit is expected to be relatively short. Once stabilized, it is essential that mental health professionals engage people with mental illness in discharge planning, and arrange for appropriate follow-up mental health care in correctional facilities or in the community. Developing a community care plan and connecting people with mental illness who are in custody with community-based mental health services during their incarceration and/or hospitalization is critical (Bond et al., 1999). Individuals who are remanded must have timely access to community mental health services when they are released, and mental health staff in correctional facilities have an important role to play in making these links to community services (Key informant consultation).

Research and Evaluation

Little published research is available on the relative effectiveness of different models of mental health service delivery in correctional facilities, including designated mental health units (Brooker et al., 2009). This is particularly true for the Canadian examples described earlier in this paper. Given the high rates of people with mental illness in correctional settings, and the dearth of literature on this model, it is clear that there is an urgent need for rigorous evaluation research on correctional mental health service delivery: "with the ever-increasing mentally ill population in correctional settings, it is clear that more research is needed to ensure that evidence-based best-practice models can be developed to address these inmates' clinical needs" (Hagar et al., 2008, p. 231).

Evaluation research should focus on outcomes measures associated with the intervention or model of care, as well the experiences of staff involved in service delivery and patients receiving psychiatric care in correctional settings. An evaluation of designated mental health units in correctional facilities should gather data on the number of individuals referred to and receiving services in the unit, the nature and severity of their symptoms upon admission and discharge, wait times for admission to the unit and average length of stay on the unit, follow-up mental health evaluations to determine mental well-being and engagement with mental health services post-discharge. Evaluations of training programs should also be conducted. In federal corrections, for example, mental health training is accompanied by an evaluation involving pre- and post-testing, and a one-year follow-up with trained staff (Key informant consultation). A cost-benefit analysis of the designated mental health unit, or social return on investment, may also be beneficial.

Importantly, planning for a full evaluation of a designated mental health unit must begin before implementation of the unit and, ideally, alongside the unit design to ensure that indicators of success are clearly defined and appropriately measured. A comprehensive evaluation should include both formative and summative evaluations. The former would generate information that would assist with refining the unit and programming, whereas the latter would examine the potential benefits, return on investment, and indicators of success identified prior to implementation. Finally, health and justice leaders, and quality management staff, should review the unit on a regular basis to improve performance and accountability, and ensure that the goals of the designated mental health unit are being achieved (Blanding, 2008).

[17] The average length of stay is 28 days for remand clients and 69 days for sentenced offenders.

Rights and Ethics

Upholding the rights of people with mental illness must be a priority in the design and implementation of a designated mental health unit within a correctional setting. Mental health and correctional services must respect the rights of people with mental illness to receive quality mental health services in a timely manner, as well as their right to refuse treatment and their right to privacy. In the federal correctional system, anyone who meets the criteria for involuntary treatment under mental health legislation is connected with a patient advocate. People with mental health needs who are voluntary patients have access to the grievance process, and the Office of the Correctional Investigator, the ombudsman for federally sentenced offenders in Canada (Key informant consultation). Similarly, at the Secure Treatment Unit in Ontario, offenders are connected with a Rights Advisory within 24 hours of being admitted to the unit (Key informant consultation). In BC, people with mental illness who are admitted under the *Mental Health Act* have the right to contact a lawyer, to be examined regularly by a physician, to apply for a Review Panel hearing, and to appeal their involuntary status to the Supreme Court of British Columbia. Inmates in provincial custody also have access to a grievance process, the Ministry of Justice Investigation and Standards Office, and the BC Ombudsperson.

Conclusions

The implementation of designated mental health units in correctional facilities offers a number of benefits, such as increased communication and collaboration between mental health and correctional staff, and more specialized knowledge and treatment for people with mental illness who are incarcerated (Thigpen et al., 2004). However, the implementation of designated mental health units in correctional centres has also been described as 'short-sighted.' Ogloff (2002), a scholar who first held the position of Director, Mental Health Services, BC Corrections, has gone so far as to conclude that "MDO [mentally disordered offender] units are undesirable" (p. 11) because they remove responsibility from community hospitals and mental health services to provide treatment to offenders with mental illness, and disconnect inmates from the very mental health services that will support them once released to the community.

> If gaols provide mental health services to these people in isolation, without linking these inmates to the mental health service providers or agencies in the community, it will make it all the more difficult for inmates to become reintegrated in the community upon release. (p. 12)

In light of this caution, it will be important to develop innovative strategies to connect inmates with community-based mental health services throughout their stay in the designated mental health unit of a correctional centre, particularly given the short timeframe (less than two years) that provincial corrections has to treat people with mental illness. Release planning and aftercare will be a key consideration, in addition to determining whose needs such a unit may serve and how best to address the unique needs of diverse populations within corrections. Staff training will be important in this regard, and leadership will be important to ensure collaboration of mental health and correctional staff. Research and evaluation will generate much-needed evidence and inform the development of best practices, which can then be used to improve correctional mental health services in BC.

