Evaluation of the Saskatoon Mental Health Strategy (MHS) Court: Outcome and Cost Analysis

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Glossary of Terms

Charge. The charge differs at the arrest, case and conviction stage of the justice system. The arrest charge is the initial charge for which a justice-involved person is arrested by the police; the prosecutor may amend or drop (decline to prosecute) the arrest charge; the case charge is the charge for which a justice-involved person is adjudicated for in a court of law; the conviction charge is the charge the justice-involved person is found guilty of. An arrest, case and conviction may include several charges; that is, several charges may result from one criminal act. Typically, the most serious charge is used to characterize the arrest, case or conviction.

Client. A justice-involved person/defendant transferred from the traditional justice system to the Saskatoon Mental Health Strategy (MHS) Court.

ER. Emergency Room.

In-program. Mental health and criminal justice experiences of clients while their case was in the MHS Court.

Instant case. The client's case that was transferred to the MHS Court.

Justice-involved. Someone who is a current or former defendant in a criminal case.

MHC. Mental health court.

MHS Court. Saskatoon Mental Health Strategy Court; the name of Saskatoon's mental health court.

Pre-Court. Events that occurred prior to a client's first appearance in the MHS Court.

Police contacts. Involvement in a crime not resulting in an arrest, crime victimization, witnessing a crime, suicide involvement (i.e., client was at the scene but did not personally attempt suicide) and suicide attempt by the client.

Post-Court. Events that occurred after a client's first appearance in the MHS Court; excludes the instant case/arrest/conviction, but includes in-program cases/arrests/convictions.

1 year Pre-Post interval. A 2-year period, comprising of the period 1 year prior to entry into the Court to 1 year after the first appearance in the MHS Court.

2 year Pre-Post interval. A 4-year period, comprising of the period 2 years prior to entry into the Court to 2 years after the first appearance in the MHS Court.

Executive Summary

Bringing together a multidisciplinary team of community stakeholders and legal professionals, the Saskatoon Mental Health Strategy (MHS) Court, hereafter the MHS Court, aims to assist justice-involved individuals living with mental illness and cognitive impairments (Barron et al., 2015). To determine the effectiveness of the MHS Court and the extent to which it is achieving its intended outcomes, the Centre for Forensic Behavioural Science and Justice Studies (CFBSJS) was invited to conduct a multi-phase evaluation of the Court. The purpose of the current evaluation is to provide the Steering Committee of the Saskatoon MHS Court with an outcome and cost evaluation detailing the outcomes of the MHS Court's first year cohort of defendants. This evaluation was guided by the following questions:

1. Did the MHS Court succeed in diverting clients out of the traditional criminal justice system?

2. Did the MHS Court succeed in reducing further justice involvement for clients?

3. Did involvement with the MHS Court improve clients' mental health?

4. Did involvement with the MHS Court reduce clients' future health service utilization?

5. Did involvement with the MHS Court reduce criminal justice costs of clients?

Methods

Data Sources

1. **Saskatchewan Ministry of Justice (SMJ)**
   SMJ data on arrests, convictions, court cases, court appearances, and sentencing.

2. **Saskatoon Police Service (SPS)**
   SPS data on calls for service and police contacts.

3. **Saskatoon Health Region Authority (SRHA)**
   a. ***Addictions and Mental Health Information System (AMIS)***
   AMIS data on mental health episodes, presenting problems, service utilization, and mental health and addictions treatment.
   b. ***National Ambulatory Care Reporting System (NACRs)***
   NACRS data on in-patient and emergency room visits at the Royal University Hospital, Saskatoon City Hospital, and St Paul's Hospital.

Analytic Approach

1. **Pre-post Analysis of Criminal Justice and Health Outcomes**
   a. Pre-program entry variables compared to post-program entry variables for a 1-year and, where available, a 2-year period.
   b. Pre- and post-program entry means were compared using paired-samples *t*-tests for the same participants (Field, 2009).
   c. Pre- and post-program entry dichotomous (yes/no) variables were compared for the same participants using the McNemar Test (Field, 2009).

2. **Pre-post Cost Analysis**
    a. Pre- and post-program entry Court cases compared for the 1- and 2-year intervals using Garbor's (2015) mean cost (outliers removed) estimates.

MHS Court Clients' Profile

Participants
Ninety-two defendants participated in the MHS Court in the first-year cohort, that is, were transferred into the MHS Court between November 18, 2013 and November 17, 2014. Data was available for 89 clients adjudicated through the MHS Court.

Instant Case Arrest Charge, Conviction, and Sentence
Over half of the cases transferred to the MHS Court were for non-violent arrests (57%) followed by violent (40%) and traffic (2%) arrest charges. Almost three-quarters of clients (74%) received a conviction on their MHS case. The most common index conviction charge was for non-violent offences (46%), while just over one quarter (26%) of clients were convicted of a violent crime. The most common sentence for the instant case was probation (47%) followed by suspended sentences (25%), jail sentences (19%), fines (12%), and conditional sentences (10%).

Pre-Post Outcome Evaluation Findings

Overall, findings indicate that arrest recidivism was low for clients involved with the Saskatoon MHS Court although the seriousness of the charges received tended to increase after entry into the Court. Conversely, court cases and convictions both increased following participation in the MHS Court. Notably, a large proportion of the recidivist cases and convictions resulted from system generated or non-compliance issues. Additionally, results of this evaluation suggested that clients have high-risk peer groups which could result in an increased risk of involvement with crime or encounters with police. As social supports for crime such as criminal associates have been identified as an important criminogenic risk factor in the Risk-Needs-Responsivity Model (Andrews & Bonta, 2010), antisocial peers could be an important factor to target during the time that the client is involved with the Court.

Given that arrests declined post-Court entry while convictions and court cases increased, there is strong evidence of over-supervision and over-punishment by the MHS Court (i.e., increased detection of non-compliance due to greater supervision by the MHS Court compared to the traditional justice system). In fact, the increases in conviction, cases, and sentences were lower in the 2-year post entry period, when only 7% of clients' cases were still being adjudicated. This means that accessing the mental health and case management services provided by the Court comes with a possible penalty for clients: increased convictions and additions to their criminal record. Due to these increases, defence counsel may advise clients to take their chances with the traditional criminal justice system, meaning that the Court may not be fully accomplishing its goals of diverting clients out of the traditional criminal justice system.

Due to the increase in administrative charges and convictions, many clients also received an increase in fines. Although this evaluation was not able to ascertain the socio-economic status (SES) of the clients involved, typically, many of the clients involved in the Saskatoon MHS

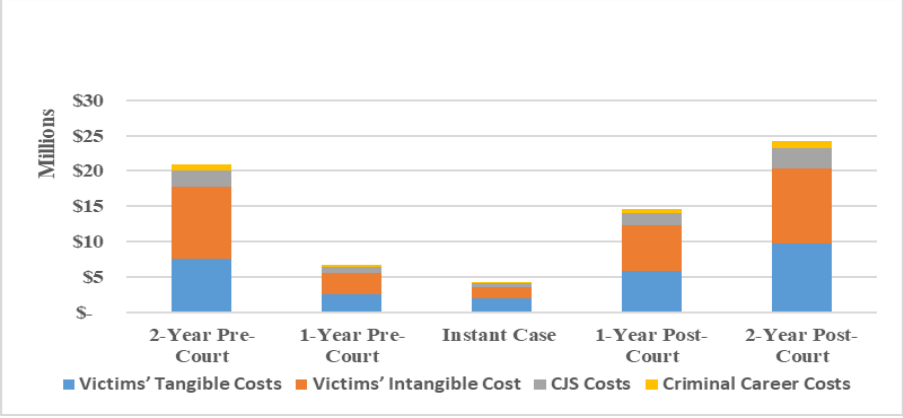
Court are from marginalized populations and tend to be from lower SES levels. When low SES individuals are given financial penalties, rather than acting as a deterrent for future crimes, these penalties tend to result in the individual being jailed for failure to pay the fine and losing their support networks when they are unable to repay loans (Wool et al., 2019). In addition to these social and legal implications, over-supervision and punishment tended to increase costs for the Court as well.

In terms of clients' mental health, fewer clients experienced a mental health episode 1-year post-Court entry; however, these episodes lasted significantly longer post-Court. Further, slightly more clients accessed services post-Court entry, with access to group counselling, individual counselling, and detox increasing. However, utilization of consultation, drug addiction treatment, psychiatric in-patient, and other programming decreased following entry into the Court. Clients' ER utilization appeared to be very promising: ER visits declined significantly at the 1-year pre-post interval, and there was a reduction in both urgent and non-urgent ER visits. As such, these ER utilization results suggest that participation in the MHS Court helped reduce issues that could lead to urgent visits and also reduced non-urgent visits that may put strain on the health care system.

Cost Analysis Findings

Based on Gabor's (2015) mean excluding outliers estimate, total cost of the instant case was slightly over 4 million dollars ($4,186,110). The majority of this expense was attributed to victim tangible ($1,890,812) and intangible ($1,693,977) costs, while the criminal justice system cost accounted for approximately 10% of the total cost ($447,063). Totals costs increased in both the 1- and 2-year pre-post intervals (see Figure A). Total 1-year recidivism cost ($14,636,423) was more than two times greater than total 1-year pre-Court cost ($6,695,916). Total 2-year recidivism cost also exceeded total 2-year prior cost ($24,228,986 vs. $20,925,128), with the highest costs attributed to victim tangible and intangible costs. However, the total cost increase was less drastic in the second year.

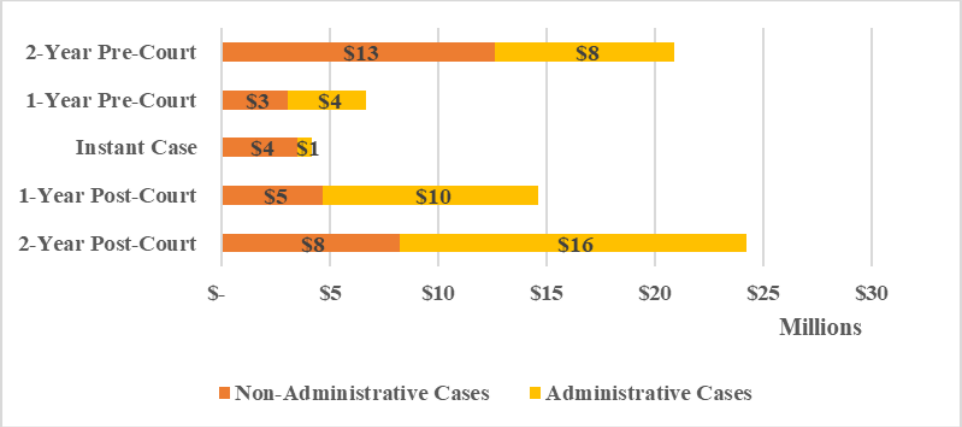
Figure A. Total Cost:
Victim, Criminal Justice System and Criminal Career Costs (Million Dollars)



From a cost standpoint, the burden pre- vs. post-Court entry switched from non-administrative (i.e., criminal behaviour) to administrative charges (failure to comply with conditions/orders),

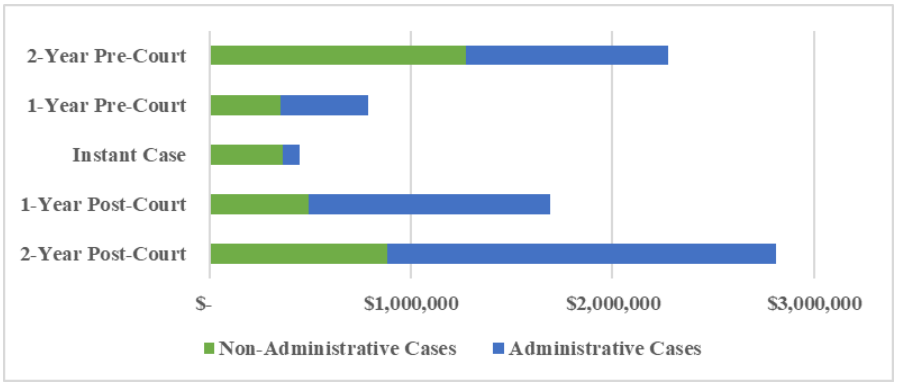
illustrated in Figure B. Administrative cases accounted for 54% of total costs 1-year pre (close to $4M out of approximately $7M), and 40% of total costs 2-year pre-Court (approximately $8M out of close to $21M). In contrast, post-Court entry administrative case costs accounted for about two-thirds of total recidivism costs (almost $10M out of $14.5M 1-year post-Court; and approximately $16M out of $24M 2-year post-Court cost).

Figure B. Total Costs:
Non-Administrative vs. Administrative Cost (Million Dollars)



As illustrated in Figure C, much of the 1-year and 2-year criminal justice recidivism costs also resulted from administrative charges—71% of 1-year recidivism (slightly over $1M), and 69% of 2-year criminal justice recidivism cost (almost $2M) were due to non-compliance issues. If subsequent MHS Court cohorts have similar criminal and mental health backgrounds as the first-year cohort, reducing the use of administrative charges for non-compliance could potentially save the province almost $2M in criminal justice costs in the 2-year post-court entry period.

Figure C. Criminal Justice Costs:
Administrative vs. Non-Administrative Cost



Conclusion

This pre-post outcome and cost evaluation found several strengths of the MHS Court. Fewer clients had police contacts, were victims of crimes, or arrested in the 2-years following their MHS Court entry. Clients were able to access several mental health services and treatments post-Court entry, while their hospitalizations and emergency room utilizations declined in the 1-year post-Court entry period. The pre-post arrest analysis was also promising, as reductions were observed in any violent and non-violent arrests. However, the crime severity weight of all arrests increased in the pre-post arrest outcome analysis, indicating some caution is required in interpreting these data. Clients' court cases did increase subsequent to their MHS Court entry, but this increase declined in the second year post-Court, indicating a possible supervision effect during the MHS Court case. Inclusion of data categorizing arrests, cases, and convictions by seriousness (i.e., summary, indictable or hybrid), and a matched comparison group are required to make any definitive conclusions about any recidivism and/or the over-supervision effects.

The absence of program data, including any indicators of successful MHS Court completion, was a challenge. As a result, we used recidivism, mental health, and health utilization as our outcome measures and no analysis on completers (clients who successfully completed the MHS program) vs. non-completers was possible. Future evaluations would benefit from the inclusion of program data and a matched comparison group, demographic data, and a longer follow-up period. Further, due to the small sample size, comparisons on the effects of co-occurring (i.e., substance abuse with mental disorder) and different mental health conditions on recidivism was not feasible.

Despite these limitations, we hope that the findings and the following recommendations are useful to the Steering Committee of the Saskatoon Mental Health Strategy. Our hope is that our report will generate discussions within the Steering Committee about the purpose, direction, and outcomes of the MHS Court, and perhaps support efforts to secure funding for dedicated staff and data tracking of clients' programming and outcomes.

Recommendations

Based on the findings of the evaluation, the following recommendations are put forward to further support the MHS Court in meeting its client needs:

1. Implementation of a data tracking system and standardized reporting—quarterly or yearly—based on the needs of the MHS Court.

2. Hire a dedicated coordinator to oversee the program and clients' case files (e.g., remind clients of appointments, monitor the reward/punishment system, and arrange additional services as needed).

3. Adopt a Risk-Needs-Responsivity framework.

4. Inclusion of risk-needs assessment at intake, or shortly thereafter.

5. Administer a suicide risk screen at intake, or at pre-determined intervals, and making appropriate referrals to Saskatoon Crisis.

6. Avoid the use of financial penalties and fines.

7. Create a system of penalties and rewards to ensure clients' compliance with the MHS Court requirements. Re-arrest should only be used as a penalty as a last report.

8. Implement judicial referral hearings as an alternative to administrative charges for participants and address non-compliance with a system of penalties.

9. Consider implementing a stay of prosecution by the Crown upon successful completion of the program. Include a graduation ceremony upon successful program completion.

10. The inclusion of an Indigenous court worker as one of the professionals involved in the MHS Court, if one is not already included in on the professional Court team.

Table of Contents

Table of Figures

Table of Tables

Chapter 1: Introduction

The Centre for Forensic Behavioural Science and Justice Studies (CFBSJS) was invited to conduct an evaluation of the Saskatoon Mental Health Strategy (MHS) Court, hereafter the MHS Court. The Saskatoon MHS Court coordinates treatment for justice-involved persons with mental health, fetal alcohol spectrum disorder (FASD) or cognitive issues, who are willing to undergo treatment and plead guilty to some or all of the case charges (Saskatchewan Law Courts, n.d.-b). The CFBSJS developed a multi-phase evaluation of the MHS Court; this study presents the results of the final two components of the second phase of the evaluation: a pre-post outcome evaluation and cost analysis. The outcome evaluation utilized secondary data obtained from the Saskatchewan Ministry of Justice, Saskatoon Police Service and Saskatoon Health Region Authority, for the first-year cohort of the MHS Court (i.e., clients admitted between November 18, 2013 and November 17, 2014), and focused on criminal justice involvement (police contacts, arrests, court cases, convictions and sentences), mental health diagnosis and service utilization, and health service utilizations. The cost evaluation utilized Saskatchewan Ministry of Justice data to estimate justice system, victim and opportunity costs for the same clients.

Mental Health Courts (MHCs)

The central goal of mental health courts (MHCs) is to divert justice-involved persons living with mental illness away from the traditional court system by integrating treatment provisions with principles of the law (Baillargeon et al., 2009; Schneider et al., 2007). Canadians living with mental health concerns are already at an increased risk for becoming involved in the criminal justice system (Hartford et al., 2005) and professionals who work with this population report difficulties navigating the traditional criminal justice system with these clients (MacDonald et al., 2014; Stewart & Mario, 2016). MHCs, like other problem-solving courts (e.g., drug courts, domestic violence courts), are situated in the field of therapeutic jurisprudence (Lim & Day, 2016; Lurigio & Snowden, 2009; Redlich & Han, 2013; Schneider, 2008; Wiener et al., 2010; Winick, 2002; Winick & Wexler, 2003). Hora, Schma and Rosenthal (1999, p. 440) defined therapeutic jurisprudence as "the study of the extent to which substantive rules, legal procedures, and the role of lawyers and judges produce therapeutic [positive] or anti-therapeutic [negative] consequences for individuals involved in the legal process." When applied to MHCs, therapeutic jurisprudence attempts to identify the underlying problem(s) (e.g., mental illness, addiction, education deficits) and provide a personalized treatment plan to break the cycle of recidivism; that is, to reduce negative consequences for justice-involved persons with mental illness (Lurigio & Snowden, 2009; Schneider, 2008; Wiener et al., 2010; Winick & Wexler, 2003). Consistent with therapeutic jurisprudence, MHCs rely on multidisciplinary teams of individuals to provide a comprehensive, holistic suite of services (Lurigio & Snowden, 2009; Rankin & Regan, 2004; Wiener et al., 2010; Winick, 2002). Services provided by MHCs may

include group or individual therapy, medication, or connecting individuals to community agencies that provide social, vocational, or residential assistance.

Mental health courts are not homogenous; however, common features of MHCs are screening and determining of client eligibility based on the current charge and prior criminal history, dedicated program staff (e.g., a presiding judge, prosecutor, mental health agency representatives and community service workers), regular court hearings, clients must accept responsibility for their behaviour and voluntarily enter into the program, case management services targeted to the client, compliance monitoring, charges withdrawn/reduced after successful completion of the program and services are typically accessed in the community (see: Campbell et al., 2015; Cissner et al., 2018; Hahn, 2015; Human Services and Justice Coordinating Committee [HSJCC], 2017; Reich et al., 2014; Schneider, 2008).

Screening

In addition to legal requirements (e.g., charge, charge severity, criminal record), the intake and screening process may include a mental health screen to determine program eligibility (Campbell et al., 2015; Cissner et al., 2018; Farley, 2015; HSJCC, 2017; Pooler, 2015; Reich et al., 2015). Criminogenic risk screens may be used to determine treatment level and for case management purposes (see: Campbell et al., 2015; Hahn, 2015). Criminogenic risk screens are based on the Risk, Need, Responsivity (RNR) model, which identifies eight central risk-needs factors—criminal history; antisocial personality; pro-criminal attitudes; anti-social/criminal networks; employment instability; family or relationship problems; lack of prosocial recreational activities; and substance use—and attempts to reduce recidivism risk by matching service level to the client's reoffending risk, targeting treatment to address the client's needs and using a treatment style tailored to the client's learning style (Andrews & Bonta, 2010; Bonta & Andrews; 2007).

Compliance

Mental health courts (MHCs) may use a system of rewards and sanctions to ensure program compliance (Carey et al, 2017; Cissner et al., 2018; Farley, 2015; HSJCC, 2017; Reich et al., 2015). The Ontario MHCs most often use certificates of completion, gift cards, and praise from the Judge, while termination from the program and not withdrawing charges (i.e., returning to the traditional criminal court for processing) are the most frequently used sanctions (HSJCC, 2017). Increased court appearances, additional conditions (Campbell et al., 2015), administrative charges, admonition, and jail are also sanctions that may be applied by MHCs (Carey et al, 2017; Cissner et al., 2018; Farley, 2015).

Program Success

Typical measures of MHCs program success are recidivism (e.g., re-arrest, re-conviction, jail) measures (Carey et al, 2017; Cissner et al., 2018; Pooler, 2015; Lowder et al., 2018; Pooler 2015; Reich et al., 2015; Rossman et al., 2012; Seto et al., 2018), sanctions during the program

(in-program), and program graduation (Cissner et al., 2018; Farley, 2015; Reich et al., 2015). Recidivism studies used to evaluate MHCs typically use a matched comparison sample of justice-involved persons who did not participate in the MHCs (e.g., Campbell et al., 2015; Carey et al, 2017; Cissner et al., 2018; Pooler, 2015; Reich et al., 2015).

Several studies have found support for MHCs in successfully diverting clients and reducing future recidivism in both Canadian (Seto et al., 2018) and American legal systems (Cissner et al., 2018; Lowder et al., 2018; Pooler 2015; Rossman et al., 2012). A meta-analysis of American MHCs found that MHC participation had a significant, negative, and small effect on recidivism; specifically a reduction in charges and jail time but not arrests or convictions (Lowder et al., 2018; see also: Rossman et al., 2012). However, Cissner et al. (2018) and Pooler (2015) found a decline in treatment effect on recidivism after two years, while Rossman et al. (2012) found a decline after three years (i.e., MHC participants initially had lower recidivism rates than the matched comparison group, but this effect disappeared after a few years).

Results of a study examining a MHC Consortium in Toronto, Ontario, indicated that there are several factors associated with successful diversion by the Court including lower levels of clinical and legal needs, lower offence severity, less extensive criminal histories and more stable home lives as these individuals were more likely to report successful outcomes from their participation in the Court (Seto et al., 2018). Younger clients, and those with housing insecurity, a prior record, and a co-occurring substance abuse disorder with a mental health disorder were found to have a higher risk of a 2-year re-arrest (Reich et al., 2015) and, subsequently, program failure.

Description of the Saskatoon Mental Health Strategy (MHS) Court

The MHS Court was established in order to meet the needs of individuals with mental health conditions, FASD or cognitive impairments progressing through the criminal justice system, that is, justice-involved persons (Barron et al., 2015; Saskatchewan Law Courts, n.d.-b). Justice-involved persons in custody, and those accused of driving offenses, sexual offences, or offenses with a mandatory minimum sentence are not eligible for the Court (Saskatchewan Law Courts, n.d.-b). Furthermore, the mental health issues and alleged criminal behaviour must be related (Saskatchewan Law Courts, n.d.-b). Provincial Court Judges provide referrals to the MHS Court based on an assessment of an individual client and their mental health needs. A guilty plea is required, as the MHS Court is a sentencing court, and only pre- and post-plea matters are considered (Barron et al., 2015). From the Court's first formal sitting in November 18, 2013 to present, it has strived to bring together a multidisciplinary team of criminal justice, social service, and health care professionals to provide individualized case management and support (e.g., in-patient psychiatric treatment, individual and group counselling, residential and transitional housing, and addictions treatment) to justice-involved individuals with additional needs in Saskatoon, Saskatchewan.

The MHS Court is comprised of a designated Provincial Court Judge, a crown prosecutor, defence counsel, and representatives from a variety of services including Mental Health and Addiction Services, Saskatoon Community Corrections, FASD Network, Elizabeth Fry Society, Social Services, Saskatoon Crisis, and Saskatoon Community Mediation Services (Barron et al., 2015). Other community organizations that provide support to MHS clients include The Lighthouse Supported Living, The Salvation Army, Housing First, Community Living, Saskatchewan Brain Injury Association, Partners in Employment, 601 Outreach, Saskatoon Police Service, and various drug and alcohol treatment programs. Together, these Court personnel and community organizations are the MHS Court professionals who strive to meet the needs of the clients. Since the MHS Court has no program funding, there is no dedicated coordinator, case manager(s), data tracking, or program staff.

A process evaluation of the MHS Court found that, although MHS Court professionals reported some difficulties with certain areas of practice (i.e., difficulties with balancing the needs of the offenders with the needs of the community, unclear MHS Court goals and priorities, limited funding, and high workloads), professionals also believed that the MHS Court was meeting its goals of serving justice-involved individuals while ensuring community safety by treating the underlying causes of offending behaviour rather than simply criminalizing it (Mathias et al., 2019). Although the results of Mathias et al.'s (2019) study were favourable, further evaluation of the MHS Court is required before making any strong conclusions about its effectiveness. Therefore, the purpose of this evaluation is to provide The Steering Committee of the Saskatoon Mental Health Strategy Court with an outcome and cost evaluation detailing the outcomes of the MHS Court's first year cohort of defendants.

Saskatoon Mental Health Strategy Court Evaluation Overview

In order to determine whether the MHS Court is producing its intended outcomes, the CFBSJS at the University of Saskatchewan was invited to conduct an evaluation of the Court. To do this, a long-term evaluation plan was developed, which proposed that the evaluation be carried out in several phases. Figure 1 represents the Court's multiphase evaluation. The current study focuses on two components of the Phase 2 preliminary outcome evaluation: 1) a pre-post quantitative secondary data analysis; and 2) a pre-post cost analysis. A summary of the phases and evaluation results to date is presented in the following section.

