An Integrated Approach to Complex Cases: Adults with Intellectual Disabilities, Mental Health Disorders, and Criminal Involvement

A Research Practicum Report

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Abstract

This research report is a local current state review of supports and services available to individuals with intellectual disabilities (IWID), mental health disorders (MHD), and/or criminalized behavior. These individuals can be referred to as complex cases due to the diversity and extensiveness of their support needs. People with intellectual disabilities are a vulnerable population within our society. The addition of a mental health disorder and/or criminal involvement results in further oppression and marginalization of this group of individuals. Due to the complexity of their support needs, the government agencies responsible for providing services and support are struggling to adequately serve these individuals. The Ministry of Social Services, Justice, Health, and the Saskatchewan Health Authority, have joined together in a collaborative task team to address this issue and ultimately develop a new service model to better meet the needs of these complex clients. This document will include an extensive literature review on the factors affecting this population along with identified best practices for supporting complex clients. In addition, a local review of programs and services within the community of Saskatoon will be explored to identify service gaps complex clients face. Finally, recommendations will be made for service development for IWID and complex support needs.
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Chapter 1: Introduction

This research practicum report will provide a review of best practices, services, and supports for complex clients, adults with intellectual disabilities and co-existing mental health disorders and/or criminalized behavior. I participated in a project led by Community Living Service Delivery (CLSD), a division of Disability Programs with the Saskatchewan Ministry of Social Services. The project was the Integrative Approach to Complex Cases (IACC). The goal of this project was to have collaboration with the Ministry of Justice, Ministry of Health, and the Saskatchewan Health Authority to develop a comprehensive service model that will allow the various agencies to safely support clients with complex needs in the community. The purpose of the research practicum was to determine best practices of how to provide these services within the community. Appreciative Inquiry (AI) was used to explore the current state of programs and services offered in Saskatoon to this target population. In addition to a local review, an extensive literature review was conducted to explore research within this area of focus. The literature reviewed highlighted models of best practices for supporting individuals with intellectual disabilities (IWID) and complex support needs along with recommendations for interdisciplinary work across government ministries and agencies.

Working in the disability field for the past five years with CLSD I have had the opportunity to work alongside and support IWID and complex support needs. I observed many barriers and gaps in services for this population specifically around mental health supports. I developed a strong motivation to try and make a change for these individuals. As the literature highlights, IWID have high rates of concurrent Mental Health Disorders (MHD) (Torr, 2013). Unfortunately, there is a significant gap in knowledge and programs available to offer treatment and support to these individuals. Without adequate supports, services, or an acknowledgement of
the lived experiences of the individual, mental health needs go unmet and often manifest into behaviour; primarily violence and physical aggression to oneself or others (Lunsky, Lake, Balogh, Weiss, & Morris, 2013). This is what is observed in the community and attracts attention due to safety concerns for the individual and community members. The underlying unmet mental health need is overlooked and labelled as a “behavioural problem” as the behaviour is what is observed and overshadows the underlying cause for the behaviour (Torr, 2013). These omissions result in a vulnerable group of individuals not receiving the support they need to live a happy and healthy life. They experience high police involvement or hospitalization due to the violent behavior that is observed as unsafe and dangerous in the community.

Walking alongside clients as they have experienced this difficult journey has driven me to advocate for social justice, equality, and the right for IWID to access supports and service within their own community. Having an intellectual disability should not prevent any person from accessing services that individuals without an intellectual disability have access to. It is not my belief that our community is intentionally discriminating against this group of complex individuals, rather we are at a loss of how to support them. Being aware of this is the first step towards making change. Our community leaders from the Ministry of Social Services, Health, Justice, and the Saskatchewan Health Authority have acknowledged this gap in services. This is demonstrated by their commitment to the IACC project as they work collaboratively towards acting and bringing about change in Saskatchewan.

For my research I was part of an inter-agency task team developing a collaborative service model that will allow systems to safely support individuals with complex support needs. The task team was comprised of the Ministry of Social Services, Justice, Health, and the Saskatchewan Health Authority. Community Living Service Delivery was the lead agency for
the project and who I worked with for this practicum. The IACC project was in the preliminary stages when I joined the team. The CLSD representatives had been continually conducting research while collaborating with the partnering agencies to bring the IACC project forward and obtain the support from the Assistant Deputy Minister, Deputy Minister and Minister of Social Services. This project is identified as a priority in the Ministry of Social Services tactical plan and the team is required to provide quarterly status updates. The tactical plan is a collection of initiatives or projects that are identified as a priority for the Ministry. These prioritized items are allocated time and resources to complete the required work needed to reach the desired outcome or change. Quarterly reports and updates are required to illustrate the progress of each project to ensure the teams are meeting their identified targets in achieving their expected outcomes.

The inter-agency task team was assembled to develop a new service delivery model and residential resource for complex clients in Saskatchewan. The IACC Project Charter (Appendix A) is a document used by the team which outlines the project description, objectives, responsibilities, and timeline. The Project Charter was accepted by all IACC team members, initiating the beginning of the collaborative work. Complex clients are identified within this document as individuals who have highly specialized, intensive, or unique service needs, which in their absence, could lead to serious and negative outcomes for the individual. These clients have multi-system involvement such as with justice, mental health, disability services, and due to their complex needs they require significant time, energy, resources and support. The team identified that due to the current lack of system collaboration, there is a significant strain on each service system. The service systems referred to within this research document are Disability Services, Justice, and Mental Health. These ministries and departments each have different
mandates and responsibilities for the programs and services they offer within Saskatchewan. The impact of complex cases on these systems is the time and resources allocated from each department in attempts to adequately support the client. Due to the complexity of each individual’s support needs, they experience higher levels of placement breakdown, have higher recidivism rates within the criminal justice system and repeated admissions to mental health facilities (MSS, 2018b).

The IACC project started in 2015 and continued to be in the early stages in June 2018. My learning goals and objectives were developed in line with the IACC Project Charter and the project’s current state. These goals and objectives while working on the IACC project were to complete an extensive literature review on best practices to provide recommendations to the team. In addition, I conducted a community program inventory to specifically examine what programs and services were being offered in Saskatoon to IWID and complex support needs. Through this exploration, I was able to provide the team with a local current state assessment while bringing in data and evidence from the broader research in this field to inform the team and build project engagement.

Engagement of the various task team members was a key step required to gather momentum and ensure there was equal buy-in from all parties involved. Community Living Service Delivery was the lead agency and the only members actively doing research and data collection for the project during the preliminary stages. Their goal was to use the data they had collected around complex clients to engage the other members in hopes they would allocate more of their time and resources to the project. Data that was shared focused on costs allocated to housing complex clients in inappropriate resources, such as acute care facilities, jail, or other high cost resources. In addition, information was included around a real case example that
illustrated the complexity of client needs and the high level of resource allocation required from each agency in attempts to adequately support complex clients.

