An Analysis of the Initial Contact Characteristics and Recidivism of Offenders with a Serious Mental Illness

by

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

This thesis addresses the growing number of inmates with a mental illness in correctional facilities in Canada which continues to attract public attention and concern. Several explanations have been put forward to explain the rise in the number of inmates with a mental illness. These include: the deinstitutionalization of the mentally ill that began in the 1970's, lack of treatment availability for those released into the community, and criminalization of persons with a mental illness by the justice system. The increasing numbers of persons with a mental illness in the correctional system has led to serious concerns about the capacity of this system to manage, treat, and rehabilitate individuals with a mental illness. Lack of proper treatment, management, rehabilitation and monitored discharge means that inmates with serious mental illness are more likely to come into contact with the criminal justice system more frequently.

This thesis examines the incidence seriously mentally ill offenders and their propensity to recontact. Three hundred and ninety eight face-to-face assessments were conducted using the Resident Assessment Instrument-Mental Health 2.0 (RAI-MH) and from total scores from the Level of Service Inventory Ontario Revision (LSI-OR). These assessments were conducted in 14 Ontario Provincial Correctional facilities during the years 2005-2008. Bivariate and multivariate regression analysis was conducted to assess recontact rates for serious mentally disordered and non-mentally disordered offenders.

With regards to recontact, no differences were revealed between the seriously mentally ill offender and non-mentally ill offender. This null finding on recontact is very surprising given the current literature on the seriously mentally ill. An additional finding revealed that for offenders with or without a serious mental illness, having a higher score on the scale of criminogenic tendencies (LSI-OR) increased rates for recontact. Another surprising finding is that seriously mentally ill offenders were more likely to commit minor crimes upon release, rather than violent crimes as current literature suggests. A more accurate research tool, as well as a larger sample size, will be required to assess the validity of these results.

The implications of the negative outcome with respect to recontact and issues of identifiable risk factors for recidivism for both seriously mentally ill and non-mentally ill inmate populations are discussed in relation to outcomes in terms of both improvements to Corrections policy and theories of criminology. It is important to continue research in this area, to determine the true gravity of the incidence and recontact rates of mentally ill offenders.

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Dedication

I would like to dedicate this thesis to my late Grandma Mary Hogan-McTaggart who supported me throughout all my schooling and told me to never give up. I wish you were still here to see this day but I know you're looking down on me. I love you!

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1.0 Introduction

> "...Treating mentally damaged offenders can be close to impossible in provincial jails, where inmates are on short court remands or serve sentences of less than two years. Longer federal sentences allow time for treatment, but it's rarely available."
>
> -Howard Sapers, Canada's Correctional Investigator

Approximately 20 percent of Canadians will experience mental illness during their lifetime (Health Canada, 2002). Ford and Trestman (2005) observe that in the past ten years the number of individuals with a mental illness apprehended by police, appearing in court and sentenced to a period of correctional supervision, has grown dramatically. According to the Ontario Ministry of Health and Long Term Care (2002) the number of mentally ill persons in the criminal justice system has reached crisis proportions. This in turn creates problems for corrections, the mental health system and the Ontario government. Hartford (2005) reports similar findings for Canada as a whole. In fact, the Correctional Service of Canada (2007) estimates that as many as 35 percent of inmates in correctional institutions in Canada have a mental illness.

Correctional Services of Canada (2007) reports that inmates with a mental illness pose one of the most serious challenges to the modern correctional system in terms of managing and rehabilitating offenders. At the same time, institutional and socioeconomic changes have led to an increase of individuals detained with mental illnesses (Ford &Trestman, 2005). The dramatic increase in individuals with a mental illness involved in the criminal justice system is believed to be the result of deinstitutionalization from psychiatric hospitals, coupled with the failure to provide the necessary treatment programs for individuals with a mental illness who are now living in the community. At the same time, lack of affordable and supportive housing is pointed

to as a key factor in homelessness among individuals with a mental illness (Northeast Mental Health Implementation Task Force, 2002), with the result that individuals with mental illness who are homeless or in a transient housing situation are more frequently brought into contact with police (Brown, 2006; Hartford et al., 2005).

An increased number of inmates is problematic with respect to the burden of cost. It is very costly to house inmates every year with Basen (2006: 2) estimating this to a total $110,223 for a male prisoner in a federal prison and $150,867 for a female, and $52,000 per year in a provincial facility. Furthermore, managing inmates with mental illness is especially problematic. This can be attributed to a lack of programming in correctional facilities, specifically treatment programs for the mentally ill, due to a lack of money in the correctional system (Canadian Mental Health Association, 2005:1). If those inmates who have a mental illness do not receive the proper treatment they require when institutionalized, it can be very problematic for the communities in which they are released (Champlain District Mental Health Implementation Task Force, 2004). Unfortunately, those inmates who are not treated when in the community go through a vicious cycle and are more likely to have more contact with the legal system and police authorities leading to further contact with the correctional system and increased incarceration rates.

Currently in Canada, there is not much known about the characteristics of mentally disordered offenders, specifically those classified as “seriously mentally disordered”. Those offenders who have a serious mental illness are those classified to have AXIS I disorders under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Serious mental disorders include schizophrenia, bi-polar disorder and so forth. This is due to lack of adequate assessment tools available for use in the corrections system.

When offenders are brought into correctional facilities, an intake assessment is conducted. The mental health screening tool for inmates is an important part of this routine intake process in order to gather information on each inmate and their mental health state. Mental health screening programs in prisons are of particular importance given the chaotic nature of the prison environment. Teplin and Swartz (1989) state that "without a systematic screening procedure, jail personnel may not be able to differentiate the mentally disordered inmate from the merely disorderly inmate" (2). Statistics have shown that some Canadian jails process over three hundred people on a daily basis (Grisso, 2006). Screening individuals upon admission means "reviewing every person admitted in order to determine whether he or she needs referral" (Grisso, 2006: 1049).

In Ontario, there are currently no assessment tools in place that are effective in positively identifying mental illness in prison populations, or that can predict recontact or recidivism. According to Ford and Trestman (2005: 6-7), "fewer than one in three incarcerated adults with psychiatric disorders is identified in routine entry screening." Correctional staff need a brief, cost-effective, easy-to-administer and reliable mental health tool to identify mentally ill offenders upon admission to correctional facilities. Unfortunately, currently available screening tools are not appropriate for the prison setting because of: (1) length of administration time, (2), paucity of mental health professionals, (3) requisite reading scales, and (4) lack of validity in jail settings (Teplin & Swartz, 1989). Prisons in the U.S. use tools such as the Minnesota Multiphasic Personality Inventory (MMPI) and the Millon Personality Inventory. These tools often take 1-2 hours to administer per inmate, which in Canada is considered too long for a jail intake procedure (Teplin & Swartz, 1989). Other scales, such as the Brief Psychiatric Rating Scale or the Rorschach Inkblot test, require a trained mental health professional to administer

and score the test (Teplin & Swartz, 1989). This is problematic because there are not enough mental health personnel to conduct these evaluations. Additionally, the cost to employ such professionals is a burden because of the large number of inmates admitted per day.

Beyond administration issues, many of the current tools (such as the MMPI,) require inmates to have a minimum reading level. Studies have shown that inmates usually have grade nine or less education, making such tools inappropriate in many cases (Teplin & Swartz, 1989). It is also the case that assessment tools to date are most often not valid for the use with female inmates. This is associated with difference in emotional and physical needs. Females offenders require more supervision and care because their needs are so high (Scott & Gerbasi, 2005).

Finally, studies have revealed that many jail screening assessment tools lack validity within the subscales they incorporate. An example would be in the MMPI where special subscales were developed to the test whether inmates could adapt to prison settings well. Some studies suggest these subscales had no real usefulness demonstrating little predictive validity (Teplin & Swartz, 1989). Screening instruments in general also tend to create false positives, suggesting the occurrence of a mental health problem when none exists.

There are many negative consequences if inmates are not properly assessed upon admission. First, mentally ill inmates may not receive adequate or appropriate treatment. Research by Nicholls et al. (2004) looked at the prevalence rates of mentally ill in prison. They showed that if an offender with a mental illness is not properly assessed upon admission, there can be negative consequences in the correctional setting, such as mental illnesses not being properly treated and managed accordingly. Incarceration for an individual with a mental illness can serve to worsen their mental health functioning. Some individuals may develop mental illnesses during the course of their stay in a correctional setting (Nicholls et al., 2004). Often

individuals with mental illnesses in prisons feel threatened by the stress of this environment and are unable to access treatments for their illnesses. The Correctional Service of Canada has recognized this increased problem and are working on implementing a screening assessment tool to "assist jails in meeting legal and professional standards of care, to identify and manage the diverse mental health needs and risks commonly found among new detainees, to ensure equitable care to all inmates, and to protect professionals and institutions against civil liabilities" (Nicholls et al., 2004: 169).

More important to this thesis is a second consequence that there is not much known about the factors associated with serious mentally disordered offenders and recidivism/recontact. The literature available does not provide adequate answers to the connection between mental illness and recidivism. Recidivism can be defined "as a return to criminal behaviour during or after correctional intervention" (Brown, 2003: 3). The broader understanding of recidivism is recontact which focuses more on system involvement using police, courts and corrections. Recontact can be defined as how many times offenders came in and out following a release from custody whether a new offense, bail conviction or reoffense. The difference between these two terms is important because recontact provides a better measure of system involvement. At this point there has been very little research carried out to identify the unique characteristics of recontact trajectories for offenders with a mental illness that would promote effective treatment and discharge planning (Ministry of Community Safety and Correctional Services, 2005).

Two leading academic psychologists, James Bonta and Don Andrews, are the Canadian experts in the field of recidivism for normal offenders. They have identified factors that predict recidivism for normal offenders which have been termed the 'Big 4' risk predictors for

recidivism (Bonta & Andrews, 2003). Unfortunately, these factors have not been tested with seriously mentally disordered offenders.

With the lack of research taking place in this area and not enough studies conducted on offender populations, it is difficult for Correctional Services to properly assess inmates who constantly come in and out of prison. It is problematic to gain access to these unique prison populations due to the all the security clearances and safety protocols necessary. Studying inmates and effective screening measures takes a long time and unfortunately some inmates fall through the cracks of a poor judicial and correctional system. This thesis will look to provide some answers to the gaps in the literature.

Conceptual Focus and Theoretical Approach

Overall, the purpose of this thesis is to investigate recontact with serious mentally disordered offenders and non-seriously disordered offenders in Ontario provincial correctional facilities. The thesis will explore whether mental illness is a factor in recontact; other risk factors will also be assessed which could be associated with recontact. Statistical models will analyse whether recontact is occurring more with those who have a serious mental illness and will imply possible solutions for overcoming this problem. Therefore, the objective of the thesis is to examine recontact rates with a focus on serious mental illness. This thesis is unique as it uses a new screening instrument the Resident Assessment Instrument-Mental Health version 2.0 (RAI-MH 2.0), to contribute evidence in regards to serious mental illnesses and recontact. The RAI-MH assessment tool will help to identify specific problems with the seriously mentally ill and whether certain characteristics impact recontact rates.

The findings from this thesis will have a number of criminal justice system implications. Firstly, they should help answer whether individuals with mental illnesses, and more specifically serious mental illnesses, should be placed in correctional facilities or be cared for in the mental health care system. Secondly, this research should assist in answering the questions of whether mental health facilities are able to adequately house offenders, some of whom may be violent.

Thirdly, in 2005 the Ontario government initiated the criminal justice system diversion strategy as a first step in recognizing this problem. This strategy was designed to divert persons with a mental illness out of the criminal justice system and into the mental health care system where they can be treated (Ministry of Community Safety and Correctional Services, 2005). A key component of this strategy is to provide treatment and release support (discharge planning) for individuals with a mental illness who have been incarcerated. Thus, this thesis will directly address this knowledge gap, by making use of previously unavailable data to examine the characteristics and recontact trajectories between offenders with serious mental illnesses and those who are normal.

It is clear that prisons should include a mental health screening tool for inmates upon admission as a routine intake process. To this date there has been no assessment tool created that is appropriate for the forensic/offender population. The development of such an appropriate assessment tool would be the ideal solution in predicting the level of mental illness and possible recontact and recidivism rates. It is clear that there are many areas that need to be looked at in order to come up with the ideal screening tool. A screening tool must be brief, cost-effective, and easily administered by correctional staff and appropriate for a jail setting along with sound psychometric properties (validity and reliability).

One relatively new and potentially effective screening tool is the RAI-MH 2.0 (Hirdes, 2002). The RAI-MH 2.0 is defined as a "standardized data collection system for mental health, and it is intended to identify key clinical issues related to patient care planning, quality improvement and outcome measurement, all of which are ultimately linked to resource utilization and funding" (Hirdes et al., 2003: iii). This assessment tool was designed to be used by front line staff, provide data about patient severity, the quality and outcome of care provided, and to bring a better understanding of hospital operations and funding (Hirdes et al., 2003). The tool also has the benefit of being compatible with previously used RAI instruments which were designed to meet the needs for patients in long term, acute, forensic, and geriatric psychiatric settings (Hirdes, 2002).

Thesis Organization

This chapter provides a brief overview of the research problem and the approach to be taken for addressing it. Next, Chapter Two consists of the literature review and conceptual models to review factors of the mentally ill being incarcerated by society today, including a review of their prevalence, characteristics that are reflective of them, and ways of measuring conditions in the criminal justice system. The focus is on mental illness, plus past studies that have been conducted on mental illness, recidivism and prevalence rates both in Canada and the United States. A conceptual approach will be proposed that includes two analytical models relating to the factors affecting recontact, recidivism and mental illness. The chapter will also include a discussion on the current problems of seriously mental ill inmates and recontact and recidivism rates.

Chapter Three reviews the methodology employed in this study. The chapter describes the measures employed to examine recontact and recidivism and the various independent variables used to predict them based on statistical approaches, which include both logistic regression and a comparison of means, as well as other significance tests. It also looks at the instrument employed in this study—the RAI-MH assessment tool—explaining how this assessment tool was used in 522 face-to-face assessments in Ontario Correctional Facilities.

Chapter Four reviews the findings. The statistical models developed in chapter two are applied to examine what impacts on recontact and recidivism. Following this, Chapter Five summarizes and discusses the findings from the research and offers conclusions and policy insights. It concludes the thesis by addressing the need for a valid assessment tool at every correctional facility. Possible solutions to the problem will be presented for Corrections to try and deal with the seriously mentally ill, both while in prison and before or after time spent in the facility. The need for further research along the lines of better assessment and training together with recommendations will be reviewed.

2.0 Literature Review

2.1 Background

The prevalence of mental illness in Canada appears to be on the rise. According to the Government of Canada (2006), mental illnesses are identified as changes in thought patterns, which can either cause distress or impaired judgment. Mental illnesses can be mild or severe in nature, for example, depression or schizophrenia. There could be a number of causes for mental illness such as: "genetic, biological, personality and environment factors" (Health Canada, 2002). That being said there are high numbers of individuals in the community with mental disorders that are often not treated. Ford and Trestman (2005) observed that in the past ten years the number of individuals apprehended by police, appearing in court and sentenced to a period of correctional supervision, has grown dramatically. Increasing proportions of these cases are represented by individuals with a mental illness and have grown at a rapid rate since 1992 (Barbaree, 2002). In order to identify the reason for this growth, a provincial forensic survey was implemented, the 'Forensic Psychiatric Clients in Ontario' (Barbaree, 2002). Findings from the survey provide evidence of the degree of growth of the mental illness problem. According to the Champlain District Mental Health Implementation Task Force (2002), there were "more than a 100 percent increase in forensic patient numbers [provincially between] 1988 and 1998" (4).

It is estimated that within the Canadian prison population 25 percent of inmates have a mental illness requiring an extensive mental health evaluation (Grisso, 2006). Storey and White (2005) report that one in eight inmates in the Canadian federal corrections system has a diagnosed mental illness; approximately 1,500 individuals out of a prison population of about 12,500. The dramatic increase in individuals with a mental illness involved in the criminal justice system is believed to be the result of many different causes such as: lack of programming

for the mentally ill, lack of training for correctional staff and dangerous settings for the mentally ill.

There is not a lot of Canadian research on why there are so many mentally ill offenders in the correctional system. However, there are some ideas as to why this may be occurring. These relate to: (1) deinstitutionalization from psychiatric hospitals, (2) propinquity with police, (3) lack of treatment availability, and (4) stigma. The following will outline these possible grounds for the increase of the mentally ill in the corrections system.

2.2 Deinstitutionalization from Psychiatric Hospitals

Prior to the deinstitutionalization movement, individuals with mental illnesses were seen as 'abnormal' and were housed in asylums and mental hospitals away from society. Often the mentally ill were included among other so-called "abnormals" such as political dissidents, homosexuals and the homeless. Negative patient treatment often occurred in mental hospitals and public asylums. Asylums and mental hospitals had roles in society to 'control' the abnormal (Cockerham, 2003). These asylums served as warehouses, which housed the non-criminal deviants of our society (Conrad, 1985, Brown, 2006). Among the forms of social control exercised were forced medications, lobotomies and electroshock therapy. Ken Kesey's 1962 *One Flew Over the Cuckoo's Nest* was a novel which brought notoriety to these conditions.

The deinstitutionalization movement of the mentally ill began in the 1960s. Psychiatric treatment in mental hospitals and asylums started to be replaced with treatment that was delivered within the community by mental-health community based agencies (Brown, 2006). By this time psychotropic drugs such as sedatives were being developed giving the mentally ill person the chance for the first time to be released in the community. Psychotropic drugs are still

used as ‘control’ mechanisms for the mentally ill in order for them to be allowed to stay in the community.

Prior to deinstitutionalization there was little basis for ongoing contact between the mentally ill and with the police. However, the deinstitutionalization movement brought much greater contact between these two groups. This means that mentally ill patients are often out in the community and do not have the resources available to them for proper treatment. They may end up coming into conflict with the police and in the correctional system. Consequently, this creates serious implications for correctional staff and health care workers managing mentally ill individuals. This is because these individuals can be difficult to deal with and often do not co-operate in a corrections setting. Another important problem is that correctional services have a mandate for safety and security—not for mental health care.