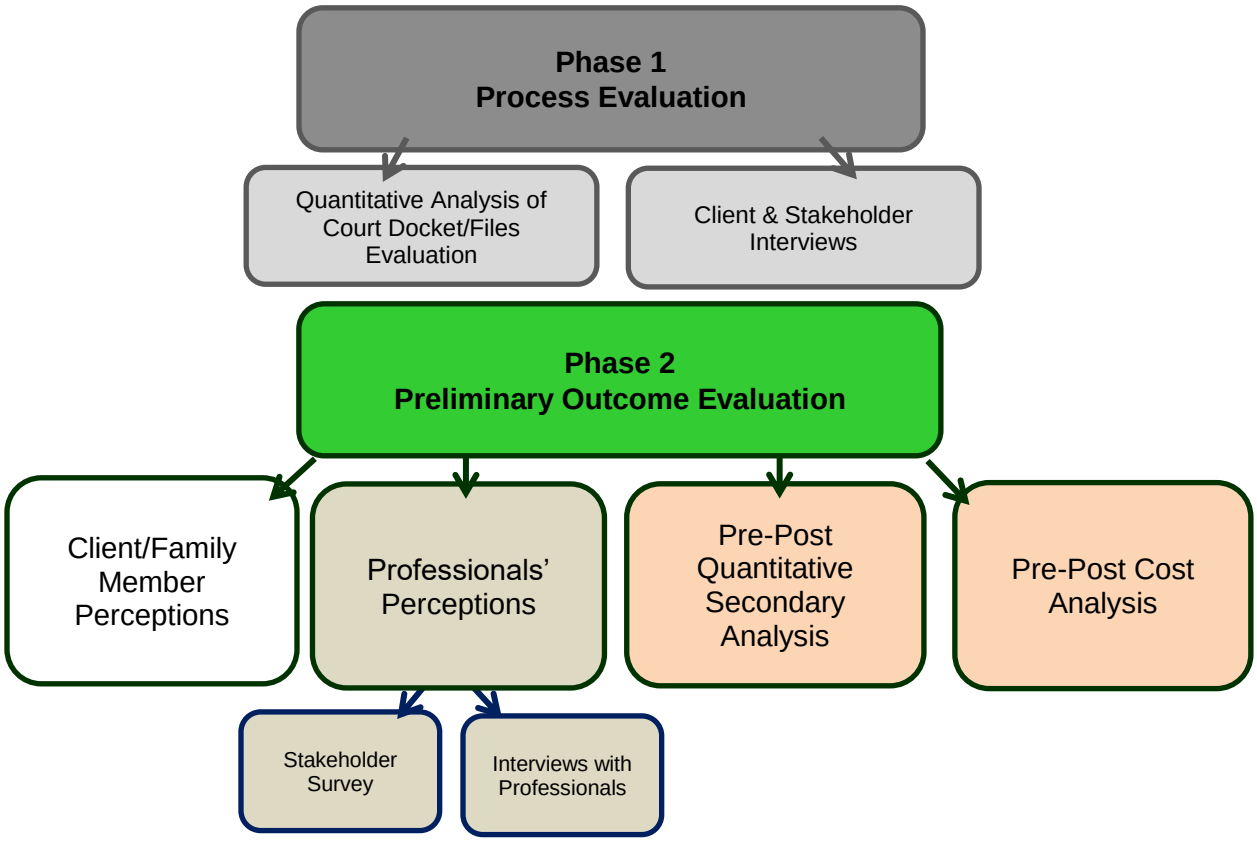
Phase 1 – Process Evaluation

After the first nine months of operation, a process evaluation was conducted by Barron et al. (2015) to complete the first phase of the MHS Court evaluation. Barron et al. (2015) utilized both qualitative and quantitative methodologies to identify patterns in the MHS Court's functioning, expectations, and satisfaction. The study analyzed information on the demographic characteristics and the types of offences committed by those appearing before the MHS Court from November 2013, when the MHS Court began, to August 2014. Some of the most prevalent

offences processed by the MHS Court were failure to attend Court while on undertaking or recognizance, failure to comply with probation order, common assault, and failure to attend Court (Barron et al., 2015). With the exception of common assault, these charges are administrative or due to a failure to comply with the Court's rules, and are not new offenses (i.e., recidivism).

Barron et al.'s (2015) qualitative analysis included interviews with fourteen MHS Court professionals and two MHS Court clients. Professionals included both legal and community support (e.g., social work and health) workers involved in the MHS Court. In their analysis, Barron et al. (2015) aggregated professional and client samples, and cautioned that the client sample may have had a self-selection bias (i.e., clients with negative impressions of the MHS Court likely refused to be interviewed, while those with positive impressions of the Court consented to be interviewed). Themes identified across all interviews included overall positive attitudes toward the MHS Court, improved levels of buy-in among professionals and clients as compared to traditional court (i.e., clients were more motivated to address their mental health concerns and legal professionals were motivated to participate in the process), and ameliorations in legal effectiveness and communication between agencies (Barron et al., 2015).

Figure 1. Overview of the MHS Court Evaluation Phases



In addition to these broad themes, interviewees – including one MHS Court client – believed the amount of time invested into each client's file had a positive impact. Interviewees perceived clients to be more comfortable with the legal process compared to defendants in traditional courts and theorized that this improved client buy-in resulted in more positive outcomes for clients. Professionals regarded their involvement in the MHS Court as conducive to developing more reasonable expectations of their clients. Although the ultimate goals of the MHS Court are to eliminate reoffending and to improve public safety, many interviewees recognized that some MHS Court clients would not stop reoffending completely. However, interviewees maintained that the MHS Court can assist in reducing the rate of reoffending, thereby improving public safety. Overall, professionals and clients involved with the MHS Court regarded it as a continually evolving program that will improve over time (Barron et al., 2015).

While interviewees displayed confidence in the ability of the MHS Court to grow, several areas of concern were identified, most of which were related to the size of the docket. Areas in need of improvement included the oversized docket, an insufficient number of Court sessions to support the large docket size, the length of time needed to progress through the MHS Court due to the docket size and concerns related to public safety (e.g., a client could commit a new offence while progressing through the program; Barron et al., 2015). Broad entrance criteria were employed by the MHS Court to prevent individuals from "falling through the cracks"; however, several interviewees raised safety concerns about the more "serious" offenders being admitted into the MHS Court. Furthermore, additional training for professionals involved in the MHS Court was viewed by many interviewees as a way to improve the skills of those involved in the MHS Court team. Specifically, legal professionals wanted more education regarding the mental health system and community support professionals wanted more information about the legal system—further highlighting the divide between these two sectors in the traditional legal system. While identifying both strengths and areas that need improvement, Barron et al. (2015) found that, overall, the MHS Court appeared to be functioning well in meeting the expectations and needs of those involved.

Phase 2 – Preliminary Outcome Evaluation

The MHS Court is currently in the second phase of the evaluation. Phase 2 is a preliminary outcome evaluation comprised of four distinct components:

1. *Examination of Professionals' Perceptions*

A stakeholder survey to examine the MHS Court from the perspective of a broad network of professionals (*N*=45) with either direct or indirect involvement in the MHS Court and its clients was administered in 2016 (Mathias et al., 2019). Following the survey, interviews were conducted with nine stakeholders of the MHS who appeared regularly before the Court. Of the 45 respondents who completed the survey, 22 (48.9%) provided criminal justice services, 8 (17.8%) provided social support services, and 15 (33.3%) provided mental health services to MHS Court clients. Results of the survey indicated that respondents had positive attitudes

towards mental health courts and the MHS Court specifically. Additionally, respondents agreed that the MHS Court had increased their awareness of MHS clients' unique needs as well as of existing services that can be accessed by the MHS Court. It was also perceived to result in greater collaboration between their organization and other services.

In general, respondents agreed that the pre-Court meetings helped professionals understand how to better support MHS Court clients; strengthened their organization's connections with other service providers; and were an effective use of professionals' time (Mathias et al., 2019). As well, respondents agreed that the MHS Court sessions allowed professionals time to consult with clients; helped professionals understand how to better support the MHS Court clients; and allowed professionals to connect clients to other community services. Attending MHS Court sessions was also seen as an effective use of their time. Further, respondents reported that the MHS Court engaged a comprehensive network of service providers to support the needs of clients and made it easier for clients to receive support from a variety of community service providers. On average, respondents rated the MHS Court as being more effective at connecting clients to criminal justice services than health care services and social support services within the last six months.

Respondents also believed that the MHS Court empowers clients by allowing them to speak openly in Court; that treatment plans supervised by the MHS Court support the needs of clients; and that the MHS Court diverts clients from prison sentences (Mathias et al., 2019). As well, respondents perceived that, compared to the traditional court system, the MHS Court is more effective in reducing recidivism among clients with mental illness, FASD and other cognitive impairments.

Results from open-ended questions on the survey indicated that, while there were many positives to the MHS Court experience (i.e., connecting clients to services, improved collaboration among service providers), there were also some barriers (i.e., program/service wait times, timely access to reports, lack of follow-up, and need for a case manager/coordinator) that needed to be addressed to improve the MHS Court's functioning (Mathias et al., 2019).

A total of nine professionals were also interviewed with representation from judicial services, legal services (prosecution and Legal Aid), FASD and cognitive support services, mental health and addictions and probation services (Mathias et al., 2019). Among the nine professionals interviewed, only two had not completed the mail survey. The semi-structured interviews provided a more in-depth overview of how the MHS Court functions, the benefits to clients, client outcomes, barriers and gaps in the MHS Court, systemic issues, additional services that should be connected to the Court, and areas of improvement from the perspective of professionals involved in the strategy.

For instance, professionals described the benefits and challenges of trying to find balance among the various professionals involved in the MHS Court as well as among the competing priorities of the MHS Court. Specifically, professionals discussed the delicate balance that exists between the opposing goals of the MHS Court, such as meeting the needs of the clients, taking mental health concerns of clients into consideration, and managing public safety. Although the

professionals believed that the MHS Court is meeting its goals of diverting clients from the traditional criminal justice system and treating the underlying causes of the offending behaviour, professionals pointed out that the goals of the MHS Court were sometimes unclear and that there was difficulty achieving a balance between providing services to as many people as possible while also maintaining the ability to provide each client with the depth of service and personal attention they required to be successful. Additionally, professionals sometimes reported difficulties reconciling the different viewpoints and approaches of the various professionals involved in the MHS Court. Despite these challenges, professionals appreciated the collaborative nature of the MHS Court and pointed to an increased awareness of services and other professionals who could provide the best holistic service to their clients. Pre-Court meetings were identified as an important driver of collaboration amongst the professionals involved in the MHS Court and provided suggestions (i.e., changing the seating arrangements and more formalization of these meetings to produce and circulate a written summary of what is discussed) in order to maximize the utility of these meetings.

Professionals discussed having to operate within the existing judicial system and network of community services, which is often not amenable to providing all of the supports required to fully support justice-involved individuals living with mental illness. Some of the specific challenges that were identified related to insufficient forensic and community mental health resources, a lack of dedicated funding to support the MHS Court, and increased workload volumes for professionals involved in the Court. Another challenge identified by professionals was the lack of a dedicated coordinator position for the MHS Court. A coordinator would be responsible for coordinating cases, keeping track of clients and their use of community services, and following up with clients to ensure that their needs are being met. Without this position, professionals were often stepping outside of their job descriptions and taking on extra duties to ensure that their clients were receiving the best care and not falling through the cracks; placing strain on the professionals and leading to concerns about burnout.

Professionals discussed how their participation in the MHS Court has shaped their personal knowledge and perspectives and how the MHS Court fits into the broader picture of society. Professionals indicated that their participation in the MHS Court broadened their own perspectives and understanding of the ways that mental illness and the judicial system interacted. The MHS Court was seen as being an important source of support for clients and a facilitator for making connections to other required services. Although professionals recognized the need for clients to access additional supports, there were often barriers (e.g., lack of resources and funding, lack of a dedicated person to coordinate services) to clients receiving the support they required (Mathias et al., 2019).

2. *Exploration of MHS Court Clients and Family Member Perceptions*

As part of a Master's thesis, nursing student Carmen M. Dell conducted interviews with clients from the initial MHS Court cohort and/or their family members between April and July, 2017 (Dell, 2020). The purpose of her qualitative explorative study was to assess clients and

family members' perspectives on the how well the MHS Court is meeting their needs. Dell (2020) reported mixed findings with some participants describing their experiences as extremely positive and others reporting that they felt violated by the processes of the Court. Overall, both participants and their support persons indicated that the legal processes were extremely stressful and anxiety-inducing, especially for those with personal histories of trauma. Support people expressed frustration with the process of the Saskatoon MHS Court where they felt both burdened by and excluded from the process. Notably, Dell also found that very few MHS Court clients were Indigenous. Given the overrepresentation of Indigenous persons in the Saskatchewan justice system, this finding suggests there may be differential access to justice and mental health programming based on race/ethnicity. Based on these findings, Dell (2020) recommends incorporating trauma-informed practices and restorative justice principles into the MHS Court. She also calls for further education for the criminal justice professionals involved in the Court and further integration and communication among community partners, echoing many of the recommendations from previous evaluations of the MHS Court (Mathias et al., 2019).

3. *Pre-Post Quantitative Secondary Data Analysis*

The pre-post quantitative secondary data analysis comprises one component of the current study. This component of the evaluation included the pre-post evaluation of court, police and health data collected on the initial MHS cohort (*N*=89) admitted to the Court between November 18, 2013 and November 17, 2014. Clients' first scheduled appearance in the MHS Court was used to determine the pre-post cut-off date. Client outcomes evaluated included: police contacts; arrests; convictions; court appearances and sentences; mental health diagnosis, service utilization and treatment; and psychiatric care hospitalization and emergency department admissions. The length of follow-up time on clients varied based on clients' MHS Court entry date and the duration of follow-up data. Data from the Saskatoon Health Region (1-year pre-post MHS Court entry, *N*=89), Saskatoon Police Service (1-year pre-post MHS Court entry, *N*=88; 2-year pre-post MHS Court entry, *N*=87) and the Ministry of Justice (1- and 2-year pre-post MHS Court entry, *N*=89) supported these analyses.

4. *Pre-Post Cost Analysis*

A cost assessment was undertaken with support from the Saskatchewan Ministry of Justice and other stakeholders involved in the MHS and is also presented in the current report. This included pre-post cost analysis of Saskatchewan Ministry of Justice data collected on the initial MHS cohort (*N*=89) admitted to the MHS Court between November 18, 2013 and November 17, 2014. The cost analysis compared the total costs associated with clients' 2-years pre- and 2-years post MHS Court entry, with the first scheduled appearance in the MHS Court used as the MHS Court entry date. Total costs were further broken down into criminal justice system cost, criminal career cost (cost lost from someone engaging in criminal activities instead of participating in the workforce), and victim tangible and victim intangible costs. These terms are described in detail in the Analytic Approach section.

The Present Evaluation

Evaluation Purpose and Questions

The purpose of this evaluation is to provide the Steering Committee of the Saskatoon Mental Health Strategy with an outcome evaluation exploring the outcomes of the activities of the MHS Court. This report will be guided by the following questions:

1. Did the MHS Court succeed in diverting clients out of the traditional criminal justice system?

2. Did the MHS Court succeed in reducing further justice involvement for clients?

3. Did involvement with the MHS Court improve clients' mental health?

4. Did involvement with the MHS Court reduce clients' future health service utilization?

5. Did involvement with the MHS Court reduce criminal justice costs of clients?

Outline of the Evaluation Report

The next chapter describes the methodology of the evaluation. Chapter 3 outlines clients' profile, including their demographics, the instant case which led to clients' transfer into the MHS Court, and clients' criminal history and health history. Chapter 4 contains the pre-post outcome evaluation and Chapter 5 contains the pre-post cost evaluation. The last chapter summarizes the findings and provides the evaluation team's recommendations for The Steering Committee of the Saskatoon Mental Health Strategy.

Chapter 2: Methods

This chapter describes the data sources, measures and analytic approach used in the current 1- and 2-year pre-post outcome evaluation and cost analysis of the MHS Court. Clients' first scheduled appearance in the MHS Court was used as the cut-off date to determine pre- and post-Court entry. The case associated with the first MHS Court appearance, or instant case, was excluded from pre-post analyses. The data sources described below were also used to identify clients' in-program criminal and health experiences (i.e., experiences of clients while their case was in the MHS Court) and 3-year prior MHS Court entry record. Chapter 2 concludes with a discussion of the limitations of the evaluation.

Data Sources

Individual client level data was compiled and merged from the following sources:

1. Saskatchewan Ministry of Justice (SMJ)

The SMJ provided criminal record data for all MHS Court clients who had at least one appearance in the MHS Court in the first year of operation, between November 18, 2013 and November 17, 2014. Two clients missed their MHS initial appearance and were excluded from the data extraction. These two clients were dropped from the study. Criminal record data included all arrests, convictions, court cases, court appearances and sentences for 89 clients for a five-year period, which spanned 3 years pre-Court entry to 2 years post-Court entry.

2. Saskatoon Police Service (SPS)

The SPS provided data on calls for services, arrests, and charges for 91 MHS Court Clients. However, this study only utilized the calls for services data—arrest, along with cases and convictions were computed from the Saskatchewan Ministry of Justice data. Due to missing data in the Ministry of Justice files, successful matches were made for 89 clients. Police contact data was available for 89 clients 3 years pre-Court entry; 1 year post-Court entry data was available for 88 clients; and 2 years post-Court entry data was available for 87 clients. Clients without corresponding post-Court entry data were dropped from the pre-post analysis.

3. Saskatoon Health Region Authority (SHRA)

The SHRA provided client data from two databases for the period of April 1, 2010 to August 31, 2015. Accordingly, three years of pre-Court data was available for 89 clients, but only one year of post-Court entry data was available. The following data were obtained:

a. Addictions and Mental Health Information System (AMIS)

Data on mental health episodes, presenting problems, service utilization and mental health and addictions treatment.

b. ***National Ambulatory Care Reporting System (NACRs)***

Data on all in-patient and emergency room visits at the Royal University Hospital, Saskatoon City Hospital, and St Paul's Hospital.

Measures

Variables were computed for 3-year, and 1-year pre-Court entry; the instant case; in-program; and 1-year post-Court entry. When 2 years of post-Court entry follow-up data was available, variables were also computed for 2-year pre- and post- MHS Court entry. The cut-off date to compute variables was the first appearance date in the MHS Court. The 'instant case' was the case that was transferred to the MHS Court during the initial year of operations. 'In-program' was defined as the date the instant case was transferred to the MHS Court (Circuit Code 29M) to the last date the case appeared on the MHS Court docket. In-program data for up to 365 days was included in the 1-year post-Court entry variables, and in-program data for up to 730 days was included in the 2-year post-Court entry variables. The final dataset of merged court, police, and health data included the following measures:

Arrest and Conviction Charges

Data were coded as three mutually exclusive categories: violent, non-violent, and traffic offenses. Non-violent offenses were further disaggregated into property, drug, weapons, and administrative and other charges. If there were multiple charges in the arrest/conviction, the charge with the highest crime severity index weight was used as the 'top charge' (most serious charge) and less serious charges were not counted to avoid over counting arrests and convictions. As no conviction variable was included in the data extraction, the following court appearance result codes were used as indicators of a conviction: absolute discharge, conditional sentence, conditional discharge, custodial sentence, for sentence, lessor included offence, reprimand, sentenced and suspended sentence. Continuous and dichotomous variables were computed for 3-year, 2-year, and 1-year pre-Court entry; the instant case; in-program; and 1-year and 2-year post-Court entry. Instant case data was excluded from the prior and recidivism variables; however, in-program data were included in the recidivism variables (which were computed from the date the instant case was transferred into the MHS Court).

Case and Case Charges

For cases with multiple charges, the case was coded based on the most serious charge to create 'case type' categories using the following order: homicide, rape, aggravated assault, assault, robbery, motor vehicle theft, arson, burglary, theft, fraud, administrative (breach of probation, failure to appear and failure to comply charges) and other. Thus, for court case variables, if a case had both an assault and a burglary charge, it was coded as an 'assault' case. This coding ensures cases were not counted multiple times. 'Case charges' was computed as a

continuous variable and provides the total charges for all court cases within a specified period. Thus, if a case had 5 charges, all 5 charges were counted in the case charge variable. 'Case type' categories were selected to maximize the use of the cost estimates provided by Gabor (2015). Continuous and dichotomous variables were computed for 3-year, 2-year, and 1-year pre-Court entry; the instant case; in-program; and 1-year and 2-year post-Court entry. Instant case data was excluded from the prior and recidivism variables.

Court Appearances

Continuous and dichotomous court appearances variables were computed for 3-year, 2-year and 1-year pre-Court entry; the instant case; in-program; and 1-year and 2-year post-Court entry. Instant case data was excluded from the prior and recidivism variables; however, in-program data were included in the recidivism variables.

Sentencing

Data were coded as six *non-mutually exclusive* categories: community service, jail, probation, fine, and conditional sentence. Continuous and dichotomous variables were computed for 3-year, 2-year, and 1-year pre-Court entry; the instant case; in-program; and 1-year and 2-year post-Court entry. Instant case data was excluded from the prior and recidivism variables; however, in-program data were included in the recidivism variables.

Police Contacts

Saskatoon Police Service calls for service data were coded as the following mutually exclusive categories: involvement in crime, victim of crime, witness of a crime, suicide involvement (not a victim), and suicide victim. Arrests were excluded from these variables, as they were computed and analyzed from the Saskatchewan Ministry of Justice data. Continuous and dichotomous variables were computed for 3-year, 2-year, and 1-year pre-Court entry; the instant case; in-program; and 1-year and 2-year post-Court entry. In-program data were included in the recidivism variables:

Mental Health

Persons may display several conditions in a mental health episode; the Saskatoon Health Region Authority refers to the main issue as the 'primary presenting problem' and other issues are termed 'secondary problems.' For both primary and secondary problems, data were coded as three mutually exclusive categories: substance-related; other mental health; and unknown disorders. Other mental health disorders were further disaggregated into neurocognitive (including FASD) or neurodevelopmental; personality; schizophrenia spectrum and other psychotic; trauma- and stressor-related; anxiety; bipolar and related; depressive; paraphilic; and other condition that may be a focus of clinical attention. Additional secondary presenting problems included: conduct disorder, obsessive compulsive disorder, gender dysphoria, sleep disorder, and somatic disorder. Continuous and dichotomous variables were computed for any problem, primary presenting problem, and secondary problem ever experienced. The primary

presenting problem was also used to compute continuous and dichotomous variables for 3- and 1-year pre-Court entry; in program; and 1-year post-Court entry, based on the episode start date. As many clients had several conditions, the condition that resulted in the instant case transfer to the MHS Court could not be ascertained. Due to the long-term nature of mental health conditions, no attempts were made to identify the mental health condition associated with the instant case.

Mental Health Treatment

Data were coded as the following mutually exclusive categories: consultation, detox, drug addiction (excluding detox), psychiatric in-patient, individual counselling, group counselling, case management, residential/transitional housing program, and other program. Continuous, dichotomous and length of stay variables (in days) were computed for 3- and 1-year pre-Court entry; in program; and 1-year post-Court entry. In-program data were included in the recidivism variables.

Mental Health Services

Data were coded as the following mutually exclusive categories: compulsory mental health facility order or a community treatment order. Continuous, dichotomous, and length of stay variables (in days) were computed for 3- and 1-year pre-Court entry; in program; and 1-year post-Court entry. In-program data were included in the recidivism variables.

In-Patient Admits

Data were coded as the following mutually exclusive categories: psychiatric or non-psychiatric visit. Continuous, dichotomous and length of stay variables (in days) were computed for 3- and 1-year pre-Court entry; in program; and 1-year post-Court entry. In-program data were included in the recidivism variables.

Emergency Room Visits

Data were coded as the following mutually exclusive triage categories: resuscitation, emergent, urgent, less urgent, not urgent or unknown. Continuous, dichotomous and length of stay variables (in hours) were computed for 3- and 1-year pre-Court entry; in program; and 1-year post-Court entry. Emergency room length of stay should be interpreted with caution—when discharge date and time were unavailable, mean length of stay was used as an estimate. In-program data were included in the recidivism variables.

Analytic Approach

Statistical analyses were conducted using the IBM Statistical Package for the Social Sciences (SPSS) version 24. Analysis included the MHS Court clients' profile; a pre-post analysis of criminal justice and health outcomes; and a pre-post cost analysis using court data.

Client Profile

MHS Court clients' profile included descriptions of the instant case and three year prior criminal and health history. Unfortunately, demographic data was limited to age. Three-year prior variables were used to describe the MHS Court clients' criminal history profile, mental health service utilization, and hospital utilization. The criminal history profile included police contacts / requests for service (excluding arrests), arrests, and convictions. Clients' full diagnosis are presented in their mental health profile, which included primary presenting problems and secondary problems. Full historical diagnosis was presented because, while mental health disorders can be controlled, they are long-term. These results are presented in Chapter 3.

Pre-Post Outcome Evaluation

The outcome analysis utilized a one-group pre-test/post-test design. For the pre-post analysis, the pre-Court entry variables were compared to post-Court entry variables for the 1-year and, where available, a 2-year period. Pre- and post-Court entry means were compared using paired-samples *t*-tests for the same clients (Field, 2009). Pre- and post-Court entry dichotomous (yes/no) variables were compared using the McNemar Test, which is used to determine the effect of a treatment on the same individuals measured at Time 1 (before treatment) and Time 2 (after treatment). From a practical standpoint, data from the 89 clients in this study constitute the 1st year MHS Court population. Therefore, results focus on describing patterns in criminal behaviour and health needs. Significance tests are reported in the results tables, but have limited usefulness until adequate data becomes available to establish that the 1st year population approximates: 1) a sample of the subsequent years' client intake; or 2) a sample of Canadian mental health court clients. These results are presented in Chapter 4.

Pre-Post Cost Analysis

Data for jail, prison, and parole length of stay was unavailable. Thus, we decided to use Gabor's (2015) cost estimates which itemized costs of crime by court case type for four categories of costs:

1. ***Victim Costs*** (including property losses, lost wages, and medical costs due to injuries);
2. ***Criminal Justice System Costs*** (law enforcement, court, corrections, programs and services);
3. ***Criminal Career Costs*** or the opportunity cost lost when someone forgoes legitimate employment in lieu of a criminal career; and
4. ***Intangible Costs*** (loss in quality of life, pain and suffering of victims).

Gabor's (2015) cost estimates were based on a literature review of global publications from 1988 to 2016. He adjusted costs for inflation and converted them to August 1, 2014 Canadian Dollars, which was deemed most appropriate for analyzing cost of the first year MHS Court cohort (i.e., November 18, 2013 and November 17, 2014). To avoid the problem of overestimating costs due to outliers, cost estimates were computed using Gabor's (2015) "mean cost outliers removed" estimates for case types (homicide, sexual assault, assault, aggravated

assault, robbery, motor vehicle theft, arson, burglary, theft and fraud). Cost estimates for administrative cases—coded as breach of probation, failure to appear and failure to comply charges—and other cases were based on the average cost for all case types, excluding homicide. No additional adjustments were made to Gabor's (2015) estimates. These results are presented in Chapter 5.