Although the purpose of this discussion paper was to envision a model for designated mental health units within BC correctional facilities, Brooker et al. (2009) point to "the futility of seeking a single ideal solution" (p. S112). Other scholars echo this perspective, arguing that designated mental health units in correctional facilities are inadequate in terms of responding to the needs of mentally ill inmates (Holton, 2003). As such, it is important to consider a range of treatment options that meet the varying levels of need for mental health services in correctional settings.

The findings and recommendations of this cross-jurisdictional review of designated mental health facilities in correctional settings must be considered in light of the following limitations. First, few such models exist in Canada and other jurisdictions, and relatively little research has been conducted and/or published on service models of this kind. As a result, it is possible that good examples of this type of service delivery model in place in other jurisdictions were not identified in the published literature or by key informants who were consulted as part of this review. Second, the review included consultations with a small number of key informants, drawn mostly from Canada. As such, most of the examples of service delivery models provided are from the Canadian context. Despite this limitation, the key informant consultations were extremely valuable as the knowledge gathered from diverse perspectives had direct relevance to the Canadian context. Finally, gaps in the delivery of mental health services in provincial correctional facilities and the realities of correctional mental health practice on the ground may limit the vision of designated mental health units in correctional facilities articulated in this discussion paper. It is anticipated that these realities will be brought to light and discussed at the upcoming planning day, to explore possibilities for implementing designated mental health units in BC correctional facilities.

Recommendations

1. Legislation and Policy—Upholding the rights of people with mental health and/or substance use disorders who are in provincial correctional facilities must remain a priority. Fine-tuning of the *Mental Health Act* may be considered if there is evidence that existing provincial mental health legislation serves as a barrier to timely access to mental health services for individuals who are in custody, as long as any changes do not infringe the rights of people with mental illness who are in custody.
2. Roles and Responsibilities—A balanced approach that recognizes the need for mental health care and safe and secure custody, and clearly outlines the roles and responsibilities of the Ministry of Justice, Ministry of Health, and Health Authorities in the treatment of offenders with mental health and/or substance use disorders will be critical.
3. Equity Enhanced Services—Services should be delivered on both a voluntary and involuntary basis to men and women in correctional centres who have a range of mental health needs. Service planners should design mental health services to respond to the unique needs of diverse populations, particularly Aboriginal people and women, and resist a one-size-fits-all approach.
4. Staffing and Training—Multi-disciplinary treatment teams should receive ongoing mental health training that is tailored to the correctional setting and delivered by qualified health professionals. Mental health professionals working with correctional populations should also receive training related to correctional practice, including safe and secure custody and community reintegration, and mandatory training on gender-specific, culturally safe, and trauma-informed approaches.
5. Therapeutic Milieu—Designated mental health units must provide a therapeutic milieu and treat individuals as patients rather than prisoners, while striking a balance between care and custody. Mental health treatment should also be recovery-oriented.
6. Continuity of Care—People with mental illness in correctional facilities should have access to a range of treatment options, including intermediate and intensive inpatient services, depending on their mental health needs. Services should include discharge planning and aftercare to enhance the continuity of care for people returning to correctional centres or discharged to the community.
7. Evidence and Evaluation—The model of mental health service delivery in designated mental health facilities within correctional settings should be evidence-based and reflect best practices in correctional mental health. The service delivery model should be rigorously evaluated, on an ongoing basis, to assess and improve outcomes for offenders with mental health and/or substance use disorders.

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Appendices

A. Guiding Questions

Consultation questions were tailored to the specific position, experience, and expertise of the key informants. The following list is a sample of the types of questions posed:

- What are some key challenges in providing effective mental health services to correctional populations, generally, and within correctional facilities in particular?
- What is the referral process and care pathway for mentally disordered individuals in correctional institutions who are in need of acute psychiatric care?
- What models of care are helpful in reducing wait times for acute psychiatric treatment and length of stay in mental health facilities?
- What staffing levels are required on designated mental health units in correctional facilities? What is the role of correctional staff? What mechanisms do you think are most effective in overcoming competing goals of care and custody?
- What policies, practices, or procedures facilitate information-sharing, coordination of care, and collaboration among mental health and correctional staff?
- What training is available to mental health and correctional staff working with this population of offenders? What training exists related to gender-specific responses, trauma-informed care, and/or cultural safety? What are the gaps in training?
- What are the key components of an effective model of care for the treatment of mentally ill offenders who require acute psychiatric care?
- What safeguards need to be in place to ensure that the rights of acutely mentally ill patients in prisons are protected?
- What do you consider to be the benefits (or potential benefits) of this model of care? What do you consider to be the drawbacks (or potential drawbacks) of this model of care? What concerns do you have (if any) about the implementation of this model of care – that is, designated mental health units within correctional facilities?
- What is the required leadership for the implementation of this kind of intervention?
- What would be useful to include in an evaluation of this model of care?
- Are you aware of any existing mental health units within correctional facilities in other jurisdictions, or published evaluations of this type of intervention?