2.3 Propinquity with Police

Police contacts with the mentally ill have continued to increase significantly since deinstitutionalization. According to Bonovitz and Bonovitz (1981) research in the United States shows an increase in the number of mental illness related cases between 1975 and 1979 by 200 percent. Due to limited funding to house mentally disordered patients, the police were often those to have first contact with the mentally ill (Brown, 2006). A recent study undertaken in London, Ontario by Hartford, Heslop, Stitt and Hoch (2005), reported that individuals with a mental illness who come into contact with the law are more likely to be arrested, and be re-arrested, than members of any other groups. Toronto Police also reported an increase of 30 percent per year in mental health apprehensions between 1999 to 2002 (Brown & Maywood, 2002). Brown (2006) states that due to increased police contacts with mentally disordered offenders, “the police are being called on to perform as ‘psychiatrists’ in blue” (6). According to

Lamb *et al*. (2002) "[the police] are responsible for either recognizing the need for treatment for an individual with a mental illness and connecting the person with the proper treatment resources or making the determination that the individual's illegal activity is the primary concern and that the person should be arrested" (1266). However, this is problematic because the police do not have enough training to deal with the mentally ill (Lamb et al, 2002) and there are not enough community treatment programs for the police to bring the mentally ill individuals to.

Police officers are often called to respond to calls in which mentally disordered individuals violate a Community Treatment Order (CTO). A CTO is given out by a psychiatric facility when an individual is released from their services (Brown, 2007). An individual can live in the community as long as he or she takes medications and attends treatment programs. However, many individuals violate CTOs. When an individual violates a CTO, the police are able to apprehend the individual immediately and take them back to the psychiatric hospital or to a hospital for further assessment (Brown, 2007). This is dangerous for police officers as those individuals being arrested are often dangerous due to the instability of their mental capacities. Another situation in which the police are called on to apprehend the mentally ill is when they feel that they are a threat to themselves or someone in the community (Brown, 2007).

One serious problem that the police face today is that they may have minimal training for dealing with the mentally ill. Therefore, it is difficult for them to determine if an individual is suffering from a mental illness. Each police service provides a different form of training to deal with those who are mentally ill. According to Hartford *et al* (2003) this training may consist of "modest in-service education on mental health issues, …and forty hours of additional training in mental health issues for officers who would then be first responders to calls involving persons with mental illnesses" (847).

Another problem is a lack of community services programs where police can take the mentally ill upon apprehension; therefore they are often forced to bring them into police custody (Brown, 2007). The Ontario Government has attempted to address this problem by providing both more training for police officers and the implementation of Assertive Community Treatment Programs (ACT). ACT programs provide individuals with mental illnesses with "highly structured case management [plans], with a designated professional charged with the overall responsibility for the individual's treatment and rehabilitation plan" (Goin, 2004: 6). It is hoped that with more community programs, the mentally ill will receive the treatment they need to be less of a community disturbance and problem for police services.

2.4 Lack of Treatment Availability

Another basis used to explain why so many mentally ill individuals are overrepresented in the correctional system is the lack of treatment programs available. According to the Canadian Mental Health Association (2005) more than 20 percent of offenders in Canada require some form of mental health treatment. Since the closing of psychiatric facilities there are now an abundance of offenders in prisons with mental health problems. Reductions in forensic beds were a result of new community treatment programs starting up. These new programs moved forensic patients out into the community, therefore increasing the numbers in the correctional system (Champlain District Mental Health Implementation Task Force, 2002: 4).

Another serious problem is that treatment options for the mentally ill offender is either "sub-standard or sometimes almost non-existent" (Canadian Mental Health Association, 2005:1). Additionally, there are no specific programs for seriously mentally disordered offenders. With no adequate treatment programs for the mentally ill once in the community they often come into contact with the law. Penny Marrett, CEO of the Canadian Mental Health Association (CMHA),

has stated “this is an inhumane and unsafe way to address offenders with mental illnesses, especially when they are often serving time for low-level, non-violent crimes that are the result of little to no availability of treatment or support in the community” (Canadian Mental Health Association, 2005: 1).

It is also known that prisons are not suitable environments to house the mentally ill. Prisons can aggravate the symptoms for those who are mentally ill and place them at risk of suicide because prison staff do not fully understand how to deal with mental illness (Nicholls *et al.*, 2004). The combination of poor quality of treatment and the prison setting can often cause more problems for mentally ill offenders and the correction facilities in which they are housed.

Possibly the biggest problem relating to treatment availability is the lack of money to fund treatment programs for the mentally ill in both the correctional system and the health care system. According to Sharpe (2005) Correctional Services of Canada has created a four step strategy to alleviate the problem of the mentally ill in the correctional system. This four step strategy involves: (1) complete jail screening assessments upon intake, (2) fixing existing mental health treatment in jails, (3) creating new mental health facilities in jails, and finally (4) making sure that there are an adequate number of community resources available to offenders upon their release (Sharpe, 2005). However, without adequate funding the mentally ill will continue to be a problem for the correctional system. Furthermore, in order for offenders with mental illnesses to stay out of jails, there needs to be communication between the mental health system and the correctional system with respect to treatment programs.

2.5 Stigma: Criminalization of the Mentally Ill

Goffman (1963) states that mental illness is a form of stigma where individuals have 'blemishes of character' and society discriminates against them. The negative labeling of the mentally ill in our society has been going on for years. One may be labeled as 'criminal', 'mentally ill' or 'both'. Once an individual is labeled as 'mentally ill', the individual starts his/her career as a chronic mental patient. It becomes very difficult for this individual to shed this label. Scheff (1999) has linked mental disorder and labeling theory. Labeling theory describes how society sets up certain rules and norms which an individual must follow. If an individual fails to obey these rules they are considered to exhibit abnormal behaviour and hence labeled deviant (Scheff, 1999).

Scheff looks at two concepts when defining those who are mentally ill: rule-breaking and deviance. Rule breaking simply means behaviour which violates the norms created by the rules of the group (Cockerham, 2003:120). Most norms violated do not constitute a person as being mentally ill, instead they could be sinful or criminal. Deviance, on the other hand, is any behaviour or act that contravenes social norms (120). To simply break a rule is not enough to view an individual as mentally ill. However, Scheff uses the term 'residual rule breaking' in describing how one obtains a label. Residual rule breaking is based on the fact that most social conventions and norms are pretty clear; however, there is a residual part of social convention that is assumed to be natural, derived from human nature (120). Residual conventions, for example, could be as simple as looking at someone when having a conversation with them (120). In order to break these residual conventions, one must act in a way that goes against 'human nature'. This behaviour may be regarded by others as unnatural and seen by others as a mental illness (120). In order to accept the label of being mentally ill, one's behaviour must be normalized,

which means an explanation must be given as to why the behaviour went against the norm. Also, the label is usually placed on the individual because people embellish the rule-breaking behaviour. The label is stabilized if it is defined to be evidence of mental illness and the individual (rule breaker) is put in a role of deviant status and starts to play the role of a mad person (Scheff, 1999). Once in this role, social stereotypes shape the symptoms of mental illness in society.

In understanding how one becomes labeled as mentally ill, it is now important to look at how one is controlled by society. Scheff (1999), states that "the power of social control is not limited to the operation of actual censure but includes the operation of imagined censure" (33). Individual's actions are created in response to social control. According to Scheff (1999), "systems of social control exert pressure for conformity to social norms through the operations of sanctions: conformity to shared expectation is rewarded, and nonconformity is punished" (35). When an individual becomes labeled, the mental health system (agent of social control) becomes the 'vehicle' of construction and upholding of illness (Grusky & Pollner, 1981). Horwtiz (1982) claims that once an individual is labeled mentally ill they receive sympathy, are ignored or are placed in institutions to keep them away from society. When society places labels on the mentally ill, it produces stigma. Keeping individuals with a mental illness incarcerated reinforces the stigma to society that individuals with a mental illness should be kept away from the community. The criminalization of the mentally ill has created a stigma for the mentally ill, specifically the seriously mentally ill, and unfortunately has not be recognized as a growing problem for corrections until recently. Specifically, by creating the label 'severely mentally ill,' society tends to assume that these individuals are more dangerous to society and offend at greater rates than normal offenders. This often creates fear and people think it is best to keep these

individuals off the streets and throw them in jail. Understanding mental illness and specific factors relating to recontact, for example, homelessness, and substance abuse, is very important and not many individuals really know much about the subject. Therefore, it is important to understand severe mental illness and the specific factors relating to criminal offending (and recontact) to help to remove this stigma. The relationship between serious mental illness and recontact will be discussed further below.

2.6 Prevalence Studies of Serious Mental Illness among Inmates

Overrepresentation of the mentally ill in correctional facilities has caused numerous problems for correction officials. This is mainly because Correctional Services do not have the proper training and knowledge of the mentally ill. Studies on the prevalence of mental disorder are important because there is not enough research concerning the scope of the problem to know how big it really is and how it can be addressed. Previous studies have suggested that the prevalence of mentally disordered inmates within the Canadian prison population is represented by approximately 25 percent of inmates identified as requiring an extensive mental health evaluation (Grisso, 2006). Most of the studies presented use the DSM-IV definitions for mental disorders. Inmates suffering from Axis I disorders suffer from serious mental disorders while those who suffer from Axis II disorders which are not as serious. The focus of early studies outlined below will be on Axis I, which are those individuals suffering from a serious mental illness. Also, these studies have produced a wide range of estimates of prevalence. For example, Olgoff (2002) found that upon intake variance in mental illnesses both serious at 5% and common mental illnesses at 88% of the prison population in the United States. The enormous variation is cited because there are different populations studied, the research methods employed were different and the assessment instruments and the definition of mental illness used by each

researcher is different. The fact is there is an extraordinary range of seriously mentally ill in the criminal justice system. Various other studies have shown that there are a large number of serious mentally ill individuals in the prison system (psychoses, mood disorders, anxiety disorders, substance abuse disorders and personality disorders) (Thompson, 2007). On the other hand, they have discovered the overrepresentation of the seriously mentally ill in prisons. The seriously mentally ill are more of a burden for correctional institutions due to their high risk to harm either themselves or prison workers.

Brink, Doherty, and Boer (2001) examined the prevalence of mentally ill offenders in Abbotsford, British Columbia. The sample consisted of 267 randomly selected male offenders. The offenders were interviewed using a screening intake assessment instrument which mainly focused on criminogenic factors (Brink et al., 2001). A Structured Clinical Interview for DSM-IV (SCID) was used to help diagnose major Axis I disorders (346). SCID looks at 40 psychiatric disorders using a computer program. In order for inmates' answers to be interpreted, four forensic psychiatrists and two forensic psychologists were present. To obtain additional information for the study, supplementary file reviews were conducted (Brink et al., 2001). Results from this study indicated that of the 267 inmates interviewed, 84.2 percent were seriously mentally ill. Specific Axis I disorders were found in this offender group with approximately 75.7% of offenders having a substance abuse disorder, 30.2% with mood disorders, 18.3% with anxiety disorders, and 8.4% with psychotic disorders (Brink et al., 2001). These results yielded evidence of a high proportion of mental illness in prison. Brink et al. (2001) also reviewed 15 prevalence studies from 1978-1997. Findings revealed major mental disorders such as schizophrenia, psychosis, mood disorders, anxiety disorders, personality disorders, and substance use disorders (Brink et al., 2001).

Corrado, Cohen, Hart and Roesch (2000) looked at the prevalence rates of mental disorders among Canadian federal inmates in Vancouver. The study was composed of a sample of 790 men which took part in a two stage assessment (Corrado et al., 2000). A semi-structured interview was used with inmates who were also rated using the Referral Decision Scale (RDS), the screening instrument for mental illness used for offenders upon their admission to the institution. The second stage of the study used the Diagnostic Interview Schedule to formulate results (Corrado et al., 2000). A Diagnostic Interview Schedule can be defined as "[an instrument which] yields diagnoses of several major mental disorders according to the criteria from the DIS manual of mental disorders" (Corrado et al., 2000: 640). Results revealed that, out of the sample of inmates studied, 15.6% had some form of major mental illness. As well, of these 790 inmates, 85.9% had a substance abuse disorder, 41.1% had an anxiety disorder and 64.3% has a form of anti-social personality disorder (Corrado et al., 2000).

Diamond et al. (2001) also looked at mental illness prevalence among inmates in both Canada and the United States. Of fifteen studies examined all used some form of psychiatric evaluation or structured clinical interview. Numbers of inmates in these studies ranged from 50-2,185 and included both males and females (Diamond et al., 2001). Findings from each study suggested a prevalence of Axis I major mental disorders. Common findings were schizophrenia (1.5%), mood disorders (10.5%), antisocial personality disorders (2.6%) and other forms of mental illness (25%) (Diamond et al., 2001).

Blaauw, Roesch, and Kerkhof (2000) used previously conducted studies to estimate the level of mental illness in thirteen European institutions. Results were compared from 1991 to 1998 and found that most inmates had either a major mental disorder (2-14%), a substance abuse problem (23-85%), anxiety disorders (6-27%), or psychiatric disorders (2-9%).

Fazel and Danesh (2002) conducted a meta analysis based upon 62 surveys from 1996 through 2001 examining mental disorders. The researchers searched for articles from on-line journals that focused on individuals diagnosed with mental illnesses based on validated assessment instruments and used prevalence rates of disorders determined for inmates studied (Fazel et al., 2002). They also sought to find characteristics of the 22,790 offenders. It was found that the majority of inmates were male and that "about one in seven prisoners in western countries have a psychiatric illness or major depression" (Fazel et al., 2002: 548). Other findings revealed that 47% had antisocial personality disorder, and 4% had a psychotic illness (Fazel et. al, 2002).

More recent prevalence studies have revealed similar findings. Duffy, Linehan, and Kennedy (2006) studied 438 men from 15 different prisons using a structured interview to measure mental illness and substance abuse among offenders. Results indicated a high incidence of mental illness among offenders. Common serious disorders found were: psychosis (0.8%), mood disorders (9.2%), anxiety disorders (13.8%), substance abuse (73.7%), and any other form of mental illness (22.6%) (Duffy et al., 2006). These results indicate that there is a high prevalence among inmates in the institutions studied. This means that inmates need to be treated in a mental health setting, whether that is in a hospital or mental health facility.

Tye and Mullen (2006) focused on estimating the prevalence of mental disorder among female inmates in prison and those in the community. The sample consisted of 103 females from a prison in Victoria, Australia. Inmates were studied using a clinical interview called the Composite International Diagnostic Interview. They were also administered a demographic questionnaire for additional information. The data collected compared the female inmates to the Australian Bureau of Statistics (ABS) Australian National Mental Health Study. Results

revealed 24% of female inmates had psychosis where as in the community only 1% had psychosis; 52% of inmates had anxiety disorders while only 13% in the community did. Other results revealed that 43% of inmates had personality disorders compared to 3% in the community. It was also found that 49% of inmates had mood disorders in comparison to 8.1% in the community. Lastly, it was found that 63% of inmates had substance use disorders, while only 5% had substance abuse problems in the community.

All of these studies demonstrate that there are a vast number of offenders in correctional institutions who have a serious mental disorder. The importance of these studies is to show that since de-institutionalization correctional systems are becoming full of the seriously mentally ill creating problems for correctional officials and for the mentally disordered offender due to lack of treatment. The studies presented show the seriousness of the problem of overrepresentation of the seriously mentally ill in correctional institutions and underscore the need for further research.

2.7 Characteristics of the Mentally Ill Inmate

According to most literature the characteristics the mentally ill offender are that they are young, male, less likely to be an ethnic minority, have a substance abuse problem, be more likely to be convicted for minor offences, homeless, have a history of psychiatric hospitalization, be in poor health and to have been victims of earlier trauma in their lifetime (Diamond et al., 2001, Brown, 2009, Rodriguez et al., 2006). According to Rice *et al*. (1998), "forensic patients [mentally ill] tend to be male, middle-aged [young], diagnosed with a psychotic disorder, and involved with substance use; they also have histories of prior psychiatric hospitalizations, and criminal offenses [violent]" (578). Forensic patients are not the same as inmates with a mental illness as usually they are deemed by the courts to not be criminally responsible. However, these two groups share the same characteristics as individuals with mental disorders. It is important to

look at all possible characteristics in detail to focus on the mentally ill offender to understand recidivism rates.

Homelessness (residential instability) is often found to be associated with inmates with mental illnesses. Susser et al. (1997) state that "in the United States men and women with chronic mental illnesses such as schizophrenia have 25% to 50% risk of becoming homeless, which is about 10 to 20 times the risk of homelessness for the general population" (256). They also state that these offenders are more likely to be victimized due to their current state. As well, the authors state that the reason there are so many homeless mentally ill inmates is due to the discontinuation of mental health services in the United States (Susser et al., 1997).

A 1999 study conducted of the mentally ill and homelessness in Toronto found that 66 percent of homeless individuals also had a mental illness, primarily depression (Wasylenki & Tolomiczenko, 1999). Mental illness in combination with substance abuse was also found to be a problem for most homeless individuals in Toronto. Wasylenki & Tolomiczenko (1999) have argued there needs to be more active outreach programs developed to help those with mental illnesses from being on the streets and to prevent incarcerations. Lack of affordable and supportive housing is pointed to as a key factor in homelessness among individuals with a mental illness (Northeast Mental Health Implementation Task Force, 2002), with the result that individuals with mental illness who are homeless or in a transient housing situation are more frequently brought into contact with police (Brown, 2006; Hartford et al., 2005).

Another study by DeLessi (2000) was conducted in order to seek out reasons for homelessness. The sample consisted of 200 inmates. Data collection involved file reviews to answer questions on demographics and history. Results revealed that most homeless were male,

alcoholics and were rearrested equally for both violent and petty crimes (DeLesi, 2000). Mentally disordered offenders are often homeless and lack adequate housing due to low levels of education and limited job opportunities (Northeast Mental Health Implementation Task Force, 2002).