Limitations

The following limitations should be kept in mind when reviewing this evaluation's findings:

No Comparison Group

As there was no comparison group, conclusions about outcomes for similarly situated individuals (i.e., those with similar criminal and mental health backgrounds and current charge) processed via the traditional Criminal Justice System are beyond the scope of this study. The study avoided testing effects and regression to the mean, common when analyzing primary data, by using secondary administrative health and justice data.

Duration of Follow-up Data

Unfortunately, adequate data was not available to compare pre-Court entry to post-Court *exit*. Instead, we compare pre-Court entry to post-Court *entry*, with the date the instant case was transferred to the MHS Court being used as the cut-off date. As such, in-program data were included in the post-Court entry variables. Ideally, in-program data should be analyzed separately from the pre-post analysis (along with a matched comparison group), for the most accurate analysis of a program or court's impact on recidivism, and mental health needs.

Data Availability

Demographic data was unavailable, which stymied subgroup analysis by gender and ethnicity. Additionally, we were unable to obtain information on case management and non-mental health services and could not make any conclusions about the Court's success or failure based on services received or levels of service dosage.

Available Mental Health Data

Since mental health data was not tracked by the Court, the evaluation team was unable to link data received from the Addictions and Mental Health Information System (AMIS) to the instant case. Instant case data is typically excluded from pre-post analysis to avoid over-counting. Therefore, pre- and post-Court entry mental health analysis included the instant case diagnosis.

Ethics

Ethics approval was granted by the University of Saskatchewan's Behavioural Research Ethics Board (Beh# 14-290) to conduct this evaluation (see Appendix A).

Chapter 3: MHS Court Clients' Profile

This chapter describes the MHS Court clients' demographics, the instant case, and clients' 3-year prior criminal record and health history. Clients' in-program mental health and service utilization is also discussed. Note: in-program data for up to 365 days was included in the 1-year post-Court entry variables, and in program data for up to 730 days was included in the 2-year post-Court entry variables.

Demographics

Ninety-two defendants participated in the MHS Court in the first-year cohort, that is, were transferred into the MHS Court between November 18, 2013 and November 17, 2014. Data was available for 89 clients adjudicated through the MHS Court.[1] Clients were born between 1950 and 1995 with a median birth year of 1985. Clients were processed by the MHS Court for index offences committed between March 2008 and May 2014 (only three index offenses occurred before 2010), indicating that Court entry was triggered by an administrative charge stemming from a prior arrest (see: Instant Case section below). Unfortunately, information on client gender, ethnicity, or other demographic variables was unavailable.

Instant Case

Mean duration of MHS Court cases was 153 days, and seven cases (7%) lasted for more than one year. This figure excludes the duration of the court case prior to transfer into the MHS Court. Nineteen clients attended the Court once, suggesting these clients requested their case be returned to the criminal courts or became ineligible for the Court. It is possible that other clients may also have requested their cases be returned to the criminal courts; however, the Ministry of Justice data did not flag/identify these clients. For clients who requested their case be returned to the criminal courts, the duration of the instant case subsequent to transfer into the MHS Court was also excluded from the instant case duration computation.

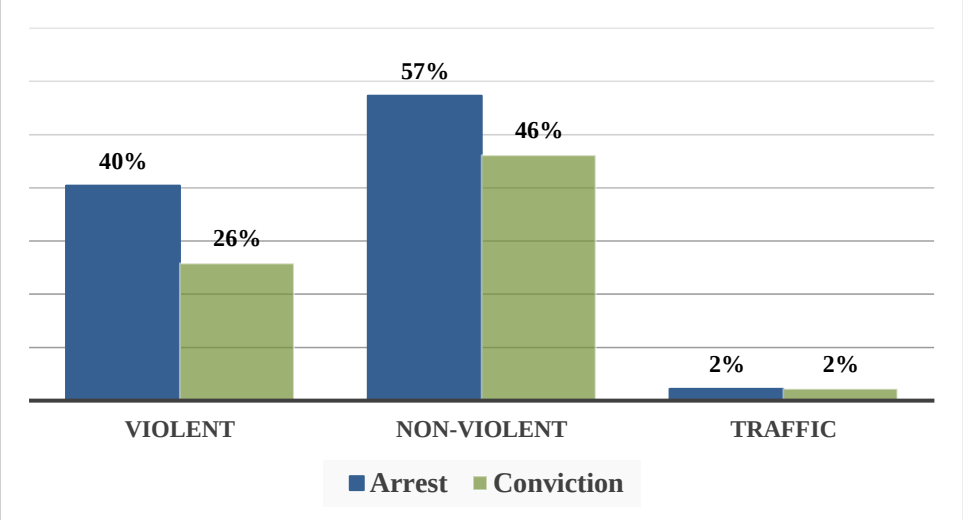
Instant Case Arrest Charge

Instant case arrest and conviction charges are displayed in Figure 2; Figure 3 breaks down the non-violent columns in Figure 2 (3rd and 4th columns), into property, drug, weapon, and administrative, and other charges. Over half of the cases transferred to the MHS Court were for non-violent arrests (57%), which were comprised of the following categories illustrated in Figure

[1] Due to issues with aliases, the Saskatoon Police Service provided data for 91 MHS clients; however, two clients missed their MHS initial appearance and were dropped from the program. As such, the Ministry of Justice did not provide their criminal records. From a practical standpoint, data from the 89 clients in this study constitute the 1st year cohort population.

3: property (32%), drug (2%), weapon (2%), and administrative and other charges[2] (21%). The second most common arrest charge was violent (40%) followed by traffic (2%). The average Crime Severity Index, which measures the frequency and seriousness of crime, was 87.83 for instant cases arrest. See Appendix B for full details.

Figure 2. Instant Case: Arrest and Convictions

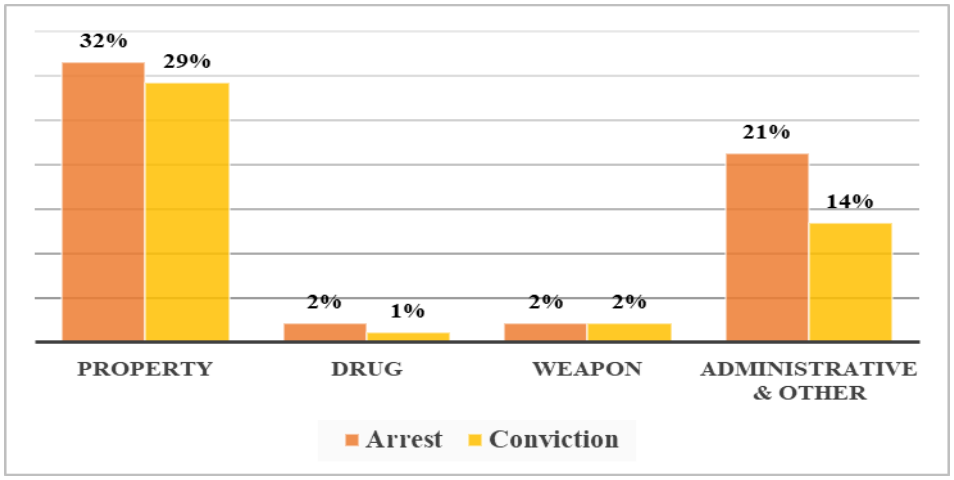


Instant Case Conviction Charge

Not all arrests result in a conviction: the case may be dismissed or the client may be found guilty (i.e., convicted). Almost three-quarters of clients (74%) received a conviction on their MHS case. The most common index conviction charge was for non-violent offences (46%) which are comprised of property (29%), drug (1%), weapon (2%) and administrative and other charges (14%). Slightly over one quarter (26%) of clients were convicted of a violent crime. The mean Crime Severity Index Weight for convictions was 69.99. See Appendix B for full details.

[2] The vast majority of "administrative and other" were administrative charges (78%; e.g., failure to appear and failure to comply).

Figure 3. Instant Case: Non-Violent Arrest and Convictions

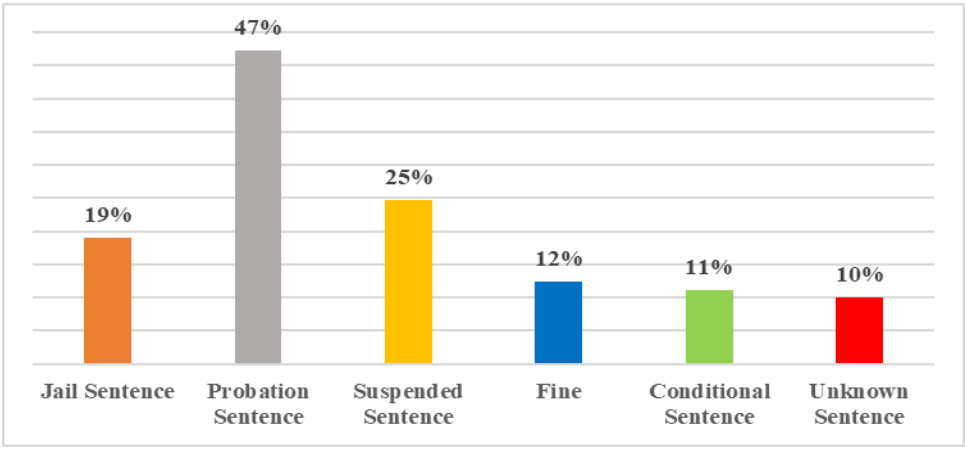


The conviction rate was higher for non-violence arrests: 80% of clients arrested on a non-violent offense were convicted, while only 64% of clients arrested on a violent offense were convicted. Consequently, the Crime Severity Index was higher for the instant case arrest (mean = 87.83), compared to the instant case convictions (mean = 69.99). Given the fact that clients are required to plead guilty to access the MHS Court's services, the 74% conviction rate on the instant case suggests some clients decided to request their case be returned to the criminal courts, which subsequently dropped the charges.

Instant Case Sentence

Sentences are not mutually exclusive, as fines and probation are frequently combined with other sentences. The most common sentence for the instant case was probation (47%). This was followed by suspended sentences (25%), jail sentences (19%), fines (12%), and conditional sentences (10%). Ten percent of the population had an unknown sentence for their index offence. No client received community service as a sentence. Figure 4 displays instant case sentence.

Figure 4. Instant Case: Sentence



Criminal History

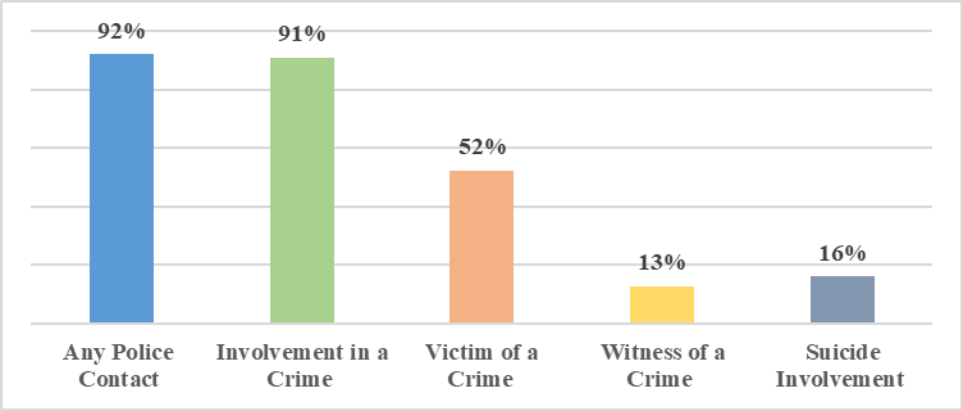
This section describes the criminogenic risk of clients. Police contacts (excluding arrests), arrests and convictions for the three years prior to MHS Court entry are described.

Police Contacts

Clients 3-year pre-Court police contacts are illustrated in Figure 5: the first column represents the percent of clients with at least one police contact, and successive columns represent the percent of clients who had at least one incident of the listed contact type. Based on their police contact history, clients demonstrated high risk and needs, and a social network that is similarly situated. Almost all clients (92%) had at least one contact with the police in the 3 years prior to their first appearance in the MHS Court. Many were involved in a crime (91%), and over half were victims of a crime (52%). Since about one-third of crimes are reported to the police, the level of crime victimization among clients is likely to be much higher than the official data reported in this evaluation (Moreau, 2019; Sinha, 2015).[3] Furthermore, 16% of clients called the police when someone they knew attempted suicide, suggesting that these clients' social networks included individuals with high mental health needs.

Figure 5. Criminal History (3 Year Priors):

Police Contacts (excluding arrests)



Arrests and Convictions

Figure 6 illustrates the clients' 3-year pre-Court arrest (blue columns) and conviction (grey columns) record; the two columns on the far left represent the percent of clients who had at least one arrest or conviction, and successive columns represent the percent of clients who had at least one of the specified arrest or conviction charge types. The vast majority of clients (80%) had at least one arrest in the 3 years prior to their MHS court entry date. Most of these 3-year pre-Court arrests were non-violent: almost three-quarters of clients (74%) had at least one non-violent arrest, and close to one half (45%) had at least one violent arrest. Slightly over half of

[3] Rates of police reported crime vs. actual crimes were computed using the Uniform Crime Reporting (UCR) Survey, and the General Social Survey (GSS), respectively.

clients (56%) had at least one conviction in the 3 years prior to their MHS court entry date. Similar to the 3-year prior arrest pattern, clients were more likely to be convicted on a non-violent (48%), compared to a violent charge (34%). See grey columns in Figure 6 for details.

Figure 6. Criminal History (3 Year Priors):
Any Arrest and Convictions

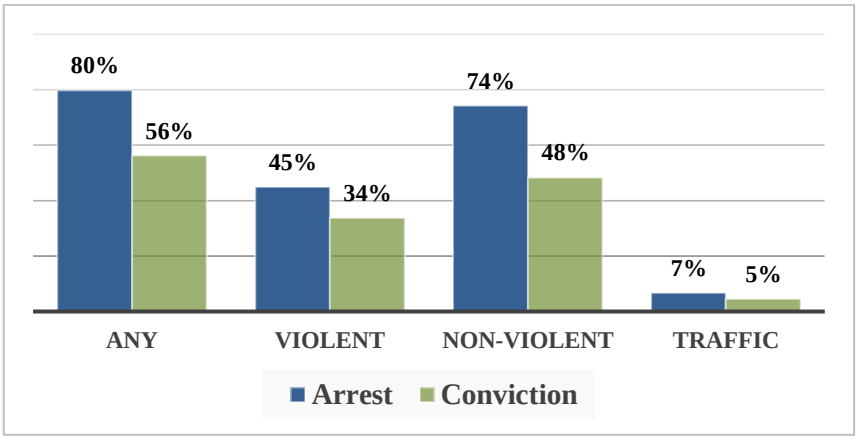
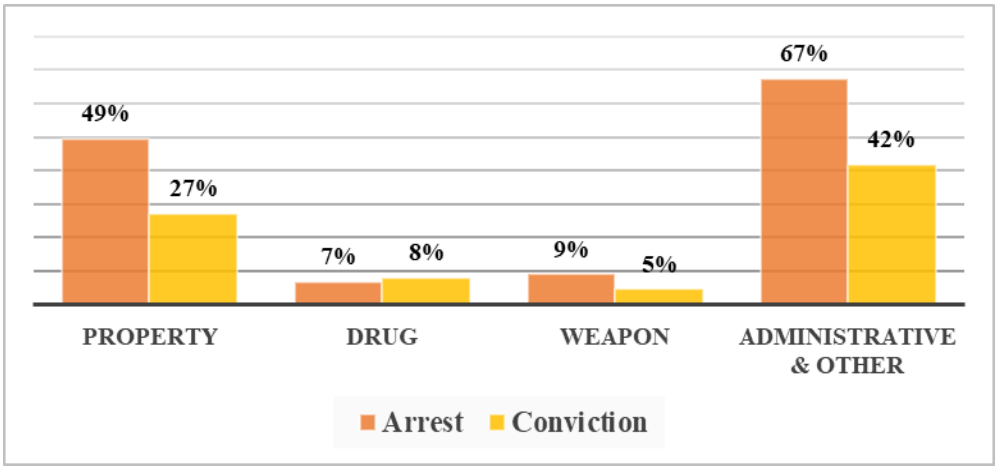


Figure 7 disaggregates the 3-year pre-Court non-violent arrest and conviction columns displayed in Figure 6, into property, drug, weapon, and administrative and other charges. Overall, clients were generalists—meaning that they committed both violent and non-violent offences—and many had issues with compliance: 67% of clients had at least one administrative or other arrest and 42% of clients had at least one administrative or other conviction. In other words, the majority of clients' 3-year pre-Court arrests and convictions were due to problems complying with court orders and failure to attend court hearings. See Appendix C for details on clients' 3-year prior arrests and convictions.

Figure 7. Criminal History (3 Year Priors):
Any Non-Violent Arrest and Convictions



Health History

This section describes clients' mental health conditions. Due to the fact that psychiatric conditions may last several years, all available mental health diagnoses are provided for clients for the period April 1, 2010 to August 31, 2015, which covered approximately 3-years pre-Court entry and about 1-year post-Court entry. Clients' 3-year pre-Court mental health service, mental health treatment, and hospital utilization are also provided in this section.

Mental Health Diagnosis

Table 1 illustrates clients' mental health episodes, primary presenting problems, and secondary problems for the period of April 1, 2010 to August 31, 2015. A mental health episode may include several co-occurring conditions: the major issue in each episode was captured in the 'primary presenting problem' variable, while all other mental health issues were captured in the 'secondary problem' variable. To accurately portray the complexity of clients' mental health needs, both primary presenting and secondary mental health problems were also measured in the 'any problem ever' variable.

Mental health episodes were measured as three mutually exclusive categories: substance-related disorders; other mental health disorders; and unknown disorders. Other mental health disorders were further disaggregated into neurocognitive or neurodevelopmental (which included any FASD; personality; schizophrenia spectrum and other psychotic; trauma- and stressor-related; anxiety; bipolar and related; depressive; paraphilic; and other condition that may be a focus of clinical attention. In addition to these conditions, secondary presenting problems included: conduct disorder, obsessive compulsive disorder, gender dysphoria, sleep disorder and somatic disorder (not presented in Table 1). Note, averages include data for all clients (n = 89), including those without the particular disorder.

Table 1. Health History: Mental Health Diagnosis

Mental Health Episodes	Any Problem Ever	Primary Presenting Problem	Secondary Problem
Participants=89			
Any Mental Health Episode	80%	80%	62%
Mean # of Mental Health Episodes	5.21 (4.83)	2.46 (2.64)	2.75 (3.30)
Any Substance-Related and Addictive Disorders	58%	42%	39%
Mean # of Substance-Related and Addictive Disorders	2.10 (2.97)	1.30 (2.49)	0.8 (1.19)
Any Other Mental Health Disorder	60%	46%	54%
Mean # of Other Mental Health Disorders	2.66 (3.32)	0.71 (.92)	1.96 (2.71)
Any Neurocognitive or Neurodevelopmental Disorder	*32%*	*5%*	*29%*
Mean # of Neurocognitive or Neurodevelopmental Disorder	*.38 (.61)*	*0.04 (.21)*	*0.34 (.56)*
Any Personality Disorder	*19%*	*5%*	*17%*
Mean # of Personality Disorders	*.28 (.69)*	*0.06 (.28)*	*0.22 (.56)*
Any Schizophrenia Spectrum and Other Psychotic Disorder	*39%*	*23%*	*19%*
Mean # of Schizophrenia Spectrum and Other Psychotic Disorders	*.56 (.83)*	*0.34 (.69)*	*0.22 (.49)*
Any Trauma- and Stressor-Related Disorder	*23%*	*10%*	*17%*
Mean # of Trauma- and Stressor-Related Disorders	*.31 (.67)*	*0.10 (.30)*	*0.21 (.51)*
Any Anxiety Disorder	*12%*	*2%*	*10%*
Mean # of Anxiety Disorders	*.15 (.41)*	*0.02 (.15)*	*0.12 (.39)*
Any Bipolar and Related Disorder	*8%*	*5%*	*5%*
Mean # of Bipolar and Related Disorders	*.09 (.32)*	*0.04 (.21)*	*0.04 (.21)*
Any Depressive Disorder	*10%*	*2%*	*8%*
Mean # of Depressive Disorders	*.11 (.35)*	*0.02 (.15)*	*0.09 (.33)*
Any Paraphilic Disorder	*2%*	*1%*	*1%*
Mean # of Paraphilic Disorders	*.02 (.15)*	*0.01 (.11)*	*0.01 (.11)*
Any Other Condition That May Be a Focus of Clinical Attention	*34%*	*7%*	*28%*
Mean # of Other Conditions That May Be a Focus of Clinical Attention	*.56 (1.00)*	*0.07 (.25)*	*0.49 (.94)*
Any Unknown Disorders	30%	30%	
Mean # of Unknown Disorders	0.45 (.81)	0.45 (.81)	

Note. The following mental health conditions are not presented in the table: 2% of defendants had a Conduct Disorder, 2% had OCD, 3% had Gender Dysphoria, 3% had a Sleep Disorder and 8% had a Somatic Disorder.

Mental Health Episodes

Most clients had mental health needs—80% had at least one mental health episode—and, on average, more than five mental health care issues (mean = 5.21) during the period April 1, 2010 to August 31, 2015. More than half of clients had at least one substance-related and addictive mental health episode (58%), and close to two-thirds had at least one other mental health episode (60%). Interestingly, about a third of clients had at least one episode with an unknown disorder (30%); that is, the psychiatrist was unable to determine the nature of the mental health episode. Within other mental health disorders, over one third of clients (39%) experienced at least one episode of schizophrenia as either a primary or secondary problem, and 32% experienced at least one episode of a neurocognitive or neurodevelopmental disorder. Although FASD is typically classified as a neurocognitive or neurodevelopmental disorder, the Saskatoon Health Region Authority data did not specifically identify any clients with FASD.

Primary and Secondary Problems. When comparing primary and secondary problems, clients were more likely to have at least one substance-related and addictive disorder episode (42% primary presenting problem vs. 39% secondary problem) and schizophrenia spectrum and other psychotic (23% vs. 19%) as a primary mental health issue. Neurocognitive or neurodevelopmental (5% vs. 29%), personality (5% vs. 17%), trauma- and stressor-related (10% vs. 17%), anxiety (2% vs. 10%) and other conditions that may be a focus of clinical attention (7% vs. 28%) more frequently appeared as secondary problems in clients' mental health episodes.

Table 2. Mental Health History: Service Utilization

Mental Health Services (3 Year Prior)	Pre-Court
Participants=89	
Any Mental Health Service	70%
Mean # of Mental Health Services	6.00 (8.41)
Duration Mental Service (Days)	557.02 (1051.17)
Any Consultation	43%
Mean # of Consultations	1.38 (2.31)
Any Detox	20%
Mean # of Detox	2.06 (6.39)
Any Drug/Addiction Treatment (not detox)	26%
Mean # of Drug/Addiction Treatment (not detox)	0.37 (.77)
Any Psychiatric In-Patient	34%
Mean # of Psychiatric In-Patient	0.88 (1.78)
Any Individual Psychiatric or Mental Health Counselling	34%
Mean # of Individual Psychiatric or Mental Health Counselling	0.51 (.87)
Any Group Counselling/Treatment (not drug)	12%
Mean # of Group Counselling/Treatment (not drug)	0.22 (.75)
Any Intake & Case Management (Screening/Risk Assessment)	10%
Mean # of Intake & Case Management (Screening/Risk Assessment)	0.11 (.35)
Any Residential/Transitional Program	20%
Mean # of Residential/Transitional Program	0.24 (.52)
Any Other Program	17%
Mean # of Other Program	0.24 (.64)

Note: Duration of services counts ALL days of service utilization, from the start to end date. Participants may access multiple services during the same period.

Mental Health Services

Clients accessed several mental health services in the 3 years prior to their first MHS Court appearance, as illustrated in Table 2. More than two-thirds of clients (70%) utilized at least one mental health service, corresponding to an average of 6 services and 557.02 days spent

accessing these services. Nearly half (43%) of these services were consultations, approximately one third were psychiatric in-patient services (34%) and individual mental health services (34%), and nearly a fifth were detox (20%), drug/addiction treatment (26%), residential/transitional programs (20%), and other programs (17%).

Mental Health Psychiatric Treatment Orders

Psychiatrists in Saskatchewan may place persons under a Compulsory Mental Health Facility Order (Form G) or Community Treatment Order (CTO; Form H). Compulsory orders may be issued by a physician with admitting privileges to a mental health care centre, a physician without admitting privileges to a mental health care centre, when a peace officer apprehends and takes the person to a non-admitting physician who issues the order, or when a judge issues a Form G order (eHealth Saskatchewan, 2015). Compulsory orders last for 21 days and may be renewed indefinitely; however, the patient is granted mandatory appeals at the end of the initial 21 days, and every six months thereafter (eHealth Saskatchewan, 2015). A CTO can be issued for up to six months for persons with prior CTOs or at least one admission on a compulsory order in the previous two years and in need of services available in the community (eHealth Saskatchewan, 2015). Table 3 displays the type of treatment orders, number of treatment orders, and number of days on a treatment order for clients' 3-years pre-Court entry.

Table 3. Health History: Treatment Orders

Treatment Orders (3 Year Priors)	**Pre-Court**
Participants=89	
Any Treatment Order	29%
Mean # of Treatment Orders	1.3 (3.32)
Mean # of Days in Treatment	41.36 (158.85)
Any Compulsory Mental Health Facility Order	*29%*
Mean # of Compulsory Mental Health Facility Orders	*.89 (1.93)*
Mean # of Days in Compulsory MH Treatment Facility	*7.21 (21.06)*
Any Community Treatment Orders	*10%*
Mean # of Community Treatment Orders	*.42 (1.74)*
Mean # of Days on Community Treatment	*34.15 (150.67)*

Nearly one third of clients (29%) had at least one treatment order 3-years pre-Court, representing an average of 1.3 treatment orders and a mean of 41.36 days spent in treatment. As averages were computed using the entire sample—to be comparable to the means reported in the *t*-tests used in the pre-post analysis—this means that clients with treatment orders, received multiple orders. Most of these orders were compulsory mental health facility orders (29%) and only 10% were CTOs. Individuals spend fewer days in mental health facilities (7.21 days) than they did in community treatment (34.15 days).