Focusing on cross-agency collaboration and service development, Appreciative Inquiry (AI) stood out as an appropriate framework to apply to this project. AI is an approach that incorporates positive psychology to facilitate new ideas, alternatives, enthusiasm, and commitment from all people involved from a strengths-based perspective (Whitney & Trosten-Bloom, 2010). This approach can be used when working towards organizational change or when looking to increase cross agency capacity (Whitney & Trosten-Bloom, 2010). AI stood out as a positive way to build engagement and enthusiasm from the broader team. The AI approach was used for this research and data collection with the overall goal of sharing information back to the team in a way that facilitated discussion around new ideas and opportunities for service expansion.

The purpose of this research was to determine best practices to support complex individuals in the community while examining the current state of the existing programs and services within Saskatchewan. The following literature review is focused on adults with intellectual disabilities with concurrent mental health disorders and/or criminal involvement. Models of best practice for service delivery and support for this group of complex individuals is summarized, and recommendations are made for future service development.
Chapter 2: Literature Review

2.1 Adults with Intellectual Disabilities and Co-Morbid Mental Health Disorders

Intellectual disabilities are diagnosed in individuals under the age of 18 who have an IQ below 70 and severe impairments in their adaptive functioning (American Psychiatric Association, 2013). Individuals with intellectual disabilities are at a higher risk of developing mental health disorders (MHD) such as anxiety, depression, or attention deficit/hyper-activity disorder (APA, 2013). Recent findings have shown that individuals with intellectual disabilities (IWID) are 3-4 times more likely to develop a co-morbid psychiatric disorder, which is a 30-40% prevalence rate (NADD, 2018). Individuals with intellectual disabilities also have a lower threshold for experiencing trauma (Razza & Tomasulo, 2005). Trauma or other MHD often manifest as behaviours for IWID, resulting in high levels of diagnostic overshadowing (Torr, 2013). Torr (2013) completed a review of Australian research focusing on studies of prevalence, vulnerability/risk, and protective factors for IWID and MHD. This review found that IWID were being denied mental health services as they were deemed to have behaviour disorders as opposed to an MHD (Torr, 2013). This diagnostic overshadowing prevents IWID from receiving the proper treatment and services, resulting in inadequate care and support.

Standard treatment for mental health disorders for individuals without an intellectual disability will vary based on the individual, but often include a combination of medication and therapeutic intervention (Lunsky, Garcin, Morin, Cobigo, & Bradley, 2007). Acute or crisis-based psychiatric interventions are often referred to as inpatient services, meaning the individual is admitted into a hospital for treatment and monitoring until their symptoms are stabilized, when they are no longer a threat to themselves or the community (Lunsky et al., 2013). Outpatient services are intended to provide ongoing support and treatment for individuals living in the
community with the goal of ameliorating the need for inpatient treatment (Lunsky et al., 2013). Currently in Canada there is no national policy which directs healthcare for IWID and mental health needs (Lunsky et al., 2007). As a result, IWID do not receive the same standardized treatment. Therapeutic intervention and specialized mental health services are less accessible for IWID than for individuals without intellectual disabilities, and in some cases non-existent (Lunsky et al. 2007; Lunsky et al., 2013; Torr, 2013). Lunsky et al. (2007) found that clinicians are not comfortable or trained to provide therapy to IWID resulting in medication being the primary treatment for MHD for IWID.

The lack of national policy and direction for dual diagnoses treatment illustrates the importance and need for further exploration in this area of research. IWID are a vulnerable population who are at a greater risk to face oppression and barriers in their daily life (Hamdani, Ayelet, & Lunsky, 2017). Since 1982, IWID have been protected under the Canadian Charter of Rights and Freedoms to be treated with equality and to receive the same level of health care supports as other Canadians (Government of Canada, 2016b). More recently, Canada has adopted the Convention on the Rights of Persons with Disabilities (2010) under the United Nations Human Rights which protects the rights to equality and non-discrimination of persons with disabilities (Government of Canada, 2018). As a vulnerable and protected group, it is imperative that adequate mental health services are available to them.

2.1.1 Lack of policy for mental health services.

The Canadian Health Care Act requires each province to be responsible for the provision of health services and does not have any guidelines specific to services for IWID (Government of Canada, 2016a). Lunsky et al. (2007) reviewed various policy documents from the United Kingdom and United States. They found that national policy existed regarding the provision of
mental health services for IWID (Lunsky et al., 2007). These are valuable findings as it highlights the existence of national policies in other parts of the world, which have been created to protect and ensure adequate services are in place for IWID. Without a Canadian national policy, the responsibility is placed at a provincial level (Lunsky et al., 2007). This approach appears to be inadequate as there are insufficient provincial guidelines impacting the existence of specialized services for IWID (Lunsky et al., 2007). Lunsky et al.’s (2007) findings illustrated that the generic service model is not enough for IWID and greater access to specialized services is needed along with the training and education to develop these supports. Concerned Canadian organizations have recognized the need for a federal policy and as a result have created an association for persons with developmental disabilities and mental health needs (NADD) (NADD, 2018). This group was organized in 2008 with the goal of advocating for the inclusion of IWID into the work of the Mental Health Commission of Canada (Bradley & Cheetham, 2010). NADD has published research within this area, held national conferences, and hosts training and consultations worldwide.

The impact of not having a national policy has resulted in inadequate services and an inability for provinces to be held accountable for their standards of service provision (Lunsky et al., 2013). If provinces are not being held accountable there is a major concern regarding the quality and appropriateness of services (Lunsky et al., 2007). Research by Lunsky et al. (2013) provides a relatively recent account of current policy in Canada with respect to mental health services for IWID. Their findings illustrate that the lack of current research in this area will continue to directly influence the lack of policy development and implementation (Lunsky et al., 2013). Lunsky et al. (2013) identified from their national survey, “The organization and delivery of health, mental health, and social care, therefore, remains varied across the different provinces
and territories with availability of specialized mental health services for people with intellectual disabilities being inconsistent and unevenly distributed” (p. 107). The only nationally observed policy in Canada is the UN Convention on the Rights of Persons with Disabilities which upholds the rights to equality of IWID but does not address mental health care specifically (Lunsky et al., 2013). The work of IACC and this project is bringing attention and awareness to a much-needed area of research with the goal of developing a new service model to support individuals with intellectual disabilities (IWID) and mental health disorders (MHD).

2.1.2 Shift in care and provision of services.

Historically, IWID were sent to live in institutions which negatively shaped the perceptions people held about IWID (Whitehouse, Tudway, Look, & Kroese, 2006). Perceptions are now shifting to acknowledge that IWID have the same emotional experiences as any other person (Whitehouse et al., 2006). In many parts of the world, IWID are now supported to live independently within their community (Hamdani et al., 2017; Lunsky et al., 2007; Lunsky et al., 2013; Torr, 2013). In Saskatchewan, residential services for adults with intellectual disabilities are in contract with CLSD and Community Based Organizations. They are regulated by The Residential Services Act (2017), The Rehabilitation Act (2014), Fire Code, and Comprehensive Personal Planning and Support Policy (CPP & SP) (2017). The legislation that protects the rights and freedoms of the client is the CPP & SP. This policy has been developed by the Ministry of Social Services Disability Programs department to ensure the rights of the clients are upheld.