Studies suggest homelessness is on the rise in Canada and it is estimated that the mentally ill represent 20-30 percent of the homeless population in Canada (Chenier, 1999). An explanation for the rise of the homeless population is that services for the mentally ill have decreased. With many institutional treatment centres closed, and the mentally ill now relying on community-based treatment, a source of shelter for those individuals is also being lost. According to Chenier (1999) there has been a decrease in psychiatric beds available in mental hospitals, leading to homelessness for some mentally ill individuals. Research has shown a link between serious mental illness and violence. Douglas et al. (2009) state in their research that prior to the 1990s, a conservative view existed that there was no relationship between mental illness and violence. However, starting in the 1990s researchers noticed a small association between violence and mental illness. Mulvey and Fardella (2006) made one such finding. They posited that individuals who suffered from a mental disorder were more likely than those individuals who had no mental disorder to "act out more violently" (Mulvey & Fardella, 2006: 2). According to Mulvey and Fardella (2006), "violence is more likely to take place when an individual is experiencing active symptoms of a mental disorder—[e.g.,] the low of a depressive jag, the panic of an anxiety attack [, etc]—than while the disorder is lying dormant" (3). These authors also identified risk factors associated with mental illness and violence, these being substance abuse problems and a previous history of violence. Another factor found was that the locale in which a person with a mental illness lived could have a strong association to violence

(Mulvey & Fardella, 2006). If an individual lived on the streets, they were more likely to be violent.

Arboleda-Florez (1996) conducted research for the Public Health Agency of Canada focusing on the relationship between mental illness and violence. A meta-analysis showed there was a causal relationship between mental illness and violence. Early studies showed that mentally ill offenders are no more likely than normal offenders to be violent. On the other hand, two studies showing the opposite are from a Canadian sample by Blan and Orn (1986) and another from an American sample conducted by Swanson, Holzer, Ganju and Jono (1990). Both studies used large Epidemiological Catchment Area site (ECA) methodology showing those with mental illnesses to be in fact are more violent than those without illness. A diagnostic interview schedule (DIS) and a computer program were used to score the responses (Arboleda-Florez, 1996). The Canadian study showed that individuals with either major depression, anti-social personality disorder and alcohol and drug problems, were seven times more likely to be violent (Arboleda-Florez, 1996). Substance abuse problems are considered a mental illness. Individuals who do not have a substance abuse problem but combine drugs and alcohol with their diagnosed mental illness are 80-93% more likely to have a violent encounter (Arboleda-Florez, 1996). The American study revealed that individuals who suffered from a mental illness and had a substance abuse issue appeared to be at risk to commit more violence (Arboleda-Florez, 1996). Both studies found relationships between violence and mental illness. However, neither study could determine the causal direction, making it hard to conclude that the mentally ill were in fact more violent than normal offenders (Arboleda-Florez, 1996).

Most mentally ill inmates have a substance abuse issue stemming from many different causes. Research has revealed that the majority of offenders who have a mental illness often

have a substance abuse problem (Clark *et al*, 1999; Naples *et al.*, 2003; Nicholls *et al.*, 2004; Rice *et al.*, 2004; Blitz *et al.*, 2006). It is estimated that 66 percent of males and 60 percent of females used drugs or alcohol three months prior to incarceration, and 33 percent were intoxicated upon admission (Scott & Gerbasi, 2005). It was also found that in the same group, almost 80 percent of those inmates used substances other than alcohol three months prior to incarceration (Scott & Gerbasi, 2005). According to Sims (2005) men and women often have substance abuse issues and suffer different types of mental health problems. She posits that women who have mental health problems usually turn to drugs due to having "a history of experiencing physical, sexual, and psychological abuse at higher rates than males" (Sims, 2005: 229, Scott and Gerbasi, 2005). It has also been known that most female offenders have turned to drugs and alcohol to cope with their past experiences (230). Most of these inmates suffer from Post Traumatic Stress Disorder (PTSD) which is common with female inmates. Sims goes on to state that if individuals with a mental illness are not properly assessed upon admission, they are more likely not to engage in treatment programs due to fears and anxieties. Also, offenders often turn to substance abuse to serve as a coping mechanism for past abuse they have incurred (Sims, 2005). Drake (1994) has another explanation as to why those with mental health problems turn to drugs and alcohol. He posits that individuals with a mental illness often turn to drugs and alcohol "in a misguided attempt to alleviate symptoms of their illnesses or side effects from their medications" (1). He also states that those offenders with mental illnesses are often prone to using drugs and alcohol due to poverty, lack of intelligence, social isolation and anxiety. Substance use problems among inmates are a significant problem for correctional facilities today. According to Bonta and Andrews (2003) "51 percent of the offenders reported being under the influence of alcohol or an illegal substance during the commission of the offense"

(411). There are many consequences of substance abuse. Substance abuse can cause social, economical, and physical and emotional issues for an offender. Research has suggested that inmates who use drugs or alcohol are more likely to be associated with committing violence crimes (Bonta & Andrews, 2003).

As stated earlier, substance abuse can be the result of being abused. Most of the literature on abuse focuses on female offenders. In Canada, the 'Creating Choices Report' (Correctional Service of Canada, 1990) examined prevalence studies for female offenders with mental disorders. The report revealed that most women (80%) suffered abuse in their lifetime, with almost 70% stating they had been physically abused and 54% reporting sexual abuse in their past. An interesting finding is that "69% [of females] reported substance abuse had played a major role in their offense or their offending history" (Laishes, 2002:8).

Race and ethnicity and overrepresentation of the mentally ill within the criminal justice system have been serious issues for years. According to Pinals et al. (2004) black minorities are more likely to be discriminated against in the criminal justice system and have a higher likelihood to be assessed for an inpatient screening. A study conducted by Washington State University focused on ethnic minorities with mental illnesses. The research revealed that minorities with a mental illness were more likely to be incarcerated rather than sent to a psychiatric hospital (Pinals et al., 2004). It was also found that clinicians were biased in their assessments and were more likely to diagnose a person belonging to a minority with serious mental illnesses than a non-minority group member. This in turn leads to more incarceration of individuals with a mental illness rather than being placed in a proper psychiatric facility.

According to Roberts and Doob (1997), aboriginal and black offenders account for a "disproportionate number of admissions" in Canadian prisons (469). Roberts and Melchers (2001) stated that "Aboriginal Canadians represent 19% of provincial admissions to custody and 17% of admissions to federal penitentiaries" (212). Bonta et al. (1992) looked at previous research of aboriginal offenders and non-aboriginal offenders to see if the characteristics for recontact were the same for both groups. His research revealed the same characteristics for both aboriginal and non-aboriginal offenders: age at incarceration, prior incarcerations and prior convictions. There are, however, very few Canadian studies presently that show the relationship between mental illness and aboriginal offenders.

All these characteristics, homelessness, violence, substance abuse and race/ethnicity, have a significant impact on whether individuals with a mental illness are more likely to have a recontact with the criminal justice system. The next section looks at assessment tools that have been used in prisons in North America and focuses on their effectiveness for prisons.

2.8 Measuring Mental Illness in Prisons

Another serious problem concerns the challenge of measuring mental illness in prisons. Tools created in the United States, such as the Jail Screening Assessment Tool (JSAT), the Referral Decision Scale (RDS), and the Brief Jail Mental Health Screen (BJMHS) have been steps in the right direction for screening for mental illnesses but, as stated previously, current screening tools are not ideal for the prison setting because of: (1) length of administration time, (2) paucity of mental health professionals, (3) requisite reading scales (not all inmates have a high enough reading level to complete the assessments), and (4) the tools lack elements of validity (not suitable for all types of offenders).

2.8.1 The Jail Screening Assessment Tool (JSAT)

The Jail Screening Assessment Tool (JSAT) was developed by Tonia L. Nicholls, Ronald Roesch, Maureen Olley, James Ogloff, and James Hemphill in British Columbia in 2005. This assessment tool was developed in part to fit with British Columbia's two tiered assessment approach: screening followed by comprehensive assessments to identify individuals at jail intake with mental conditions (Nicholls et al., 2004). When this tool was created, Nicholls et al claimed that no other tool had been developed for screening adults entering the correctional system. The tool is a two page structured interview which has its questions focused on screening for mental disorders, violence, suicide/self-harm and victimization (Nicholls et al., 2004). This tool is administered in the form of a semi-structured interview and includes questions on... "demographic characteristics; current charges/legal status; criminal history; social circumstances (e.g. family support, housing, finances); past and present substance use and treatment; past and present mental health status/treatment; suicide violence, and self-harm history as well as current ideation and intent" (Nicholls et al., 2004: 172). The inmate's current mental state is evaluated as well using the Brief Psychiatric Rating Scale. This rating scale was designed to assess the severity of specific psychopathological symptoms (Nicholls et al, 2004). By conducting a file review and a 10-20 minute interview, the mental health screener makes an informed judgment on whether an inmate should be referred for mental health services or placement in a specialized area within the prison facility (Nicholls et al., 2004).

The purpose of the JSAT is to: "assess the inmate's current level of functioning, predict an expected level of psychological adjustment within the institution; identify any need for mental health services, and refer to appropriate correctional personnel and licensed mental health professionals those inmates who have special needs or risks that require unique intervention,

supervision, or management" (Nicholls et al, 2004:170). To administer the JSAT, personnel must have experience with offenders in prison, have experience with acute psychiatry, be aware of psychological assessment techniques and must understand and have experience conducting semi-structured interviews (Nicholls et al., 2004). According to the authors of the JSAT, "graduate training in psychopathology and assessment, which suggests that master's degree psychologists or social workers would be preferred" (Grisso, 2006: 1050). The JSAT manual also states that cross-discipline training between correctional officers and mental health professionals to ensure understanding of what each others practices are (Nicholls et al., 2004).

This tool also has several problems that should be addressed. For one the JSAT has not been validated in all offender populations—it has only been used for female inmates (Grisso, 2006). The tool also requires screeners to have graduate training in psychology or social work and requires a supervisory clinician when administering it. This is not appropriate for the intake prison process as these individuals and clinicians are expensive to bring to the facility. Another issue is the reliance on structured clinical judgment and the implications it can bring with the screening process. Individuals must be familiar with mental health disorders and have sensitivity in interviewing people that may have a mental disorder. If proper training is not done with this tool and individuals do not have a good grasp of psychological disorders, false conclusions may be drawn regarding whether an offender may actually have a mental illness. In addition, it is difficult to establish validity of an instrument that relies on administrator judgments. Grisso states that "validity is a problem for any psychological test but a greater problem for tools that have no scores and rely on the interviewing and inferential skills of the user" (2006: 1050). This also ties into the issue of reliability due to the fact that there is no structure to the questions that the interviewers ask-- the tool is fully reliant on personal judgement.

2.8.2 The Referral Decision Scale (RDS)

A second screening tool is the Referral Decision Scale. It was created in the United States and is intended to assess the mentally ill in prisons on intake. Early and effective detection of mentally disordered inmates calls for quick and easy screening upon admission. This led Teplin and Swartz to develop the Referral Decision Scale in 1989. The RDS was also designed to point out individuals who had a high probability of having a treatable mental illness or indicate if a person should be referred for possible evaluation and treatment by mental health professionals (Teplin & Swartz, 1989). This tool was created to identify individuals that had three major mental health disorders: manic-depression, major depression and schizophrenia (Teplin & Swartz, 1989). Teplin and Swartz focused on these three disorders because they are among the most severe and can also be treated (Teplin & Swartz, 1989). Secondly, jails have limited resources to accommodate individuals with mental illness and therefore treatment should be set aside for those who need it.

The RDS evolved from the National Institute of Mental Health Diagnostic Interview (NIMH DIS). The RDS was a proposed smaller version of the DIS suitable for the initial screening of inmates upon entering correctional facilities. The RDS has fourteen items and three subscales to distinguish between ill and non-ill individuals (Teplin & Swartz, 1989). For these three forms of mental illness, three subscales were created from narrowing thirty-two differentiating variables from three sub-groups for major depression, schizophrenia and bipolar-manic disorder (Vesey et al., 1998). The three subscales each consist of five items with one item that is shared between both the bipolar and manic depression subscales. Each sub-scale "contained a cut-off score that if met or exceeded, should result in a referral for mental health assessment" (Osher et al., 2006: 8).

In developing the RDS, Teplin and Swartz conducted a study using 728 randomly selected male inmates from the Cook County Illinois Jail. Inmates ranged from 16-68 years of age, were black, white, Hispanic or 'other' (Indian or Oriental) and had committed both misdemeanors or felonies. Nevertheless, the majority of the inmates in the sample were young, black, poorly educated and unemployed at the time of these arrests and most had committed misdemeanors (Teplin & Swartz, 1989). Differences on individual symptoms between inmates using the NIMH DIS were tested (Rogers et al., 1995). When tested thoroughly, this tool showed acceptable reliability.

A number of validity issues have been discovered with this assessment tool. This assessment tool produces a high proportion of false positives (Vesey et al, 1998). This means the assessment tool reports that an offender has a mental illness when they really do not. False positives can result in numerous unnecessary and expensive psychiatric assessments of non-mentally ill offenders, which in turn create high costs to correctional facilities that have scarce mental health resources already. The construct and face validity of the RDS have been examined. Questions were raised by Vesey and colleagues regarding the face validity of certain items in the assessment tool. They found that several items did not seem appropriate for the use of inmates in correctional settings and the "use of lifetime occurrence of symptoms rather than current symptoms may overestimate the need for further mental health services in the resource-poor jail environment" (Osher et al., 2006: 9).

2.8.3 The Brief Jail Mental Health Screen

Due to the problems with the Referral Decision Scale, Vesey et al. decided to revise the RDS to create a more practical tool for assessments in jail—the Brief Jail Mental Health Screen. This tool minimized 14 items in the RDS to 8 items, dropping the six items considered to have

questionable face validity (Osher et al., 2005). As well, several items from the RDS were rephrased to provide greater clarity in the assessment. The time frame was also reduced to the last six months versus the RDS which focused on lifetime occurrences (Steadman et al., 2005). The tool asks two yes/no questions about any history of hospitalization or medication for mental or emotional problems and six questions regarding current mental disorders. If in this questionnaire inmates answer "yes to two or more questions about current mental disorders or acknowledge having been hospitalized or taking medication for mental or emotional problems [they] are [then] referred for further evaluation" (Goldberg & Higgins, 2006: 82). This BJMHS takes approximately two and half minutes to administer and only requires minimal training, (the instructions on how to administer it are simply printed on the back of the form) (Goldberg & Higgins, 2006).

The BJMHS has been found to have a number of problems. One significant shortcoming with this tool is that it is not validated for assessing the mental health needs of *women* in prisons. A study conducted to assess the validity of this instrument using 10,330 male and female inmates correctly predicted 73.5 percent of males but only 61.6 percent of females as mentally ill (Steadman et al., 2005). BJMHS data were collected from these inmates and 357 Structured Clinical Interviews for DSM-IV standardized clinical cross-validation (Steadman et al, 2005). This screening tool does not nearly identify mental illnesses among female offenders as effectively as it does their male counterparts. The BJMHS "missed 34.7 percent of women with current symptoms, and 45.1% of women who were identified for referral did not have a current serious diagnosis…[creating false negative rates]" (Steadman et al., 2005: 821). This may be due to the fact that women detainees suffer from anxiety and post-traumatic stress disorders and the BJMHS does not measure these symptoms (Osher et al., 2006). Another reason why this tool

might not capture the mental health picture for women could be due to the fact that women are less likely to talk about symptoms or personal issues to correctional officers, and in most cases these officers are male (Osher et al., 2006). A similar problem to what was found in the RDS is also found in this BJHMS. This tool creates issues of reliability because the eight questions aren't structured and interviewers use their own judgment regarding whether an inmate should be referred for further treatment.

2.8.4 Level of Service Inventory-Ontario Revision (LSI-OR)

The LSI was originally developed by Andrews to assist with risk prediction for recidivism and to focus on specific needs of offenders entering the correctional system (Ferguson *et al*, 2009). This tool started as a 54-item scale that focused on static and dynamic risk factors of 10 subscales. Originally the LSI was used in general offender populations. The Ontario Revision of the LSI was developed later because case workers/probation officers thought it did not thoroughly address all the issues for case management plans for offenders. Also, workers wanted this tool to have more of a focus on continuity of care once offenders were released into the community. The General/Risk needs section of this tool has been validated for this specific instrument. Further discussion of this instrument will be presented in the methodology chapter.

The assessment tools so far discussed are the most well-known tools used to address mental health needs in prison. The discussion above focused on the pros and cons of their effectiveness in prisons, and their lack of effectiveness in screening for serious mental illness. An effective screening tool needs to be found so that inmates are properly screened upon admission in order to receive proper care and treatment if they have a serious mental illness. Without such a screening tool, offenders with a serious mental illness will continue to be placed in provincial institutions and not get the proper treatment they require. The next section looks at

recontact and recidivism and focuses on past and current studies on offenders with a serious mental illness.

2.9 Recontact and Recidivism

As stated previously, recidivism can be defined "as a return to criminal behaviour during or after correctional intervention" (Brown, 2003: 3). The term re-offending is also known as *recidivism*. Therefore, recidivism is the reconviction for a new offense committed after release from surviving a prior conviction. Recidivism can be subsumed by the more general term of *recontact*. Recontact is defined as how many times offenders come in and out of the criminal justice system following a release from custody. This includes all new offenses, bail convictions, or reoffenses. As compared to recidivism rates, recontact rates focus more on involvement with the police, courts and correctional systems. Recontact is different from recidivism as it concerns whether an individual has contact with any component of the criminal justice system, not specifically if an offense has been committed.

Much of the literature suggests that higher rates of recontact are associated with the mentally ill compared to normal offenders. According to Bonta, Law and Hanson (1998), "when compared with the general population, mentally disordered patients *appear* at a higher rate for re-offending" (123). Three case studies discussed below portray characteristics of a seriously mentally disordered offender as related to recidivism. Overall, the studies discussed show that there is evidence of the mentally ill re-offending more frequently than normal offenders.

Lovell, Gagliardi & Peterson (2002) conducted a study on recidivism and the mentally ill using a sample of post-released offenders with mental disorders (N=337), a group not previously

studied. They wanted to see if released inmates recidivated upon release. The results revealed that the majority of the sample that recidivated did so with less serious offenses (61%). Overall, they found that the mentally disordered recidivist was white, male, had a substance abuse problem, had a previous criminal history of a violent offense, and recidivated with a less serious crime (Lovell, Gagliardi & Peterson, 2002).