Hospital and Emergency Room Utilization

In addition to mental health services and treatment, clients also accessed hospitals for psychiatric and other health reasons. Table 4 displays the number, type, and duration of clients' in-patient hospital visits 3-year pre-Court entry. For clients with multiple admits or different types of admits (psychiatric and non-psychiatric), this was counted once in 'any in-patient admits.' One third of clients had at least one in-patient admit 3-years pre-Court entry and stayed an average of 15.25 days. Twenty-one percent of clients had at least one psychiatric admit with an average stay of 11.37 days, and 17% had at least one non-psychiatric admit with an average stay of 3.91 days.

Table 4. Health History: Hospital Admits

In-Patient admits (3 Year Priors)	**Pre-Court**
Participants=89	
Any In-Patient Admit	33%
Mean # of In-Patients Admits	0.98 (1.94)
Mean # of In-Patient Days	15.25 (36.74)
Any Psychiatry Admit	*21%*
Mean # of Psychiatry Admits	*0.60 (1.51)*
Mean # of In-Patient Days	*11.37 (32.29)*
Any Non-Psychiatry Admit	*17%*
Mean # of Non-Psychiatry Admits	*0.38 (1.05)*
Mean # of In-Patient Days	*3.91 (17.30)*

Note . In-Patient hospital admits were coded either as a Psychiatric or Non-Psychiatric visit. For defendants who had both types of visits, it was counted one in 'Any In-Patient Admit.' All Admits and days in the hospital were counted in 'Mean # of In-Patient Admits' and Mean # of In-Patient Days', respectively. Any Admit and Total Admit variables were computed based on the MHS Court entry date; days in the hospital were computed based on the relevant time period rather than on the start date. Therefore, if a 15 day visit started 10 days before the case was transferred to the MHS Court, 10 days would be counted in pre-Court, and 5 days would be counted in post-Court.

Table 5 illustrates clients' emergency room (ER) visits by triage level and duration of stay (in hours) in 3-years pre-Court entry. Emergency Room visits were computed as the following mutually exclusive categories: resuscitation, emergent, urgent, less urgent, not urgent, or unknown. For clients with multiple types of ER visits, it was counted once in 'any ER visit,' while total number of ER visits and hours in the ER were averaged in 'mean # of ER visits' and 'mean # of hours in ER', respectively.

Just over half of clients (51%) had at least one ER visit 3-years pre-Court, with an average of 5.28 visits and 29.10 hours spent in the ER. Urgent visits, less urgent visits, and non-urgent visits were all about equally numerous, representing respectively 43%, 38%, and 40% of visits. Six percent of ER visits were for unknown reasons. Urgent visits to the ER were the most time consuming with an average of 11.89 hours spent in the ER. Duration of ER visits should be interpreted with caution: discharge time was missing for some visits, and the average length of stay was used to fill in the missing data.

Table 5. Health History: Emergency Room (ER) Visits

ER Triage Level (3 Year Priors)	Pre-Court
Participants=89	
Any ER Visit	51%
Mean # of ER Visits	5.28 (10.20)
Mean # of hours in ER	29.10 (56.66)
Any ER Resuscitation Visit	*2%*
Mean # of ER Resuscitation Visits	*0.03 (.24)*
Mean # of hours in ER	*0.40 (2.89)*
Any ER Emergent Visit	*20%*
Mean # of ER Emergent Visits	*1.56 (2.84)*
Mean # of hours in ER	*2.88 (10.94)*
Any ER Urgent Visit	*43%*
Mean # of ER Urgent Visits	*0.37 (1.00)*
Mean # of hours in ER	*11.89 (24.49)*
Any ER Less Urgent Visit	*38%*
Mean # of ER Less Urgent Visits	*1.67 (4.05)*
Mean # of hours in ER	*7.55 (19.02)*
Any ER Not Urgent Visit	*40%*
Mean # of ER Not Urgent Visits	*1.57 (4.23)*
Mean # of hours in ER	*6.24 (16.03)*
Any ER Unknown Visit	*6%*
Mean # of ER Unknown Visits	*0.07 (.29)*
Mean # of hours in ER	*0.14 (.74)*

Note. Any and total visit variables were computed based on the start date; hours in the hospital were computed based on the relevant time period rather than on the start date. The average length of stay was used to estimate ER hours when the exit date/time was missing: interpret these variables with caution.

In-Program Mental and Physical Health

In-program refers to the date the instant case was transferred to the Saskatoon MHS Court (Circuit Code 29M) to the last date the case appeared on the MHS Court docket. The majority of MHS Court cases were concluded within 1 year (92%), and these health data are also included in the post-Court variables used in the pre-post outcome analysis. Since defendants' mental health was a major factor in determining whether their case should be transferred to the MHS Court, in-program mental health diagnoses, service utilization, and hospital utilization are presented in this section to explain the mental and physical health needs of clients during their MHS Court case.

Table 6. In-Program Mental Health Episodes and Treatment

Mental Health Episodes[1]	**In-Program**
Participants=89	
Any Mental Health Episode	20%
Mean # of Mental Health Episodes	.26 (.59)
Any Substance-Related and Addictive Disorders	9%
Mean # of Substance-Related and Addictive Disorders	.11 (.41)
Any Other Mental Health Disorder	9%
Mean # of Other Mental Health Disorders	.10 (.34)
Any Bipolar and Related Disorder	*2%*
Mean # of Bipolar and Related Disorders	*.02 (.15)*
Any Personality Disorder	*1%*
Mean # of Personality Disorders	*.01 (.11)*
Any Schizophrenia Spectrum and Other Psychotic Disorder	*1%*
Mean # of Schizophrenia Spectrum and Other Psychotic Disorders	*.01 (.11)*
Any Trauma- and Stressor-Related Disorder	*5%*
Mean # of Trauma- and Stressor-Related Disorders	*.04 (.21)*
Any Other Condition That May Be a Focus of Clinical Attention	*1%*
Mean # of Other Conditions That May Be a Focus of Clinical Attention	*.01 (.11)*
Any Unknown Disorders	5%
Mean # of Unknown Disorders	.04 (.21)
Treatment Orders[2]	
Any Treatment Order	12%
Mean # of Treatment Orders	.25 (.80)
Mean # of Days in Treatment	7.07 (26.83)
Any Compulsory Mental Health Facility Order	*10%*
Mean # of Compulsory Mental Health Facility Orders	*.19 (.67)*
Mean # of Days in Compulsory Mental Health Treatment Facility	*2.19 (7.58)*
Any Community Treatment Orders	*3%*
Mean # of Community Treatment Orders	*.06 (.35)*
Mean # of Days on Community Treatment	*3.38 (23.32)*

[1] No defendants had Anxiety, Depressive Disorder, Neurocognitive Disorder, Neurodevelopmental Disorder or Paraphilic Disorder episodes during the Saskatoon MHS Court case. Results not presented. Each episode was coded based on the primary presenting diagnosis. However, defendants may experience multiple types of mental health episodes.

[2] Each Treatment Order was coded as either a Compulsory Mental Health Facility Order or a Community Treatment Order. For defendants who received both types of Orders, it was counted once in 'Any Treatment Order;' all orders and days on orders are counted in 'Mean # of Treatment Orders' and 'Mean # of Days in Treatment', respectively.

In-Program Mental Health Diagnosis

Table 6 illustrates clients' in-program mental health episodes and psychiatric treatment orders related to their mental health needs. One fifth of clients (20%) had at least one mental

health episode during their MHS Court case. Clients were equally likely to have at least one substance-related and addictive disorder (9%) or other (non-substance-related) mental health disorder (9%).

In-Program Psychiatric Treatment Orders

Twelve percent of clients received a treatment order during their MHS Court case with an average of 7.07 days in treatment. Most (10%) of these treatment orders were compulsory mental health facility orders with fewer clients (3%) receiving community treatment orders. Individuals who received community treatment orders (mean = 3.38 days) spent, on average, one day more in treatment than those who received a compulsory mental health facility order (mean = 2.19 days). These figures are also displayed in Table 6.

Table 7. Mental Health Services: In-Program Utilization

Mental Health Services	In-Program	In-Program: Active	In-Program: Completed	In-Program: Terminated
Participants=89				
Any Mental Health Service	35%	3%	23%	24%
Mean # of Mental Health Services	1.21 (2.45)	0.04 (.26)	0.72 (1.82)	0.45 (1.01)
Any Consultation	15%		14%	1%
Mean # of Consultations	0.29 (.96)		0.28 (.95)	0.01 (.11)
Any Detox	11%		8%	8%
Mean # of Detox	0.36 (1.52)		0.20 (.98)	0.16 (.66)
Any Drug/Addiction Treatment (not detox)	3%		1%	2%
Mean # of Drug/Addiction Treatment (not detox)	0.03 (.18)		0.01 (.11)	0.02 (.15)
Any Psychiatric In-Patient	11%		11%	1%
Mean # of Psychiatric In-Patient	0.15 (.47)		0.13 (.40)	0.01 (.11)
Any Individual Psychiatric or Mental Health Counselling	17%	2%	8%	8%
Mean # of Individual Psychiatric or Mental Health Counselling	0.20 (.50)	0.02 (.15)	0.08 (.27)	0.10 (.40)
Any Group Counselling/Treatment (not drug)	6%	1%		5%
Mean # of Group Counselling/Treatment (not drug)	0.10 (.43)	0.02 (.21)		0.08 (.38)
Any Intake & Case Management (Screening/Risk Assessment)	2%		1%	1%
Mean # of Intake & Case Management (Screening/Risk Assessment)	0.02 (.15)		0.01 (.11)	0.01 (.11)
Any Residential/Transitional Program	2%			2%
Mean # of Residential/Transitional Program	0.04 (.33)			0.04 (.33)
Any Other Program	1%			1%
Mean # of Other Program	0.01 (.11)			0.01 (.11)

Note. Participants may enrol in the same service multiple times, and may have different outcomes for each enrollment. For each enrollment, service outcome were broken down as in-program: completed (participant completed the service during their Court case), in-program: terminated (the provider terminated the service during the client's Court case), or in program: active (service continued after client's Court case was completed

In-Program Mental Health Service Utilization

Clients, as Saskatoon residents, may also access multiple mental health services. This was counted once in 'any mental health service,' while total enrollments were averaged in 'mean # of mental health services.' Clients may also enrol in the same service multiple times, which was counted once for each service type in the 'any' service variables, while totals of each type of enrollment was averaged in the 'mean #' variables. For each enrollment, service outcomes were

broken down as 'in-program: active,' 'in-program: completed' and 'in-program: terminated.' Clients' mental health service utilization during their MHS Court case is displayed in Table 7.

Contrary to the goals of the MHS Court to divert and treat clients with mental health concerns, only 35% of clients received at least one mental health service in-program (i.e., during their Court case). Individual psychiatric or mental health services (17%), consultations (15%), detox (11%) and psychiatric in-patient services (11%) were the most frequent mental health services accessed by clients during their MHS Court case. Close to one quarter of clients completed at least one mental health service in program (23%), and 24% were terminated for at least one service by the mental health provider during their Court case. Few clients (3%) were actively receiving mental health services at the end of their MHS case.

In-Program Hospital Admits

Clients' in-patient hospital admits and duration of hospital stays, which occurred during their MHS Court case, are displayed in Table 8. Few clients had in-patient admits during the MHS Court: 10% had at least one in-patient admit while in the program and stayed an average of 3.61 days. In-patient admits were further broken down into psychiatric mental health admits and non-psychiatric admits. Psychiatric admits were more frequent and longer than non-psychiatric admits: 7% of clients had any psychiatric and 5% of the clients had any non-psychiatry admit. On average, psychiatric in-patient visits lasted around 2 days (mean = 2.47 days), while non-psychiatric visits lasted less than a day (mean = .17 days).

Table 8. In-Program Hospital Visits

In-Patient admits	**In-Program**
Participants=89	
Any In-Patient Admit	10%
Mean # of In-Patients Admits	0.13 (.46)
Mean # of In-Patient Days	3.61 (19.09)
Any Psychiatry Admit	*7%*
Mean # of Psychiatry Admits	*0.09 (.39)*
Mean # of In-Patient Days	*2.47 (14.76)*
Any Non-Psychiatry Admit	*5%*
Mean # of Non-Psychiatry Admits	*0.04 (.21)*
Mean # of In-Patient Days	*0.17 (.84)*

Note. In-Patient hospital admits were coded either as a Psychiatric or Non-Psychiatric visit. For defendants who had both types of visits, it was counted once in 'Any In-Patient Admit.' All admits and days in the hospital were counted in 'Mean # of In-Patient Admits' and Mean # of In-Patient Days', respectively. Any and mean hospitalization admits were computed based on the start date; days in the hospital were computed based on the relevant time period rather than on the start date. Therefore, if a 15 day visit started 10 days before the case was transferred to the MHS Court, 5 days would be counted in the In Program variables.

In-Program Emergency Room Visits

Clients' emergency room (ER) visits, triage level, and duration of ER stays during their MHS Court case are displayed in Table 9. In terms of ER visits, 18% of clients had a visit to the ER corresponding to an average of 0.85 visits and 3.69 hours in the emergency room. The most frequently reported triage level was 'not urgent visit' (12%; average 0.25 visits and 0.88 hours), while the highest triage level, emergent visits (3%), was the least frequently reported (average 0.08 visits and 0.84 ER hours). Urgent visits were reported for 11% (average 0.25 visits and 1.17 hours) of clients, less urgent visits were reported for 10% (average 0.24 visits and 0.75 hours), and unknown ER visits were reported by 5% (average 0.04 visits and 0.05 hours).

Table 9. In-Program Emergency Room (ER) Visits

ER Triage Level	**In-Program**
Participants=89	
Any ER Visit	18%
Mean # of ER Visits	0.85 (2.52)
Mean # of hours in ER	3.69 (11.67)
Any ER Emergent Visit	*3%*
Mean # of ER Emergent Visits	*0.08 (.46)*
Mean # of hours in ER	*0.84 (4.55)*
Any ER Urgent Visit	*11%*
Mean # of ER Urgent Visits	*0.25 (.92)*
Mean # of hours in ER	*1.17 (4.43)*
Any ER Less Urgent Visit	*10%*
Mean # of ER Less Urgent Visits	*0.24 (.97)*
Mean # of hours in ER	*0.75 (2.68)*
Any ER Not Urgent Visit	*12%*
Mean # of ER Not Urgent Visits	*0.25 (.79)*
Mean # of hours in ER	*0.88 (2.92)*
Any ER Unknown Visit	*5%*
Mean # of ER Unknown Visits	*0.04 (.21)*
Mean # of hours in ER	*0.05 (.31)*

Chapter 4: Pre-Post Outcome Evaluation

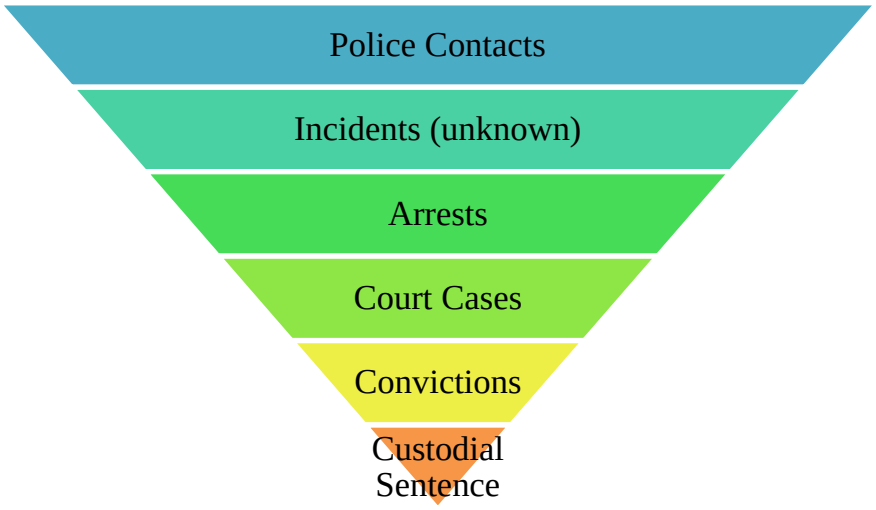
This chapter describes the pre-post MHS Court analysis findings and contains two subsections: the criminal record pre-post analysis (1- and 2- year pre-post MHS Court entry), and health record pre-post analysis (1-year pre-post MHS Court entry). The MHS Court entry date, that is, the 1st appearance in the MHS Court, was used as the date to compute the pre- and post-analysis variables. Due to limited data, in-program data—crimes and health utilization that occurred during the court case—was included in the post analysis variables. As such, 365 days of in-program data was included in the 1-year pre-post post analysis and 730 days of in-program data was included in the 2-year pre-post analysis. Most MHS Court cases were disposed in one year, and only 7% of cases extended into a 2nd year. Consistent with recidivism analysis protocols, the instant case was excluded from the pre-post outcome evaluation.

Criminal Record

This section includes the 1- and 2- year pre-post analysis of clients' police contacts, arrests, court cases, convictions, and sentences. Typically, there is diminishing counts from one stage of the justice system to the next, referred to as the criminal justice (or crime) funnel (Walker, 2011), illustrated in Figure 8. Not all police contacts end in an arrest, as some police contacts may be requests for service or witnessing a crime. Crime incidents are unknown: some lead to an arrest, but others are never detected. If the police do make an arrest, the Crown prosecutor decides whether to prosecute the case—that is, proceed with the charges—if there is a reasonable likelihood of conviction and it is in the public interest to proceed with the case (Director of Public Prosecutions Act, SC 2006).

If the Crown prosecutor decides to proceed, the defendant's case is: (1) transferred to a Provincial Court for summary or minor offenses; or, (2) for an indictable or more serious offense to (i) either a Provincial Court for a judge trial, (ii) a Court of Queen's Bench for a judge trial, or (iii) a Court of Queen's Bench for a trial by judge and jury (Saskatchewan Law Courts, n.d.-a). Many crimes are dual procedure, also known as hybrid offenses, and the Crown decides whether to proceed as a summary or indictable offense (Saskatchewan Law Courts, n.d.-a).

Figure 8. The Criminal Justice Funnel



Court cases may end in a conviction if the defendant pleads guilty or is found guilty by the presiding judge, or judge and jury. There was no conviction variable in the Ministry of Justice data, as such, the following court appearance outcome codes were used to determine convictions: *absolute discharge*, *conditional discharge*, *suspended sentence*, *conditional sentence, custodial sentence* (jail),[4] *for sentence, lessor included offence*, *reprimand*, and *sentenced*. Defendants are likely to have fewer convictions than court cases.

Not all convictions result in a sentence (e.g., absolute discharge does not carry a fine or sentence; Saskatchewan Law Courts, n.d.-a). Since conditional discharge and suspended sentences places the defendant on probation (Saskatchewan Law Courts, n.d.-a), both are counted in probation sentences in this evaluation. However, convictions may carry multiple sentences (e.g., a custodial sentence may include a fine and be followed by several years on parole / community supervision). Thus, while custodial sentences are typically fewer than court cases, total sentences imposed in a given time period may exceed total court cases.

Police Contacts

This section compares police contacts for 1- and 2-year pre- and post-Court entry. Police contacts include involvement in a crime not resulting in an arrest, crime victimization, witnessing a crime, suicide involvement (i.e., client was at the scene but did not personally attempt suicide), and suicide attempt by the client. All police contacts, excluding arrests, are aggregated in the any and mean police contacts variables; the pre-post arrest analysis is covered in the subsequent section. The 'any' rows in the pre-post analysis tables indicate the percent of clients with at least one occurrence of the particular event; chi-square tests were used to determine statistically significant difference between the 'any' variables. The 'mean # of' rows

[4] Absolute discharge, conditional discharge, suspended sentence, conditional sentence, and custodial sentences (jail) are sentences imposed by the judge after a case is disposed / concluded. They are only applied if a defendant is found guilty, which is why these appearance outcome codes were used to identify convictions. Absolute discharge and conditional discharge convictions are removed from the defendant's record.

in the pre-post analysis tables indicate the mean or average incidents for all clients in the evaluation; paired-samples *t*-tests were used to analyze differences across average events. Paired samples *t*-test compare the mean of a single sample measured at time 1 and time 2; therefore, sample members who did not experience the event (the 0s in the 'any' variables) are included in paired samples t-tests (Field, 2009). The 'any' and 'mean # of' variables should be interpreted together: for example, 82% of clients had at least one police contact 1-year pre-Court period, and clients had an average of 6.72 police contacts in the same period.

Fewer clients had at least one police contact (82% vs. 75%) in the 1-year pre-post Court entry interval, while mean police contacts were relatively unchanged at the 1-year pre-post (6.72 vs. 6.74) interval. Thus, accounting for the effect of the increased number of 0s or 'no police contacts' in the post-Court period mean computation, some clients had an *increased* number of police contacts in the post-Court period. Indeed, 6% of clients had 20 or more police contacts in the 1-year pre-Court period, while 10% of clients had 20 or more police contacts in the 1-year post-Court period. This increase in mean police contacts was due to crime involvement (not arrests), which increased from an average of 6.05 incidents 1-year pre-Court to 6.30 incidents 1-year post-Court entry.

Table 10. Police Contacts: Pre-Post Analysis

Police Contacts	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=88			
1 year			
Any Police Contact	82%	75%	6.52
Mean # of Police Contacts	6.72 (11.36)	6.74 (12.30)	-0.03
Any Crime Involvement	*81%*	*69%*	*4.91†*
Mean # of Crime Involvements	*6.05 (10.97)*	*6.30 (12.11)*	*-0.27*
Any Crime Victimization	*27%*	*18%*	*8.28*
Mean # of Crime Victimizations	*.43 (.92)*	*.20 (.46)*	*2.18**
Any Crime Witness	*7%*	*7%*	*0.47*
Mean # of Crime Witness	*.07 (.25)*	*.09 (.39)*	*-0.44*
Any Suicide Involvement	*9%*	*7%*	*0.45*
Mean # of Suicide Involvements	*.17 (.63)*	*.15 (.72)*	*0.33*
Any Suicide Attempt	*0%*	*1%*	
Mean # of Suicide Attempts	*.00 (.00)*	*.01 (.11)*	*-1.00*
Participants=87			
2 years			
Any Police Contact	90%	84%	2.21
Mean # of Police Contacts	11.23 (15.45)	12.17 (20.83)	-0.57
Any Crime Involvement	*89%*	*82%*	*7.52*
Mean # of Crime Involvements	*9.92 (14.70)*	*11.24 (20.44)*	*-0.81*
Any Crime Victimization	*47%*	*29%*	*6.13***
Mean # of Crime Victimizations	*.86 (1.30)*	*.44 (.83)*	*2.97***
Any Crime Witness	*12%*	*9%*	*0.01*
Mean # of Crime Witness	*0.15 (.47)*	*.13 (.50)*	*0.31*
Any Suicide Involvement	*15%*	*12%*	*0.22*
Mean # of Suicide Involvements	*.30 (.92)*	*.37 (1.83)*	*-0.4*
Any Suicide Attempt	*0%*	*2%*	
Mean # of Suicide Attempts	*.00 (.00)*	*.02 (.15)*	*-1.42*

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.

Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables. Police contact data excludes arrests. Crime involvement was coded as police contacts where the defendant was involved in crime (warned, suspect, involved, responsible, diverted, person of interest, MVA) but not arrested. Suicide involvement was coded as calls for police service for a suicide attempt or completed suicide by the defendant on behalf of another individual.

A similar pattern emerged in the 2-year pre-post police contacts analysis. Fewer clients had police contacts 2 years (90% vs. 84%) after having their cases transferred to the MHS Court.

However, as with the 1-year period, average contacts were slightly higher for the 2-year post-Court (12.17), compared to the 2-year pre-Court (11.23) period. Total police contacts revealed that, while 2-year pre-Court police contacts ranged from 0 to 86, 2-year post-Court contacts ranged from 0 to 148 (results not presented in Table 10). Furthermore, only 3% of clients had 35 or more police contacts in the 2-year pre-Court period, while 10% of clients had 35 or more police contacts in the 2-year post-Court period. Therefore, although fewer clients engaged in risky behaviour, their frequency of risky behaviour increased 1-year post-Court entry and continued to increase 2-years post-Court entry. This increased risky behaviour manifested as crime involvement, which led to an increase in average incidents (9.92 vs. 11.24) in the 2-year interval.

Suicide Involvement and Attempts

Overall, any suicide involvement, where the client did not personally attempt suicide, decreased in in the 1-year (9% vs. 7%) and 2-year (15% vs. 12%) intervals. However, suicide involvement continued to increase yearly post-Court entry, indicating that clients' social network included high-risk individuals. It is also important to note that one client attempted suicide 1-year post-Court entry and a second client attempted suicide in the 2-year post–Court entry period; one of those attempts was completed (i.e., the client died by suicide during the program).

Crime Victimization

At the 1-year interval, there was a significant reduction in average police contacts where the client was a victim (0.43 vs. .20) from the 1-year pre-Court (27%) to the post-Court (18%) interval. This downward trend continued in at the 2-year interval: fewer clients experienced at least one incident of crime victimization post-Court entry (29%), compared to pre-Court entry (47%). In addition, clients' average crime victimization reduced significantly in the 2-year (0.86 vs. 0.44) pre-post interval.

Arrests

This section covers the arrest analysis for the 1- and 2-year intervals. The instant case arrest was excluded from this analysis; however, in-program arrests that occurred within 365 and 730 days of the MHS Court entry date were included in the 1-year post-Court data, and 2-year post-Court data, respectively. As there was no summary or indictable identifier in the court file, arrests were categorized as violent (i.e., crimes against a person), non-violent and traffic; non-violent arrests were further disaggregated into property, drug, weapons, and administrative and other—rather than by seriousness of the arrest charge. The arrest data should be interpreted similarly to the police contact data, whereby the 'any' rows in the pre-post analysis tables indicate the percent of clients with at least one occurrence of the particular event; and the 'mean # of' rows in the pre-post analysis tables indicate the mean or average incidents for all clients in the evaluation (i.e., 0s are included in the mean computation).