B. Glossary

- *Acute mental illness*—The presence of active symptoms requiring intensive or emergency psychiatric care.
- *Chronic mental illness*—Persistent mental illness that may require less intensive services and ongoing supports.
- *Community hospital*—General hospitals, many of which are equipped with psychiatric units or designated observation rooms.
- *Concurrent disorders*—Co-occurring mental health and substance use disorders.
- *Correctional facility*—Federal, provincial, or territorial institutions where offenders serve custodial sentences following conviction in a court of law.
- *Designated mental health facility or unit*—Psychiatric facilities that are designated under the *Mental Health Act,* including provincial mental health facilities, hospitals designated as psychiatric units, and hospitals designated as observation units.
- *Involuntary Treatment*—Individuals who have met the criteria for involuntary treatment under provincial mental health legislation because they present a danger to themselves or others due to mental illness; they may receive psychiatric treatment on an involuntary basis.
- *Jail*—Provincial correctional facilities for offenders in Canada serving custodial sentences of less than two years.
- *Mental illness*—Serious mental disorders, including schizophrenia spectrum and other psychotic disorders, bipolar and depressive disorders, and substance-related and addictive disorders, described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V).
- *Prison*—Federal correctional facilities for offenders in Canada serving custodial sentences of two years or longer.
- *Remand centre*—Provincial correctional facility for accused in Canada who are awaiting trial (also known as a pretrial centre).
- *Substance use disorders*—Disorders associated with drug and alcohol problems, including both illicit and licit drugs.

C. Relevant Sections of BC's Mental Health Act

Prisoners and youth custody centre inmates

29 (1) On receiving 2 medical certificates completed in accordance with section 22 concerning the mental condition of a person imprisoned or detained in

(a) a correctional centre,
(b) a youth custody centre, or
(c) a prison or lockup operated by a police force or police department or by a designated policing unit or designated law enforcement unit, as those terms are defined in section 1 of the *Police Act*,

the Lieutenant Governor in Council may order the removal of the person to a Provincial mental health facility.

(2) When an order is made under subsection (1), the person in charge of the correctional centre, youth custody centre, prison or lockup must, in accordance with the order, cause the person to be transported to the Provincial mental health facility named in the order and send to the director of the Provincial mental health facility copies of the medical certificates.

(3) A person transported to a Provincial mental health facility under subsection (2) must be detained in that or any other Provincial mental health facility the Lieutenant Governor in Council may order until the person's complete or partial recovery or until other circumstances justifying the person's discharge from the Provincial mental health facility are certified to the satisfaction of the Lieutenant Governor in Council, who may then order the person

(a) back to imprisonment or detention if then liable to imprisonment or detention, or
(b) to be discharged.

(4) On receiving 2 medical certificates completed in accordance with section 22 concerning the mental condition of a person imprisoned or detained in

(a) a correctional centre,
(b) a youth custody centre, or
(c) a prison or lockup operated by a police force or police department or by a designated policing unit or designated law enforcement unit, as those terms are defined in section 1 of the *Police Act,*

the person in charge of the correctional centre, youth custody centre, prison or lockup may authorize the transfer of the person to a Provincial mental health facility.

(5) The director of a Provincial mental health facility may admit to the facility the person authorized to be transferred under subsection (4) if the director receives copies of the 2 medical certificates from the person in charge of the correctional centre, youth custody centre, prison or lockup.

(6) A person who is authorized to be transferred and is admitted under subsection (4) must be detained in the Provincial mental health facility until the person's complete or partial recovery, or until other circumstances justifying the person's discharge from the facility are certified to the satisfaction of the director, who must,

(a) if the person is not liable to further imprisonment or detention, discharge the person, or
(a) if the person is liable to further imprisonment or detention, return the person to the correctional centre, youth custody centre, prison or lockup from which the person was transferred.

(7) If a person is detained in a Provincial mental health facility under subsection (3) or (6), the director may authorize that the person receive care and psychiatric treatment appropriate to the person's condition.

(8) Sections 23 to 25 apply to the detention of a patient admitted under subsection (4) and subsection (6) (a) or (b) applies to a patient who is discharged under sections 23 to 25.

(9) Section 33 applies to the transfer or admission of a person to a Provincial mental health facility under subsection (4), and subsection (6) (a) or (b) applies to a patient who is discharged under section 33.