Deinstitutionalization has shifted the provision of services from being the responsibility of the institution to be the responsibility of community service providers (Lunsky et al., 2007). As the community adjusts to the impacts of deinstitutionalization, correctional facilities or acute care units are often where IWID are placed when safety concerns arise in their home or within
the community. This shift in responsibility has been provided as a rationale for why mental health services are not being properly administered in the community (Torr, 2013). Standards are currently being developed and tested in communities focusing on interdisciplinary care for IWID to better respond to the diverse needs of this population (Bradley & Cheetham, 2010). Best practices identified in The Framework Report (Simpson, Martin, & Green, 2001) recommended interdisciplinary supports and treatment as the best approach for working with IWID and MHD particularly, teams comprised of counsellors, case managers, addictions workers, outreach, and psychiatry. An integrated approach to supporting IWID and MHD has been demonstrated among the literature reviewed as best practice (Hamdani et al., 2017; Lunsky et al., 2013; Kaehne, 2011; Torr, 2013), which aligns with the goals and objectives of the IACC project.

2.1.3 Provision of services.

Individuals with a dual diagnosis have significantly higher rates of hospitalization for mental health treatment (Lunsky et al., 2013). In Lunsky et al.’s (2013) review, inpatient services are often for behavioural management and assessment. This treatment is crisis-based and in response to a lack of suitable community intervention. Bradley & Cheetham (2010) highlight that there are no medication guidelines specific to IWID. This is a limitation in treatment that will have a negative impact on inpatient care and has been identified by scholars as creating a lack of research and standards for treatment (Bradley & Cheetham, 2010; Lunsky et al., 2013). Adequate outpatient services and support is one way to help decrease psychiatric hospitalization for IWID and assist with the transition to outpatient services (Lunsky et al., 2013).

Improved outpatient services would mean that IWID and mental health diagnoses are connected to the appropriate professional networks to ensure they are receiving support and treatment in their community. Lunsky et al. (2007) conducted a national survey to inquire about
mental health services for IWID in Canada. Their questionnaire was administered to frontline professionals and clinicians in this area of practice, and focused on mental health staff, services, and the perceived view of the levels of adequacy in services (Lunsky et al., 2007). Their findings indicated inadequate specialized services in many areas of Canada, specifically a need for training regarding intellectual disability services. It was found that the generic service model is not appropriate for IWID and as a result the needs of this population are not being met (Lunsky et al., 2007). The response rate was quite low at 35% with equal representation across the country (Lunsky et al., 2007). From the questionnaires returned, 52% came from professionals working within the intellectual disability services field, 36% from professionals in the health sector, 11% from clinicians and researchers, and 9% from policy makers (Lunsky et al. 2007). Although the low response rate limits the generalizability of the outcomes, it remains another piece of national level research reinforcing that insufficient services exist for IWID with mental health diagnoses.

Another identified problem with mental health services for IWID is the lack of clarity regarding the transition from child and youth mental health services to adult mental health services in addition to accessing adult disability services after aging out of youth services (Kaehne, 2011). For IWID, planning for adult services, such as residential or vocational placements, takes place months, and even years before their schooling is complete. Kaehne (2011) reiterates that transitions are stressful and important times for IWID and there is a complexity involved in the transition to adult mental health services. Kaehne (2011) conducted semi-structured interviews to examine the views of mental health professionals from three local agencies in Wales on the collaborative work and transition for youth with intellectual disabilities. Themes from the findings indicated that no specialized services exist for IWID, knowledge
regarding adult criteria for a diagnosis of an MHD was limited, and there was poor coordination for transition planning. Many service gaps were highlighted in this study that bring attention to the underdevelopment of transition planning within mental health services for IWID. Limitations include a small sample size and that the study was conducted in Wales, so it is difficult to determine how these results may apply to agencies in Canada. It does recommend future research and exploration in the area of transition and service delivery to IWID needing mental health services. Existing research identifies a need for the development of mental health services for IWID. Not having access to these supports not only impacts the individuals overall mental health and well-being but can be correlated to an increased risk for criminal involvement (Riches, Parmenter, Wiese, & Stancliffe, 2006).

2.2 IWID Involvement with the Criminal Justice System

The literature reviewed illustrated an overrepresentation of IWID in the corrections system (Riches et al., 2006). Riches et al. (2006) examined various studies to determine the prevalence of IWID in the criminal justice system. The primary data by White (1991) on this area of focus shows that in the USA 11% of inmates on death row had an intellectual disability (as cited in Everington & Fulero, 1999). Hayes (2000) illustrated that New South Wales prisons indicated that up to 20% of their inmate population had an intellectual disability (as cited in Riches et al., 2006). Although these numbers are not representative of all communities, it does give a representation of what could be expected within our own justice systems. Increasing research has been conducted illustrating significant correlation of MHD as a factor increasing criminalized behaviour for IWID (Riches et al., 2006; Burke, Griggs, Dykens, & Hodapp, 2012; Lindsay et al., 2006). Riches et al. (2006) stated that as a result of diagnostic overshadowing and a lack of mental health services for IWID, an increase in challenging behaviour occurs, which
can escalate to a level which involves criminal charges. Diagnostic overshadowing is described as “ascribing the symptoms of mental illness to the person’s life-long intellectual or developmental disability” (Riches et al., 2006, p. 388). They also found that prison is often a last resort for IWID when they experience increased challenges in the community and the standard programs and services have failed (Riches et al., 2006). Using jail as a placement option or way of dealing with challenges in the community has been identified as an example of the impact of deinstitutionalization of IWID (Hutchison, Hummer, & Wooditch, 2013). The closure of institutions, although a much-needed shift for our society, resulted in a lack of adequate community supports.

In the provincial context, in 2002 the Saskatchewan Government decided there would be no new admissions to Valley View Centre, the only residential institution in the province located in Moose Jaw, Saskatchewan (Government of Saskatchewan, 2014). It was determined that best practice was to have IWID residing in the community as the research demonstrated they, as a whole, did better in a community setting (Government of Saskatchewan, 2014). As illustrated throughout the literature, deinstitutionalization is a shift that has occurred in various communities world-wide (Hamdani et al., 2017; Lunsky et al., 2007; Lunsky et al., 2013; Torr, 2013). The literature and service providers in Saskatchewan state that individuals with complex needs are still finding themselves being institutionalized through jail or acute care facilities as a negative result of a lack of sufficient services.