Table 11. Arrests: Pre-Post Analysis

Arrests	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=89			
1 year			
Any Arrest	70%	61%	12.14
Mean # of Arrests	2.85 (3.7)	2.69 (3.36)	0.44
Any Violent Arrest	25%	12%	0.04*
Mean # of Violent Arrest Arrests	0.27 (.52)	0.18 (.56)	1.30
Any Non-Violent Arrest	64%	60%	13.15
Mean # of Non-violent Arrests	*2.58 (3.66)*	*2.49 (3.20)*	*0.24*
Any Property Arrest	*26%*	*27%*	*4.29*
Mean # of Property Arrests	*0.42 (.84)*	*0.63 (1.56)*	*-1.38*
Any Drug Arrest	*2%*	*0%*	
Mean # of Drug Arrests	*0.02 (.15)*	*.00 (.00)*	*1.42*
Any Weapons Arrest	*5%*	*1%*	*0.05*
Mean # of Weapons Arrests	*0.04 (.21)*	*0.01 (.11)*	*1.35*
Any Administrative and Other Arrest	*55%*	*55%*	*9.05*
Mean # of Administrative and Other Arrests	*2.10 (3.18)*	*1.85 (2.48)*	*0.79*
Any Traffic Arrest	0%	1%	
Mean # of Traffic Arrests	.00 (.00)	.01 (.11)	-1.00
Arrest Crime Severity Index Weight			
CSI Weight (most serious charge only)	128.35 (188.30)	147.92 (240.02)	-0.79
2 years			
Any Arrest	78%	67%	16.44†
Mean # of Arrests	5.02 (5.87)	4.92 (6.57)	0.155
Any Violent Arrest	36%	24%	0.06†
Mean # of Violent Arrest Arrests	0.49 (.81)	0.36 (.74)	1.37
Any Non-Violent Arrest	72%	64%	15.503
Mean # of Non-violent Arrests	4.48 (5.70)	4.54 (6.37)	-0.087
Any Property Arrest	*40%*	*36%*	*16.613*
Mean # of Property Arrests	*0.76 (1.21)*	*1.04 (2.13)*	*-1.356*
Any Drug Arrest	*6%*	*3%*	*0.19*
Mean # of Drug Arrests	*0.06 (.23)*	*0.03 (.18)*	*0.705*
Any Weapons Arrest	*8%*	*2%*	*0.18*
Mean # of Weapons Arrests	*0.11 (.44)*	*0.02 (.15)*	*1.81†*
Any Administrative and Other Arrest	*62%*	*61%*	*6.321*
Mean # of Administrative and Other Arrests	*3.55 (4.88)*	*3.44 (5.13)*	*0.212*
Any Traffic Arrest	5%	2%	0.10
Mean # of Traffic Arrests	0.04 (.21)	0.02 (.15)	0.82
Arrest Crime Severity Index Weight			
CSI Weight (most serious charge only)	222.58 (304.84)	261.17 (360.23)	-0.964

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.

There was an overall reduction in arrests in the 1-year pre-post Court entry interval—with the exception of any property arrest, which increased slightly in the 1-year post-Court entry period from 26% pre-Court to 27% post-Court entry—which generally continued in the 2-year interval. There was a downward trend in clients with at least one arrest between the 1-year (70%

vs. 61%) and 2-year intervals (78% vs. 67%). Violent arrests accounted for most of the downward trend in arrests, with a 50%[5] reduction in the 1-year interval (25% vs. 12%) and 34% reduction in the 2-year (36% vs. 24%) pre-post intervals. The downward trend in any non-violent arrests was more modest, with a 7% reduction in the 1-year interval (64% vs. 60%) and 11% reduction in the 2-year (72% vs. 64%) interval. Additionally, there was a downward trend in any weapon arrest, namely, a 76% reduction (5% vs. 1%) in the 1-year interval and 72% reduction in the 2-year (8% vs. 2%) pre-post interval.

The downward trend in the number of clients with any, violent, non-violent and weapon arrest in the pre-post analysis is promising and suggests the MHS Court is accomplishing one of its goals of reducing clients' recidivism. However, the 15% increase in clients' average crime severity index weight in the 1-year interval (128.35 vs. 147.92) and the 17% increase in the 2-year interval (222.58 vs. 261.17), suggests that clients may be committing fewer, but more serious crimes.

Court Cases

Arrests that are not dropped by the crown prosecutor are adjudicated in a criminal court (i.e., becomes a court case). This section describes the 1- and 2-year pre-post court cases analysis. The instant court case was excluded from this analysis; however, in-program court cases that occurred within 365 and 730 days of the MHS Court entry date were included in the 1-year post-Court data, and 2-year post-Court data, respectively. Unlike the categorization system used for arrests and conviction, court cases were categorized as: homicide, rape, aggravated assault, assault, robbery, motor vehicle theft, arson, burglary, theft, fraud, youth criminal justice act, administrative, and other. The coding for court cases was selected based on the cost estimate categories provided in Gabor (2015). Importantly, the administrative and other categories used in the arrests and convictions pre-post analysis were disaggregated into separate categories to identify the effect of system-generated administrative charges on the justice system. Similar to an arrest, a court case may have multiple charges; to avoid over counting, cases were characterized based on the most serious charge.

1-Year Pre-Post Court Case Analysis

Table 12 displays the 1-year pre-post court case analysis. At the 1-year pre-post interval, there was a significant *increase* in clients with any court cases from pre-Court entry (53%) to post-Court entry (73%) corresponding to an increase in average court cases (1.63 vs. 3.78) per client. This increase was predominantly due to the significant increase in administrative court cases (.84 vs. 2.33) from 1-year pre-Court entry (27%) to post-Court entry (66%). Increases in assault and motor vehicle theft cases also contributed to the overall increase in court cases. Specifically, there was a significant increase in any assault court cases from pre-Court entry (11%) to post-Court entry (25%), as well as in average assault court cases (0.12 vs. 0.27).

[5] Pre-post change rates were computed as follows: (Time 2 value - Time 1 value) / Time 1 value, e.g., [(12% - 25%) / 25% = -50% or 50% reduction].

Table 12. Court Case (1 Year): Pre-Post Analysis

Court Cases	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=89			
Any Court Appearance	73%	78%	36.84
Mean # Court Appearances	6.88 (6.90)	9.51 (8.35)	-3.05**
Any Court Case	53%	73%	10.20**
Mean # of Court Cases	1.63 (3.03)	3.78 (4.96)	-3.90***
Mean # of Charges	2.43 (4.54)	6.24 (8.19)	-4.07***
Any Homicide Court Case	*0%*	*0%*	
Mean # of Homicide Court Cases	*.00 (.00)*	*.00 (.00)*	
Any Rape Court Case	*1%*	*1%*	*89.00*
Mean # of Rape Court Cases	*.02 (.21)*	*.01 (.11)*	*1.00*
Any Aggravated Assault Court Case	*0%*	*2%*	
Mean # of Aggravated Assault Court Cases	*0 (0)*	*.02 (.15)*	*-1.42*
Any Assault Court Case	*11%*	*25%*	*1.31**
Mean # of Assault Court Cases	*.12 (.36)*	*.27 (.50)*	*-2.18**
Any Robbery Court Case	*2%*	*1%*	*0.02*
Mean # of Robbery Court Cases	*.02 (.15)*	*.01 (.11)*	*0.58*
Any Motor Vehicle Theft Court Case	*6%*	*18%*	*13.82***
Mean # of Motor Vehicle Theft Court Cases	*.09 (.47)*	*.42 (1.27)*	*-2.33**
Any Arson Court Case	*0%*	*1%*	
Mean # of Arson Court Cases	*.00 (.00)*	*.01 (.11)*	*-1.00*
Any Burglary Court Case	*3%*	*2%*	*0.07*
Mean # of Burglary Court Cases	*.03 (.18)*	*.02 (.15)*	*0.45*
Any Theft Court Case	*2%*	*8%*	*5.01*
Mean # of Theft Court Cases	*.02 (.15)*	*.09 (.33)*	*-1.93†*
Any Fraud Court Case	*0%*	*5%*	
Mean # of Fraud Court Cases	*.00 (.00)*	*.06 (.28)*	*-1.92†*
Any Youth Criminal Justice Act Court Cases	*3%*	*2%*	*13.66*
Mean # of Youth Criminal Justice Act Court Cases	*.04 (.26)*	*.03 (.24)*	*0.58*
Any Aminstrative Court Case	*27%*	*66%*	*4.27****
Mean # of Aminstrative Court Cases	*0.84 (2.19)*	*2.33 (3.13)*	*-4.11****
Any Other Court Case	*26%*	*30%*	*0.29*
Mean # of Other Court Cases	*0.43 (1.02)*	*0.51 (.91)*	*-0.66*

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.

Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables. Court case categories are mutually exclusive. For cases with multiple charges, the case was coded based on the most serious charge using the following order: Homicide, Rape, Aggravated Assault, Assault, Robbery, Motor Vehicle Theft, Arson, Burglary, Theft, Fraud, YCJA and Other. Thus, for court case variables, if a case had both an assault and a burglary charge, it was coded as an 'Assault' case. This coding ensures cases are not counted multiple times. 'Mean # of Charges' provides the total charges, thus, if a case had 5 charges, all 5 charges were counted in this variable.

Furthermore, there was an increase in any motor vehicle theft cases from pre-Court entry (6%) and post-Court entry (18%) and an increase in average motor vehicle theft cases (0.09 vs.

0.42). Additionally, there was an increase in average theft court cases (0.02 vs. 0.09) and fraud cases (0.00 vs. 0.06), which contributed to the overall increase in court cases, but to a lesser extent than the increases in administrative, assault, and motor vehicle theft cases.

Table 13. Court Case (2 Year): Pre-Post Analysis

Court Cases	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=89			
Any Court Appearance	80%	80%	30.16
Mean # Court Appearances	11.93 (10.78)	15. 64 (15.43)	-2.49*
Any Court Case	66%	79%	17.27*
Mean # of Court Cases	4.01 (6.14)	6.24 (7.82)	-2.61*
Mean # of Charges	5.85 (9.40)	10.78 (13.98)	-3.27**
Any Homicide Court Case	*1%*	*0%*	
Mean # of Homicide Court Cases	*.01 (.11)*	*.00 (.00)*	*1.00*
Any Rape Court Case	*1%*	*2%*	*43.99*
Mean # of Rape Court Cases	*.02 (.21)*	*.02 (.15)*	*0.00*
Any Aggravated Assault Court Case	*2%*	*2%*	*0.047*
Mean # of Aggravated Assault Court Cases	*.02 (.15)*	*.02 (.15)*	*0.00*
Any Assault Court Case	*23%*	*36%*	*0.917†*
Mean # of Assault Court Cases	*.31 (.63)*	*.48 (.77)*	*-1.66*
Any Robbery Court Case	*2%*	*2%*	*0.05*
Mean # of Robbery Court Cases	*.02 (.15)*	*.03 (.24)*	*-0.38*
Any Motor Vehicle Theft Court Case	*15%*	*24%*	*24.02†*
Mean # of Motor Vehicle Theft Court Cases	*.29 (.86)*	*.64 (1.90)*	*-1.80†*
Any Arson Court Case	*1%*	*2%*	*0.023*
Mean # of Arson Court Cases	*.01 (.11)*	*.03 (.24)*	*-0.82*
Any Burglary Court Case	*5%*	*7%*	*0.303*
Mean # of Burglary Court Cases	*.06 (.28)*	*.09 (.36)*	*-0.69*
Any Theft Court Case	*8%*	*10%*	*2.85*
Mean # of Theft Court Cases	*.08 (.27)*	*.12 (.39)*	*-0.94*
Any Fraud Court Case	*0%*	*6%*	
Mean # of Fraud Court Cases	*.00 (.00)*	*.07 (.29)*	*-2.17**
Any Youth Criminal Justice Act Court Cases	*5%*	*2%*	*43.48*
Mean # of Youth Criminal Justice Act Court Cases	*.33 (2.28)*	*.04 (.33)*	*1.19*
Any Aminstrative Court Case	*45%*	*70%*	*10.94***
Mean # of Aminstrative Court Cases	*1.94 (3.56)*	*3.74 (4.92)*	*-3.32***
Any Other Court Case	*39%*	*40%*	*6.67*
Mean # of Other Court Cases	*0.91 (1.90)*	*0.93 (1.77)*	*-0.13*

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.

Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables.

Charges and Appearances. At the 1-year pre-post interval, there was a 157% increase in average number of charges (2.43 vs. 6.24). Given the increase in administrative cases, this increase in average charges per case suggests an over-supervision effect; that is, increased

detection of non-compliance due to greater supervision by the MHS Court, compared to the traditional justice system. Finally, there was an increase in average court appearances at the 1-year pre-post interval (6.88 vs. 9.51), which may be due to the MHS Court's attempts to address the needs of their high-risk/needs clients.

2-Year Pre-Post Court Case Analysis

The 2-year pre-post court case analyses are illustrated in Table 13. The patterns at the 1-year interval were also observed at the 2-year interval: there was a significant increase in any court cases from pre-Court entry (66%) to post-Court entry (79%) and, accordingly, there was an increase in mean court cases (4.01 vs. 6.24) and mean number of charges (5.85 vs. 10.78) in the same period. Also similar to the 1-year interval, the increase in court cases was mostly due to an increase in average administrative cases (1.94 vs. 3.74) from pre-Court entry (45%) to post-Court entry (70%). However, the 2-year pre-post interval increase (66% vs. 79%) in administrative cases was smaller than the 1-year interval increase (53% vs. 73%), which may be due to the fact that 93% of MHS Court cases concluded within one year.

Again, similar to the 1-year pre-post analysis, assault and motor vehicle theft also contributed to the 2-year interval increase in court cases. There was an increase in any motor vehicle theft cases from pre-Court entry (15%) to post-Court entry (24%), along with an increase in average vehicle theft cases (0.29 vs. 0.64). There was no statistically significant increase in average assault cases, but there was an increase in clients with at least one assault court case from pre-Court entry (23%) to post-Court entry (36%). Additionally—although it was impossible to calculate a chi-square for any fraud court cases as no clients had a fraud case pre-Court entry—there was an increase at post-Court entry (0% vs. 6%) and a significant increase in the mean number of fraud cases (0.00 vs. 0.07).

Charges and Appearances. Similar to the 1-year interval, there was an increase in mean court charges (5.85 vs. 10.78) and court appearances (11.93 vs. 15.64) at the 2-year pre-post interval. The 2-year increase (84%) in charges was less extreme than the 1-year pre-post (157%) increase, possibly due to only 7% of clients being under the MHS Court jurisdiction 2 years after their MHS Court entry date.

Convictions

Court cases in which the client (1) pleads guilty, (2) is found guilty by the judge, or (3) is found guilty by a judge and jury result in a conviction. This section covers the conviction analysis for the 1- and 2-year intervals, which is displayed in Table 14. The instant case conviction was excluded from this analysis; however, in-program convictions that occurred within 365 and 730 days of the MHS Court entry date were included in the 1-year post Court data, and 2-year post Court data, respectively. Similar to arrests, convictions were categorized as violent (i.e., crimes against a person), non-violent, and traffic; non-violent convictions were further disaggregated into property, drug, weapons, and administrative and other convictions.

Table 14. Convictions: Pre-Post Analysis

Convictions	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=89			
1 year			
Any Conviction	28%	51%	1.24**
Mean # of Convictions	1.09 (2.5)	2.45 (3.74)	-3.22**
Any Violent Conviction	11%	17%	4.31
Mean # of Violent Convictions	0.15 (.44)	0.21 (.51)	-1.14
Any Non-Violent Conviction	25%	48%	2.75**
Mean # of Non-violent Convictions	*0.93 (2.33)*	*2.21 (3.53)*	*-3.26***
Any Property Conviction	*11%*	*21%*	*2.33†*
Mean # of Property Convictions	*0.17 (.63)*	*0.51 (1.55)*	*-1.93†*
Any Drug Conviction	*7%*	*8%*	*0.69*
Mean # of Drug Convictions	*0.07 (.52)*	*0.09 (.33)*	*-0.53*
Any Weapons Conviction	*1%*	*2%*	*0.02*
Mean # of Weapons Convictions	*0.01 (.11)*	*.02 (.15)*	*-0.58*
Any Administrative and Other Conviction	*20%*	*47%*	*3.43****
Mean # of Administrative and Other Convictions	*0.69 (1.92)*	*1.60 (2.32)*	*-3.56***
Any Traffic Conviction	1%	2%	0.02
Mean # of Traffic Convictions	0.01 (.11)	0.02 (.15)	-0.58
Conviction Crime Severity Index Weight			
CSI Weight (most serious charge only)	54.74 (143.88)	99.13 (213.06)	-1.78†
2 years			
Any Conviction	48%	64%	13.99*
Mean # of Convictions	2.72 (4.59)	4.39 (6.47)	-2.47*
Any Violent Conviction	25%	28%	4.36
Mean # of Violent Convictions	.34 (.66)	.42 (.75)	-0.90
Any Non-Violent Conviction	42%	61%	14.17**
Mean # of Non-violent Convictions	2.34 (4.28)	3.93 (6.15)	-2.45*
Any Property Conviction	*23%*	*34%*	*15.21†*
Mean # of Property Convictions	*.48 (1.19)*	*.96 (2.35)*	*-1.86†*
Any Drug Conviction	*8%*	*11%*	*0.07*
Mean # of Drug Convictions	*.09 (.33)*	*.13 (.40)*	*-0.82*
Any Weapons Conviction	*3%*	*3%*	*8.56*
Mean # of Weapons Convictions	*.06 (.32)*	*.03 (.18)*	*0.71*
Any Administrative and Other Conviction	*34%*	*57%*	*9.53****
Mean # of Administrative and Other Convictions	*1.71 (3.37)*	*2.81 (4.53)*	*-2.39**
Any Traffic Conviction	5%	5%	0.20
Mean # of Traffic Convictions	.04 (.21)	.04 (.21)	0.00
Conviction Crime Severity Index Weight			
CSI Weight (most serious charge only)	133.19 (260.94)	203.48 (334.07)	-1.85†

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.

Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables.

1-Year Pre-Post Conviction Analysis

At the 1-year interval, there was a significant increase in any conviction from pre-Court entry (28%) to post-Court entry (51%) and, accordingly, there was a significant increase in the mean number of convictions (1.09 vs. 2.45). Much of this increase was due to an increase in

average administrative and other convictions (0.69 vs. 1.60) from pre-Court entry (20%) to post-Court entry (47%). The more modest increase in any (11% vs. 21%) and average property convictions (0.17 vs. 0.51) also contributed to the increase in 1-year pre-post convictions. Since administrative and other, as well as property convictions, were sub-categories of non-violent convictions, there was a corresponding significant increase in any (25% vs. 48%) and average non-violent convictions (0.93 vs. 2.21) in the 1-year pre-post interval. Finally, there was an increase in the crime severity index weight between the 1-year pre-Court entry (54.74) and post-Court entry (99.13) interval.

2-Year Pre-Post Conviction Analysis

At the 2-year interval, there was a significant increase in any conviction (48% pre-Court vs. 64% post-Court) and, accordingly, there was a significant increase in the mean number of convictions (2.72 vs. 4.39). Much of this increase was due to non-violent convictions, specifically administrative and other convictions and, to a lesser extent, property convictions. Average administrative and other convictions increased (1.71 vs. 2.81) from 2-years pre-Court (34%) to 2-years post-Court (57%). Additionally, there was an increase in average property convictions (0.48 vs. 0.96) from pre-Court entry (23%) to post-Court entry (34%). Finally, crime severity index weight increased (133.19 vs. 203.48) in the 2-year pre-post interval.

When both 1-year and 2-year pre-post conviction intervals are analyzed together, the increase in system generated convictions during the MHS Court case is obvious: administrative and other convictions increased by 135% in the 1-year interval, but only increased by 68% in the 2-year interval (when only 7% of clients had an ongoing MHS Court case). In other words, much of the increase in the post-Court entry convictions were due to clients' inability or failure to comply with the MHS Court rules and not because clients committed new crimes.

Sentencing

Defendants who are found guilty or plead guilty are sentenced by the Court. Possible sentences in Saskatchewan include conditional discharge, probation, fine, suspended sentence, conditional sentence, and jail. Unlike police contacts, arrest, cases and convictions, sentences were not coded as mutually exclusive categories. In terms of sentencing, there were significant increases in jail, probation, and fine sentences at both the 1- and 2-year intervals, as illustrated in Table 15.

1-Year Pre-Post Sentencing Analysis

At the 1-year interval, there was a significant increase in average jail sentences (0.60 vs. 1.32) and clients with any jail sentence between pre-Court entry (17%) and post-Court entry (34%). Average (0.48 vs. 1.13) and clients with at least one probation sentence (15% vs. 34%) also increased at the 1-year interval. Additionally, average conditional sentences increased between pre-Court entry (0.02) and post-Court entry (0.18) at the 1-year interval. Importantly, there was a 156% increase in clients fined at least once between pre-Court entry (8%) and post-

Court entry (20%), while average number of fines also increased (0.18 vs. 0.65), indicating that when clients were fined, this occurred multiple times.

Table 15. Sentences: Pre-Post Analysis

Sentences	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=89			
1 year			
Any Community Service Sentence	0%	0%	
Mean # Community Service Sentences	.00 (.00)	.00 (.00)	
Any Jail Sentence	17%	34%	0.40*
Mean # Jail Sentences	.60 (1.84)	1.32 (2.64)	-2.35*
Any Probation Sentence	15%	34%	0.06**
Mean # Probation Sentences	.48 (1.62)	1.13 (2.48)	-2.19*
Any Fine Sentence	8%	20%	0.33*
Mean # Fine Sentences	.18 (.73)	.65 (1.63)	-2.46*
Any Conditional Sentence	2%	7%	0.148
Mean # Conditional Sentences	.02 (.15)	0.18 (.75)	-1.93†
2 years			
Any Community Service Sentence	1%	0%	
Mean # Community Service Sentences	0.02 (.21)	.00 (.00)	1.00
Any Jail Sentence	26%	42%	7.13*
Mean # Jail Sentences	1.35 (3.07)	2.63 (5.60)	-2.39*
Any Probation Sentence	30%	45%	0.75†
Mean # Probation Sentences	1.27 (2.90)	1.73 (3.13)	-1.099
Any Fine Sentence	17%	27%	1.56
Mean # Fine Sentences	.36 (1.04)	.92 (1.96)	-2.43*
Any Conditional Sentence	11%	16%	0.155
Mean # Conditional Sentences	.19 (.64)	0.31 (.96)	-.99

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.

Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables. Sentences are not mutually exclusive: someone found guilty of an offense may be given multiple sentences, e.g., jail with a fine.

2-Year Pre-Post Sentencing Analysis

At the 2- year interval, average (1.35 vs. 2.63) and any jail sentences increased significantly between pre-Court entry (26%) and post-Court entry (42%). Clients with at least one probation sentence (30% vs. 45%) increased between pre- and post-Court entry. Finally, average fine sentences continued to increase in the 2-year interval (0.36 vs. 0.92), with these high-risk clients receiving multiple fines. However, the rate of increases in jail, probation, and

fines sentences were smaller than the 1-year increases. Regardless, increases in the frequency of fines is troubling, as persons with mental health concerns and criminal records typically have problems maintaining stable employment and, therefore, risk re-arrest from their inability to pay fines.

Health Record

Unlike criminal record data where 2 years of pre-post data was available for the outcome analysis, mental health and hospitalization records were only available for 1-year post MHS Court entry. This section details clients' 1-year pre-post mental health conditions, services, and treatment accessed, as well as clients' hospital utilizations.

Table 16. Mental Health Conditions: Pre-Post Analysis

Table 16. Mental Health Conditions: Pre-Post Analysis	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=89			
Any Mental Health Episode	40%	36%	5.18
Mean # of Mental Health Episodes	.63 (.96)	.48 (.80)	1.56
Duration Mental Health Episodes (Days)	119.33 (147.11)	148.63 (153.30)	-2.49*
Any Substance-Related and Addictive Disorders	24%	19%	25.74
Mean # of Substance-Related and Addictive Disorders	.40 (.90)	.26 (.65)	2.32*
Any Other Mental Health Disorder	10%	15%	2.82
Mean # of Other Mental Health Disorders	.10 (.30)	.16 (.40)	-1.15
Any Neurocognitive or Neurodevelopmental Disorder	*1%*	*0%*	
Mean # of Neurocognitive or Neurodevelopmental Disorder	*.01 (.11)*	*.00 (.00)*	*1.00*
Any Personality Disorder	*0%*	*2%*	
Mean # of Personality Disorders	*.00 (.00)*	*.02 (.15)*	*-1.42*
Any Schizophrenia Spectrum and Other Psychotic Disorder	*3%*	*3%*	*0.11*
Mean # of Schizophrenia Spectrum and Other Psychotic Disorders	*.03 (.18)*	*.03 (.18)*	*0.00*
Any Trauma- and Stressor-Related Disorder	*1%*	*5%*	*0.05*
Mean # of Trauma- and Stressor-Related Disorders	*.01 (.11)*	*.04 (.21)*	*-1.35*
Any Anxiety Disorder	*0%*	*1%*	
Mean # of Anxiety Disorders	*.00 (.00)*	*.01 (.11)*	*-1.00*
Any Bipolar and Related Disorder	*0%*	*3%*	
Mean # of Bipolar and Related Disorders	*.00 (.00)*	*.03 (.18)*	*-1.75†*
Any Paraphilic Disorder	*0%*	*1%*	
Mean # of Paraphilic Disorders	*.00 (.00)*	*.01 (.11)*	*-1.00*
Any Other Condition That May Be a Focus of Clinical Attention	*5%*	*0%*	
Mean # of Other Conditions That May Be a Focus of Clinical Attention	*.04 (.21)*	*.00 (.00)*	*2.04**
Any Unknown Disorders	11%	7%	0.81
Mean # of Unknown Disorders	.12 (.36)	.07 (.25)	1.15

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.

Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables. Mental Health Episodes were coded as three mutually exclusive categories: Substance-Related, Other Mental Health, and Unknown disorders. Other Mental Health Disorders were further broken down into Neurocognitive or Neurodevelopmental; Personality; Schizophrenia Spectrum and Other Psychotic; Trauma- and Stressor-Related; Anxiety; Bipolar and Related; Depressive; Paraphilic; and Other Condition That May Be a Focus of Clinical Attention. Analysis is based on primary presenting problems. No defendant was diagnosed with a Depressive Disorder 1 year pre- or post- MHS Court entry (results not presented).

Mental Health Conditions

Table 16 illustrates the 1-year pre-post mental health conditions analysis. Over one third (36%) of clients had at least 1 mental health episode post-Court entry and most (19%) of these were due to substance-related and addictive disorders. Although one of the aims of the MHS Court was to focus on supporting individuals with FASD, neurocognitive disorders only accounted for 1% of mental health episodes in pre-Court entry and there were none recorded for post-Court entry. Unknown disorders also accounted for a fair share of mental health episodes at pre-Court entry (11%) and post-Court entry (7%). There was a decrease for any unknown disorders and mean number of unknown disorders (.12 vs. .07) from pre- to post-Court entry.