Gagliardi et al. (2004) conducted a second study on recidivism which focused on 333 mental disordered offenders released from Washington State Corrections between 1996-1997. Offenders were selected based on being diagnosed with a mental disorder by checking medical records and an offender-tracking database. The study was able to predict recidivism among these inmates upon its completion. Results revealed that of the 333 inmates in this study, 77% (258) recidivated (Gagliardi et al., 2004: 139). The majority of new crimes were felony offenses, (serious crimes). Approximately 41% of mentally ill offenders were convicted of felony crimes versus 38% from the general population. The results showed that the total reconviction rate for those who had a mental illness was very high at 69% (Gagliardi et al, 2004).

Hartwell (2003) conducted a study on mentally disordered offenders that focused on recontact, with or without substance abuse problems. Secondary data were used for this analysis of 226 mentally disordered offenders enrolled in the Massachusetts Forensic Transition Program. The data used were from a three month post release follow up. The results revealed that those offenders who had a prior involvement in the mental health system had a 23% recontact rate while those offenders with no prior involvement in the mental health system had only a 7% recontact (Hartwell, 2003). This suggests that the seriously mentally disordered offenders are much more likely to recontact over those inmates who have no mental illness.

The literature also documents the characteristics of recidivism for normal offenders. Of particular importance is a study done by Bonta and Andrews (2003). Bonta and Andrews (2003) have identified the major factors which predict recidivism for normal offenders. They have categorized risk factors into two categories: static predictors and dynamic predictors. Static predictors are those risk factors which cannot be changed, for example, age (Gendreau *et al.*, 1996). Dynamic predictors are those factors, which can be changed, for example, substance abuse (Gendreau *et al.*, 1996). Bonta and Andrews (2003) posit that there are four risk factors, known as the 'Big Four', as good predictors of recidivism: antisocial behavioural history (criminal history), antisocial attitudes, antisocial personality, and having antisocial peers. These factors have been identified again throughout various studies (Ferguson *et al*., 2009, Girard & Wormith, 2004, Bonta, Hanson & Law, 1998) and continue to be a very important finding in the literature on recidivism.

In order to compare the prediction of criminal and violent recidivism among mentally disordered offenders and non-disordered offenders, Bonta, Hanson and Law (1998) conducted a meta-analysis based on seventy-four predictor variables. These predictors were organized into four categories: demographics, criminal history, deviant lifestyle and clinical. The analysis revealed that the predictors of recidivism for the mentally ill were generally the same as for non-disordered offenders. These predictors are the same as the previously mentioned 'Big Four' risk factors: antisocial behavioural history, antisocial attitudes, antisocial personality, and having antisocial peers (Bonta, Hanson & Law, 1998). The factor found most strongly related to recidivism was criminal history. According to the authors, "these results strongly suggest that risk assessments of mentally disordered offenders should pay close attention to the general offender prediction literature" (Bonta, Hanson & Law: 137). This means that assessment tools

should have a focus on possible risk factors for re-offending when being used to classify offenders according to their mental health.

Girard and Wormith (2004) also looked at the difference in recidivism between the seriously mentally ill offender and the non-mentally ill offender using the Level of Service Inventory-Ontario Revision (LSI-OR) to assess the two offender groups. They found no significant differences between the two groups in association to violent offending. In addition, they discovered that although seriously mentally disordered offenders scored higher on the LSI-OR assessment, in fact they had a lower rate of recontact/recidivism. The conclusion here, then, is that having a serious mental illness could just emphasize the lower rates of recontact.

In summary, the results of Bonta and Andrews (2003) and Bonta, Hanson & Law (1998) show that the factors associated with predicting recividism are similar to the factors that predict recidivism in normal offenders, whereas the findings by Girard and Wormith (2004) show a relationship between recontact and mental illness that does not exist. This major contradiction is counter to the majority of the literature written to date on the seriously mentally ill and recidivisim. Bonta and Andrews (2003) suggest that mentally ill offenders lie "somewhere between the common citizen and the common criminal' in terms of the danger they pose to the public" (425).

Hence an important research question to be addressed questions which major finding is right: the studies which predict significant differences in recidivism between the mentally ill and the non-mentally disordered? Or the studies that show the factors which predict recidivism ('Big Four') are similar between these two groups? Therefore, an important research question asks whether mental illness is likely or unlikely to predict recontact. Given that this apparent

contradiction that has not been well-explored, it is an important area to investigate and will thus will be a focus of analysis in this thesis.

2.10 Conceptual Approach

Recidivism and the Mentally Ill

Overall, mental illness is a growing problem for the Canadian correctional system. The seriously mentally disordered offender has become a new problem for correctional institutions due to the increased care needs of these individuals due to the closing of psychiatric hospitals and the lack of treatment programs in and out of custody. Police forces are often left with no choice but to apprehend the mentally ill and bring them into the criminal justice system. This dramatic increase of serious mentally ill offenders in correctional institutions is highly problematic for society. This type of offender population needs to be studied immediately due to the resultant overrepresentation of these offenders in the correctional systems, and the number of issues that surface related in regards to mentally ill and criminality.

Much of the literature has looked at the characteristics of mentally disordered offenders in comparison to normal offenders. Bonta and Andrews (2003) show that there are four predictors of recidivism among the general prison population – the 'Big Four' (1) having antisocial behavioural history, (2) antisocial attitudes, (3) antisocial personality and (4) antisocial peers. Although normal offenders and mentally ill offenders exhibit some of the same characteristics for offending, less is known about the seriously mentally ill. One important question is whether these 'Big Four' factors also affect recidivism and recontact to an equivalent degree within the population of the seriously mentally ill in correctional institutions.

This thesis considers eight risk factors for both types of offenders (normal and seriously mentally disordered) to see if they apply similarly to each offender population. This thesis will use the 'Big Four' criminogenic factors (antisocial behavioural history, antisocial attitudes, antisocial personality, and having antisocial peers) as an index and incorporate them into a comparison model and a combined model. By using eight risk factors, comparisons will be made between the two populations (normal and seriously mentally ill) in order to assess the relationship between mental illness and recontact.

These eight measures for the analytical approach are selected based on previous research conducted on normal offenders, and constitute outcomes and causal factors considered important to recontact/recidivism rates among the two populations:

1. *Age*: Age will be included to see whether offenders who recidivate are more likely to be younger or older. Research states that the majority of offenders are young. This measure will be used, for example, to isolate mentally ill and non-mentally ill offenders while removing the influence of youth (the predominant category associated with crime).
2. *Sex (gender)*: Current research states that offenders who often recidivate are more often male. Sex is needed as a control because being male is a striking characteristic in Canadian correctional facilities.
3. *Criminal Offending Index*: This measure is chosen to see whether those who had a recontact were more likely to have a misdemeanour or felony crime. This variable will control for the nature of the crime.
4. *Aboriginal Status*: Aboriginal status is included because these individuals are overrepresented in the Canadian criminal justice system along with increased probability of recontact.

5. *Substance Abuse*: This measure is used to see if offenders with a mental illness are more likely to have a substance abuse condition, thus increasing the likelihood of recontact.
6. *Residential Instability*: The residential instability variable is a measure of homelessness and is chosen to see whether this and being mentally ill increases the likelihood of recontact. Research suggests that those who are homeless are more vulnerable and are therefore more exposed to crime.
7. *Abuse*: This measure is used to control for past abuse as a factor which may influence recontact. Research has shown that abuse is more likely to be a part of female offender background so it will be interesting to see its interaction with being male and recontact.
8. *A composite 'scale of criminogenic tendencies' based on the 'Big Four' (Total LSI-OR Score)*: This measure is composed of the four main risk predictors for recidivism. It is used in this study to test whether the risk factors are equally predictive for the mentally ill offender.

This research is needed because currently there is not enough evidence as to whether these two groups of offenders act differently. Nor are there clear findings related to the seriously mentally ill and recontact rates. It is speculated by previous research studies that the mentally ill are more of a risk to reoffend than normal offenders. However, there is some doubt that this is still the case due to new studies that show there is little relationship between mental illness as a risk factor and re-offense. Furthermore, there is a need to study the recontact rates of the two types of offenders to make sure proper classification of offenders is conducted upon admission. Having offenders properly classified will also give Correctional Services a reason to build specific institutions for the seriously mentally ill.

Screening Tools

Several psychiatric assessment tools have been created in order to detect mental illness upon admission to a corrections facility. As stated previously, screening tools that have developed in the United States thus far are not appropriate for screening inmates upon admission due to the various shortcomings exhibited by various studies presented earlier. Therefore, there is a strong need to search for an effective screening instrument. The importance of having a proper screening tool will allow probation officers to be able to effectively identify those offenders who are likely to have strong risk/needs factors to re-offend. There also have been no tools successfully developed in Canada to screen appropriately for serious mental illnesses. With no proper classification in place for North America, there is a concern of how valid current screening tools are for doing intake assessments. Screening tools need to be brought into place to ensure proper classification of offenders. Offenders are often brought into jails on short remands or to serve sentences of less than two years, so a classification system needs to be in place to classify all offenders upon admission. Without valid assessments and classification, treatment of the mentally ill offenders in provincial jails on short remands is not available.

If it is the case that there are no effective screening tools for mental illness, a strong instrument must be implemented to overcome the current problem. This tool should focus on capturing the overall factors that affect recidivism and to distinguish and gain an understanding of the differences in the two types of offender's backgrounds. Correctional Services need a better tool that has strong validity for addressing the seriously mentally ill and recontact. A candidate for a strong new tool to address these concerns is the Resident Assessment Instrument-Mental Health Version 2.0. The RAI-MH is a standard data collection system designed to assess mental health status and inquire about an inmate's personal situation using various scales. This

tool (Hirdes, Perez, Curtin-Telegdi, Prendergast, Morris, Ikegami, Fries, Phillips and Rabinowitz, 1996) is under development and will be discussed further in the methodology chapter (Chapter 3).

Objectives

Overall, this thesis will:

- Test whether having a mental illness affects recontact and will look at the possible risks of reoffending.
- Seek to validate or invalidate the risk factors associated with having a mental illness. It is anticipated that there will be a difference in findings between these two different groups of offenders.
- Provide clarification further through improved instrumentation to help to determine the overall mental health picture in prisons across Ontario.

Analytical Approach

The analysis will attempt to answer the following questions:

1. Will the mentally ill recontact more or less than the non-mentally ill offender?
2. Do the risk factors predict equally or different across the two groups?
3. Do the previously identified criminogenic tendencies hold equally for the seriously mentally ill and non-mentally ill offender?
4. Does being mentally ill contribute to a net increase in likelihood to recontact once all other risk factors have been taken into account?

2.11 Conclusion

This chapter presented how the view of the mentally ill offender has evolved over time. Due to de-institutionalization the mentally ill offender virtually has no assistance in the community. When they are suspected of committing a criminal act, they are exposed to all aspects of the criminal justice system. Different studies presented have shown the increased prevalence of the mentally ill offenders and have shown a need to study recontact rates, particularly comparing the two types of offenders (normal and seriously mentally ill) currently in custody.

A summary of screening assessment tools has also been presented and has demonstrated the current need for an effective screening tool for new inmates at correctional facilities. In order to effectively combat this issue of the mentally ill and having recontact with the criminal justice system, an effective screening instrument is required while also taking into account a number of criminogenic tendencies and risk factors for recontacting to see whether the mentally ill are different than normal offenders.

The need to study this population has been demonstrated in order to ensure effective practices are implemented that allow for the proper care and treatment of the mentally ill offender. The analysis from this study will suggest specific policy implications needed to be put in place on behalf of the seriously mentally ill offender. As a result of this research, the correctional system will be able to make more informed decisions with respect to the needs of the seriously mentally ill.

3.0 Methodology

3.1 Introduction

The 'Diversion of the Mentally Ill from the Criminal Justice System' initiative was established in 2005 by the Ministry of Community Safety and Correctional Services to address the needs of mentally ill persons upon discharge. The different components of the criminal justice system: police, courts, community agencies and corrections, were given funding to research how they could work to achieve the goals of this initiative.

One strategy of the Ontario initiative is the identification and assessment of inmates with a mental illness and their proper treatment and release planning. This strategy was intended to lead to the reduction of persons with mental illnesses reoffending after their release. It was determined that the collection of data concerning the number of inmates with a mental illness in correctional facilities and their needs for mental health care was an important step in supporting the correctional services role in this initiative. Accordingly, in April of 2005, the Ministry of Community Safety and Correctional Services entered into a service contract with Dr. Gregory Brown, Director of the Institute for Applied Social Research (IASR) at Nipissing University, to conduct a study of the prevalence and the mental health treatment requirements of inmates in Ontario Correctional Facilities. The Resident Assessment Instrument Mental Health (RAI-MH 2.0) assessment instrument was selected to be used in this study to survey inmates in correctional facilities across Ontario. The research team led by Dr. Brown sought out to see whether this tool was appropriate for this specific setting.

For the study, data were collected using a six-person research team from Nipissing University primarily using the RAI-MH 2.0. The research team was trained to use the RAI-MH

2.0 during a one-day session. Correctional nursing staff were brought into the training session to identify possible insights into the mental health picture in the selected jails and to identify any problems the researchers might encounter using this tool. Data were collected by individual assessments of inmates who volunteered to be part of the study in 14 correctional facilities across Ontario.

Inmates were interviewed privately in small rooms within each facility by members of the research team. Individual face-to-face assessments of approximately 30-45 minutes were conducted with inmates using semi-standardized interviews with the RAI-MH 2.0 assessment tool. Semi-standardized interviews were conducted because of the combination of structure and flexibility they provide. This is because the answers may be recorded during the interview, wording of questions is flexible, the level of language may be adjusted, and the interviewer or interviewee may answer questions and make clarifications at any time (Berg, 2004). Questions on the RAI-MH 2.0 tool ranged from demographic questions, to questions about committing violence, substance/alcohol abuse problems, life events, number of psychiatric admissions, mental state indicators, self-injury, health conditions and medications, and so forth.

3.2 Instrumentation

3.2.1 Resident Assessment Instrument- Mental Health 2.0 (RAI-MH 2.0)

The RAI-MH is a "standardized data collection system for mental health, and it is intended to identify key clinical issues related to patient care planning, quality and outcome measurement, all of which are ultimately linked to resource utilization and funding" (Hirdes et al., 2003: iii). The RAI-MH assessment tool is designed to assess mental health status by using mental health indicators and asking questions about the inmate's personal situations using

various scales. Key psychiatric care staff (including nurses, psychiatrists, social workers, recreational therapists and family doctors) are trained on the RAI-MH in order to collect information directly from patients and their family members and health care providers and from the patient's files using the Minimum Data Set Mental Health collection tool (MDS-MH) (Hirdes et. al, 2003).

Originally, the RAI tool was designed to meet the needs for patients in long term, acute, forensic, and geriatric psychiatry patients (Hirdes, 2002). The RAI-MH 2.0 was developed and implemented in October 2005. It was constructed through a series of steps including literature reviews, meetings with front-line clinicians and experts, data from other RAI assessment tools, previously mandated administrative forms, surveys done by frontline staff, focus groups, debriefing sessions from the previous assessment tools and a study of measurement properties (Hirdes, 2002). According to the Canadian Institutes for Health Information (CIHI 2005), the RAI-MH "is a comprehensive, standardized instrument for evaluating the needs, strengths, and preferences of adult psychiatric patients in institutional settings" (19).

The RAI-MH 2.0 comprises of a two-part psychiatric assessment consisting of the MDS-MH and the Mental Health Assessment Protocols. The Minimum Data Set (MDS-MH) is a screening form that allows individuals administering the tool to briefly review key area of function, mental and psychical health, service support and social support. The MDS-MH, an 11-page questionnaire of 116 questions to be answered by adults 18 or older, is administered shortly after admission to an impatient psychiatric program. It requires direct questioning of the patient and is usually observed by a health professional and administered in a mental health setting. This tool is designed to uncover past key behavioural patterns and to predict present mental and physical health, substance abuse, self-injury, medication compliance, social support, service

usage and suitability for release. Scoring on individual and grouped factors is designed to show the need for care planning in a particular area (Hirdes et al, 2000). The Mental Health Assessment Protocols (MHAPs) are guidelines for further assessment or individual care planning (Hirdes et al., 2003:1).

The RAI-MH has been standardized and mandated for use in Ontario mental health facilities. This tool has been validated for both males and females and on international samples. The development process established content and face validity through a variety of communication methods obtained by stakeholders. A large scale study was also conducted to test the inter-rater reliability and convergent validity in sixteen mental health hospitals in Ontario with version 1.0 of the RAI-MH. From there in 2002, a second reliability trial was completed with version 2.0 of the MH. Researchers used a variety of methods to test for reliability such as testing individual items for inter-rater reliability. The study of measurement properties revealed that all domain areas had average kappa[1] values for acceptable reliability falling within industry standards. The study revealed "in fact, 19 out of 29 domain areas had average kappa values in excess of industry standards for excellent reliability "[and]" when all items are considered individually, 65.4 % of MH items have kappa values in excess of .65" (Inter-RAI, Retrieved November 20, 2006).

3.2.2 Level of Service Inventory: Ontario Revision (LSI-OR)

Inmates interviewed using the RAI-MH were also scored using the Level of Service Inventory: Ontario Revision (LSI-OR). This tool is used by the Ontario Ministry of Correctional Services to predict possible risk factors relating to an inmate's behaviour. It is currently the best

[1] Kappa is a statistical measure of inter-rater agreement for categorical items (Hirdes et al., 2002).

measure of risk prediction for recontact. The LSI assessment tool was first created by Andrews in 1984 to assist probation officers in their levels of services for supervision of offenders (Girard, L. & Wormith, J.S., 2004). It has most recently been updated for use in Ontario correctional facilities to determine security classification for inmates for rehabilitation or case management planning (Andrews & Bonta, 2006). According to Bonta and Yessine (2004), "[the LSI-OR is] an extensive, theoretically based body of knowledge on both the static risk factors and criminogenic needs of offenders" (583).