2.2.1 Service gaps and recidivism.

As our communities adjust to the closure of institutions there is a greater level of dependency on community programs and services to meet the needs of individuals with complex needs (Torr 2013). Research currently illustrates that there is not enough being done to prevent
IWID from incarceration (Burke, et. al, 2012). Jail is being used as a housing option or way of dealing with a problem in the community. The development of proper residential programs and specialized services is required to prevent incarceration and build capacity within the community (Simpson et al., 2001). There is a lack of specialized services to work with the combination of IWID, MHD, and criminal behaviour, specifically programs and services to help these individuals avoid reoffending (Simpson et al., 2001). In many communities there are groups and programs for various offenders such as users of domestic violence, sex offenders, and violent offenders which have been supported by evidence and research to be successful in decreasing recidivism rates (Cockram, 2005a). There is a need for specialized groups, individual therapy, case managers, and probation officers to have education and training specific to IWID and MHD entering the justice system (Riches et al., 2006). These services are needed to help decrease criminal involvement or recidivism rates for IWID (Riches et al., 2006). Hutchison et al. (2013) conducted a study surveying correctional facilities in Pennsylvania examining reoffending rates for IWID. Surveys were administered to 35 county jails with 34 respondents. Findings from this survey illustrated the following: 17% reported the offenders only returned once, 72% stated they returned on average two to four times, and 9% indicated that the offenders with intellectual disabilities returned four or more times to jail (Hutchison et al., 2013).

Primary factors impacting this population and their risk of criminal involvement include inappropriate housing, lack of employment, and low socioeconomic status (Cockram, 2005b; Burke et al., 2012). These factors are commonly known as part of Maslow’s Hierarchy of Needs. They are the basic needs that are essential to human well-being and have the potential to negatively impact an individual if unmet (McLeod, 2018). Without one’s basic needs being met, it is difficult to have positive and meaningful daily experiences. Research has shown that IWID
have a high rate of reoffending (Hutchison et al., 2013; Cockram, 2005a; Burke et al., 2012). Two longitudinal studies, one conducted in the United Kingdom (Lindsay et al., 2006) and another in New South Wales (Riches et al., 2006), illustrated extremely high recidivism rates. Lindsay et al. (2006) found IWID recidivism rates ranged between 40% and 70%, and Riches et al. (2006) found IWID had a 68% recidivism rate compared to individuals without an intellectual disability who had a rate of 38%. No local studies were found illustrating recidivism rates for IWID in Canada or Saskatchewan. Some identified factors influencing recidivism included; impulsivity, suggestibility, exploitability, desire to fit in, criminal history, lack of family support, and inappropriate housing (Cockram, 2005a). Of these factors, some are characteristics of one’s disability and others are representative of services and supports from the community. Services that are needed to help prevent reoffending include; specialized treatment, therapy, social networks, and psychiatric support (Lindsay et al., 2006). Unfortunately, the literature has illustrated mental health supports are often non-existent for IWID. Education and training on skill development along with therapeutic support is an essential support for this group of complex individuals (Cockram, 2005a; Riches et al., 2006). The lack of treatment and available services only results in exacerbated behaviour ultimately impacting the individual’s ability to remain safe in their community.

2.2.2 Role of collaborative community supports.

Safety within one’s community is always a primary focus when it comes to supporting IWID. Upon release from custody or sentencing in court, individuals often have probation orders which they are required to follow with the goal of keeping themselves and community members safe. A common theme that emerged from the literature was the difficulties IWID have in following their probation orders and the need for probation officers to adapt their approach for
this group of clients. Probation officers can play a large role in the success or failure of their clients. Hutchison et al. (2013) identified that more frequent contact, strong rapport and relationship, participating in safety planning, and taking the time to explain the rules resulted in more success for IWID on probation orders. These recommendations require probation officers to work in a way that is not their standard practice (Hutchison et al., 2013). This approach is one that is person-centered and focuses on building a strong relationship with the client to help guide them in their community reintegration. In addition to a shift in probation's approach, more aftercare programs are also needed to help IWID transition from jail to the community (Hutchison et al., 2013). Transitional programs such as groups for individuals recently released from jail help with reintegration while also providing additional support and education to the individual around the rules and restrictions of their probation order. The support and services discussed are to be provided in addition to other community supports from disability and mental health services. Across the literature the recommendations call for collaboration among various service providers and support workers.

The complexity of IWID and comorbid MHD or criminal involvement requires an integrated approach. Various ministries or departments are specialized in either disability services, mental health, or justice. Cross-ministry collaboration and education is required to achieve the type of community support and services required to meet the needs of complex individuals (Riches et al., 2006). In Saskatchewan there is a shift in approach to human services delivery, this framework is called Community Safety and Well-Being (CSWB) (Nilson, 2018). This model focuses on multi-sector collaboration and has shaped many cross-ministry collaborations within the province. In Saskatchewan, a demonstration of this approach is called the Hub. The Hub is a group of agencies who work together to connect individuals and families
to various services. Referrals are made to the Hub when there is an elevated risk within the community requiring a quick response and connection to supports (Nilson, 2014). Saskatchewan has expanded its Hub program and now has 14 across Saskatchewan and is a strong demonstration of the CSWB approach in practice.

Community Safety and Well-Being is a researched approach focusing on shifting service delivery to a more interdisciplinary collaborative model. This framework aligns with the recommendations and best practices identified in the broader literature. Key findings from Nilson’s (2018) national scan of multi-sectoral collaboration models within criminal justice include:

- collaboration helps close service gaps,
- positively impacts clients, frontline professionals, and partner organizations,
- increases service access while reducing barriers,
- improves understanding of client needs,
- fosters shared goals,
- reduces duplication, and
- increases overall effectiveness.

The research around CSWB provides a framework to guide collaborative work and service development. This framework is in accordance with the two models of best practice found in the literature being practiced in Washington State and New South Wales (Riches et al., 2006).

2.3 Models of Best Practice

Washington State’s Department for Social and Health Services (DSHS) has developed a voluntary residential program for IWID and justice involvement which has been running since 1996. Their residential program has a treatment focus with high levels of supervision and has
been identified as the model of best practice within their community (DSHS, 2009). The Department for Developmental Disabilities (DDD) contracts with agencies to run the program which they design and train the staff on (DSHS, 2009). The material is developed specifically for IWID and criminal involvement. Key components of their program focus on this group’s vulnerability, potential levels of danger, level of client ability, comprehension, and potential concurrent MHD or addictions (DSHS, 2009). This comprehensive training material provides education and awareness to many aspects of the individual’s experience or current state that are often overlooked.