Due to the lengthy duration of mental health conditions, this section should be interpreted as the number and types of mental health episodes clients were actively seeking treatment for during the 1-year pre-post MHS Court entry period. Overall, fewer clients experienced at least one mental health episode 1-year post-Court entry (40% vs. 36%); however, these episodes lasted significantly longer post-Court (119.33 vs. 148.63 days). This reduction was likely due to the decline in clients with at least one substance-related (24% vs. 19%) and unknown disorders (11% vs. 7%). It is promising that few clients had an unknown type of mental health episode in the 1-year post-Court period, which suggest the MHS Court provided clients' with the appropriate the mental health care needed to diagnose clients' mental health conditions.

Mental Health Services

Clients accessed multiple services to address their mental health needs described above. Mental health services accessed by clients in the 1-year pre-post interval are displayed in Table 17. Any and average mental health services received by clients were captured in the "Any Mental Health Service" and "Mean # of Mental Health Services" variables. About one half of clients accessed any mental health service pre-Court, and slightly more accessed services post-Court entry (55% vs. 58%). Clients' access to group counselling (8% vs. 12%), individual counselling (19% vs. 24%), and detox (18% vs. 20%) increased in the 1-year pre-post interval. However, any consultation (36% vs. 28%), drug addiction treatment (16% vs. 9%), psychiatric in-patient (28% vs. 25%) and other programming (11% vs. 6%) health services decreased in the 1-year interval.

Importantly, mental health screening and risk assessment, which was extremely low 1-year pre-Court (3%), declined post-Court (1%). It is possible that screening and risk assessment were conducted shortly prior to clients' transfer to the MHS Court; however, a 4% screening and risk assessment rate is likely to be inadequate to sufficiently match treatment levels to clients' needs. The MHS Court judge requests mental health screening and risk assessment to determine clients' eligibility for the Court.[6] Given the low rate of screening and risk assessment in the

[6] The MHS Court does not use risk screens for case management purposes, that is, to determine treatment type of levels. This is discussed in further detail in Chapter 6: Risk, Needs and Health.

Saskatoon Health Region Authority data, it is likely that many screening and risk assessments were conducted by an independent psychiatrist.[7]

Table 17. Mental Health Services: Pre-Post Analysis

Mental Health Services (1 Year)	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=89			
Any Mental Health Service	55%	58%	13.10
Mean # of Mental Health Services	2.90 (4.22)	3.17 (5.92)	-0.55
Duration Mental Service (Days)	219.11 (374.70)	253.26 (365.34)	-2.49*
Any Consultation	36%	28%	11.87
Mean # of Consultations	0.74 (1.43)	0.62 (1.39)	0.73
Any Detox	18%	20%	54.72
Mean # of Detox	1.00 (3.35)	1.42 (4.93)	-1.32
Any Drug/Addiction Treatment (not detox)	16%	9%	0.57
Mean # of Drug/Addiction Treatment (not detox)	0.19 (.47)	0.10 (.34)	1.52
Any Psychiatric In-Patient	28%	25%	4.36
Mean # of Psychiatric In-Patient	0.39 (.78)	0.36 (.80)	0.29
Any Individual Psychiatric or Mental Health Counselling	19%	24%	1.60
Mean # of Individual Psychiatric or Mental Health Counselling	0.21 (.46)	0.30 (.61)	-1.13
Any Group Counselling/Treatment (not drug)	8%	12%	0.03
Mean # of Group Counselling/Treatment (not drug)	0.15 (.59)	0.19 (.60)	-0.49
Any Intake & Case Management (Screening/Risk Assessment)	3%	1%	0.04
Mean # of Intake & Case Management (Screening/Risk Assessment)	0.03 (.18)	0.01 (.11)	1.00
Any Residential/Transitional Program	7%	8%	0.69
Mean # of Residential/Transitional Program	0.07 (.25)	0.11 (.44)	-0.85
Any Other Program	11%	6%	12.63
Mean # of Other Program	0.11 (.32)	0.06 (.23)	1.68†

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.

Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables. Duration of services counts ALL days of service utilization, from the start to end date. Participants may access multiple services during the same period.

Mental Health Treatment

In addition to recommending mental health services, psychiatrists may also place clients on treatment orders to ensure they receive needed mental health services in a mental health facility or in the community. As illustrated in Table 18, there were no significant changes in mental health treatment orders at the 1-year pre-post interval. There was an overall reduction in treatment orders, but this was not statistically significant. One quarter of clients had at least 1 treatment order pre-Court, and a similar percentage (23%) had a treatment order post program entry. Most of the orders were for in-patient mental health treatment (24% vs. 20%) and far fewer were for community treatment orders (6% vs. 3%). This suggests that the clients being

[7] In retrospect, attempts should have been made to capture intake screening and assessment information from the Saskatchewan Ministry of Justice data and the evaluators should not have assumed this data was captured by the Saskatoon Health Region Authority.

served by the MHS Court have significant mental health concerns and these concerns are severe enough to warrant compulsory mental health facility orders.

Table 18. Treatment Orders: Pre-Post Analysis

Treatment Orders (1 year)	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=89			
Any Treatment Order	25%	23%	12.71
Mean # of Treatment Orders	.57 (1.42)	.45 (1.08)	0.75
Mean # of Days in Treatment	14.49 (46.79)	10.11 (37.19)	0.82
Any Compulsory Mental Health Facility Order	*24%*	*20%*	*5.44*
Mean # of Compulsory Mental Health Facility Orders	*.46 (1.24)*	*.37 (.95)*	*0.63*
Mean # of Days in Compulsory Mental Health Treatment Facility	*5.65 (19.98)*	*3.99 (10.64)*	*0.86*
Any Community Treatment Orders	*6%*	*3%*	*21.82*
Mean # of Community Treatment Orders	*.11 (.53)*	*.08 (.48)*	*0.48*
Mean # of Days on Community Treatment	*8.84 (39.67)*	*6.12 (35.60)*	*0.58*

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.
Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables.

Hospital Visits

Hospital visits included in-patient admits, displayed in Table 19. For in-patient admits, there was a decrease in average number of in-patient admits (0.47 vs. 0.27) and any in-patient admits from pre-Court entry (25%) to post-Court entry (15%). Most of this reduction was due to psychiatry admits, which declined 40% in the 1-year interval, from 19% to 11%.

Table 19. Hospital Admits: Pre-Post Analysis

In-Patient admits (1 year)	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=88			
Any In-Patient Admit	25%	15%	10.86†
Mean # of In-Patients Admits	.47 (.98)	.27 (.78)	1.73†
Mean # of In-Patient Days	6.25 (16.93)	5.31 (18.73)	0.40
Any Psychiatry Admit	*19%*	*11%*	*18.59†*
Mean # of Psychiatry Admits	*.31 (76)*	*.19 (.66)*	*1.17*
Mean # of In-Patient Days	*3.98 (12.31)*	*5.09 (18.68)*	*-0.54*
Any Non-Psychiatry Admit	*9%*	*8%*	*0.25*
Mean # of Non-Psychiatry Admits	*.16 (.60)*	*.08 (.27)*	*1.19*
Mean # of In-Patient Days	*2.28 (12.11)*	*0.24 (.95)*	*1.58*

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.
Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables.

Emergency room (ER) visits are displayed in Table 20. Clients' ER utilization appeared to be very promising: ER visits declined significantly at the 1-year pre-post interval (43% vs. 29%). In terms of triage level, there was a 40% reduction in clients with at least one urgent ER visit between pre-Court entry and post-Court entry (34% vs. 20%). There was also a 36% decrease in any non-urgent ER visits between pre-Court entry (28%) and post-Court entry (18%). While there was a decrease in any ER visits from pre- to post-Court entry, there was no significant decrease in the average ER visits from pre- to post-Court entry (2.10 vs. 2.03) or average time spent in the ER (13.13 vs. 12.44 hours). Overall, ER utilization suggested that participation in the MHS Court helped to reduce issues that could lead to urgent visits and also reduced non-urgent visits that may put strain on the health care system.

Table 20. Emergency Room Visits: Pre-Post Analysis

Emergency Room (ER) Triage Level (1 Year)	Pre-Court Entry	Post-Court Entry	Test Statistic
Participants=89			
Any ER Visit	43%	29%	26.38*
Mean # of ER Visits	2.10 (4.72)	2.03 (5.87)	0.19
Mean # of hours in ER	13.13 (28.55)	12.44 (39.61)	0.24
Any ER Emergent Visit	*9%*	*9%*	*18.07*
Mean # of ER Emergent Visits	*.16 (.54)*	*.16 (.60)*	*0.00*
Mean # of hours in ER	*1.41 (5.95)*	*2.18 (8.03)*	*-.86*
Any ER Urgent Visit	*34%*	*20%*	*30.75***
Mean # of ER Urgent Visits	*.80 (1.72)*	*.61 (1.68)*	*1.37*
Mean # of hours in ER	*6.55 (15.01)*	*4.66 (17.01)*	*1.05*
Any ER Less Urgent Visit	*25%*	*18%*	*10.42*
Mean # of ER Less Urgent Visits	*.61 (1.92)*	*.79 (3.39)*	*-0.80*
Mean # of hours in ER	*2.75 (8.96)*	*3.72 (21.62)*	*-0.60*
Any ER Not Urgent Visit	*28%*	*18%*	*7.66†*
Mean # of ER Not Urgent Visits	*.49 (1.13)*	*.42 (1.11)*	*0.72*
Mean # of hours in ER	*2.31 (6.77)*	*1.80 (5.20)*	*0.65*
Any ER Unknown Visit	*5%*	*7%*	*0.303*
Mean # of ER Unknown Visits	*.04 (.21)*	*.07 (.25)*	*-0.63*
Mean # of hours in ER	*.10 (.63)*	*.09 (.42)*	*0.17*

***Significant at the 0.001 level, **Significant at the 0.01 level, *Significant at the 0.05 level, †Significant at the 0.1 level.

Note. Chi-squares and McNemar Test significance levels are reported for binary variables. Paired-samples t-test are reported for mean differences of count variables.

Chapter 5: Cost Analysis

This chapter describes the cost analysis utilizing secondary data obtained from the Saskatchewan Ministry of Justice; it estimates the costs associated with the 1- and 2-year pre-post court cases analysis presented in Chapter 4. While the most serious charge (i.e., top charge) is typically used in recidivism analysis, more precise cost estimates are possible by itemizing police contacts, arrests charges, case charges, court appearances, conviction charges, health utilization, and sentence duration transactions (i.e., all charges in an arrest/case/conviction are costed, and sentences are costed by duration in federal, provincial, or community supervision), and the inclusion of a matched comparison group (e.g., Carey et al., 2017).

However, while Canadian estimates are available for policing, court proceedings, adult and youth custody, community supervision (Gabor, 2015) and mental health addictions by the Policy and Research Unit (Mental Health Commission of Canada [MHCC], 2017), the evaluation team was unable to obtain length of custodial and community sentences required to fully estimate transactional costs of MHS clients. Instead, Gabor's (2015) cost estimates, which itemized total costs of crime by case type, was used to conduct the pre-post cost analysis. The main benefits of this techniques are that it is intuitively easy for policy makers to understand and Gabor (2015) provided cost estimates in August 1, 2014 Canadian Dollars, which was appropriate for analyzing cost of clients with an MHS Court entry between November 18, 2013 and November 17, 2014.

Gabor (2015) used a review of global publications from 1988 to 2016 to estimate costs for the following types of court cases: homicide, rape, aggravated assault, assault, robbery, motor vehicle theft, arson, burglary, theft, and fraud. These costs, excluding homicide, were averaged to estimate the cost of administrative (breach of probation, failure to appear, and failure to comply charges) and other cases. Costs by case type was further disaggregated into: (1) tangible victim (including property losses, lost wages, and medical costs due to injuries); (2) intangible victim (loss in quality of life, pain, and suffering of victims); (3) criminal justice system (CJS) (i.e., law enforcement, court, corrections, programs, and services); and (4) criminal career costs or the opportunity cost lost when someone forgoes legitimate employment in lieu of a criminal career. Three decisions were made to avoid over-estimations of costs: homicide cases were excluded when estimating administrative and other case costs due to extremely high and low homicide cost estimates in some of the studies used by Gabor (2015); mean costs with outliers removed were used to estimate case costs; and cases were counted only once, coded based on the charge with the highest cost estimate. See Appendix E for detailed cost computations.

Total Cost

Table 21 lists the number of cases for the five time periods used in the cost analysis—1- and 2-year pre-Court, the instant case (i.e., case transferred to the MHS Court), and 1- and 2-year post-Court entry. As with the outcome evaluation, the 1st scheduled appearance in the MHS

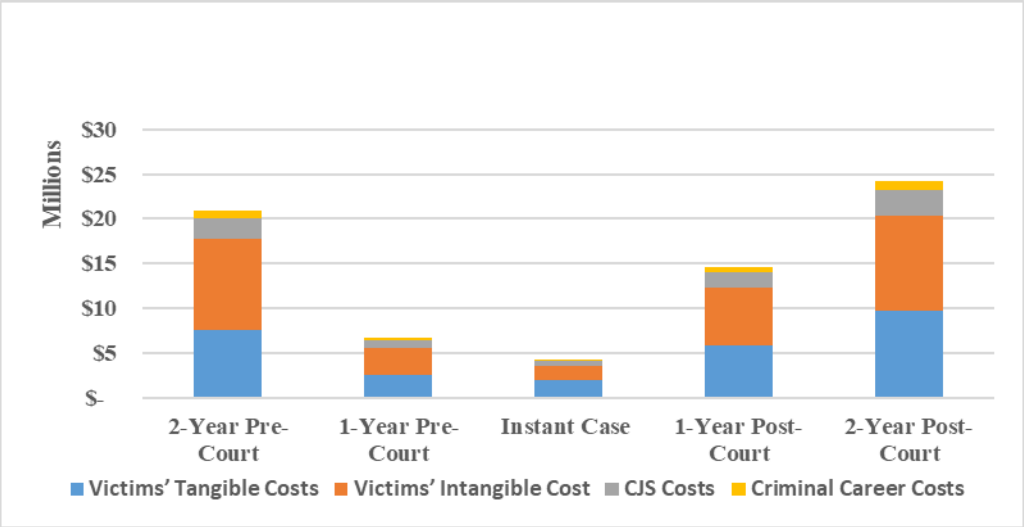
Court for the instant case was used as the cut-off date to compute the prior and recidivism variables. Approximately one quarter of instant cases were assault (26%) and less than one-fifth were administrative (16%). When cases are analyzed by pre-post MHS Court entry, the administrative cases constitute the vast majority of clients' pre-Court cases: approximately half of 1-year pre-Court (52%), and 2-year pre-Court (48%) court cases were administrative. The rate of administrative cases increased post-Court entry, to approximately two-thirds in the 1-year post-Court (62%) and 2-year post-Court (60%) periods.

Table 21. Case Type by Time Period

Case Type	2-Year Pre-Court Cases	1-Year Pre-Court Cases	Instant Case	1-Year Post-Court Cases	2-Year Post-Court Cases
Homicide	1	0	0	0	0
Sexual Assault / Rape	2	2	3	1	2
Assault	28	11	23	24	43
Aggravated Assault	2	0	2	2	2
Robbery	2	2	2	1	3
Motor Vehicle Theft	26	8	9	37	57
Arson	1	0	1	1	3
Burglary	5	3	4	2	8
Theft	7	2	3	8	11
Fraud	0	0	2	5	6
Administrative/Other	283	117	40	255	420
Youth Criminal Justice Act	*29*	*4*	*2*	*3*	*4*
Administrative	*173*	*75*	*14*	*207*	*333*
Other	*81*	*38*	*24*	*45*	*83*
Total	357	145	89	336	555

Figure 9 depicts the client costs associated with the time periods displayed in Table 21 (i.e., 2-year prior, 1-year prior, the instant case, 1-year post and 2-year post-Court cases). Costs are separated into victim tangible and intangible, criminal justice, and criminal career costs.

Figure 9. Total Cost:
Victim, Criminal Justice System and Criminal Career Costs (Million Dollars)



Detailed costs for these periods are presented in Table 22. Based on Gabor's (2015) mean excluding outliers estimate, total cost of the instant case was slightly over 4 million dollars ($4,186,110). The majority of this expense was attributed to victim tangible ($1,890,812) and intangible ($1,693,977) costs, while the criminal justice system cost accounted for approximately 10% of the total cost ($447,063).

Table 22. Total Cost: Gabor's (2015) Mean excluding outliers estimate

	2-Year Pre-Court Cost	1-Year Pre-Court Cost	Instant Case Cost	1-Year Post-Court Cost	2-Year Post-Court Cost
Total Cases					
Victims' Tangible Costs	$ 7,511,622	$ 2,579,376	$ 1,890,812	$ 5,883,395	$ 9,757,608
Victims' Intangible Cost	$ 10,229,295	$ 3,011,815	$ 1,693,977	$ 6,403,959	$ 10,571,633
CJS Costs	$ 2,275,129	$ 785,949	$ 447,063	$ 1,693,145	$ 2,811,083
Criminal Career Costs	$ 909,082	$ 318,775	$ 154,259	$ 655,925	$ 1,088,662
Total Cost	**$20,925,128**	**$ 6,695,916**	**$ 4,186,110**	**$14,636,423**	**$ 24,228,986**

Totals costs increased in both the 1- and 2-year pre-post intervals. Total 1-year recidivism cost ($14,636,423)[8] was more than two times greater than total 1-year pre-Court cost ($6,695,916). Again, the vast majority of costs was attributed to victim tangible and intangible costs for both periods, while criminal justice system costs accounted for slightly more than 10% of total costs (see grey portion of the stacked bars in Figure 9). Total 2-year recidivism cost also

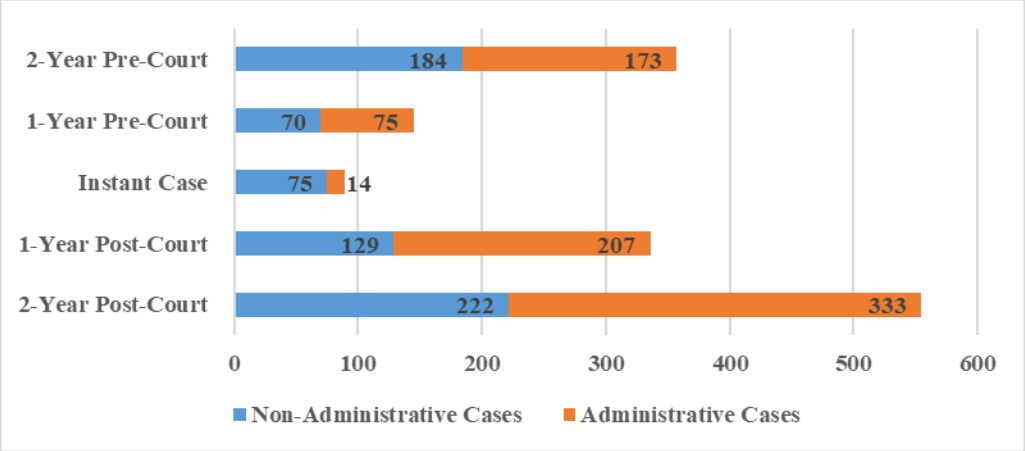
[8] In addition to the total cost of crime, 52 clients accessed mental health services 1-year post court entry and 49 MHS Court clients accessed mental health services 1-year prior at an estimated cost $1,400 per person (MHCC Policy & Research Unit, 2017). Thus, the MHS Court total 1-year recidivism societal cost was estimated at $14,708,691 ($14,636,423 + ($1,400 * 52), while the total 1-year prior societal cost is estimated at $6,764,446 ($6,695,916 + ($1,400 * 49).

exceeded total 2-year prior cost ($24,228,986 vs. $20,925,128), with the highest costs attributed to victim tangible and intangible costs. Although total costs of clients' criminal behaviour increased each successive year after MHS Court entry, total cost increase was less drastic in the second year.

Administrative vs. Non-Administrative Cases

The MHS Court clients often had problems complying with programming and court requirements, in addition to problems with recidivism. For this section of the cost analysis, cases generated by compliance failure were classified as "administrative", which included breach of probation, failure to appear, and failure to comply charges. All other cases, referred to as "non-administrative"—homicide, rape, aggravated assault, assault, robbery, motor vehicle theft, arson, burglary, theft, fraud, and other—result from actual criminal behaviour. Administrative and non-administrative case counts are summarized in Figure 10.

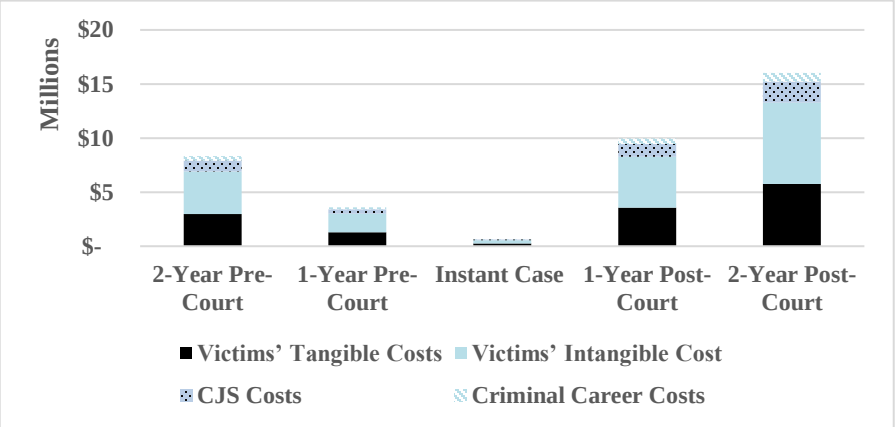
Figure 10. Case Counts: Non-Administrative vs. Administrative Cases



Criminal recidivism increased in the 1- and 2-year pre-post intervals, but at a more modest rate compared to non-compliance/administrative cases. In the 1- and 2-years prior to their MHS Court case, about half of clients' cases were administrative in nature—52% of 1-year priors and 48% of 2-year priors were administrative. However, post-MHS Court entry, administrative cases increased—62% of 1-year recidivism cases and 60% of 2-year recidivism cases were administrative (see orange portions of the stacked bars in Figure 9).

Figures 11 and 12 details the victim, criminal justice, and criminal career costs for administrative and non-administrative cases, itemized in Table 23. When Figures 11 and 12 are reviewed together, it is evident that clients' crimes shifted from non-administrative pre-Court to administrative post-Court. Furthermore, the brunt of clients' criminal behaviour were tangible (e.g., loss of property, wages, and medical costs) and intangible (e.g., pain and suffering) costs borne by victims.

Figure 11. Cost of Administrative Cases:
Victim, Criminal Justice System and Criminal Career Costs (Million Dollars)



Consequently, from a cost standpoint, the burden pre- vs. post-Court entry switched from non-administrative (i.e., criminal behaviour) to administrative charges (failure to comply with conditions/orders), illustrated in Figure 13. Administrative cases accounted for 54% of total costs 1-year pre (close to $4M out of approximately $7M), and 40% of total costs 2-year pre-Court (approximately $8M out of close to $21M). In contrast, post-Court entry administrative case costs accounted for about two-third of total recidivism costs (almost $10M out of $14.5M 1-year post-Court; and approximately $16M out of $24M 2-year post-Court cost).

Figure 12. Costs of Non-Administrative Cases:
Victim, Criminal Justice System and Criminal Career Costs (Million Dollars)

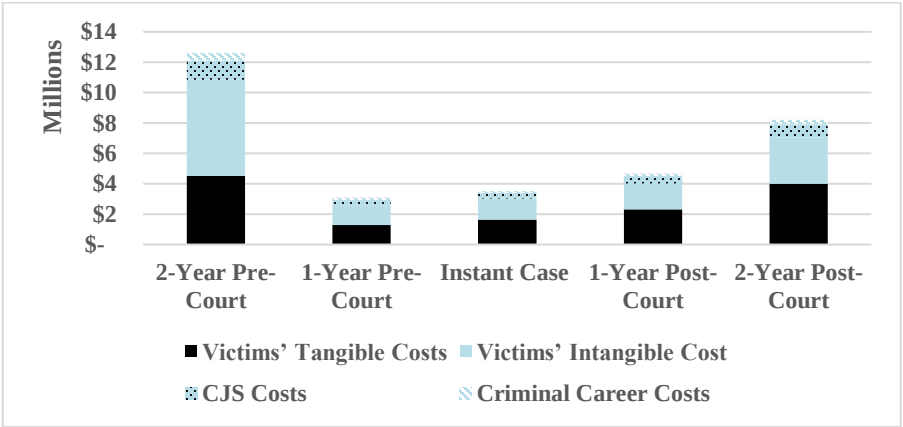


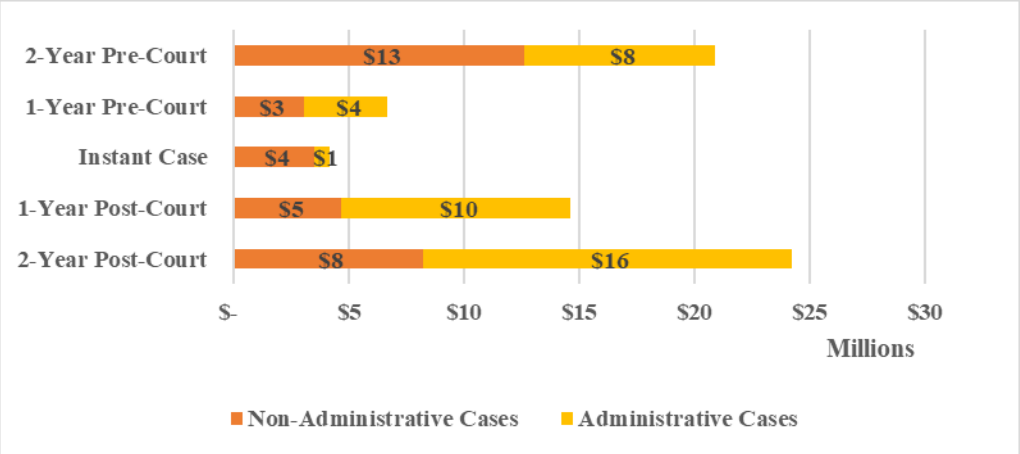
Table 23. Total Cost - Administrative vs. Non-Administrative Cases

	2-Year Pre-Court Cost	1-Year Pre-Court Cost	Instant Case Cost	1-Year Post-Court Cost	2-Year Post-Court Cost
Administrative Cases					
Victims' Tangible Costs	$ 2,986,439	$ 1,294,699	$ 241,677	$ 3,573,369	$ 5,748,464
Victims' Intangible Cost	$ 3,915,586	$ 1,697,508	$ 316,868	$ 4,685,123	$ 7,536,937
CJS Costs	$ 1,001,478	$ 434,167	$ 81,044	$ 1,198,300	$ 1,927,701
Criminal Career Costs	$ 414,514	$ 179,703	$ 33,545	$ 495,980	$ 797,880
Total Cost	**$ 8,318,018**	**$ 3,606,077**	**$ 673,134**	**$ 9,952,773**	**$ 16,010,982**
Non-Administrative Cases					
Victims' Tangible Costs	$ 4,525,183	$ 1,284,677	$ 1,649,135	$ 2,310,026	$ 4,009,145
Victims' Intangible Cost	$ 6,313,709	$ 1,314,306	$ 1,377,108	$ 1,718,836	$ 3,034,696
CJS Costs	$ 1,273,651	$ 351,782	$ 366,018	$ 494,844	$ 883,382
Criminal Career Costs	$ 494,568	$ 139,073	$ 120,714	$ 159,945	$ 290,782
Total Cost	**$12,607,110**	**$ 3,089,839**	**$ 3,512,976**	**$ 4,683,650**	**$ 8,218,005**

Jurisdictions differ on their treatment of administrative or non-compliance charges. The Toronto mental health courts respond to compliance issues with adjustment to case management and services, rather than generating a new charge—and subsequently, new arrest, court case and conviction (HSJCC, 2017). A similar approach by the MHS Court could potentially save the province and city $16M within a two-year period.