The LSI-OR is composed of twelve sections (A-L). Each section is comprised of a variety of sub-scales that vary in length. Section A and B focus on both general and specific risk/need factors, including criminal history, education/employment, family/marital conditions, leisure/recreation, companions, procriminal attitude/orientation, substance abuse and antisocial behaviour pattern. Here, the assessors can also note specific strengths of the offender. Section C focuses on prison experience and institutional factors. Section D and E provide the risk/need summary and profile of the offender. Section F and G look at client issues such as social, health, mental health and barriers to release and special responsivity considerations. Section H is the program/placement decision which states where the inmate should be placed, for example, in minimum, medium or maximum custody. Section I is the disposition length in which the assessor puts in the admission date, sentence date, parole eligibility, discharge possible date and final warrant expiry. Section K of the form is the offender's progress record, and the final section, Section L, is the discharge summary for the offender (Ministry of the Solicitor General and Correctional Services, 2009).

For this particular project not every offender had an LSI-OR assessment. This was because many inmates were on remand (not sentenced) and LSI-OR assessments are typically

done on sentenced offenders. However, some inmates who had been previously incarcerated and were presently on remand, may have had one available conducted during in their last prison stay. Inmates without an LSI-OR score were excluded from the present analysis.

For this thesis, data collected using the RAI-MH (as part of this larger study conducted by Dr. Brown) are used to explain prevalence rates and risk factors for recontact rates, as related to serious mentally disordered inmates. The current research uses data both from the RAI-MH and LSI scores (scale of criminogenic tendencies) to consider recontact rates in relation to the various problems and issues relating to mentally ill offenders discussed in Chapter Two. This study is unique because it uses a new assessment tool not prior used in offender populations.

3.3 Sampling

The sample is drawn from adult inmates from correctional facilities in Ontario (Ministry of Community Safety and Correctional Services) who had an LSI-OR assessment completed either in their previous incarceration or during their recent admission. This sample consists of male and females inmates who voluntarily chose to participate in this study. The time span for sampling was between May 2005 until August 2007. Participants in the study include both remand and sentenced offenders, as well as some inmates held on immigration warrants, on parole or on youth warrants.

The sample is not a representative probability sample because inmates were volunteers. Random sampling of the inmate population was not a practical solution due to the Ministry standard that face-to-face mental health assessments be given freely and voluntary, and due to the fact that remand offenders be part of the study. Additionally, the research team deliberately oversampled both the Aboriginal and female populations. This oversampling was done in order

to collect enough cases for the analysis. In Ontario Corrections approximately 9% of the population is Aboriginal and 6% are female (Brown, 2009), therefore if a true random sample was used there may not have been enough cases. Overall, a total of fourteen facilities were used in the study in order to obtain a quota sample intended to draw as widely as possible from the population of volunteers. The research team started off by interviewing at seven provincial prison facilities but more cases were needed so more prison facilities were added to the study (Brown, 2009). To obtain data on the number of inmates with recorded mental health alerts in these fourteen facilities, the Offender Tracking and Information System (OTIS) was used. A total of 522 inmates were interviewed. However, because many of the offenders interviewed were on remand, only 398 LSI-OR assessments were completed in the offender files. Thus, the total analysis group for the present research equals an N of 398.

The superintendent of each correctional facility selected was contacted to coordinate study visits. At each facility, a brief presentation concerning the research was made to the correctional staff. Next, all inmates were invited to participate in the research and correctional staff assisted the members of the research team by gaining access to different areas of the facility in order to meet with the offenders, to explain the research study and to request inmates to volunteer to participate in the study. Correctional and medical staff at each facility were asked to request all inmates be part of the study and to refrain from targeting offenders with known mental health problems. Including all inmates helped to reduce possible selection bias because all inmates had an equal opportunity to voluntarily participate. Volunteers were asked to complete a 'consent to participate in research' form prior to participating. The common feature in all facilities with respect to the participants was that only those inmates who volunteered to participate based on the information given to them were selected. Although not representative of

the total inmate population, an advantage of this sampling plan is that as volunteers this represents the willing participation of all those selected.

3.4 Categorization of Mental Illness

The RAI-MH was used in order to determine if the inmates were mentally ill on the basis of symptoms (psychosis, mania, mood disturbance, cognitive impairment) based over 1-3 days. An algorithm developed by the University of Michigan was used to discriminate between 'no mental illness' and 'current severe symptoms of mental illness within the last 3 days'. This algorithm was based on an index of five subscales and any psychiatric admissions within the last 2 years.

These five subscales were developed by the university research team heading the Ontario research initiative and researchers from the University of Michigan. Scores from these 5 subscales: Depression Rating Scale (DRS), Positive Symptoms Score (PSS), Negative Symptoms Score (NSS), Cognitive Performance Scale (CPS), Mania Symptoms Scale (MSS), as well as recent hospitalizations (within the last two years), were re-coded to group severe symptoms of serious mental illness. As a result of the re-coding, a total symptoms score index was created. This summary measure counts the presence of any of the indicators at the severe level on any of the five subscales, plus any psychiatric admissions within the last two years.. The scale has a range of 0 through 6. Therefore, inmates with a mental illness were those with a score of 1 or more. For this thesis, only inmates with a score of zero or 1 were included. Scoring 1 or more means that an individual has current severe symptoms of mental illness. A zero means that there is no mental illness present. This scale therefore captures both serious mental illness and its magnitude.

These five subscales comprising serious mental illness were a part of the initial stages of creating the index variable of serious mental illness:

1. Positive Symptoms Scale (PSS)
2. Depression Rating Scale (DRS)
3. Negative Symptoms Scale (NSS)
4. Mania Symptoms Scale (MSS)
5. Cognitive Performance Scale (CPS)

The first of these, the Positive Symptoms Scale (PSS), reflects psychiatric symptoms including self-worth, hyper arousal, pressured speech and abnormal/unusual movements (Brown, 2009). The scale range is from 0-12, with 0 indicating no psychotic symptoms, scores of 1-2 indicating the presence of mild to moderate psychotic symptoms, and scores of 3 or more indicating severe psychotic symptoms.

The Depression Rating Scale (DRS), describes the mood of an individual. This scale measures at negative symptoms, persistent anger, unrealistic fears, repetitive health complaints, repetitive anxious complaints, sadness, worried facial expression and crying/tearfulness (Brown, 2009). Scores on this scale range from 0-14, with 1-5 indicating the presence mild to moderate depression and scoring 6 or more indicating severe depression.

The Negative Symptoms Scale (NSS) combines scores from four mental state indicators, including anhedonia (inability to get pleasure from pleasurable experiences), withdrawal, lack of motivation and reduced interaction. Scale scores range from 0-20. A score of 3-6 indicates mild symptoms and greater than the presence of severe symptoms.

The Mania Symptoms Scale (MSS) measures mania, which is a mood disorder in which a person can act excessively or violently. This variable consisted of inflated self-worth, hyper-arousal, irritability, increased sociability/hyper sexuality (excessive sexual drive), pressured speech (rapid, non-stop, loud and hard to interrupt), labile affect (involuntary crying or episodes of uncontrollable crying or laughing) and sleep problems due to hypomania (mood state of elevated or irritated mood) (Brown, 2009). The scores range from 0-20 on this scale. Scores ranging from 1-5 indicate a mild to moderate level of symptoms present of mania; scores of 6 more indicate severe symptoms of mania.

The last scale used was the Cognitive Performance Scale (CPS). This scale measures one's cognitive status of short term memory, communication skills, cognitive decision making and self-performance in eating. If one scores two or more on this scale, this indicates cognitive impairment of the individual.

Along with these scales, recent psychiatric hospitalizations was also taken into account to create the serious mental illness variable. Recent psychiatric hospitalizations were any hospitalizations an individual had within two years.

Overall, in the case of the serious mental illness variable, it is brought down from over seventy items to one, and at best is a convenient surrogate of recent mental state but should not be considered a clinical assessment of mental health. This is not a diagnostic tool for serious mental illness but an index created to measure serious mental symptoms in the last three days (symptoms the inmate felt when assessed with the RAI-MH).

3.5 Variables

The data will be analyzed based on information collected from 398 of the 522 face-to-face assessments conducted. After collecting the data, the research team in collaboration with the Ministry entered all the data into data sets. The data collected focused on alerts, LSI-OR information, and offender information. The variables for this study were constructed out of the information gathered from the 398 offenders with an LSI-OR evaluation on file.

The dependent variable used in this study will be recontact. As stated previously, recontact is defined as how many times offenders comes in and out of contact with the criminal justice system following a release from custody whether a new offense, bail conviction or reoffense. Recontact will be compared across mentally disordered offenders and non-mentally disordered offenders. It is coded as '0' for no recontact and '1' recontact. The key independent variable, is serious mental illness which is coded a '0' for no mental illness present or '1' exhibits current severe symptoms of mental ill.

Independent variables to be included as controls include: residential instability, abuse index, criminal offending index, sex, age, substance abuse, aboriginal status and scale of criminogenic tendencies. These are explained further:

1. *Age* is coded as actual age (in years). This information was collected during the supplementary file reviews of each offender.
2. *Sex* is used to see who re-offends at a greater rate—males or females. The variable is coded '0' for females and '1' for males.

3. *Criminal Offending Index* is coded as '1' for serious crimes (eg. Homicide) through '21' for petty crimes, such as theft. Violence characteristics will be used to observe whether or not people who have committed serious crimes recontact more often.
4. The *Aboriginal status* variable is coded as '0'= Not aboriginal and '1'= aboriginal.
5. The *Substance abuse* variable is created from the Mental Health Assessment Protocols (MHAP) 17 score on the RAI-MH assessment form. Substance abuse is scored as '0'=no substance abuse problem and '1'= substance abuse problem.
6. *Residential instability* was coded as 0= no instability found and 1= instability such as homeless, or living in boarding house.
7. *Abuse* demonstrates the amount of trauma and abuse that an inmate reports having occurred throughout their lifetime. It is constructed from an index to measure trauma based sexual abuse, physical abuse, emotional abuse, abuse by family and the individual's measure of trauma. As stated previously, due to past experiences many inmates suffer from mental illnesses due to past abuse. Indices were composed of five symptom sub-scales on the RAI-MH assessment form. Several variables of varying frequencies of abused were combined to form a scale ranging from 1 to 5 with a 5 representing that the individuals suffered from all types of abuse in their lifetime.
8. *Scale of Criminogenic Tendencies (Total LSI-Score):* To investigate recontact and recidivism, Andrews (2003) created the LSI for classification of inmates for institutional classification or decisions of release. This variable is the total score that an offender receives on section A and B of the LSI-OR form. These include the 'Big Four' 'to predict recidivism: antisocial behavioural history, antisocial attitudes, antisocial

personality, and having antisocial peers[2]. This variable is comprised of the total score from four measures from Section A of the LSI-OR form (General Risk/Needs Factors). The total of measure one of the Criminal History Subscale, the total of six of the Pro-criminal Attitudes and Orientation, the total of eight of the Antisocial patterns, and the total of five of the Companions subscale composed the Total LSI-OR Score. Inmates are given an LSI-OR once they have been sentenced to see what their level of risk to reoffend is and their level of need.

3.6 Analytical Strategy

The analysis will provide an examination of recontact comparing the seriously mentally ill offender and the non-seriously mentally ill offender. There will be some preliminary analysis of descriptive statistics of recontact and all the independent variables and controls. This is followed by a bivariate analysis examining crosstabular patterns and correlations. Then, lastly, the main multivariate analysis will examine, first, each of the samples separately—seriously mentally ill and non-mentally ill, and then with the samples combined to predict recontact rates.

Overall, the goal is to examine eight risk factors and their abilities to predict recontact for the seriously mentally ill and non-seriously mentally ill while incorporating data from the RAI-MH and LSI-OR. In terms of the multivariate analysis, the first model is comparative looking at serious mentally ill offenders versus normal offenders using eight predictors for recontact. The second combined model tests whether being seriously mentally ill continues to have an impact on recontact rates once all the other eight predictor variables are controlled. The extent that this

[2] When LSI-OR data was given on each offender, the Ontario Ministry of Community Safety and Correctional Services only provided the total scores of each section off the LSI-OR form. The LSI-OR does not specifically test any one factor or group such as the 'Big 4'.

is the case will show whether after controlling for all the major risk factors, being mentally ill either contributes to or detracts from the probability of recontact.

3.7 Strengths and Limitations

The major strength of this research project is that it reports on a very unique sample of individuals who have rarely been studied. This type of study has never before taken place in provincial prisons in Ontario primarily because of the possible risk factors involved with studying such a unique sample. An advantage of studying this type of population is that it allows researchers to use their background history of the inmate population in order to look at mental illness and recidivism rates in the provincial correctional system. This is especially important in a provincial setting as most inmates have not been sentenced. The data collected for this thesis will allow for a better understanding of recontact rates of the mentally ill offender.

The information collected on each offender was done using an improved assessment tool—the RAI-MH 2.0. This assessment tool has the benefit of not requiring a licensed psychologist to administer it and therefore requires very little specialized training. It is a tool that mainly relies on observation, rather than clinical opinion. This assessment tool is very cost-efficient and has been found to have sound psychometric properties as an initial screening tool (Brown, 2006). The RAI-MH 2.0 is the first, and only, system of consistent data collection on mentally ill offenders across the province (Brown, 2006). This is important as the seriously mentally ill need to be studied in order to predict their recontact rates and whether they serve as a specific threat to Corrections or whether they share the same characteristics of normal offenders.

One limitation with using the RAI-MH is that this tool is still in development stages and was used as a pilot to see whether it was an effective screening tool for prisons. However, the

advantage of using this tool still in its pilot stages is that it gives researchers and creators the opportunity to add more variables specific to predicting risk of recontact for offenders. Future research will rectify this limitation by providing an improved RAI-MH assessment tool.

A limitation of this thesis is in the way the inmates were selected to participate. This is not a true probability sample, as inmates were solicited through correctional staff either by flyers or by personal contact. Undoubtedly there could be some selection bias with respect to what group of people were interested in participating. For example, at the London jail the number of aboriginal subjects was underrepresented relating to the jail population as a whole. Therefore the question arises concerning what type of Native participant chose to volunteer.

A particular challenge is that a significant number of subjects were seriously mentally ill and may have not had the specific mental capacity to answer questions correctly and accurately. Also, across all inmates in provincial prisons the literacy level is very low; therefore the offenders may have not understood the nature of the questions and/or guessed at specific answers. This in turn could lead to inaccuracies in the data. Importantly, in order to verify responses researchers also looked at file reviews at each institution. This helped to ensure the data were accurately portrayed.

4.0 Findings

4.1 Introduction

This thesis considers recontact rates for the seriously mentally ill. A comparison analysis and a combined sample will be reviewed to determine whether there is a difference between the seriously mentally ill offender and non-mentally ill offender with respect to recontact. These analysis will not only test if the Bonta and Andrews 'Big Four' factors are relevant for the seriously mentally ill, but will test whether the LSI-OR is a good predictor for recontact rates for the seriously mentally ill and non-seriously disordered offenders. Using the scale of criminogenic tendencies (within the LSI-OR) is effective as it incorporates a number of other criminogenic key factors which predict recontact. Further analysis employing a combined sample will examine the net influence of mentally ill over and beyond (controlling for and taking into account) all the other factors contained in the model and which have been demonstrated by past research to influence recontact.

First, a demographic breakdown of the sample will be provided. Next, the descriptive statistics for all the measures to be included in the analysis will be provided starting with the dependent variable. Correlational analysis will also be performed to show relationships, if any, between variables. Then bivariate relationships between mental illness and recontact will be analyzed. Following this bivariate relationship, the multivariate models will be tested using logistic regression.

4.2 Demographic Breakdown of the Sample

The sample of offenders was composed of 398 inmates interviewed having an LSI-OR score for the study. A description of the demographic characteristics of inmates involved is given in Table 4.1.

Table 4.1-Demographic Characteristics n=398

Characteristic		Sample %	N
Gender	Male	78.1%	311
	Female	29.1%	87
Aboriginal Status	Yes	25.4%	101
	No	74.6%	297
Age (range)		19-62	
Legal Status	Sentenced	27.4%	109
	Remand	71.1%	283
	Other	1.5%	6

As the table indicates, there were more males in the study at 78 percent. There is much higher prevalence of males in the prison population (Rice et al., 1998), so this was to be expected to be the case in the data.

The Aboriginal representation in the sample (25 percent) is higher than the actual proportions in the prison population, which is estimated at approximately 9 percent (Brown, 2009). Researchers have shown that Aboriginals are often overrepresented in the Canadian Criminal Justice System (Roberts & Grossman, 2004). In this case, the Ontario Ministry of Community Safety and Correctional Services wanted to know the impact of Aboriginal overrepresentation in prisons.

The mean age for the sample was 33.71 years. Most inmates that were interviewed were in fact young and fit the characteristics of offenders in general (Rice et al., 1998, Bonta & Andrews, 2003).

Out of the 398 inmates, 283 (71.1%) were sentenced offenders, 109 (27.4%) were on remand (not sentenced) and 6 (1.5%) inmates were other. All 109 remand inmates had an LSI-OR completed. This is surprising because usually there is a high turnaround rate with inmates and there is not enough time to complete the assessment. These means that these offenders were in the system previously and had one completed or had one while on remand. Therefore, it is not surprising that some of the original 522 sample of 398 did not have an LSI-OR completed as they were most likely not incarcerated long enough to have one completed for their file. There is a possibility that the inmate had been incarcerated previously and had already had an LSI-OR assessment completed in the past.

4.3 Description Statistics

Descriptive statistics for the remaining variables used in this study are presented in Table 4.2.

Table 4.2- Descriptive Statistics of the Variables

(n=398) DV= Dependent Variable IV= Independent Variable

Variable	Range	Mean	Sy
Dichotomous Variables			
DV-recontact	0-1	.66	.48
IV-serious mental illness	0-1	.48	.50
IV-substance abuse	0-1	.73	.44
IV-residential instability	0-1	.12	.32
IV-aboriginal origin	0-1	.25	.44
IV-sex (male)	0-1	.78	.41
Continuous Variables			
IV-age	19-62	33.71	10.12
IV-criminal offending index	1-20	7.94	4.49
IV-abuse	0-5	2.46	1.7
IV-scale of criminogenic tendencies	2-41	24.80	8.14

Overall, table 4.2 reveals that that recontact rate of the sample is relatively high at nearly two-thirds (65.74%). This is consistent with the literature as often times offenders recontact once released from jail if they do not have proper community programs set up or are not surrounded by positive supports once released from jail (Canadian Mental Health Association, 2005).