In addition to the specialized staff who provide 24-hour support and supervision within the residential program, there is an integrative support team in the community. This team is comprised of a DDD caseworker, a therapist trained in counselling IWID, and other specialists as needed such as addiction workers or outreach (DSHS, 2009). This team works closely with the client to engage them in community programs as they work to strengthen their community networks. The high levels of support and integrative approach provides the client with an opportunity to learn and grow in a safe environment. Washington State’s DSHS found success with this model of support and none of their clients have been charged with an offence since entering the program (DSHS, 2009). The review and evaluation of the program highlighted their success as being attributed to the development of specialized programming and strong integration of services (DSHS, 2009). A similar model has also been found to be successful in New South Wales.

New South Wales proposed two ideas for improving practice for IWID and criminal involvement, a community-based support unit and a prisoner release project (Riches et al., 2006). The prisoner release project is a specialized case management approach with the goal of linking
the client to supports and services within their community to promote long-term rehabilitation (Riches et al., 2006). They found that a structured residence with 24-hour supervision was needed to allow individuals to develop everyday skills and access the support they need such as counselling or other specialists (Riches et al., 2006). From this project, key barriers were found impacting the clients from accessing the supports and services they needed. There was a lack of residential services available to assist with transitioning from jail to the community and an “urgent need” to develop and establish specialized and training programs targeted towards this group of complex individuals (Riches et al., 2006). The second model developed and implemented in New South Wales was the community-based support unit, which was evaluated after two years as having a positive impact on the clients involved (Riches et al., 2006).

This specialized unit was guided by The Framework Report by Simpson et al. (2001), which is an extensive report of compiled research and recommended best practice for supporting complex individuals with intellectual disabilities and involvement with the justice system (Riches et al., 2006). The community-based support unit is a restrictive residential unit that is comprised of intensive supervision, support, and a treatment focus (Riches et al., 2006). Any restriction that is in place for a resident is done through the criminal justice system or through an order of the Guardianship Board (Simpson et al., 2001). Their level of restriction is evaluated on an ongoing basis by the support team. In addition, the client is seen by a psychiatrist for regular assessments (Simpson et al., 2001). In Riches et al.’s (2006) evaluation they stated that:

…the critical importance of balancing the needs of individual rights and freedoms and introducing safeguards to protect both the community and the individuals themselves and their fellow residents means the level and use of restrictive practices was of prime consideration during the evaluation (p. 392).
The goal of this unit and program is to decrease the level of restriction over time and increase the level of skills and independence of the client (Riches et al., 2006). The program was observed to have a positive impact on the clients by decreasing the overall aggression and disruptive behaviour of the people residing in the home (Riches et al., 2006). Riches et al. (2006) attributed this progression to a stable and predictable living environment in addition to one-to-one and group therapy offered within the home.

From the models of best practice found within the literature there are primary factors attributed to their success including:

- a combination of a specialized residence along with integrative case management and community support,

- the development of a specialized community support unit comprised of a caseworker and interdisciplinary team members such as other mental health professionals, addictions workers, social work, and outreach,

- custom training of residential staff,

- therapeutic support within the home and community, and

- cross-ministry collaboration to train and educate service providers (DSHS, 2009; Riches et al, 2006; Nilson, 2018).

These models, along with the strong recommendations and guidelines from Simpson et al.’s The Framework Report (2001), provide communities a foundation to begin developing more appropriate and responsive services for complex clients. A consistent theme found in the literature reviewed was the great need to build awareness, education, and expand the services and supports for IWID, MHD, and criminal involvement. This vulnerable group of individuals have
the right to access the programs and supports necessary to allow them to participate fully within their community and live positive meaningful lives.
Chapter 3: Methodology

Data was collected for this project through a community inventory and extensive case analysis. The community inventory was completed through informal interviews with front line service providers in the area of disability services, mental health, justice, and research from the various government websites. An in-person meeting was held with the Saskatoon Hub committee to interview their committee members and review their 2018 statistics report. The Hub is a group of agencies who work together to connect individuals and families to various services. Lastly, a comprehensive file review and analysis was completed on one complex case that had extensive involvement with disability services, mental health, and justice. The collection of this information was done utilizing an appreciative inquiry (AI) approach with the intention of providing an illustration of the current state of services and supports for complex clients in Saskatoon.

3.1 Ethical Considerations

The Integrative Approach to Complex Cases (IACC) working group has an information sharing agreement allowing client information to be shared among the group. This project was covered under the IACC shared agreement. All confidential file information was held in the Community Living Service Delivery (CLSD) offices and stored on their secure computer database. Data used for this report did not contain any confidential client information and no confidential information was removed from the CLSD offices. Client consent was obtained from the participant whose file information was utilized for the client mapping exercise (Appendix H). In addition to the consent form an individual letter was provided to the case worker to share with the client discussing the purpose of utilizing their information and their right to withdraw their file information from this research at any time (Appendix I).
Community Living Service Delivery has developed a process to support clients in understanding and giving consent. This process is called Supported Decision Making and is carried out with the individual’s support team. Supported Decision Making is a process to assist adults with intellectual disabilities to make their own informed decisions. A support team comprised of people the client has selected meet together to discuss the decision at hand. The role of the support team is to give objective information and lead the client through the stages of making a decision through information sharing and questioning. This process is used when obtaining consent for CLSD clients and was used for this project. Any client related information for this project will remain confidential to the project team and will be presented in a non-identifying manner.

A non-disclosure form was completed for the Hub committee to allow their data to be released for this project (Appendix J). This non-disclosure agreement ensured the information shared was only being used for research purposes, would be safely stored and destroyed, and would not include any confidential client-related information. The ethical considerations taken for this project are guided by the Social Work Code of Ethics (CASW, 2005). This is the foundation on which all social work practice and research is grounded, and served as a practical compass to guide this exploratory study.

3.2 Appreciative Inquiry

The primary objectives of the IACC team is to create a new service delivery model through developing and implementing new community supports (MSS, 2018b). This requires a level of organizational change which can be initiated through an AI approach focusing on a few key principles: a change agenda, an advisory team, engagement, strategy, and an implementation process (Whitney & Trosten-Bloom, 2010). The IACC Project Charter serves as the team’s
change agenda as it outlines the goals and objectives while listing the advisory team members who are in support of the project. Team engagement was identified as the current stage of the IACC project and a primary focus of this study.

The CLSD team members identified key pieces of information that were needed to help build engagement. This included research on what models of best practice exist and a cost analysis to illustrate the financial gains that could be achieved through a new approach to service delivery for complex clients. These areas of interest guided the focus of this project which is to determine best practices of how to support complex individuals in the community while examining the current state of the existing programs and services within Saskatchewan.

Appreciative Inquiry focuses on exploration and discovery to build on what is working and provide an opportunity to highlight areas to strengthen (Whitney & Trosten-Bloom, 2010). Through the community inventory and interviews, information was collected on the current state of service delivery. An important piece of these conversations was to ask the various agencies what they envisioned as ways to improve the current supports. The file review was conducted to provide client specific data while also illustrating the client experience. Focusing on client and agency experiences is another AI method utilized to build engagement and cohesion of a team working towards a shared goal.