Figure 13. Total Costs:

Non-Administrative vs. Administrative Cost (Million Dollars)

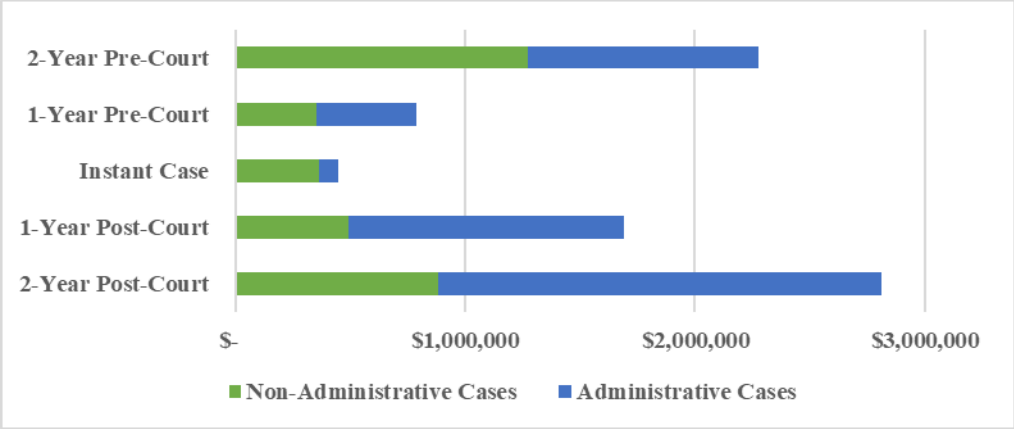


Criminal Justice System Cost

As noted previously, the justice system covers about 10-12% of the total societal cost of crime. This section focuses on the cost burden to the criminal justice system, rather than to

society as a whole. Clients' criminal justice costs are illustrated in Figure 14. Similar to clients' total cost, administrative cases accounted for the majority of criminal justice cost. As illustrated in the blue portions of the stacked bars in Figure 14, much of the 1-year and 2-year criminal justice recidivism costs resulted from administrative charges—71% of 1-year recidivism (slightly over $1M), and 69% of 2-year criminal justice recidivism cost (almost $2M) were due to non-compliance issues. If subsequent cohorts of the MHS Court have a similar criminal and mental health background as the first-year cohort, reducing the use of administrative charges for non-compliance—similar to the Toronto mental health court model (HSJCC, 2017)—could potentially save the province almost $2M in criminal justice costs in the 2-year post-court entry period.

Figure 14. Criminal Justice Costs:
Administrative vs. Non-Administrative Cost



Chapter 6: Discussion, Recommendations and Conclusion

This chapter discusses the key findings in this MHS Court outcome and cost evaluation and presents recommendations to maximize the Court's outcomes. However, it must be noted that, due to an absence of a comparison group, these findings and recommendations should not be considered to be conclusive. The evaluators recognize the absence of designated funding for Canadian diversion courts in general (HSJCC, 2017), and the MHS Court in particular (Barron et al., 2015), is an impediment to the implementation of several recommendations.

Program Duration and Services

Average program duration in the MHS Court was about four months shorter than the Nova Scotia Mental Health Court, which applies a similar model (153 vs. 280 days; Campbell et al, 2015). It is difficult to make any conclusive statement about the program duration or services without having accurate information about the: (1) type of referrals made for each client; (2) the services provided by community partners—Mental Health and Addiction Services, Saskatoon Community Corrections, FASD Network, Elizabeth Fry Society, Social Services, Saskatoon Crisis, and Saskatoon Community Mediation Services—and supporting agencies—The Lighthouse Supported Living, The Salvation Army, Housing First, Community Living, Saskatchewan Brain Injury Association, Partners in Employment, 601 Outreach, Saskatoon Police Service, and various drug and alcohol treatment programs; (3) the duration of services; and (4) the outcome of services provided by the MHS Court.

> **Recommendation 1.** The MHS Court should strive to record data about its functioning and participants, including information such as demographics (e.g., gender, race/ethnicity), risk screen data, referrals to partner agencies and services provided via the MHS Court network to more fully explore its functioning. Data tracking is also required for each Court hearing and service; at a minimum, data tracking is required listing the date of each intervention, type of intervention and outcome of the intervention (e.g., positive, neutral or negative; or, success vs. failure). Standardized reporting and more partnerships/information sharing between agencies would facilitate future (internal and external) evaluations of the MHS Court and potentially allow for better services for clients.

> **Recommendation 2.** Hiring a dedicated coordinator / case manager, who can maintain a record of all referrals, follow-up with clients, and facilitate appointments may help participants remain compliant, thereby improving the completion rate of mental health services (and reducing recidivism). A previous evaluation of the Manhattan Mental Health Court found fidelity to the MHC's model improved after hiring a dedicated, full-time coordinator (Farley, 2015).

Risk, Needs and Health

Clients in the first-year cohort tended to be high in criminogenic risk: 8 in 10 had an arrest or conviction in the 3 years prior to their entry into the MHS Court, and almost half of clients had a violent arrest in this same period. Clients also had high mental health needs and associates/friends with high mental health needs: 8 in 10 clients had a mental health episode between April 1, 2010 and August 31, 2015, and almost 2 in 10 witnessed an attempted suicide in the 3 years pre-Court entry. Notably, only 1 in 10 clients were screened or given a mental health or psychiatric risk assessment in the 3 years pre-Court entry, which indicated a possible mismatch between clients' mental health needs and the services they received in this 3-year pre-Court period.

While their MHS Court case was ongoing, clients were able to obtain a diagnosis for many mental health conditions that were unknown prior to entering the Court. During their MHS Court case, clients who had mental health concerns that did not reach the level of an active mental health episode were able to access individual and group counselling, psychiatric in-patient care, detox, and other drug addictions services. Although screening was a requirement of the MHS Court while in progress, only two clients received any screening or risk assessment to determine their mental health treatment needs in-program. This detection indicates that the inadequate mental health screening and assessment of clients may have continued to be a barrier in matching treatment with clients' mental health needs in-program. However, it is possible the data the evaluation team received from the Saskatoon Health Region Authority did not capture the MHS Court screening. Furthermore, many clients experienced termination of at least one mental health service by the provider during their MHS Court case. Thus, although about one-third of clients were able to *access* mental health services in-program, a quarter were unable to *complete* the necessary mental health service.

> **Recommendation 3.** Adopting a Risk-Needs-Responsivity (RNR) approach (Andrews & Bonta 2010; Campbell et al., 2015; Cissner et al, 2018; Hahn, 2015; Reich et al., 2015) could help reduce post-Court entry contact with the police and courts. The patterns observed in this report seem to indicate that participants have high-risk peer groups or that they engage in other high-risk behaviours, leading to additional contact with the criminal justice system. Targeting these needs and having the level of treatment and services be commensurate with the level of risk posed by the participant could help ensure that resources of the Court are being used effectively and in a way that best promotes public safety while serving clients. The use of an RNR approach is recommended to determine treatment level and not necessarily as an inclusion criteria, as previous studies have found justice-involved persons with *more serious* offenses to be both more compliant in treatment courts and less likely to be rearrested (Reich et al., 2015).

Recommendation 4. We agree with Campbell et al. (2015), in their evaluation of the Nova Scotia MHC: both clinical mental health or psychiatric screening and criminogenic risk screening are required to address the needs of justice-involved persons with mental health issues. Consistent with an RNR approach, all clients should be screened with an evidence-based risk and needs assessment tool (e.g., Level of Service Inventory-Revised [LSI-R], Level of Service/Case Management Inventory [LS/CMI]) to determine their criminogenic risks and needs at intake, soon after intake, or when clients are referred to MHS Court. This information should be used for case management purposes, to determine treatments/services and dosage/treatment levels (Andrews & Bonta 2010; Campbell et al., 2015; Cissner et al, 2018; Hahn, 2015). The Level of Service/Risk-Need-Responsivity instrument (LS/RNR; Andrews et al., 2008 used MHC) as cited in Campbell et al. (2015) to evaluate the Nova Scotia MHC, may be a good starting point for the Steering Committee to consider. Professionals involved in the MHS Court would require training in the use of risk tools, including the limitations of risk tools, and how criminal justice responses (e.g., jail sentence, bail and inability to pay bail, and administrative charges) increase recidivism risk levels, prior to implementation (Andrews & Bonta 2010; Campbell et al., 2015; Hahn, 2015).

There was a reduction in police contacts from pre-Court entry to post-Court entry which seems to be driven by a reduction in crime victimization. The patterns observed in police contacts indicate that clients either have high-risk friends or engage in other high-risk behaviours: a large proportion of clients witnessed crimes, were victims of crimes, and were involved in an associate's suicide attempt. Attempted suicide rates for the province are unknown; however, clients' involvement in suicides (9% vs. 7%) and suicide attempts (0% vs. 1%) in the 1-year pre-post interval were much higher than the provincial completed suicide rate in the corresponding period (i.e., .0129% or 12.9 per 100,000 in 2013 and .0128% or 12.8 per 100,000 in 2014, respectively; computed from the Saskatchewan Coroners Service [2019] data).

Recommendation 5. The MHS Court should consider including a suicide risk screen in the intake process and making appropriate referrals to Saskatoon Crisis (which has a representative on the MHS Court). The Ontario Hospital Association's *Suicide Risk Assessment Guide: A Resource for Health Care Organizations* (Perlman et al., 2011), provides an inventory of the several suicide risk tools, including appropriate populations / demographics for each tool and a framework for implementing these tools, which may be a good starting point for the Steering Committee to consider.

Diversion and Recidivism

The MHS Court efforts to divert clients from the traditional criminal justice system produced mixed results: arrests declined in both the 1-year and 2-year pre-post intervals, while

court cases increased in the 2-year interval, and convictions increased in both the 1-year and 2-year pre-post intervals. Although arrests decreased at the 1-year and 2-year pre-post intervals, this downward trend was less obvious at the 2-year interval, which suggests a need for a longer or more targeted treatment program to control recidivism risk (see recommendations 3 and 4). However, any decision about a longer treatment program should consider the effects of longer supervision on recidivism.

Generally, convictions increased for all charge types at the 1-year and 2-year pre-post intervals. Much of this increase in both periods was due to administrative and other convictions—which predominantly comprised administrative charges—indicating that, while clients were committing fewer crimes post-Court, they were being convicted at a higher rate. An alternate explanation is clients were committing fewer but more serious crimes, as the average Crime Severity Index Weight increased for both arrests and convictions in the 1- and 2-year pre-post intervals. However, a comparison group is needed to make any definitive conclusion about the effect of the MHS Court on this increase in clients' recidivism.

Jail, probation, and fines sentences increased in both the 1- and 2-year pre-post intervals. Importantly, clients were significantly more likely to be: (1) fined in the year after MHS entry compared to the 1-year pre-Court period; and (2) fined multiple times. Persons with mental health conditions may have problems obtaining and maintaining employment (MHCC, 2013; 2018); fines essentially amount to a tax on the poor, who are further punished when unable to pay the fine (Brett & Nagrecha, 2019; Wool et al., 2019). Therefore, while clients are able to access multiple mental health services via the MHS Court, they paid a price for these services. Additionally, due to the increases in convictions and sentences—including fines—post-Court, defense attorneys may advise their clients to take their chances with the traditional criminal justice system (Cissner et al., 2018) and forgo access to vitally needed services facilitated by the MHS Court. It is possible that the imposed fines were from recidivist events adjudicated by the traditional justice system, and therefore outside of the scope of the MHS Court jurisdiction.

> **Recommendation 6.** The MHS Court should carefully consider the use of financial penalties, including fines, when trying to balance public safety against the needs of clients. Although it is important to hold clients accountable for their justice-involved behaviour (and financial penalties are built into the recommended sentencing guidelines), and Saskatchewan allows justice-involved persons to participate in a Fine Option Program[9] to settle fines by doing supervised community work (Government of Saskatchewan, n.d., para. 1), clients may not meet the program's eligibility criteria or be aware of the program.

> **Recommendation 7.** The Professionals involved in the MHS Court should create a system of penalties (e.g., verbal admonishment, more frequent Court hearings, residential

[9] On March 18, 2020, the Fine Option Program was temporarily suspended due to the Covid-19 pandemic. The suspension was lifted on June 12, 2020.

stay, or short-term jail—without terminating service) and rewards (e.g., praise, gift cards, bus cards, food vouchers, certificate of completion) for non-compliance of mental health treatment mandates (see: Cissner et al., 2018; HSJCC, 2017). Rewards and penalty policies should be clearly defined and communicated to clients at intake into the MHS Court. Termination of services should be the last penalty used, and only when all other penalties fail. Furthermore, the reason for non-compliance should be ascertained before assigning penalties. For example, for clients who did not attend court appearances due to financial constraints, the provision of bus cards until the client obtains employment would be more equitable (and reduce recidivism), compared to an administrative arrest charge. In addition to financial constraints, memory may be an issue with persons with mental health issues; text or phone call reminders may reduce compliance issues in these situations (see Ferri, 2019 for New York City's reminder program used to improve court appearance). The MHS Court should consider creating a partnership agreement with the Saskatoon Health Region Authority (and other appropriate partners) to share compliance data and facilitate this penalty and reward system.

Mental Health

In terms of clients' mental health, clients had fewer episodes post-Court, and increasingly accessed individual and group counselling to address their mental health needs. However, fewer clients accessed drug addictions treatment, in-patient mental health services, and mental health treatment orders in the 1-year pre-post interval. It is impossible to know if this reduction in usage was due to a lesser need for drug addictions and in-patient mental health services, as few clients received screening and risk assessment due the 1-year pre-post interval. The implementation of recommendations 1 through 4, discussed earlier, could determine if this lower addiction and in-patient mental service utilization reflected lower client needs.

Persons with mental health issues, especially those that are untreated, have a higher risk of developing a chronic physical condition (e.g., diabetes, heart disease, and asthma), requiring increased health system usage (Canadian Institute for Health Information, 2008). Overall, the reduction in in-patient hospital admits in the 1-year pre-post interval suggests an improvement in clients' mental health. Furthermore, reductions in Emergency Room utilization in the 1-year pre-post interval suggests that participation in the MHS Court helped to reduce clients' issues that could lead to urgent visits, and also reduced non-urgent visits that may put strain on the health care system.

Cost Analysis

Participation in the MHS Court increased cost associated with clients' criminal behaviour. These increases in costs at the 1- and 2-year intervals were primarily due to an increase in administrative (i.e., non-compliance) cases and not due to the commission of new

crimes. Total costs more than doubled in the 1-year pre-post interval, when clients were under supervision of the MHS Court. In the 2-year interval, when less than 1 in 10 clients were under the MHS Court supervision, clients' recidivism and the cost of this recidivism only increased by 16%. The 1- and 2-year intervals cost patterns strongly suggested an over-supervision effect of the MHS Court resulted in increased total and criminal justice related costs. However, without a matched comparison group to determine whether this increase in administrative cases was due to changes in Saskatoon's charging policies, it is impossible to make any definitive conclusions about an over-supervision effect.

> **Recommendation 8**: The Court should reconsider the use of administrative charges for clients. Many of the clients had an arrest or conviction for administrative/other charges indicating an issue with compliance. Although compliance is important, as one of the goals of the Court is to divert justice-involved individuals away from the traditional court system and to connect them to services, alternate means of ensuring compliance may be more appropriate for the Court (see Recommendation 7 on creating a system of rewards and penalties). The MHS Court should consider implementation of judicial referral hearings as an alternative to new administrative charges (Public Prosecution Service of Canada [PPSC], 2020). Judicial referral hearings are permissible under s. 523.1(2) of the Criminal Code for administrative breaches which has not caused physical or emotional harm, property damage, or emotional loss to a victim (PPSC, 2020). Implementation of judicial referral hearings in lieu of administrative charges would reduce both recidivism and costs, without unduly affecting public safety and would be more consistent with therapeutic jurisprudence principles about celebrating successes rather than punishing mistakes. The implementation of Recommendation 2, hiring a dedicated MHS Court Co-ordinator, may also reduce non-compliance issues via the provision of adequate and appropriate services and supervision (i.e., adequately meeting clients' needs).

Other Recommendations

The following recommendations are based on the mental health court literature (Campbell et al., 2015; Cissner et al., 2018; HSJCC, 2017) and are not related to any specific findings in this evaluation:

> **Recommendation 9.** The Crown should consider staying the instant case charges upon participants' successful completion of the program. Stays of proceedings by the Crown result in a withdrawal of charges after one-year post the stay of proceedings being entered (*Criminal Code*, R.S., 1985, c. C-46, s. 579). Stays of proceedings, used by the Winnipeg MHC (Manitoba Courts, 2019), may be a palatable alternative to a withdrawal because of the on- year delay which theoretically allows the Crown to reinstate charges based on events in that year. Since stays are done by the Crown, the MHS Court would require

buy-in by the Crown to implement this recommendation. A graduation ceremony upon successful completion of the MHS Court, along with a stay or prosecutorial diversion, may provide clients with a sense of accomplishment and possibly reduce recidivism.

Recommendation 10. Given that Saskatchewan has a sizeable Indigenous population, the inclusion of an Indigenous court worker (HSJCC, 2017) would likely improve clients' buy-in and compliance. One of Dell's (2020) key findings on the experiences of participants in the MHS Court was an underrepresentation of Indigenous Court clients in comparison to their *over*representation in the Saskatchewan justice system. Given the high incidence of mental illness borne by Indigenous persons (Nelson & Wilson, 2017), this suggests the presence of differential access to justice and mental health programming by race/ethnicity. The Court should carefully consider their underlying assumptions when evaluating referrals for Indigenous clients and/or make a concerted effort to recruit Indigenous justice-involved persons with mental health issues. This strategy, along with dropping charges upon successful completion of the Court or entering a disposition such as absolute discharge, in which the conviction is dropped from the clients' criminal record, may reduce overrepresentation of Indigenous persons in the Saskatchewan justice system in the long term.

Summary of Recommendations

1. Implementation of a data tracking system and standardized reporting—quarterly or yearly—based on the needs of the MHS Court.
2. Hire a dedicated coordinator to oversee the program and clients' case files (e.g., remind clients of appointments, monitor the reward/punishment system, and arrange additional services as needed).
3. Adopt a Risk-Needs-Responsivity framework.
4. Inclusion of risk-needs assessment at intake, or shortly thereafter.
5. Administer a suicide risk screen at intake, or at pre-determined intervals, and making appropriate referrals to Saskatoon Crisis.
6. Avoid the use of financial penalties and fines.
7. Create a system of penalties and rewards to ensure clients' compliance with the MHS Court requirements. Re-arrest should only be used as a penalty as a last report.
8. Use judicial referral hearings in lieu of administrative charges for participants and address non-compliance with a system of penalties.
9. Consider pre-charge diversion and/or a stay of prosecution by the Crown upon successful completion of the program. Include a graduation ceremony upon successful program completion.
10. The inclusion of an Indigenous court worker as one of the professionals involved in the MHS Court, if one is not already included in on the professional Court team.

Conclusion

This pre-post outcome and cost evaluation found several strengths of the MHS Court. Fewer clients had police contacts, were victims of crimes, or arrested in the 2-years following their MHS Court entry. Clients were able to access several mental health services and treatments post-Court entry, while their hospitalizations and emergency room utilizations declined in the 1-year post-Court entry period. The pre-post arrest analysis was also promising, as reductions were observed in any violent and non-violent arrests. However, the crime severity weight of all arrests increased in the pre-post arrest outcome analysis, indicating some caution is required in interpreting these data. Clients' court cases did increase subsequent to their MHS Court entry, but this increase declined in the second year post-Court, indicating a possible supervision effect during the MHS Court case. Inclusion of data categorizing arrests, cases, and convictions by seriousness (i.e., summary, indictable or hybrid), and a matched comparison group are required to make any definitive conclusions about any recidivism and/or the over-supervision effect of the MHS Court.

The absence of program data, including any indicators of successful MHS Court completion, was a major challenge. As a result, we used recidivism, mental health, and health utilization as our outcome measures, and no analysis on completers (clients who successfully completed the MHS program) vs. non-completers was possible. Future evaluations would benefit from the inclusion of program data and a matched comparison group (for quasi-experimental mental health court evaluations with a matched comparison group, see: Cissner et al., 2018; Rossman et al., 2012), demographic data, and a longer follow-up period. Previous MHC evaluations with a matched comparison group found that the reduced recidivism effect of treatment courts disappeared after 2 (Cissner et al., 2018; Pooler, 2015) or 3 years (Rossman et al., 2012), underlying the importance of an adequate follow-up period in evaluating MHCs. Furthermore, it is important to control for the effects of prior criminal record and demographics (e.g., age, gender, and race), which also have been found to affect recidivism in MHCs (Pooler, 2015; Reich et al., 2015; Rossman et al., 2012).

Previous studies have found higher recidivism rates among mental health court participants with substance use problems (Reich et al., 2015; Rossman et al., 2012). Due to the small sample size, comparisons on the effects of co-occurring (i.e., substance abuse with mental disorder) and different mental health conditions on recidivism was not feasible. Finally, due to the absence of program data by the MHS Court, we were unable to conduct sub-group analysis on clients who succeeded vs. those who were non-completers.

Despite these limitations, we hope that the findings and recommendations presented in this report are useful to the Steering Committee of the Saskatoon Mental Health Strategy. Our hope is that our report will generate discussions within the Steering Committee about the purpose, direction, and outcomes of the MHS Court, and perhaps support efforts to secure funding for dedicated staff and data tracking of clients' programming and outcomes.

References

Andrews, D. A., & J. Bonta. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*, 16(1), 39–55.

Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry, 166,* 103–109. https://doi.org/10.1176/appi.ajp.2008.08030416

Barron, K., Moore, C., Luther, G., & Wormith, J. S. (2015). *Process evaluation of the Saskatoon Mental Health Strategy*. Centre for Forensic Behavioural Science and Justice Studies - University of Saskatchewan, Saskatoon, SK. https://cfbsjs.usask.ca/documents/research/research_papers/Process%20Evaluation%20of%20the%20Saskatoon%20Mental%20Health%20Strategy.pdf

Bonta, J., & Andrews, D. A. (2007). Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation (User Report 2007-06). Public Safety Canada.

Boyce, J. (2015). Police-reported crime statistics in Canada, 2014. *Juristat.* Statistics Canada Catalogue no. 85-002-X. https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2015001/article/14211-eng.pdf?st=oYNjgs-4.

Brett, S., & Nagrecha, M. (2019). *Proportionate financial sanctions: Policy prescriptions for judicial reform*. Criminal Justice Policy Program (CJPP), Harvard Law School. http;//cjpp.law.harvard.edu/assets/Proportionate-Financial-Sanctions_layout_FINAL.pdf

Canadian Institute for Health Information. (2008). *A framework for health outcomes analysis: Diabetes and depression case studies*. CIHI.

Criminal Code, R.S., 1985, c. C-46, s. 579.

Campbell, M. A., Adams, A., Ennis, A., & Canales, D. (2015). Prospective evaluation of the Nova Scotia mental health court: An examination of short term outcomes. Centre for Criminal Justice Studies - University of New Brunswick, Saint John, NB.

Carey, S. M., Rempel, M., Lindquist, C., Cissner, A., Ayoub, L. H., Kralstein, D., & Malsch A. (2017). *Re-entry court research: Overview of findings from the National Institute of Justice's evaluation of Second Chance Act Adult Re-entry Courts.* (NCJ Publication Number 251496). https://www.ncjrs.gov/pdffiles1/nij/grants/251496.pdf

Cissner, A. B., Kerodal, A. G., & Otis, K. (2018). *The Allegheny County Mental Health Court evaluation (Part I): Process evaluation findings and recommendations*. Center for Court Innovation. https://www.courtinnovation.org/sites/default/files/media/documents/2019-01/allegheny_county_mhc_evaluation.pdf

Dell, C. M. (2020).*The experience of participants and their support persons in the Saskatoon Mental Health Strategy Court: An exploratory study* (ORCID #: 0000-0002-1040-9489). [Master's thesis, College of Nursing, University of Saskatchewan] Saskatoon, SK, Canada. https://harvest.usask.ca/handle/10388/12789

Director of Public Prosecutions Act, SC 2006.

eHealth Saskatchewan. (2015). *Guide to the Mental Health Services Act.* Government of Saskatchewan. http://www.ehealthsask.ca/services/resources/Resources/GuidetoTheMentalHealthServicesAct-Nov-2015.pdf

Farley, E. J. (2015, January). *A process evaluation of the Manhattan Mental Health Court*. New York, NY: The Center for Court Innovation. https://www.courtinnovation.org/sites/default/files/documents/MMHC%20Process%20Evaluation%20Final.pdf

Ferri, R. (2019). *Brief No 45*; *Desk appearance tickets and appearance rates - The benefits of court date reminders.* https://www.nycja.org/publications/brief-no-45-desk-appearance-tickets-and-appearance-rates-the-benefits-of-court-date-reminders

Field, A. P. (2009). *Discovering statistics using SPSS* (3rd ed.). Sage.

Gabor, T. (2015). *Costs of crime and criminal justice responses*. Public Safety Canada.

Government of Saskatchewan. (n.d.). *Alternatives to paying a provincial fine*. https://www.saskatchewan.ca/residents/justice-crime-and-the-law/courts-and-sentencing/alternatives-to-paying-a-provincial-fine.