Importantly, almost 48 percent of offenders in this sample had a serious mental illness found. Although this is a high percentage, this is also not surprising due to the lack of alternate facilities open to those who have mental illnesses. Furthermore, the literature also has shown that those who are seriously mentally ill and out in the community without proper treatment are more likely to come in contact with the police (Brown, 2006).

The table also shows that 73 percent of offenders in this sample had a substance abuse problem. This is similar to what the literature suggests on offenders: more than 60 percent of offenders have a substance abuse problem (Scott & Gerbassi, 2005).

The majority of the sample, by no surprise, consists of more males than females at 78 percent. A surprising finding is that only 12% of offenders had residential instability. The literature states that the reason there are so many offenders homeless when they become released from custody is due to the fact that there are a lack of services available (Chenier, 1999, Wasylenki & Tolomiczenko, 1999, Sharpe, 2005). The reason for this could be that often offenders are not in the community long enough before they commit another offense so there is not enough time to remain on the streets.

The analysis now turns to associations. Table 4.3 provides the zero order correlations among important variables.

Table 4.3 Correlation of Variables

	Recontact	Serious Mental Illness	Substance Abuse	Aboriginal Origin	Sex	Age	Residential Instability	Criminal Offending Index	Abuse	Scale of Criminogenic Tendencies
Recontact	1	-.003	.016	.019	-,049	-.046	.079	.116*	-.035	.292**
Serious Mental Illness		1	.066	.097	-.164**	-.076	.085	.027	.316**	.095
Substance Abuse			1	.080	-.129*	-.18	.025	.115*	.045	-.039
Aboriginal Origin				1	-.013	-.067	-.031	-.015	.151**	.237**
Sex					1	-.063	-.017	-.081	-.268**	.011
Age						1	-.053	.069	.038	-.151**
Residential Instability							1	.089	.109*	.161**
Criminal Offending Index								1	-.059	.014
Abuse									1	.083
Scale of Criminogenic Tendencies										1

**Correlation is significant at the 0.01 level (2-tailed).

*Correlation is significant at the 0.05 level (2-tailed).

Table 4.3 demonstrates that the majority of associations are statistically non-significant, and of those variables which are statistically significant, the strength of the association tends to be either weak, or at best, moderately weak. Both these outcomes are very surprising since the literature suggests all those factors to be important influences of recontact.

A main question is why aren't the variables significant and showing strong associations as demonstrated in the literature?

There are, however, some interesting correlations supporting the literature with regards to recontact. The table shows a positive correlation for the scale of criminogenic tendencies and recontact (.292**). This is a weak to moderate correlation. This shows that the higher an offender's LSI-OR score, the more likely the offender is to have recontact with the criminal justice system. This demonstrates the validity of the LSI-OR, as it was designed to predict risk of reoffending. Secondly, the additional significant finding (although small) is between the criminal offending index and recontact (.116*). This means that offenders are more likely to have recontact with the criminal justice system with minor offences. This may seem surprising, but is not. More often times than not, once offenders are released from jail, they have not received any help from community programs and often times do not have the necessary life skills to obtain employment or the money to survive and often times break the law as a means to survive (Canadian Mental Health Association, 2005).

Sex was found to be negatively correlated with the abuse index (-.268**) meaning that females are more likely to suffer abuse, which is well known based on the literature (Sims, 2005, Bonta & Andrews, 2004, Scott & Gerbasi, 2005). The table also reveals that being a woman is positively correlated with having a serious mental illness (.316**). This is true as the literature

states that women more often than men suffer from depression after suffering some form of abuse throughout their lifetime (Correctional Service Canada, 1990).

Residential stability was found to be positively correlated with Scale of Criminogenic Tendencies (.161**). If an offender is more likely to be homeless, they are more likely inclined to be criminogenic as they may not have the necessary means to survive (or vice versa). This supports the literature as it states that homelessness is a significant problem for those who are mentally ill (Wasylenki & Tolomiczenko, 1999).

In summary, there were few zero-order correlations with significant associations with recontact. The associations did not come out as expected and did not fully match the current literature. This bivariate analysis fails to control for aboriginal status and residential instability and given their importance once controlled for, a truer picture of the influence of mental illness on recontact may emerge. Overall, once the variables are controlled in multivariate analysis, other significant associations may be revealed.

4.4 Cross-tabular Analysis

Table 4.4 focuses on recontact rates for seriously mentally disordered offenders and non-seriously disordered offenders, the major interest of this thesis, while answering the question: do the seriously mentally ill offenders recontact at a higher rate than normal offenders?

Table 4.4 Recontact Rates

Variable		SMI=0	SMI=1	Total	Chi-square Value	Sig.
Recontact	0=No	69 (36.1%)	63 (36.4%)	132 (36.3%)		
	1=Yes	122 (63.9%)	110 (63.6%)	232 (63.7%)	.003	0.52
Total		191	173	364		

The table shows that recontact rates are not higher for seriously mentally disordered offenders versus non-mentally disordered offenders also indicated by earlier correlational analysis. Seriously mentally disordered offenders had a recontact rate of 63.6 % (110 offenders) versus 63.9% (122 offenders) of non-mentally disordered offenders. Thus, while the likely of recontact is very high (.64), the patterns between the two groups is virtually identical, and any difference between the samples is decidedly non-significant.

This finding is surprising because we expected a difference between the two types of offenders. The literature has shown that mentally disordered offenders usually end up back in prison after release due to insufficient programming for their specific needs versus a non-mentally disordered offender (Canadian Mental Health Association, 2005). Thus, it would be reasonable to predict that the seriously mentally ill will have higher recontact rates, yet this is not the case. On the one hand, this could be seen as a positive outcome on behalf of the mentally ill—it appears at least they are not ending up re-incarcerated more often than the non-mentally ill. On the other hand, the finding is clearly negative if one considers the mentally ill not belonging in prisons in the first place.

Although there are no differences between the two types of offenders, both groups have very high recontact rates (.64). This clearly points out a serious issue that the criminal justice system is facing. It is alarming to look at these statistics and see such a revolving door effect. As well, many of the seriously mentally disordered offenders do not belong in prison in the first place and therefore if 64% end up back in, this is proof that this is a colossal failure of the justice system (more so than with non-mentally disordered offenders). Recontact rates should be lower for the seriously mentally ill, which is further evidence of mistreatment of the criminal justice system.

It also seems as though the mentally ill are not even incarcerated on basis of grounds, other than being a nuisance. These individuals should be in specific facilities that meet their needs and it seems as though our criminal justice sets the mentally ill offender up to fail once they are released back into the community.

Crosstabular analysis also does not take into account the risk factors to contributing to recontact. Therefore, the next step is to look at other possible ways of which the control variables for risk affect recontact. Before accepting the apparent null-finding that the seriously mentally ill have the same recontact rates, multivariate logistic regression will be conducted.

4.5 Multivariate Logistic Regression Analysis

Bivariate analysis was able to show some modest relationships between variables, but was not able to elucidate any differences between recontact and mental illness. However, it is clear that recontact is much more multifaceted than simply just the extent of mental illness, calling for more sophisticated, multivariate approaches to uncovering its influence. Given the binary nature of the dependent variable, recontact, the appropriate analytical approach is logistic regression.

The first logistic regressions are a comparison between seriously mentally disordered offenders and normal offenders. Do the various risk factors, including the scale of criminogenic tendencies, substance abuse, aboriginal status, residential stability, criminal offending index, abuse, age and sex influence the likelihood of recontact in relation to the serious mentally ill and non-seriously mentally ill differently? Do the overall group of predictors "fit" or explain outcomes in recontact to a different degree with respect to the samples of seriously mentally ill

and non-seriously mentally ill offenders? Table 4.5 shows the variables in the equation for the comparison sample.

Table 4.5- Comparison Model

Variables in the Equation

	Serious Mental Illness			No Mental Illness		
Variable	**B**	**Sig.**	**Exp (B)**	**B**	**Sig.**	**Exp (B)**
Substance Abuse	.166	.712	1.180	-.043	.908	.958
Aboriginal Status	.194	.643	1.214	.285	.496	1.329
Sex	.878	.045	2.407	-.356	.434	.700
Residential Instability	-.412	.447	.662	-.036	.951	.965
Criminal Offending Index	.093	.033	1.097	.54	.158	1.055
Abuse	.083	.535	1.087	-.016	.883	.984
Age	-.012	.523	.988	.000	.983	1.000
Scale of Criminogenic Tendencies	.113	.000	1.120	.084	.000	1.088
Nagelkerke r^2	.262			.129		
Chi-Square	$\chi^2 = 35.89, p < .001$			$\chi^2 = 18.05, p < .001$		

This table compares the seriously mentally offender to the non-seriously mentally ill offender and displays which factors have an effect on recontact. The model for the serious mental illness sample was statistically significant (x^2=35.890, p < .001) with the predictors accounting for 26% of the total variance (Nagelkerke R-square). The overall fit of the regression model is reasonable (Hosmer and Lemeshow Test = .091). Prediction success for cases used in the development of the model was satisfactory, with an overall prediction success rate of 69.8%. The model also had an 84.1% correct prediction rate for SMI offenders having a recontact and a 45.2% prediction rate for those SMI offenders not having recontact. On the other hand, for no mental illness, there is a weaker overall fit and set of predictors. For no mental illness, this model was found to be statistically significant (x^2= 18.052, <p.001). The Nagelkerke R Square accounted for 12.9 % of the overall variance. The overall correctly predicted cases were reasonable with a success rate of 69.6%. Correct prediction rates for non-mentally disordered

offenders having a recontact were 92.4% and 27.7% for those offenders not having a recontact. When comparing the two samples, it is perplexing on why the model does not fit better for the non-mentally ill sample as they had comparative recontact rates with the seriously mentally ill sample. In addition, the fit for serious mental illness was better than for no mental illness which contravenes the theoretical logic based upon assumptions of mental illness. This could imply that the seriously mentally disordered offenders are more strongly linked to various risk factors leading to recontact.

Surprisingly puzzling is that there are only three positive coefficients found within this comparison model, the scale of criminogenic tendencies in both cases, and the criminal offending index variable and sex in this case of the seriously mentally ill sample. The scale of criminogenic tendencies variable also had an association with an approximate 1:1.11-1.12 fold increase in the odds of having a recontact. Although this scale is interesting, it is in line with what previous research which is significant. As the above model displays, the scale of criminogenic tendencies was the only variable predictive of recontact (Exp (B) = 1.120; Exp (B) = 1.088). This means that the higher a non-mentally disordered offenders score is on the LSI-OR, the higher the likelihood of having a recontact. This was found to be true in the first model which indicated that there is not a difference whether an offender has a mental illness or not, the LSI-OR is the best predictor for recontact for both offender groups. This means that Bonta and Andrews 'Big Four' factors have also showed an association for serious mentally ill offenders. Therefore, general criminogenic tendencies lead to recontact. Having criminal history, criminal associates, antisocial personality and antisocial attitudes means that a seriously mentally ill offender is more likely to have a recontact with the criminal justice system. This also means that offenders may have scored high on the other areas on the LSI-OR form and therefore, it is not

clear which factor exactly is affecting recontact but that the 'Big Four' combined with other factors is affecting recontact rates. So, the higher an offender scores on the LSI-OR form, the more likely they are to have a recontact with the criminal justice system. Although the scale of criminogenic tendencies is significant and influences recontact to the exact same degree, it makes one wonder, why there are no differences? This is also similar to the log odds to the same degree. They are both significant but there is no way of knowing which individual risk factor from the scale of criminogenic tendencies accurately predicts recontact because it is a total score and not individual risk factors.

The criminal offending index was also found to be associated with an approximate 1:1.12-fold increase in the odds of having recontact for seriously mentally ill offenders. This means those who re-offended, did so with minor offenses which is of no surprise. For example, being a woman and committing minor crime leads to recontact. This can lead to stigma that woman are more likely to have mental illness problems. This is similar to the evidence presented in the literature review.

Sex was also found to have an association with recontact. According to the table, males are more likely to have a recontact than their female counterpart. However, this was found to be non-significant for non-mentally disordered offenders. According to the literature, males tend to have higher recontact rates than females within the criminal justice system (Rice et al. (1998), Lovell, Gagliardi & Peterson (2002)). Therefore, this fact was also found to be true with this particular group of offenders. The literature reveals that serious mentally ill offenders tend to have recontact with the law, however, with less serious offences such as theft (Lovell, Gagliardi & Peterson, 2002). There appears to be discrimination against the seriously mentally ill offender as they are back into the criminal justice system so quickly with petty crimes. These individuals

are not criminals, they are just sick and it seems as though the scale of criminogenic tendencies may actually label these individuals that way. It seems as though to be re-arrested, the mentally ill simply have nuisance like behaviours, as previously stated. So what is the definition of a criminal? How can we as a society label the mentally ill as criminal when we are setting them up to fail in our own criminal justice system? These patterns presented are shocking and should be addressed.

Overall, the comparison model does not provide much success or insights into which variables affect recontact rates. The only variable indicative of predicting recontact for both the seriously mentally ill and non-mentally ill was the scale of criminogenic tendencies. Thus, what is really comes down to, it seems, is that if persons have anti-social tendencies and the influence of criminogenic peers they are more likely to reoffend. This is hardly a surprise, but it is surprising that the influence of well established risk factors parallels so closely between the seriously mentally ill and non-seriously mentally ill samples while, for the most part not contributing to recontact, with the exception of being male and committing petty crimes in the case of seriously mentally ill offenders.

Logistic Regression Model -Combined Model

This final combined model is used to re-test the net influence and fit of the nine predictor variables using logistic regression analysis. First, it is a final test based on all notable risk factors identified in the literature. Second, it tells us whether being seriously mentally ill contributes uniquely, or not, to recontact over and beyond this set of influences. This sample controls all eight risk factors and adds the dummy variable on serious mental illness to the equation. Due to the fact that we have partialed out all factors, if serious mental illness is significant in the multi-

variate analysis and we subtract all the other factors, it will show whether the mentally ill have a higher recontact rate than normal offenders. This sample also tests the overall strength of the set of risk factors and the final fit for the model.

Table 4.6-Combined Sample

Variables in the Equation

Variable	B	Sig.	Exp (B)	Nagelkerke r^2	Chi-Square
Substance Abuse	-.019	.947	.982		
Aboriginal Status	.246	.398	1.279		
Sex	.277	.371	1.319	.171	$\chi^2 = 47.14, p < .001$
Serious Mental Illness	.254	.317	1.289		
Residential Instability	-.258	.508	.772		
Criminal Offending Index	.064	.023	1.066		
Abuse	.013	.875	1.013		
Age	-.004	.738	.996		
Scale of Criminogenic Tendencies	.094	.000	1.099		

Table 4.6 represents the variables in the equation for the combined model. The overall significance of the model is statistically significant (Chi-square = 47.138, p<.001) and the goodness of fit is reasonable-- .580 (Hosmer and Lemeshow Test). The predictors explain 17.1% of the total variance (Nagelkerke R Square) and the classification table revealed an overall model success rate of 70.3% as the likelihood to have a recontact. Correct prediction rates for recontact with serious mental illness in the data set was 92.4% and 37.8% for no recontact. Residential instability, substance abuse, age, sex, aboriginal status, serious mental illness, and abuse were all found to have no impact on recontact for this model.

The strongest predictor of recontact in this model was the scale of criminogenic tendencies again (Exp (B) = 1.099). This is hardly surprising, given the findings from the earlier

comparative analysis, and the combined model is, put simply, just a reflection of these with criminogenic tendencies being pretty much the major factor influencing recontact.

Along with this the criminal offending index, found to be significant in the seriously mentally ill only sample, is carried over to the combined model as well. This means that an offender with mental illness or not is more likely to have recontact with a lesser offence (B= .065). Previous research studies and my results reflect this finding to be true; offenders do not usually have a recontact that involves homicide, they are more likely to steal or commit petty crimes. With the scale of criminogenic tendencies has been a significant predictor for all samples tested, this partially backs up previous research from Bonta and Andrews relating to their "Big Four" of recidivism risk factors.

The main purpose of the combined model was to assess if serious mental illness leads to recontact. The question is whether the null finding in the zero-order crosstabs is supported when all the risk factors are included, and the null finding for serious mental illness still proves to be the case. It is surprising that even after everything has been included being seriously mentally ill still does not improve the chances of recontact.

4.6 Comparison of Means

While logistic regression analysis revealed that offenders with or without a mental illness will have no greater likelihood of recontact, an interesting further inspection can be considered. Although the analysis has not shown significant differences between the seriously mentally ill and non- seriously mentally ill on recontact, the latency period for recontact could be further explored. Perhaps the seriously mentally ill and non-seriously mentally ill recontact at the same rate, but is it the case that both groups tend to be back in the system within comparable

timelines? This test will show if there is in fact a difference in times to recontact between these two types of offenders. The literature often states that the mentally ill are more likely to be homeless more than normal offenders than non-seriously mentally ill offenders, however, my data did not support this fact. Other possible reasons for differences in recontact times could be greater propinquity with police and mental illness stigma. As well, lack of programming in the community, and lack of suitable treatment for their mental illnesses could be other factors for increased recontact rates for the seriously mentally ill. The question is will this particular sample follow in the same patterns as current literature? Table 4.7 provides this analysis by comparing the time lapse latency for recontact.

Table 4.7- Comparing Means

Serious Mental Illness	N	Mean	Sy	t	Sig.
.00 = No	190	509.65	458.85		
1.00 = Yes	164	399.48	414.28	2.36	.019
Total	354	458.61	441.59		

The average non-mentally ill offender is released in the community approximately 510 days before re-entering the criminal justice system. As shown in Table 4.7, the mentally ill are out in the community for a shorter amount of time: approximately 400 days, or 110 days sooner. The finding is statistically significant ($t=2.36$, $p < .02$). Therefore, it would appear that once out of the criminal justice system, the seriously mentally ill are more likely to have recontact earlier than normal offenders. The reasons for this could be that offenders with a serious mental illness are generally more likely not be on their proper medications and have substance abuse problems upon a release from incarceration. The serious mentally disordered offenders tend to be the biggest management problem for corrections. They tend to come in and out of the criminal

justice system more frequently than non-mentally disordered offender, which makes it very difficult for the correctional system today to properly address their needs.