3.3 Community Inventory

A community inventory was compiled through informal phone conversations with various community agencies and an in-person meeting with the Saskatoon Hub. Based on the complex case definition, programs and services needing further exploration were focused around mental health and correctional services specifically for IWID. Questions were developed (Appendix E) to facilitate a conversation regarding which programs and services are currently
being offered by the various agencies. The questions were approved in consultation with the project’s professional associate and a consultant working on the IACC task team. Agencies interviewed included Adult Mental Health and Addictions with the Saskatchewan Health Authority, Community Corrections with the Ministry of Justice, Community Mental Health Services with the Ministry of Health, and Community Living Service Delivery with the Ministry of Social Services. Interviews were held with program managers, supervisors, and frontline caseworkers. An AI approach was utilized to create an open discussion to explore ideas and ways in which the current programs could be improved upon. A similar approach was carried out with in-person meetings.

Prior to meeting with the Hub, a pre-discussion information sheet was sent out to all the members informing them of the purpose of our conversation while also providing background and context of the project (Appendix G). An open discussion was held at a standing Hub meeting with those in attendance which included representatives from the Ministry of Justice, Ministry of Social Services, Ministry of Health, Saskatchewan Health Authority, and Saskatoon City Police. In addition to this discussion, the Hub chair and Saskatoon City Police representative presented the 2018 Saskatoon Hub statistics report. This report highlights important information about the type of issues that are being presented to the table while also flagging systemic gaps. Systemic gaps are areas flagged for further research and service development as there is a recognized lack of available services and supports within this area in our community. Another tool to recognize service gaps is client mapping.

### 3.4 Client Mapping

Client mapping was utilized to illustrate a client’s journey while identifying service gaps and obtaining engagement from the various members of the IACC project. The client file was
selected by the IACC team. The client met the IACC complex client criteria, was currently experiencing extensive involvement from all IACC agencies, and therefore was identified by the team as priority for the client mapping exercise. This is an appreciative inquiry exercise used by the ministry to help develop an understanding of the clients’ journey. This exercise can build engagement by sharing the client’s experience and building the narrative and story which the various team members can hear and connect to. Connecting the team members to a narrative provides an opportunity for learning, inspiration, and motivation (Whitney & Trosten-Bloom, 2010). The mapping exercise consists of reviewing file information from each agency to develop a timeline. This timeline illustrates the frequency, duration, and outcome of the various agency involvements. From the various touchpoints of agency involvement, a cost analysis can be completed for resources that were involved. For this project the focus was time spent in inappropriate placements such as jail, acute care facilities, or other high cost resources.

This exercise is usually facilitated by a trained government employee who specializes in leading the client mapping process. Requests were made for a facilitator to assist with this mapping but were unsuccessful. The Community Living Service Delivery (CLSD) team approved an extensive client file review for one of the complex cases and provided key points to focus on for the review. Ten volumes of the CLSD files were reviewed. A visual timeline and supporting documents were developed to illustrate the client’s journey. The file review information was the starting point of the larger client mapping. Future steps of the IACC team will include sharing the information with the other ministries to pull in information from their perspective during their involvement along with a cost analysis based on the file information of days spent in jail, acute care, and other high cost resources. The cost analysis will be used as a primary way to build engagement from the other ministries and project members. As stated
earlier, engagement was low among the IACC team and posed a significant issue with the potential to prevent any progression of the IACC work. The cost analysis will be completed from the information gathered through the client mapping exercise. Specific costs will be calculated for every day spent in jail, acute care facilities, or other high cost resources based on financial information shared from each responsible department. Performing a cost analysis will illustrate the cost incurred by each agency and what supports were in place at that time. The objective of this process will be to engage the ministry partners and illustrate the current state of high cost resources to examine if any change in outcomes was experienced by the client as a result. Simply put, if a complex client is being supported in a high cost resource that is not adequately meeting their support needs, this is not a sustainable model of support. Implementing the researched best practices will allow the IACC team to better serve complex cases with more appropriate services, allow better use of government finances, and ultimately provide long-term monetary savings through the development of sustainable services and supports.

In learning more about client mapping and the benefits of the exercise, an important element stood out around agency empathy which will be facilitated in future team meetings. This concept focuses on developing a stronger understanding of the experiences of partnering agencies to build a sense of empathy for each involved party ultimately building cohesion amongst the group. Agency empathy would be facilitated by having each department share their experiences in trying to provide support to complex clients. Specifically, the challenges or barriers that may be only known or understood by their agency and unknown to other community partners. Learning about the experiences of each ministry and building a greater understanding promotes cohesion and helps break down silos that exist within the government. Through the education of each agency’s experience a deeper level of understanding can be developed along
with relatability among the various professionals. An opportunity for this will occur when the client mapping information is shared back to the IACC team for further discussion and examination. To include client information in this research and share among the various IACC partners a few ethical considerations were required.
Chapter 4: Findings

4.1 Community Inventory: Government Programs for IWID

An inquiry was completed to learn about the programs and services offered by the Ministry of Justice, Ministry of Health, and the Saskatchewan Health Authority that can be accessed by individuals with intellectual disabilities (IWID).

4.1.1 Saskatchewan Health Authority.

The Saskatchewan Health Authority is responsible for providing community and inpatient mental health and addiction services to adults in Saskatchewan. Interviews were held with three different units of Adult Mental Health and Addiction Services: Adult Outreach, Mental Health and Addictions Transition Team, and Community Mental Health Services. A common theme throughout each discussion was that there is no specialization in mental health services for IWID and that these individuals are required to access generalized mental health services. As a result, barriers do exist preventing IWID from accessing services. To access community counselling or therapy the client must be able to identify and articulate their goals. If the client is able to achieve this, they can access services, although there is no consideration of the individual’s disability during this process. This results in many IWID being denied services as they are unable to identify concrete therapeutic goals. Individuals with Intellectual Disabilities are welcome to join the various groups being run if they are an “appropriate fit”, but they cannot be accompanied by a support person. There are no groups specifically for IWID. The lack of specialization or accommodation for IWID to access mental health services ultimately denies them access to supports other members of the community have full access too, preventing them from receiving the mental health treatment or support they need.
Another identified reason for why mental health services are not easily accessed by IWID was the fact that Mental Health Services is deferring to CLSD to provide supports and services. Although there are mental health case managers, residential programs, and other specialized services, IWID are not able to access them as easily as they are being referred back to the agency specializing in disability. This is a demonstration of the need to develop an integrated approach. It was acknowledged that programs and services need to be set up differently for IWID in order for them to be accessible and more suited towards their needs. When asked if there is any work currently being done to address this gap one respondent stated the following in an email response:

There isn’t a lot currently. It’s either for mental health or for intellectual disabilities. That’s often where mental health falls short.

Concurrent or comorbid Dx (diagnosis) is considered “complex” and our system still likes “mainstream” patients. Unfortunately, that’s not how humans operate.