Hahn, J. W. (2015). *New York State mental health courts: A policy study*. Center for Court Innovation. https://courtinnovation.org/sites/default/files/documents/MHC%20Policy%20Study%20Report_Final.pdf

Hartford, K., Heslop, L., Stitt, L., & Hoch, J. S. (2005). Design of an algorithm to identify persons with mental illness in a police administrative database. *International Journal of Law and Psychiatry, 28*(1), 1–11. https://doi.org/10.1016/j.ijlp.2004.12.001

Hora, P.F., Schma, W.G., & Rosenthal, J.T. (1999). Therapeutic Jurisprudence and the Drug Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America. *Notre Dame Law Review, 74*(2) 439-538. http://scholarship.law.nd.edu/ndlr/vol74/iss2/4

Human Services and Justice Coordinating Committee. (2017). *Mental health courts in Ontario: A review of the initiation and operation of mental health courts across the province.* HSJCC. https://ontario.cmha.ca/wp-content/uploads/2017/11/Mental-Health-Courts-in-Ontario-1.pdf

Lim, L. & Day, 2016). An examination of stakeholder attitudes and understanding of therapeutic jurisprudence in a mental health court. *International Journal of Law and Psychiatry, 46*, 27-34

Lowder, E. M., Rade, C. D., & Desmarais, S. L. (2018). Effectiveness of mental health courts in reducing recidivism: A meta-analysis. *Psychiatric Services, 69*(1), 15– 22.

Lurigio, A. J., & Snowden, J. (2009). Putting therapeutic jurisprudence into practice: The growth, operations, and effectiveness of mental health court. *The Justice System Journal, 30*, 196–218.

MacDonald, S.A., Bellot, C., Sylvestre, M. E., Dumais Michaud, A. A., & Pelletier, A. (2014). Tribunaux de santé mentale: Procédures, résultats et incidence sur l'itinérance.

Mathias, K., Zidenberg, A., Florchinger, C., Smith, B., Jewell, L. M., Wormith, J. S., & Luther, G. (2019). *Professionals' perceptions of the Saskatoon Mental Health Strategy (MHS) Court.* Centre for Forensic Behavioural Science and Justice Studies, University of Saskatchewan, Saskatoon, SK.

Mental Health Commission of Canada. (2013). *Aspiring workforce: Employment and income for people with serious mental illness*. MHCC.

Mental Health Commission of Canada. (2017). *Strengthening the case for investing in Canada's mental health system: Economic considerations*. MHCC Policy & Research Unit.

Mental Health Commission of Canada. (2018). *Reducing employment barriers for people living with a mental illness: Using evidence-based practices to inform Canada's mental health and employment policy framework*. MHCC.

Moreau, G (2019). *Police-reported crime statistics in Canada, 2018*. *Juristat.* Statistics Canada Catalogue no. 85-002-X. https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00013-eng.pdf

Nelson, S., & Wilson, K. (2017). The mental health of Indigenous peoples in Canada: A critical review of research. *Social Science & Medicine, 176*, 93–112. https://doi.org/10.1016/j.socscimed.2017.01.021

Perlman, C. M., Neufeld, E., Martin, L., Goy, M., & Hirdes, J. P. (2011). *Suicide risk assessment inventory: A resource guide for Canadian health care organizations*. Ontario Hospital Association and Canadian Patient Safety Institute. https://www.patientsafetyinstitute.ca/en/toolsResources/SuicideRisk/Documents/Suicide%20Risk%20Assessment%20Guide.pdf

Pooler, T. (2015). *Targeting the mental health needs of misdemeanor defendants: An impact evaluation of the Bronx Mental Health Initiative*. Center for Court Innovation. https://courtinnovation.org/sites/default/files/documents/BCSMHI.pdf

Public Prosecution Service of Canada. (2020). *Public Prosecution Service of Canada Deskbook: Judicial Referral Hearings*. https://www.ppsc-sppc.gc.ca/eng/pub/fpsd-sfpg/fps-sfp/tpd/p3/ch20.html

Rankin, J., & Regan, S. (2004). *Meeting complex needs in social care: The future of social care.* Turning Points/ Institute of Public Policy Research (IPPR). https://www.ippr.org/research/publications/meeting-complex-needsthe-future-of-social-care

Redlich, A.D., & Han,W. (2013). Examining the Links Between Therapeutic Jurisprudence and Mental Health Court Completion. *Law and Human Behavior, 38*(2), 109-118. DOI: 10.1037/lhb0000041

Reich, W. A. Picard-Fritsche, S., Lebron, L., & Hahn, J. W. (2015). Predictors of mental health court program compliance and re-arrest in Brooklyn, New York. *Journal of Offender Rehabilitation, 54,* 391–405. https://doi.org/10.1080/10509674.2015.1055035

Rossman, S. B., Willison, S. B., Mallik-Kane, K., Kim, K., Debus-Sherrill, S., & Downey, P. M. (2012). *Criminal justice interventions for offenders with mental illness: Evaluation of mental health courts in Bronx and Brooklyn, New York*. Urban Institute.

Schneider, R.D. (2008). Mental health courts. *Current Opinion in Psychiatry, 21,* 510–513

Schneider, R. D., Bloom, H., & Heerema, M. (2007). *Mental health courts: Decriminalizing the mentally ill*. Irwin Law.

Seto, M. C., Basarke, S., Healey, L. V., & Sirotich, F. (2018). Correlates of mental health diversion completion in a Canadian consortium. *International Journal of Forensic Mental Health, 17*(1), 1–12. https://doi.org/10.1080/14999013.2017.1405123

Stewart, M., & Mario, B. (2016). *Regina mental health disposition court: A formative investigation.* University of Regina, SK.

Saskatchewan Coroners Service. (2019). *Suicides by year, sex and age group 2005 to 2019*. https://publications.saskatchewan.ca/#/products/90866

Saskatchewan Law Courts. (n.d.-a). *Courts of Saskatchewan: Going to court.* https://sasklawcourts.ca/index.php/home/provincial-court/going-to-court

Saskatchewan Law Courts. (n.d.-b). *Courts of Saskatchewan: Saskatoon Mental Health Strategy.* https://sasklawcourts.ca/index.php/home/provincial-court/adult-criminal-court/saskatoon-mental-health-strategy

Manitoba Courts. (2019). *Mental Health Court Informational Sheet.* http://www.manitobacourts.mb.ca/site/assets/files/1080/mental_health_court_informational_sheet_april_2019.pdf

Walker, S. (2011). Sense and nonsense about crime, drugs, and communities. Wadsworth Pub Co.

Wiener, R. L., Winick, B. J., Georges, L. S., & Castro, A. (2010). A testable theory of problem solving courts: Avoiding past empirical and legal failures. *International Journal of Law and Psychiatry, 33*, 417–427. doi:10.1016/j.ijlp.2010.09.012

Winick, B. J. (2002). Therapeutic jurisprudence and problem solving courts. *Fordham Urban Law Journal, 30*, 1055–1103.

Wool, J., Shih, A., & Chang, M. (2019). *Paid in full: A plan to end money: Injustice in New Orleans*. Vera Institute of Justice. https://www.vera.org/downloads/publications/paid-in-full-report

Appendix A: Ethics Approval

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Approval
Study Amendment

PRINCIPAL INVESTIGATOR	DEPARTMENT	Beh #
Steve Wormith	Psychology	14-290

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT
Saskatoon Provinicial Court Building
220 19th Street East

STUDENT RESEARCHER(S)
Keith Barron, Courtney Florchinger, Krista Mathias

FUNDER(S)
INTERNALLY FUNDED

TITLE
Evaluation of the Saskatoon Mental Health Strategy Court (MHS Court)- Phase 2

APPROVAL OF	APPROVED ON	CURRENT EXPIRY DATE
Phase 2 Amendment: MHS Survey Invitations Information Sheet MHS Court Preliminary Outcomes Survey	29-Feb-2016	27-Aug-2016

Full Board Meeting ☐ Date of Full Board Meeting:

Delegated Review ☒

CERTIFICATION
The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: *http://research.usask.ca/for-researchers/ethics/index.php*

Vivian Ramsden, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to:
Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1602-110 Gymnasium Place
Saskatoon SK S7N 4J8
Telephone: (306) 966-2975 Fax: (306) 966-2069

Appendix B: Instant Case Descriptives

Number of Participants	89
Arrest Charge[1]	
Violent	40%
Non-Violent	57%
Property	*32%*
Drug	*2%*
Weapon	*2%*
Administrative and Other[2]	*21%*
Traffic	2%
Crime Severity Index Weight	87.38 (100.38)
Conviction[1]	74%
Violent	26%
Non-Violent	46%
Property	*29%*
Drug	*1%*
Weapon	*2%*
Administrative and Other[2]	*14%*
Traffic	2%
Crime Severity Index Weight	69.99 (102.49)
Court Appearances[3]	15.75 (9.75)
Mental Health Court	5.191 (4.54)
Non-Mental Health Court	9.66 (7.90)
Disposition	
Absolute Discharge	2%
Conditional Discharge	11%
Sentence	
Community Service	0%
Jail Sentence	19%
Probation Sentence	47%
Suspended Sentence	25%
Fine	12%
Conditional Sentence	11%
Unknown Sentence	10%

[1] Charges were coded as three mutually exclusive categories: violent, non-violent, and traffic. Non-violent were further broken down into property, drug, weapons, and administrative & other charges. If there were multiple charges in the charge, the charge with the highest crime severity index weight was used as the 'topcharge' (most serious charge) and less serious charges were not counted to avoid overcounting charges.

[2] The vast majority of "Administrative and Other" were administrative charges (78%).

[3] Six participants missed 1 court appearance each.

Note: If an arrest/conviction had multiple charges, the charge with the highest score on the crime severity index was used to determine the most serious charge. Less serious charges are not counted, to avoid over counting arrests and convictions.

Appendix C: Criminal Record (3 Year Priors)

Participants=89	Arrests	Convictions
Three (3) year priors		
Any Charge	80%	56%
Mean # of Charges	6.96 (8.49)	4.09 (6.34)
Any Violent Charge	45%	34%
Mean # of Violent Charges	0.71 (.98)	0.46 (.76)
Any Non-Violent Charge	74%	48%
Mean # of Non-violent Charges	*6.18 (8.21)*	*3.57 (6.03)*
Any Property Charge	*49%*	*27%*
Mean # of Property Charges	*1.24 (1.92)*	*0.8 (1.75)*
Any Drug Charge	*7%*	*8%*
Mean # of Drug Charges	*0.07 (.25)*	*0.11 (.44)*
Any Weapons Charge	*9%*	*5%*
Mean # of Weapons Charges	*0.12 (.45)*	*0.07 (.33)*
Any Administrative and Other Charge	*67%*	*42%*
Mean # of Administrative and Other Charges	*4.75 (6.99)*	*2.6 (4.84)*
Any Traffic Charge	7%	5%
Mean # of Traffic Charges	0.07 (.25)	0.06 (.28)
Crime Severity Index Weight		
CSI Weight (most serious charge only)	325.70 (434.05)	199.02 (333.78)

Note. Charges were coded as three mutually exclusive categories: violent, non-violent, and traffic. Non-violent were further broken down into property, drug, weapons, and administrative & other charges. If there were multiple charges in the charge, the charge with the highest crime severity index weight was used as the 'topcharge' (most serious charge) and less serious charges were not counted to avoid over counting charges.

Appendix D: Court Case Record (3 Year Priors)

Participants=89	Pre-Program Entry
Three (3) year priors	
Any Court Case	73%
Mean # of Court Cases	5.98 (8.47)
Mean # of Charges	8.70 (12.35)
Any Homicide Court Case	*1%*
Mean # of Homicide Court Cases	*0.01 (0.11)*
Any Rape Court Case	*3%*
Mean # of Rape Court Cases	*0.04 (.26)*
Any Aggravated Assault Court Case	*2%*
Mean # of Aggravated Assault Court Cases	*0.02 (.15)*
Any Assault Court Case	*36%*
Mean # of Assault Court Cases	*0.51 (.77)*
Any Robbery Court Case	*3%*
Mean # of Robbery Court Cases	*0.06 (.35)*
Any Motor Vehicle Theft Court Case	*26%*
Mean # of Motor Vehicle Theft Court Cases	*0.56 (1.25)*
Any Arson Court Case	*1%*
Mean # of Arson Court Cases	*0.01 (.11)*
Any Burglary Court Case	*7%*
Mean # of Burglary Court Cases	*0.09 (.36)*
Any Theft Court Case	*12%*
Mean # of Theft Court Cases	*0.16 (.45)*
Any Fraud Court Case	*0%*
Mean # of Fraud Court Cases	*.00 (.00)*
Any Youth Criminal Justice Act Court Cases	*5%*
Mean # of Youth Criminal Justice Act Court Cases	*0.37 (2.60)*
Any Administrative and Other Court Case	*63%*
Mean # of Administrative and Other Court Cases	*4.15 (6.81)*

Note. Court case categories are mutually exclusive. For cases with multiple charges, the case was coded based on the most serious charge using the following order: Homicide, Rape, Aggravated Assault, Assault, Robbery, Motor Vehicle Theft, Arson, Burglary, Theft, Fraud, YCJA and Other. Thus, for court case variables, if a case had both an assault and a burglary charge, it was coded as an 'Assault' case. This coding ensures cases are not counted multiple times. 'Mean # of Charges' provides the total charges. Thus, if a case had 5 charges, all 5 charges were counted in this variable.

Appendix E: Cost Computation (Administrative and non-Administrative Cases)

Cost Category	Mean Cost	Mean Cost (Outliers Removed)	Median Cost	Minimum Cost	Maximum Cost
Prior Cases (2 year)	N=357 Cases				
Victims' Tangible/Direct	$ 14,309,670.67	$ 7,511,621.71	$ 4,983,827.06	$ 836,528.75	$ 73,473,688.58
Victims' Intangible / no data	$ 18,379,262.30	$ 10,229,295.01	$ 11,564,197.99	$ 1,443,010.57	$ 86,445,789.26
CJS Costs	$ 2,508,328.98	$ 2,275,128.72	$ 2,149,940.50	$ 713,876.34	$ 4,933,769.63
Criminal Career Costs	$ 909,817.69	$ 909,082.16	$ 909,082.16	$ 737,983.80	$ 1,113,699.99
Total Cost	**$ 36,106,772.09**	**$ 20,925,127.61**	**$ 19,607,047.70**	**$ 3,731,399.46**	**$ 165,966,947.45**
Prior Cases, excluding homicide (2 year)	N=356 Cases				
Victims' Tangible/Direct	$ 12,807,600.20	$ 6,289,494.88	$ 3,571,041.55	$ 754,849.32	$ 68,311,677.96
Victims' Intangible / no data	$ 14,552,109.02	$ 7,190,456.20	$ 8,124,258.63	$ 839,683.07	$ 76,241,552.33
CJS Costs	$ 2,109,664.99	$ 1,875,545.74	$ 1,778,426.25	$ 657,505.22	$ 4,195,569.74
Criminal Career Costs	$ 733,348.58	$ 732,613.05	$ 732,613.05	$ 564,610.89	$ 934,134.68
Total Cost	**$ 30,202,415.24**	**$ 16,088,109.88**	**$ 14,206,339.47**	**$ 2,816,648.50**	**$ 149,682,934.70**
Prior Cases (1 year)	N=145 Cases				
Victims' Tangible/Direct	$ 5,310,634.48	$ 2,579,376.49	$ 1,455,757.29	$ 304,712.47	$ 28,840,593.01
Victims' Intangible / no data	$ 5,980,331.94	$ 3,011,814.81	$ 3,404,980.43	$ 334,755.38	$ 31,052,794.09
CJS Costs	$ 881,254.33	$ 785,948.95	$ 746,966.77	$ 269,797.10	$ 1,747,774.31
Criminal Career Costs	$ 316,285.21	$ 318,775.35	$ 318,775.35	$ 247,041.31	$ 397,226.66
Total Cost	**$ 12,488,385.96**	**$ 6,695,915.60**	**$ 5,926,479.84**	**$ 1,156,306.26**	**$ 62,038,388.07**
Instant Case	N=89 Cases				
Victims' Tangible/Direct	$ 3,807,254.03	$ 1,890,811.75	$ 758,432.18	$ 139,542.03	$ 19,290,294.88
Victims' Intangible / no data	$ 4,790,115.07	$ 1,693,976.65	$ 1,850,079.26	$ 169,444.87	$ 30,430,384.48
CJS Costs	$ 496,292.63	$ 447,062.70	$ 428,463.01	$ 139,482.46	$ 985,582.66
Criminal Career Costs	$ 154,402.81	$ 154,258.98	$ 154,258.98	$ 120,754.50	$ 193,637.41
Total Cost	**$ 9,248,004.99**	**$ 4,186,110.09**	**$ 3,191,233.42**	**$ 569,223.86**	**$ 50,899,899.42**
Recidivism Cases (1 year)	N=336 Cases				
Victims' Tangible/Direct	$ 11,656,635.74	$ 5,883,394.76	$ 3,500,044.97	$ 709,736.94	$ 61,002,798.71
Victims' Intangible / no data	$ 12,915,235.73	$ 6,403,958.98	$ 7,238,958.24	$ 760,618.83	$ 67,369,381.41
CJS Costs	$ 1,911,275.08	$ 1,693,144.51	$ 1,604,678.05	$ 595,751.45	$ 3,820,634.26
Criminal Career Costs	$ 657,977.02	$ 655,924.55	$ 655,924.55	$ 504,539.88	$ 841,608.52
Total Cost	**$ 27,140,832.90**	**$ 14,636,422.80**	**$ 12,999,605.80**	**$ 2,570,647.10**	**$ 133,034,422.90**
Recidivism Cases (2 year)	N=555 Cases				
Victims' Tangible/Direct	$ 19,438,781.87	$ 9,757,608.14	$ 5,693,212.97	$ 1,176,213.88	$ 102,103,590.37
Victims' Intangible / no data	$ 21,635,701.00	$ 10,571,632.95	$ 11,920,486.94	$ 1,247,097.64	$ 114,172,535.83
CJS Costs	$ 3,165,210.05	$ 2,811,083.04	$ 2,668,168.30	$ 986,866.31	$ 6,306,486.63
Criminal Career Costs	$ 1,088,345.70	$ 1,088,662.35	$ 1,088,662.35	$ 835,828.81	$ 1,386,820.38
Total Cost	**$ 45,327,577.29**	**$ 24,228,986.48**	**$ 21,370,530.57**	**$ 4,246,006.64**	**$ 223,969,433.21**

Appendix F: Cost Computation (Non-Administrative Cases)

Cost Category	Mean Cost	Mean Cost (Outliers Removed)	Median Cost	Minimum Cost	Maximum Cost
Instant Case			N=49 Cases		
Victims' Tangible/Direct	$ 2,390,412.21	$ 1,200,305.62	$ 302,358.31	$ 38,826.25	$ 11,483,994.48
Victims' Intangible / no data	$ 3,269,279.16	$ 788,638.83	$ 811,617.57	$ 60,332.07	$ 23,655,387.10
CJS Costs	$ 235,966.67	$ 215,507.06	$ 209,651.59	$ 54,296.02	$ 473,016.70
Criminal Career Costs	$ 58,464.19	$ 58,417.51	$ 58,417.51	$ 46,305.48	$ 71,785.05
Total Cost	**$ 5,954,098.23**	**$ 2,262,869.02**	**$ 1,382,044.98**	**$ 199,759.82**	**$ 35,684,183.33**
Prior Cases (2 year)			N=74 Cases		
Victims' Tangible/Direct	$ 4,285,514.78	$ 2,626,290.82	$ 1,757,104.45	$ 123,964.62	$ 18,244,113.25
Victims' Intangible / no data	$ 7,619,348.23	$ 3,824,029.92	$ 4,217,081.54	$ 671,037.51	$ 38,512,682.81
CJS Costs	$ 666,522.84	$ 636,872.54	$ 601,849.69	$ 111,182.25	$ 1,307,365.49
Criminal Career Costs	$ 231,051.94	$ 231,003.78	$ 231,003.78	$ 211,256.97	$ 251,594.57
Total Cost	**$ 12,802,381.79**	**$ 7,318,197.06**	**$ 6,807,039.46**	**$ 1,117,441.35**	**$ 58,315,756.12**
Recidivism Cases (2 year)			N=135 Cases		
Victims' Tangible/Direct	$ 4,561,942.74	$ 2,507,293.74	$ 904,437.37	$ 118,698.21	$ 20,137,436.17
Victims' Intangible / no data	$ 5,666,923.93	$ 1,065,585.82	$ 1,016,639.21	$ 101,413.24	$ 43,035,063.36
CJS Costs	$ 431,787.52	$ 379,748.77	$ 370,648.37	$ 92,408.64	$ 924,544.10
Criminal Career Costs	$ 80,990.17	$ 82,326.95	$ 82,326.95	$ 54,114.08	$ 107,370.65
Total Cost	**$ 10,741,556.36**	**$ 4,034,955.28**	**$ 2,374,051.90**	**$ 366,634.17**	**$ 64,204,414.28**
Prior Cases (1 year)			N=28 Cases		
Victims' Tangible/Direct	$ 1,166,372.15	$ 559,646.05	$ 121,741.23	$ 10,118.82	$ 6,007,164.34
Victims' Intangible / no data	$ 1,531,886.90	$ 363,701.68	$ 367,479.99	$ 15,600.44	$ 11,235,926.76
CJS Costs	$ 119,800.91	$ 108,648.69	$ 106,943.36	$ 20,626.75	$ 248,518.89
Criminal Career Costs	$ 35,664.74	$ 38,439.06	$ 38,439.06	$ 29,277.92	$ 40,808.52
Total Cost	**$ 2,853,708.70**	**$ 1,070,435.48**	**$ 634,603.64**	**$ 75,623.93**	**$ 17,532,418.51**
Recidivism Cases (1 year)			N=81 Cases		
Victims' Tangible/Direct	$ 2,624,269.12	$ 1,481,418.16	$ 592,574.07	$ 67,673.86	$ 11,237,633.66
Victims' Intangible / no data	$ 3,219,906.80	$ 632,430.36	$ 618,764.97	$ 65,024.73	$ 24,178,773.13
CJS Costs	$ 251,697.11	$ 216,977.28	$ 209,755.23	$ 52,687.87	$ 553,026.29
Criminal Career Costs	$ 46,368.30	$ 44,935.20	$ 44,935.20	$ 29,927.36	$ 64,799.75
Total Cost	**$ 6,142,177.33**	**$ 2,375,761.00**	**$ 1,466,029.47**	**$ 215,313.82**	**$ 36,034,232.83**

Appendix G: Cost Computation (Administrative Cases)

Cost Category	Mean Cost	Mean Cost (Outliers Removed)	Median Cost	Minimum Cost	Maximum Cost
Instant Case			N=40 Cases		
Victims' Tangible/Direct	$ 1,416,841.82	$ 690,506.13	$ 456,073.87	$ 100,715.78	$ 7,806,300.40
Victims' Intangible / no data	$ 1,520,835.91	$ 905,337.82	$ 1,038,461.69	$ 109,112.80	$ 6,774,997.38
CJS Costs	$ 260,325.96	$ 231,555.64	$ 218,811.42	$ 85,186.44	$ 512,565.96
Criminal Career Costs	$ 95,938.62	$ 95,841.47	$ 95,841.47	$ 74,449.02	$ 121,852.36
Total Cost	**$ 3,293,906.76**	**$ 1,923,241.07**	**$ 1,809,188.44**	**$ 369,464.04**	**$ 15,215,716.09**
Prior Cases (2 year)			N=283 Cases		
Victims' Tangible/Direct	$ 10,024,155.89	$ 4,885,330.89	$ 3,226,722.61	$ 712,564.13	$ 55,229,575.33
Victims' Intangible / no data	$ 10,759,914.07	$ 6,405,265.09	$ 7,347,116.45	$ 771,973.06	$ 47,933,106.45
CJS Costs	$ 1,841,806.14	$ 1,638,256.18	$ 1,548,090.81	$ 602,694.09	$ 3,626,404.14
Criminal Career Costs	$ 678,765.75	$ 678,078.38	$ 678,078.38	$ 526,726.83	$ 862,105.42
Total Cost	**$ 23,304,390.30**	**$ 13,606,930.55**	**$ 12,800,008.24**	**$ 2,613,958.11**	**$ 107,651,191.33**
Recidivism Cases (2 year)			N=420 Cases		
Victims' Tangible/Direct	$ 14,876,839.13	$ 7,250,314.40	$ 4,788,775.60	$ 1,057,515.67	$ 81,966,154.20
Victims' Intangible / no data	$ 15,968,777.07	$ 9,506,047.13	$ 10,903,847.73	$ 1,145,684.40	$ 71,137,472.47
CJS Costs	$ 2,733,422.53	$ 2,431,334.27	$ 2,297,519.93	$ 894,457.67	$ 5,381,942.53
Criminal Career Costs	$ 1,007,355.53	$ 1,006,335.40	$ 1,006,335.40	$ 781,714.73	$ 1,279,449.73
Total Cost	**$ 34,586,020.93**	**$ 20,194,031.20**	**$ 18,996,478.67**	**$ 3,879,372.47**	**$ 159,765,018.93**
Prior Cases (1 year)			N=117 Cases		
Victims' Tangible/Direct	$ 4,144,262.33	$ 2,019,730.44	$ 1,334,016.06	$ 294,593.65	$ 22,833,428.67
Victims' Intangible / no data	$ 4,448,445.04	$ 2,648,113.13	$ 3,037,500.44	$ 319,154.94	$ 19,816,867.33
CJS Costs	$ 761,453.42	$ 677,300.26	$ 640,023.41	$ 249,170.35	$ 1,499,255.42
Criminal Career Costs	$ 280,620.47	$ 280,336.29	$ 280,336.29	$ 217,763.39	$ 356,418.14
Total Cost	**$ 9,634,677.26**	**$ 5,625,480.12**	**$ 5,291,876.20**	**$ 1,080,682.33**	**$ 44,505,969.56**
Recidivism Cases (1 year)			N=255 Cases		
Victims' Tangible/Direct	$ 9,032,366.62	$ 4,401,976.60	$ 2,907,470.90	$ 642,063.08	$ 49,765,165.05
Victims' Intangible / no data	$ 9,695,328.93	$ 5,771,528.62	$ 6,620,193.27	$ 695,594.10	$ 43,190,608.28
CJS Costs	$ 1,659,577.97	$ 1,476,167.23	$ 1,394,922.82	$ 543,063.58	$ 3,267,607.97
Criminal Career Costs	$ 611,608.72	$ 610,989.35	$ 610,989.35	$ 474,612.52	$ 776,808.77
Total Cost	**$ 20,998,655.57**	**$ 12,260,661.80**	**$ 11,533,576.33**	**$ 2,355,333.28**	**$ 97,000,190.07**