Although there was found to be no difference in recontact rates, the latency period is a statistic that has not been found before. The revolving door effect of 110 days for the seriously mentally ill to re-enter the criminal justice system is disturbing. It may be largely a lack of treatment programs in the community, or it could be related to more general systemic problems in the treatment of the mentally ill in Canada reflecting a willingness to have them institutionalized, If required they should be placed in proper treatment facilities, not prisons, and the dramatically shorter on average recontact times they experience is suggestive of an injustice they are facing.

4.7 Chapter Summary

In this chapter the analysis of the data collected on recontact rates was analyzed using two different levels of analysis. Bivariate comparisons were first analyzed. As this showed no differences between types of offenders, multivariate analysis was conducted. Multivariate analysis was then employed using two models: a comparison and combined model to analyze the seriously mentally ill offender and non-mentally disordered offender to see if there were any differences in recontact rates. Even when all other risk factors were controlled for, the seriously mentally ill offender and non-mentally ill offender were found to have no significant differences. Comparison of means was employed to see if in fact the seriously mentally ill and non-seriously mentally ill offenders have different latency periods for reoffending. Findings revealed from this study were that the seriously mentally ill once released into the community were more likely to re-offend on average 110 days sooner than a non-mentally ill offender. There are many risk

factors associated to the difference in recontact times and shows the need for more research to be conducted on this particular topic which will be discussed in the next chapter.

5.0 Conclusions

5.1 Introduction

This thesis addressed the issue of the rise of mental illness and focused on the increasing numbers of seriously mentally ill individuals incarcerated in Ontario provincial correctional facilities. The purpose of this study was to compare recontact rates between mentally-ill and non-mentally ill offenders. A further advantage was classification based upon an improved classification system using the most recent tool: RAI MH 2.0. Currently, there is not enough evidence to suggest whether the seriously mentally ill and non-seriously mentally ill act differently with respect to recontact. This thesis also addressed the levels and factors associated with mental illness and recontact and the effects of recontact. A number of risk factors were brought into the analysis to see if they impacted recontact rates. The analysis relied on both bivariate and multivariate comparisons for 398 offenders.

Overall, this thesis focused on three main objectives: (1) it tested whether having a mental illness affected recontact and looked at the possible risk factors of reoffending; (2) it sought out to validate or invalidate the risk factors associated with having a mental illness; and it (3) provided clarification through improved instrumentation to help assess the overall mental health picture in prisons across Ontario.

The primary objective of this study focused on if individuals with serious mental illness are more likely to experience recontact than non-mentally ill offenders. This in fact, was not the case, as the findings showed that having a mental illness had no impact on recontact. Even when controlling for all other major risk factors, the seriously mentally ill still were not more likely to

recontact. Confidence in the null-finding is heightened by the integrity of the relatively new instrument based on the RAI-MH, available to classify them.

In this study, the analysis focused on both comparing the two samples and on results when they were combined. The models tested yielded one common finding: that for any offender, either with or without a serious mental illness, having a higher score on the scale of criminogenic tendencies (LSI-OR) increased rates for recontact. The first analysis focused on whether various predictors had the same impact on recontact for serious mentally ill offenders and for non-mentally ill offenders. For the seriously mentally ill individual while the scale of criminogenic tendencies score served as a significant predictor of recontact, sex and criminal offending index were also found to be significant. Being male and having a serious mental illness increased the likelihood of recontact based on minor offences. This result implies somewhat that the seriously mentally ill offender is not more dangerous than a non-mentally ill offender. For the non-serious mentally ill individual, the only factor found to be significant was the scale of criminogenic tendencies. With criminogenic tendencies significant for both types of offenders suggests that currently, this factor is both the best and perhaps only predictor for recontact. As well, this further supports the importance that each offender should have such an assessment upon entry into incarceration, regardless if on remand or not. If individuals are not properly screened, Corrections will have difficulty assessing the level of risk each individual poses within their facilities.

Lastly, the combined model was a final attempt to see whether having a mental illness had an impact on recontact. Again it was found that criminal offending index and scale of criminogenic tendencies were the only variables found to predict recontact. This means that offenders who committed less serious crimes were more like to re-offend. It can also be shown

that the scale of criminogenic tendencies (LSI-OR) is suitable for predicting recontact for anyone in the criminal justice system.

Finally though the defensible predictors did not show a difference between the seriously mentally ill and normal offenders in what causes them to recontact, patterns in comparing the means actually shows that the mentally ill recontact approximately 110 days sooner than a normal offender in this particular sample. This finding is not surprising because the mentally ill are often released into the community with no treatment due to waiting lists in prisons and are often released into the community setting them up to fail. Upon their release in the community, mentally ill offenders also have a lack of treatment facilities to attend and there is no stable housing for them.

5.2 Limitations of Study

With any study, there are limitations; however, these limitations may lead to positive directions and hypothesizes for future research. In the present study, the first limitation was the method of recruiting inmates, which was conducted using non-probability sampling. This type of sampling can lead to bias in the data collected through self-selection in reporting. Thus, there was not a true probability, so the generalizability of findings limited. The method utilized, however, provided the best possible approach for interviewing such a unique sample. This was a challenging population for sample collection and that the sample was substantial under the circumstances, if not the best. It is very difficult to work with such populations because of access and security reasons and a non-random probability sampling was the best method available.

Another limitation involved inmates being asked questions in regards to their past and current functioning; for example, their mental and physical health, medication compliance, substance abuse and so forth; these responses were recorded onto the RAI-MH 2.0 form. There was an attempt to verify responses with file reviews; however, not every file could verify all the information. As well, it could not always be proven whether offenders were illiterate, dishonest or mentally unstable aggravating the situation. Although, some of the information in a few of the cases could not be verified, it is believed to not impact the data in a significant manner. If improved upon, a future version of the RAI-MH screening tool will potentially inhibit inmates from providing untruthful responses. If implemented, this modified assessment tool, called the International Resident Assessment Instrument, or interRAI, could provide a more accurate representation of recontact rates. Future studies focusing on offender classification and on recontact rates will assist with improving this assessment tool. In addition, this tool could improve in the following areas: offence history, risk of violence, sexual offending and future behaviour.

5.3 Future Research

From the results by using the RAI-MH 2.0 in prisons, creation of an improved interRAI forensic/offender screening tool will be beneficial for assessing mental illness upon incarceration. This will hopefully lead to deciphering which inmates require additional medical care. This tool is currently in pilot stages and focuses on specialized units within the health care system; the interRAI tool focuses on mental health statuses. Creators of interRAI desire this tool to be brief, cost-efficient, utilization upon admission and be easily administered by anyone upon intake.

InterRAI will incur higher costs and 'specialized' aspects of dealing with forensic/mentally ill offenders (greater security costs, court appearances, legal representation) (Brown, 2006). The new RAI-MH assessment tool will incorporate information about offence history, level of risk of violence and future offending, use of weapons, threatening behaviour, sexual offending, etc. Plans for improving the RAI-MH also include using parts of the Violent Risk Appraisal Guide (VRAG) and the Psychopathy Checklist Revised (PCL-R). The VRAG is an actuarial risk assessment tool that is used in prisons to assess violence and re-offending. The PCL-R is an objective assessment instrument used to measure traits of psychopathic personality disorder. Both assessment tools have a focus on violence, recidivism and the dangerousness of an offender (Bonta & Andrews, 2003). By using parts of the VRAG and PCL-R, questions can be inserted into the screening form instead of questions on the RAI-MH, which simply do not fit. By incorporating parts of these other tools, questions will be better suited for the prison population; aspects of violence, recidivism and the severity of mental illness could be assessed. InterRAI will also be a positive step for corrections, as it will hopefully give an accurate picture of how many inmates in the system actually are suffering from mental illness. From there, a specialized and integrated plan of action must be implemented to either improve current medical attention, as well, counselling/support programs will need to be established or discharge planning/transfer to a mental health facility may be required. This is essential for mentally ill inmates to receive appropriate treatment and care, in hopes of one day integrating them as productive members of our communities.

As well, assuming that the mentally ill are less criminogenic in their behaviour than normal offenders, then the RAI-MH needs to be investigated on whether it classifies as criminal behaviour or not. Also, based on the findings, it was found that the more trivial the crime, the

more likely to recontact if you are mentally ill—which must be investigated. This particular investigation also did not permit a break out of factors in the scale of criminogenic tendencies scale. Individual factors need to be looked at to see if there is a difference when not indexed together. An additional follow up across the provinces would be interesting to see whether there is in fact a difference in recontact rates for the two offender populations.

5.4 Conclusions

Currently, Corrections and health agencies do not have a way to dialogue about mental illness in the prisons; there is no common language between the two systems. There is a need for a common language and common criteria in order to assess which offenders are deemed seriously mentally ill and to ensure adequate care or transfer of these offenders to an appropriate health institution. Aside from not having the appropriate mental screening tool implemented, an additional concern with the current Corrections system is that the staff have not received sufficient education and training to handle mentally ill offenders. Dealing with mental health issues and the individual needs of this specific offender group should not be the responsibility of the Ministry of Corrections, but rather the Ministry of Health. In fact, it is questionable how these mentally ill individuals have even ended up in the prison system in the first place; perhaps the aforementioned screening tools should be implemented to assess mental stability prior to assessment of punishment by the courts. It seems unlikely that these individuals even fully understand the gravity of their actions and repercussions of their crimes. It is hopeful that the results of this study will prompt further discussion on appropriate care for mentally ill inmates, as well as improve and provide the necessary resources and facilities to handle these individuals. While there was found to be no differences between the seriously-mentally ill offender and the normal offender with respect to recontact, Corrections has a moral and legal duty to provide

adequate care and treatment options. As well, as a society we have a responsibility to take care of those that do not have a voice, or are unable to function appropriately in the community due to their mental illness. Those who are seriously mentally ill and incarcerated in a prison facility are currently not receiving adequate care and many of these individuals are unable to understand the impact of their actions. Expecting healthy reintegration of these individuals back into society upon release is naïve and irresponsible. The mentally ill are more likely to recontact with minor offenses; however, if there is not appropriate treatment provided, it is likely to cost each province greatly by repeatedly re-incarcerating these mentally ill offenders. With the current situation where mentally ill offenders are incarcerated, there needs to be both psychological and psychiatric assistance readily provided. Suitable medications and assessment of how these patients are responding to these therapies needs to be evaluated on a regular basis. Additional research needs to be conducted to assess current therapeutic regimes, including counselling and assess if the reason offenders are re-offending is due to inadequate care and counselling provided. As well, assessing how these mentally-ill offenders are re-integrating into society and making certain that these offenders are receiving appropriate medical care upon release is essential. Other contributing factors on why these offenders are re-offending could be due to improper housing or inadequate support/treatment programs provided once they are back in the community. It poses the question, are each of the provinces, the Corrections and the Medical system, implementing the best care to ensure healthy integration of these mentally ill offenders into society. If not, what changes could be implemented prior to, while incarcerated or once released, in order to ensure these offenders are deterred from re-offending and or able to integrate into society, or are provided with needed medical attention in a mental health facility. The most appropriate remedy appears to be to place mentally ill offenders in mental health

facilities rather than in prisons, where they have a chance of receiving the appropriate medical attention and services, such as counselling. By having the seriously mentally ill offenders, whom are unable to function lawfully in society, be housed in a proper facility in the first place could alleviate these offenders from coming back into the system.

Currently there is only one facility in Ontario that houses the mentally ill in specific psychiatric units. St. Lawrence Valley is a "unique facility that addresses the need for mental health and secure treatment services in a safe correctional environment" (Royal Ottawa Health Care Group, 2009). Plans to develop such a unit stemmed from the closing of mental hospitals in the area. This facility integrates secure correctional treatment, remand custody and forensic services together in one facility. This institution has 100 beds in the secure treatment unit and 44 beds in the forensic unit (Royal Ottawa Health Care Group, 2009). The province would benefit from more of these facilities and the safety and security of those individuals with serious mental illnesses, who would receive the proper care they needed upon incarceration.

Perhaps, on the other hand, a possible remedy could be improvement on existing medical attention/counselling in current prisons and programs for these individuals upon release. Instead of assessing the mentally ill and their risk to recontact, a greater focus could be on examining anti-social tendencies and how these behaviours affect recontact rates. By looking at these social tendencies as well, connections can hopefully be made as to whether these tendencies increase the likelihood of reoffending for this group. Probation officers and community workers need to be more involved in looking at these anti-social tendencies on how they could integrate more positive factors into offenders' lives such as: more programs geared towards positive supports, community housing, and workshops for creating resumes, education programs, and therapy for understanding why they commit specific crimes. If the government created more positive steps

to keeping offenders out of prison rather than building more jails and not tackling the real issue of looking at all the negative factors in offenders' lives, there would more likely fewer individuals incarcerated. It is essential that additional research needs to be conducted to assess these parameters for not just mentally ill offenders, but for all offenders.

The purpose of this study was to focus on serious mentally ill offenders and look at possible risk factors to predict recontact. The main motivation for conducting this project was that there appears to be a gap in knowledge as to incarceration of the seriously mentally ill individuals and recontact rates in Ontario. There is currently a diminutive literature on whether individuals with serious mental illnesses are more likely to recontact then non-mentally disordered offenders. This thesis focused on many factors related to predicting recontact and considered the extensive literature focusing on recontact studies for the mentally ill offender in the hopes of finding significant reasons to improve the correctional system today.

For this particular sample it did not matter whether offenders had a serious mental illness versus non-mental illness in predicting recontact. Seriously mentally ill offenders were no more likely than non-mentally disorders offenders to recontact. However, since there is a moral and ethical duty from the Ministry of Community Safety and Correctional Services, having proper assessments completed on every inmate that enters into the correctional system is of utmost importance. These individuals should not be incarcerated in these types of facilities, as there is not enough training for correctional staff and the units they are placed in often worsen their symptoms. There also needs to be further studies, with particular emphasis on the different needs of male and female offenders.

The data collected in this study also revealed, based on an unrepresentative sample, that there are a large number of offenders within Ontario that have a serious mental illness. Thus far, the RAI-MH 2.0 and the LSI-OR are the best-suited screening tools to be used to predict recontact in prisons. Using these tools for a base, creators of the new forensic tool hope that interRAI has no methodological flaws and predicts mental illness upon intake. Also, if a common language is developed between the Ministries of Corrections and Health, inmates with mental illnesses will be placed in a setting congruent with and appropriate for their particular mental state. The hope for this new tool is that people with mental illnesses will be properly assessed and new programs and will develop to give inmates the proper treatment when incarcerated. It is also hoped that new facilities will open like St. Lawrence Valley to ensure inmates with serious mental illnesses are given the proper care and treatment needed while incarcerated. Opening these new facilities will benefit both the Ministry of Health and the Ministry of Community Safety and Correctional Services.

Bibliography

Andrews, D.A., & Bonta, J. (3rd Edition) (2003). *The Psychology of Criminal Conduct.* Cincinnati: Anderson Publishing Co.

Arboleda-Florez, J. (1996). Mental Illness and Violence: Proof or Stereotype? For Health Promotion and Programs Branch Health Canada, Ministry of Supply and Services Canada, 1-14.

Babbie, E., & Benaquisto, L. (2002) *Fundamentals of Social Research*. Scarborough: Nelson.

Barbaree, H. (2002). Assessment, Treatment and Community Reintegration of the *Mentally Disordered Offender*. Final Report. Ontario Ministry of Health and Long-Term Care.

Basen, I. (2006). *Doing the crime and doing the time.* Available at http://www.cbc.ca/canadavotes2006/realitycheck/crimetime.html

Berg, B. (5th Edition) (2004). Qualitative Research Methods for the Social Sciences. United States of America: Pearson Education, Inc.

Blaauw, E., Roesch, R. & Kerkhof, A. (2000). Mental illness in European prison systems. International Journal of Law and Psychiatry, 23(5-6), 649-663.

Blitz, C., Wolff, N., and Paap, K. (2006). Availability of Behavioural Health Treatment for Women in Prison. *Psychiatric Services,* 57(3), 356-360.

Bonovitz, J.C. & Bonovitz, J.S. (1981). Diversion of the mentally ill into the criminal justice system: the police intervention perspective. *American Journal of Psychiatry Association*, 138, 973-976.

Bonta, J., Lipinski, S. & Martin, M. (1992). The characteristics of aboriginal recidivists. *Canadian Journal of Criminology*, 34, 517-522.

Bonta, J., Law, M & Hanson, K. (1998). The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta- Analysis. Psychological Bulletin, 123 (2), 123-142.

Bonta, J. & Andrews, D. (2003). *The Psychology of Criminal Conduct (3rd Ed).*Cincinnati: Anderson Publishing Inc.

Bonta, J. & Yessine, AK. (2004). Tracking high-risk, violent offenders: an examination of the national flagging system. Canadian Journal of Criminology and Criminal *Justice*, 48(4), 573-603.

Brink, J.H., Doherty, D. & Boer, A. (2001). Mental illness in federal offenders: A Canadian prevalence study. International Journal of Law and Psychiatry, 24, 339-356.

Brodhurst, R. (1997). Aborgines and crime in Australia. *Crime and Justice*, 21, 407-468.

Brown, G. (2003). Discussion Paper: Establishing Recidivism Baseline and Benchmarks for Select Ministry of Correctional Services, 1-13.

Brown, G. (2006). Presentation to Human Service and Justice Coordinating Committee Southwest Region Conference: Identifying the Psychiatric Care Needs of Offenders in the Ontario Correctional System. London, Ontario.

Brown, G. (2007). Social Control of the Mentally Ill and the Police Role: Dangerous Medicine (with R. Hoffman "forthcoming Spring 2007 chapter in book Community, Environment and Mental Health). LeClair (ed) published by Western Geographical Press/University of Victoria/UBC Press.

Brown, G. (2009). Final Report Part 1-The Prevalence and Mental Health Care Needs of Adult Inmates in Ontario Correctional Facilitie,1-112.

Brown, G. and Maywood, S. (2002). Police response in situations involving emotionally disturbed persons: An analysis and update of data reported from the Toronto *Police Service EDP report form*. Paper presented at the First National Conference on Police/Mental health Liaison, Montreal, Canada.