Overall, mental health services within Saskatoon are not fully accessible to IWID due to criteria limitations and deferring to disability services, who does not offer mental health supports. A similar trend of nonspecialized supports was found within the Ministry of Justice as well.

4.1.2 Ministry of Justice.

An interview with the Community Corrections department provided insight into the community programs and services being offered by the Ministry of Justice. Community Corrections is the division in which Probation Officers work. They are responsible for programs, mainly groups, for individuals on probation orders. Within Community Corrections, there are specialized Probation Officers assigned to work with individuals with domestic violence or sex
offences. They also have special programs and treatment for these individuals. However, no such programming or expertise exists for IWID. Corrections have partnerships with the police and mental health services for some of their programs, specifically the Serious Habitual Offender Program and Serious Violent Offender Response Program. It was identified as a need to develop more specialization for IWID as they are often struggling with how to properly support these individuals. Community Corrections is not responsible for any residential programs, and information for these programs was found on Correctional Services Canada’s website (Government of Canada, 2014).

4.1.3 Correctional Services Canada.

A phone call was made to Correctional Services Canada’s Regional Headquarters to inquire about their community residential program. Their website included information about community-based residential facilities, which include a form of half-way house, community residential facilities, and a specialized housing program with counselling and supervision (Government of Canada, 2014). Questions were asked based on the website information looking for more specifics. No information could be shared without an access for information request which was $5 per request. A request to access information was not submitted, rather two questions were asked to the Correctional Services staff over the phone.

1. From what I read on your website about the various community residential facilities, some are run by the government and others non-government agencies. What is the process to enter in a residential contract to operate one of the facilities?

2. The website states there is a “level of control and assistance” what is the level of restriction that exists in the homes? What regulations are in place?
These questions were created based on the information posted on the Correctional Services Canada website with the intention of gaining further understanding around their services. The response from the staff member for both questions was “I am unable to share that information”. Unfortunately, no further insight was gained through this conversation and no formal request for information was submitted due to time limitations for the project. The Ministry of Social Services was the third agency interviewed.

4.1.4 Ministry of Social Services.

Community Living Service Delivery is the division of Social Services that provides supports to adults with intellectual disabilities, specifically residential and vocational services along with ongoing case management support. The Outreach and Prevention Unit within CLSD is responsible for crisis and behavioural support. Two individuals from this unit were interviewed for this project along with the CLSD members on the IACC project. Community Living Service Delivery is the primary service provider for IWID and have many programs and supports to offer. They do not offer mental health services or justice programs and turn to their community partners for these supports. There is greater collaboration among CLSD, Mental Health, and Justice when trying to support complex clients, but the main barrier is lack of services within our community. The IACC project was formed by CLSD due to the lack of appropriate community services for this specific group of clients and the identified need for more integrative work among each respective agency and department. In addition to lack of appropriate services, one of the interviewees stated that with CLSD being a voluntary service, it makes it difficult to support more complex individuals at times as there is no ability to mandate or require any programs or treatment. Many of the findings from the ministry interviews were reiterated in discussion with the Saskatoon Hub members.
### 4.2 Hub Reporting

A meeting was held with the Saskatoon Hub to learn about the existing crisis services and programs for the targeted client population to explore what currently exists while identifying gaps. As previously stated, Hub is a group of agencies working collaboratively to support at risk families and individuals within our community. Representatives from the Ministry of Health, Justice, Social Services, Saskatchewan Health Authority, and Saskatoon City Police were present for the discussion. The discussion topics focused around programs and services available to complex clients, what has been successful in supporting these individuals, what barriers exist, and what is their vision for improving services and supports. Key themes of the discussion were; the impact of deinstitutionalization, the need for more specialized services, limitations of voluntary services, and shortcomings of the standardized approaches to casework and frontline support.

Within Saskatchewan, there has been a shift in deinstitutionalization. Hub representatives attributed the current challenges IWID experience as a result of the closure of Moose Jaw’s Valley View Centre and Saskatchewan Hospital North Battleford (SHNB). Valley View Centre, Saskatchewan’s largest institution for IWID stopped accepting residents in 2002 and is currently working to transition the remaining residents into community residences. Participants recollected that in the 1980’s SHNB reduced the number of long-term beds available to IWID with MHD and began a closure of long-term inpatient services shifting to the community care model. At its peak, SHNB housed over 4000 patients in 1946 (Leung, n.d.). The patients were a combination of those who were “mentally ill” and those who “did not fit” within the community (Leung, n.d). With this shift, the community is now responsible for supporting these individuals. The Hub
table expressed that our community was not ready for this transition and the programs and supports needed in the community do not exist specifically around mental health services.

Another key finding from the discussion was around voluntary services for IWID as adult services for IWID are voluntary. Some of these individuals are unable to make safe decisions for themselves or those around them but there remain limited options available for support providers in helping keep them safe. Members of the Hub table have supported individuals who have not demonstrated the cognitive capacity or ability to keep themselves or others safe and have felt at a loss with how to help promote their overall safety and well-being in the community. Across the table, all Hub members strongly felt that a level of mandated services is needed to support the most vulnerable and complex people in our community as the current model of voluntary services does not meet the support needs of this population. In addition to a level of mandated services the table stated that each department struggles with offering specialized services for IWID.

Within Saskatoon, Saskatchewan’s largest city, there is a lack of specialized residential services and programming for IWID, MHD, and/or involvement with corrections. These individuals continue to present at the Hub table due to their community risk of homelessness, high police involvement, and hospitalization. A unique and specialized approach is required when working with complex cases as the current service models do not appear to be effective. Findings in the Saskatoon Hub statistics for 2018 support the comments raised during the discussion. One of the top 12 risk factors identified was cognitive impairment/suspected cognitive impairment making up 12% of the referrals and suspected mental health problems accounted for was 47% of the referrals. Systemic issues give more context to risk factors and the
direct challenges or barriers that are being experienced by people within our community. The definition for systemic issues comes from Nilson (2014).

These include not being able to locate the client, client refusal of services, complications in identified supports for the client or systemic issues. The latter of these four reasons, systemic issues, is of particular importance to the Centre of Responsibility (COR). Where the Hub cannot successfully implement an intervention plan because of institutional barriers, they refer the matter to the COR, whose members have more time and expertise to work on difficult issues than most Hub participants do (p. 47).

Two of the eleven systemic issues reported are relevant to this study. The Saskatoon Hub has prioritized Mental Health facilities and CLSD homes as one, and CLSD mandated services for vulnerable people regardless of age. The Hub is the touchpoint for many of the most at-risk individuals in our community. Their data analysis and systemic priorities provide valuable insight to the current state of programs and services for IWID and MHD in Saskatoon. The frontline observations and feedback from the table illustrates an identified need to develop specialized services within this area. Another method used to gather frontline experience was through the client mapping.