Canadian Legal Information Institute (1985). Retrieved from http://www.canlii.org/ca/sta/c-46/sec2.html

Canadian Mental Health Association (2005). *Sub-Standard Treatment of Mentally Ill* Inmates is Criminal: Experts. Retrieved from http://www.schizophrenia.ca/mysql/PressReleaseNov4.pdf

Champlain District Mental Health Implementation Task Force (2002). *Building Community Based Services and Supports in Forensics.* Available at http://www.health.gov.on.ca/english/providers/pub/mhitf/east_ne/sec95.pdf

Chan, Dave. (2011, January 22). To heal and protect. The Globe and Mail, pp. A1.

Chenier, N.M. (1999). *Health and Homelessness*. Government of Canada: Parliamentary Research Branch, 1-8.

CIHI (2005). Ontario Mental Health Reporting System Resource Manual, 2008–2009, Module 3—Mental Health Assessment Protocols (MHAPS) Ottawa, ON: Canadian Institute for Health Information.

Clark, R., Ricketts, S. and McHugo, G. (1999). Legal System Involvement and Costs for Persons in Treatment for Severe Mental Illness and Substance Use Disorders. Psychiatric Services, 50, 641-647.

Cockerham, W. (6th Edition) (2003). *Sociology of Mental Disorder*. New Jersey: Prentice Hill.

Conrad, P. (1985). *Deviance of Medicalization.* United States of America: Merill Publishing Company.

Corrado, R.R., Cohen, I., Hart, S. & Roesch, R. (2000). Comparative examination of the prevalence of mental illness among jailed inmates in Canada and the United States. *International Journal of Law and Psychiatry, 23*(5-6), 633-647.

Correctional Service Canada (2007, August). Addressing mental health needs of offenders. *Let's Talk, 32* (1), pp. 1-20.

Correctional Service Canada (1990). Creating Choices: The Report of the Task Force on Federally Sentenced Women. Retrieved from http://www.csc-scc.gc.ca/text/prgrm/fsw/choices/toce-eng.shtml

Crown Prosecutor Service (2007). Retrieved from http://www.cps.gov.uk/legal/

DeLesi, M (2000). Who is more dangerous? Comparing the criminality of adult homeless and domiciled jail inmates: a research note. *International Journal of Offender Therapy and Comparative Criminality*, 44(1), 59-69.

Diamond, P.M., Wang, E.W., Holzer III, C.E., Thomas, C. & Cruser, des Anges, (2001). The prevalence of mental illness in prison. *Administration and Policy in Mental Health*, *29*(1), 21-40.

Douglas, K., Guy, L. & Hart, S. (2009). Psychosis as a risk factor for violence to others: a meta analysis. *Psychological Bulletin*, 135(5), 679-706.

Drake, R. (1994). Substance Abuse and Mental Illness. Retrieved from *http://www.healthyplace.com/communities/bipolar/related/substance_abuse.asp*

Duffy, D., Linehan, S. & Kennedy, H.G. (2006). Psychiatric morbidity in the male sentenced Irish prisons population. Irish Journal of Psychological Medicine, *23*(2), 54-62.

Fazel, S. & Danesh, J. (2002). Serious mental illness in 23,000 prisoners: A systematic review of 62 surveys. *The Lancet, 359,* 545-550.

Ferguson, M, Olgoff, J & Thomson, L. (2009). Predicting recidivism by mentally disordered offenders using the LSI-R: SV. Criminal Justice and Behavior, *36(1), 5-20*.

Ford, J. & Trestman, R. (2005). Evidence-Based Enhancement of the Detection, Prevention, and Treatment of Mental Illness in the Correction Systems. U.S. Department of Justice. Doc. No 210829.

Gagliardi, G. J., Lovell, D., Peterson, P. D., & Jemelka, R. (2004). Forecasting recidivism in mentally ill offenders released from prison. *Law and Human Behaviour*, *28*(2), 133-155.

Gendreau, P., Goggin, C. & Little, T. (1996). *Predicting Adult Offender Recidivism: What Works!* Public Works and Government Services Canada, 1-22.

Girard, L. & Wormith, J.S. (2004). The predictive validity of the Level of Service Inventory – Ontario revision on general and violent recidivism among various offender groups. Criminal Justice and Behavior, 31(2), 150-181.

Goffman, E. (1963). Stigma: Notes on the Management of the Spoiled Identity. New York: Patheon Books.

Goin, M.K. (2004). Mental illness and the criminal justice system: redirecting resources toward treatment, not containment. *The American Psychiatric Association*, 1-8.

Goldberg, A. & Higgins, B. (2006). Brief Mental Health Screening for Corrections Intake. *Corrections Today*, 82-84.

Government of Canada (2006). The Human Face of Mental Health and Mental illness in *Canada 2006.* Ottawa, ON: Minister of Public Works and Government Services Canada.

Grisso, T. (2006). Jail Screening Assessment Tool (JSAT): Guidelines for Mental Health Screening in Jails. *Psychiatric Services*, 57 (7), 1048-1055. Retrieved November 15, 2006, from ps.psychiatryonline.org.

Grusky, O., & Pollner, M. (1981). *The Sociology of Mental Illness.* United States of America: Holt, Rinehart and Winston.

Hartford, K., Heslop, L., Rona H., Stitt, L. and Schrecker, T. (2002). *Trends in police* contact with persons with serious mental illnesses in London, Ontario. Paper presented at the First National Conference on Police/Mental health Liaison, Montreal, Canada.

Hartwell, S. (2003). Short term outcomes for offenders with mental illness released from incarceration. International Journal of Offender Therapy and Comparative Criminology, 47(2), 145-158.

Health Canada (2002). *A Report on Mental Illness in Canada*. Ottawa, Canada.

Hirdes, J., Marhaba, M., Frise Smith, T., Mitchell, L., Lemick, R., Curtain Telegdi, N., Perez, E., Prendergast, P., Rabinowitz, T., & Yamauchi, K. (2000). Development of the Resident Assessment Instrument-Mental Health (RAI-MH), *Hospital Quarterly*, 44-53.

Hirdes, J., Smith T., Rabinowitz, T., Yamauchi, K., Perez, E., Curtin Telegdi, N., Prendergast, P., Morris, J., Ikegami, N., Phillips, C., & Fries, B. (2002). The Resident Assessment Instrument-Mental Health (RAI-MH: inter-rater reliability and convergent validity. *Journal of Behavioural Health Services & Research*, 29(4), 419-432.

Hirdes, J., Perez, E., Curtin-Telegdi, N., Prendergast, P., Morris, J., Ikegami, N., Fries, B., Phillips, C., & Rabinowitz, T. (2003). *Training Manual and Resource Guide RAI-MH. Toronto*: Ontario Joint Policy and Planning Committee.

Horwitz, A. (1982). *The Social Control of Mental Illness*. New York: Academic Press.

InterRAI (n.d.). *Mental Health*. Retrieved November 20, 2006, from http://www.interrai.org/section/view/?fnode=21

Lamb, H.R., Weinberger, L.E. and DeCuir, W.J. (2002). The police and mental health. *Psychiatric Services*, 53 (10), 126-1271.

Laishes, J. (2002). Women offender programs and issues: the 2002 mental health strategy for *women offenders.* Correctional Services of Canada, 1-70.

Lovell, D., Gagliardi, G., and Peterson, P. (2002). Recidivism and Use of Services among Persons with Mental Illness After Release from Prison. *Psychiatric Services,* 53(10), 1290-1296.

McClanahan, S. McClelland, G., Abram, K. and Teplin, L. (1999). Pathways into Prostitution Among Female Jail Detainees and Their Implications for Mental Health Services. *Psychiatric Services*, 50 (12), 1606-1613.

Ministry of Community Safety and Correctional Services (2005). Ministry of Community Safety and Correctional Services Accessibility Plan 2005 – 2006. Retrieved from http://www.mcscs.jus.gov.on.ca/english/publications/ministry/accplan05_06.html

Monahan, J. (1993). Mental disorder and violence: Another look. In S. Hodgins (Ed), Mental Disorder and Crime (287-302). Newbury Park, CA: Sage.

Mulvey, E. & Fardella, J. (2006). Are the Mentally Ill Really Violent?, *Psychology Today*, Sussez Publishers, 1-6.

Naples, M., and Steadman, H. (2003). Can Persons with Co-Occurring Disorders and Violent Charges be Successfully Diverted? *International Journal of Forensic* Mental Health, 2(2), 137-143.

Nicholls, T., Lee, Z., Corrado, R. & Ogloff, J. (2004). Women Inmates' Mental Health Needs: evidence of validity of the jail screening assessment tool (JSAT). International Journal of Forensic Mental Health, 3(2), 167-184.

Northeast Mental Health Implementation Task Force (2002). *The Time for Change is* Now, Section 9.

Olgoff, J. R. (2002). Identifying and accomodating the needs of mentally ill people in gaols and prisons. Psychiatry, Psychology and Law, 9(1), 1-33.

Osher, F., Scott, J., Steadman, H. & Clark Robbins, P. (2005). Validating a Brief Jail Mental Health Screen, Final Technical Report. *U.S. Department of Justice*. Doc No.213805.

Pinals, D., Packer, I., Fisher, W. & Roy-Bujnowski, K. (2004). Relationship between race and ethnicity and forensic clinical triage dispositions. *Psychiatric Services*, 55 (8), 873-878.

Public Sector Quality Fair (2007). Retrieved from www.psqf.org

Rice, M. , Seto, M., and Harris, G. (2004). The Criminogenic, Clinical, and Social Problems of Forensic and Civil Psychiatric Patients. *Law and Human Behaviour*, 28(5), 577-586.

Roberts, J. & Doob, A. (1997). Race, ethnicity, and criminal justice in Canada, *Crime and Justice*, 21, 469-522.

Roberts, J.& Grossman, M. (2004). *Criminal justice in Canada: a reader.* Scarborough: Thomson, Nelson.

Roberts, J. & Melchers, R. (2003). The Incarceration of Aboriginal Offenders: Trends from 1978-2001. *Canadian Journal of Criminology and Criminal Justice.* 45 (2), 211-242.

Rodriguez, J., Keene, J., & Li, X. (2006). A pilot study of assessed need and service use of offenders and ferquent offenders with mental health problems. *Journal of Mental Health*, *15*(4), 411-421.

Rogers, R., Sewell, K., Ustad, K., Reinhardt, V., & Edwards, 1. (1995). The Referral Decision Scale with Mentally Disordered Inmates. *Law and Human Behaviour*, 19(5), 481-492.

Royal Ottawa Health Care Group (2009). *Secure Treatment Unit*. Available at http://kingston.cioc.ca/record/KGN4902

Scheff, T. (3rd Edition) (1999). *Being Mentally Ill: A Sociological Theory*. New York: Aldine De Gruyter.

Scott, C. & Gerbasi, J. (2005). *Handbook of Correctional Mental Health.* Washington: American Psychiatric Publishing Inc.

Sharpe, M. (2005). Mentally ill need treatment not jail. *Capital News Online: A* publication of Carleton University's School of Journalism, (17(4), 1-4.

Sims, B. (2005). Substance Abuse Treatment with Correctional Clients. Binghamton: The Haworth Press Inc.

Steadman, H., Scott, E. Osher, F., Agnese, T., & Clark Robbins, P. (2005). Validation of the Brief Jail Mental Health Screen. *Psychiatric Services*, 56(7), 816-822.

Storey, P. & White, J. (2005). A Long Way to Go. *Visions*. 2(8), 1-40.

Susser, E., Valencia, E., Conover, S., Felix, A. Tsai, W. & Wyatt, R. (1997). Preventing recurrent homelessness among mentally ill men: a "critical time" intervention after discharge from a shelter. *American Journal of Public Health*, 87(2), 256-262.

Teplin, L. & Swartz, J. (1989). Screening for Severe Mental Disorder in Jails: the development of the Referral Decision Scale. *Law and Human Behaviour*, 13(1), 1-18.

Thompson, M. (2007). *Mental Illness.* Wesport Connecticut: Greenwood Press.

Tye, C.S. & Mullen, P.E. (2006). Mental illness in female prisoners. *Australian and* New Zealand Journal of Psychiatry, 40, 266-271.

Underhill, K. (2007). Ministry of Community Safety and Correctional Services. Unpublished Report.

Vesey, B.M., Steadman, H., Johnsen, M., & Beckstead, J. (1998). Using the Referral Decision Scale to Screen Mentally Ill Jail Detainees: validity and implementation issues. *Law and Human Behaviour*, 22(2), 205-215.

Wasylenki, D. & Tolomiczenko, G. (1999). *Mental Illness and Pathways into* Homelessness: Findings and Implications. Available at http://www.camh.net/hsrcu/html_documents/pathways_proceedings.htm

Appendix 1. Definition of Terms

Mental disorder- mental illness, arrested or incompetent development of mind, psychopathic disorder and any other disorder or disability of the mind

DSM-IV- is published by the American Psychiatric Associating and provides diagnostic criteria for mental disorders

Axis I disorders -serious mental disorders

Axis II disorders- minor mental disorders

Recidivism- as a return to criminal behaviour during or after correctional intervention

Recontact- is defined as how many times offenders come in and out of the criminal justice system following a release from custody. This includes all new offenses, bail convictions, or reoffenses.

LSI-OR- is an extensive, theoretically based body of knowledge on both the static risk factors and criminogenic needs of offenders

Normal offender- an individual who is of sound mind and "has been determined by a court to be guilty of an offence, whether on an acceptance of a plea of guilty or on a finding of guilt

RAI-MH 2.0- is a two-part psychiatric assessment consisting of the Minimum Data Set for Mental Health (MDS-MH) and the Mental Health Assessment Protocols

Offender Tracking Data Base System (OTIS)- a user-friendly computer program that allows adult and young offender probation officers to access client case notes and other new case notes directly through the Ministry's mandatory, secure central database

Community Treatment Order (CTO)- is given out by a psychiatric facility when an individual is released from their services

Assertive Community Treatment Programs (ACT)- highly structured case management [plans], with a designated professional charged with the overall responsibility for the individual's treatment and rehabilitation plan

Diagnostic Interview Schedule- an instrument which yields diagnoses of several major mental disorders according to the criteria from the DIS manual of mental disorders

Referral Decision Scale (RDS)- a screening instrument used for offenders upon their admission to the institution to screen for mental illnesses

Jail Screening Assessment Tool (JSAT)- a screening instrument used for offenders upon their admission to the institution to screen for mental illnesses

Brief Jail Mental Health Screen (BJMS)- a screening instrument used for offenders upon their admission to the institution to screen for mental illnesses

Appendix 2. MDO Consent Form

SIGNED CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

IDENTIFYING THE PSYCHIATRIC CARE NEEDS OF ADULT OFFENDERS IN THE ONTARIO CORRECTIONAL SYSTEM
You are asked to participate in a research study conducted by Dr. Gregory P. Brown and Ms Krista Mathias and two student research assistants from the Institute for Applied Social Research at Nipissing University in North Bay, Ontario. Other members of the research team are Kyla Marcoux, Kindra Houle, and Erin Hogan. The research is being sponsored by the Ontario Ministry of Community Safety and Correctional Services.

If you have any questions or concerns about the research, please feel free to contact Dr. Gregory P. Brown at (705) 474-3461 ext. 4454.

- **PURPOSE OF THE STUDY**

The purpose of this study is to identify any needs for psychiatric care that individuals in a jail or correctional centre may have. The assessment tool being used in the research will help to identify what these needs are, if any.

- **PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

Read this form describing what the study is all about and, if you agree to participate, sign that you consent to participate.

1) **With the researcher, complete the RAI-MH assessment tool. It is a paper and pencil assessment that the researcher fills out based on your answers. This will take about 1 hour, and the researcher will use one of the rooms here at the institution to complete the assessment. This tool is used by the Ministry of Health to identify whether an individual has any psychiatric care needs – anything from experiencing mild stress that keeps you awake at night through to the need to be in a hospital.**

2) **Give the researchers permission to check for additional information that may be in the files kept by the Ministry of Community Safety and Correctional Services that will help in completing the RAI-MH (e.g. health information, criminal history, offender classification assessments).**

When the research is finished and a final report has been written, you can get a copy by contacting the Superintendent's office here, by calling the Program Effectiveness, Statistics and Applied Research Unit in North Bay , Ontario at (705) 494-3352 or by contacting their website at MCSCS@gov.on.ca.

- **POTENTIAL RISKS AND DISCOMFORTS**

There are no known risks or discomforts associated with this research. However, if you begin to feel uncomfortable, you can stop the research session at any time or withdraw completely without any penalty to you.

- **POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

By participating in this research, you are helping the Ministry of Community Safety and Correctional Services to identify the needs that individuals in jails and correctional centres have for psychiatric services. This knowledge will help the Ministry to provide better treatment for those who need it.

PAYMENT FOR PARTICIPATION

There is no payment for participating in the research.

- **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission.

I understand that the information I provide is confidential, and will never be revealed to anyone except under the following circumstances: if I disclose information about plans to harm myself or others, information concerning any unknown emotional, physical or sexual abuse of children, or information about any other criminal activities not already known to authorities, the researcher is required to report this information to the appropriate authorities.

The researcher will not put your name on the RAI-MH assessment form. The number assigned by the Ministry to your file will be recorded on the form so that the researchers can fill in additional information from your file.

Once all the information collected has been entered into a computer file, the RAI-MH form will be destroyed.

- **PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

- **RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. This study has been reviewed and received ethics clearance through Nipissing University's Research Ethics Committee. If you have questions regarding your rights as a research subject, contact:

Research Ethics Co-ordinator **Telephone: 705-474-3461, # 4558**

Nipissing University

North Bay, Ontario

P1B 8L7

- **SIGNATURE OF RESEARCH SUBJECT/LEGAL REPRESENTATIVE**

I understand the information provided for the study "Identifying the Psychiatric Care Needs of Adult Offenders in the Ontario Correctional System" as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____

Name of Research Subject (please print)

_____ _____

Signature of Research Subject **Date**

- **SIGNATURE OF INVESTIGATOR**

In my judgement, the subject is voluntarily and knowingly giving informed consent to participate in this research study.

_____ _____

Signature of Investigator **Date**