4.3 Client Mapping

The client mapping exercise exemplified the client experiences that were shared in the literature and through the anecdotal recollections of the community partners. In reviewing the volumes of CLSD files a journey of a young individual with a life filled with trauma was illustrated (Appendix L). Table 1.0 captures some of the experiences and service involvement during various stages of the individual’s life.
<table>
<thead>
<tr>
<th>Age</th>
<th>Key Touchpoints and Agency Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6</td>
<td>• Child and Family Programs (CFP) involved,</td>
</tr>
<tr>
<td></td>
<td>• 12 residential placements, first removed from home at 9 months old,</td>
</tr>
<tr>
<td></td>
<td>• protection concerns included: severe neglect, physical abuse, sexual abuse, unsanitary living, lack of supervision, no food in the house, and mom suffered from health challenges, and</td>
</tr>
<tr>
<td></td>
<td>• numerous hospital admissions for health reasons.</td>
</tr>
<tr>
<td>6-12</td>
<td>• Permanent ward with CFP,</td>
</tr>
<tr>
<td></td>
<td>• little family contact,</td>
</tr>
<tr>
<td></td>
<td>• connected to Psychiatry and Neurology for ongoing support,</td>
</tr>
<tr>
<td></td>
<td>• diagnosed with six medical and psychiatric disorders, and</td>
</tr>
<tr>
<td></td>
<td>• first hospital admission at the age of 12 for a medication change.</td>
</tr>
<tr>
<td>12-18</td>
<td>• Attended a specialized residential school for 4 years and was discharged due to behavior; aggression and inappropriate sexualized behaviour towards students and staff,</td>
</tr>
<tr>
<td></td>
<td>• ongoing appointments with Psychiatry, every 4 months, and</td>
</tr>
<tr>
<td></td>
<td>• significant decrease in family contact, primarily phone calls only.</td>
</tr>
<tr>
<td>18-24</td>
<td>• Transitioned from CFP to adult services through Community Living Service Delivery, CFP file closed at the age of 20,</td>
</tr>
<tr>
<td></td>
<td>• 4 total moves,</td>
</tr>
<tr>
<td></td>
<td>• documented high levels of aggression within the various group homes,</td>
</tr>
<tr>
<td></td>
<td>• high police involvement, attending the home due to aggression, often resulted in an acute mental health admission,</td>
</tr>
<tr>
<td></td>
<td>• 5 separate acute mental health admissions for a total of 65 days, and</td>
</tr>
<tr>
<td></td>
<td>• assault charge, court ordered 30-day fitness assessment.</td>
</tr>
<tr>
<td>24-30</td>
<td>• 4 moves to 4 different cities,</td>
</tr>
<tr>
<td></td>
<td>• assault charges and high police involvement,</td>
</tr>
</tbody>
</table>
What is clearly noticeable in the client’s experiences are the patterns throughout the individual’s life of placement breakdown, hospitalization, and incarceration. The person experienced trauma since a very young age and had minimal counselling or therapeutic support for this. In addition to his trauma, the client’s complex physical and mental health resulted in professionals being unsure how to support him, deferring back to one another without getting the proper supports in place. The complex support needs of this person exceed any individual agency and require integrative support to encompass all of this individual’s needs. The complexity of the client’s needs often resulted in placement breakdowns and unsafe behaviour in the community. The individual spent a total of 638 days in jail with no sentencing to serve time but as a result of no community residential placement. In addition, he had five psychiatric assessments and was admitted to acute care facilities 20 times for medication review and stabilization whenever his behaviour escalated in the community. The work of IACC has the potential to significantly impact this client’s future and provide him with the services and supports to allow him to remain in his community.
4.4 Planning and Priorities

As it has been highlighted throughout this study, there is a need for specialized services for IWID and complex support needs. Saskatchewan Ministries have acknowledged this need in their planning and priority documents. In 2014, the Ministry of Health released their 10-Year Action Plan for Saskatchewan highlighting their priorities for services over the next 10 years. Within this report a system goal identified was to respond to diversity, specifically to improve services for individuals with disabilities (Stockdale-Winder, 2014). The Saskatchewan Disability Strategy published their plan for growth in 2015. Recommendations of this document specifically address improving access to supports to IWID, building capacity of service providers to provide effective services, and ensuring our province is inclusive to all individuals experiencing disability (The Saskatchewan Disability Strategy, 2015). Disability Programs with the Ministry of Social Services released the Valley View Centre Transition Planning Recommendations in 2013. Relevant recommendations include the expansion and enhancement of crisis prevention and support service capacity, ensure access to required specialists, and develop community-based programming (The Transition Steering Committee, 2013). Each of these action plans and visions for service development place value on the importance of accessibility to appropriate services and supports to IWID. This acknowledgement illustrates that within our community there is an identified need to improve the services and supports to IWID.

4.5 Integrative Approach to Complex Cases Points of Reference

The IACC team was in the preliminary stages of their project during this research practicum. Preliminary work had been completed providing a foundation to begin working towards the goals and objectives of the project. One of the first tasks was the creation of the
complex case definition. This definition was used to set the criteria for determining which clients in Saskatchewan would require intensive support and benefit from the integrative service model being developed by IACC project (Appendix B). Primary characteristics of these individuals, in addition to having a diagnosed Intellectual Disability, included:

- psychiatric and/or behavioural issues which require specialized treatment,
- have a history of difficulty with voluntary participation in treatment strategies or support programs,
- present a high level of risk of harm to themselves or the community at large,
- a history with loss of placement within any or all community placements (residential and/or day programs),
- have a mental health disorder that requires frequent acute mental health admission or ongoing mental health support. co-morbid mental health disorder,
- incarceration(s) or criminal justice involvement or ongoing contact with the justice system and have repeatedly breached probation orders,
- have chronic addictions issues, substance abuse/dependency problems, and/or
- lack of a natural support system and long-standing dependency on government services (MSS, 2018a).

These characteristics will be persistent and enduring in nature, requiring intensive specialized support. The definition was shared with the CLSD managers to identify clients within their region of Saskatchewan who are complex cases. Clients identified will be known by the partnering project members as they are highly involved in the mental health and justice systems. The team then established criteria which provided a foundation for the development of a shared framework and service model to meet the needs of the complex clients.
Creating a shared framework provided an outline of the vision and principles guiding the integrative service model. A draft was developed among the CLSD working group and shared with the larger task team for input (Appendix C). Figure 1.0 illustrates the key pieces of the framework. From the literature reviewed, findings on best practices for integrated case management, residential models, and outreach services were shared with the CLSD team to inform the framework (Appendix D). Material also came from a series of interviews and discussions with various community agencies.
Chapter 5: Discussion and Recommendations

5.1 Service Need

Throughout the literature and in discussion with community agencies a clear need for services expansion and development for complex cases is identified. Many individuals with intellectual disabilities (IWID) have comorbid mental health disorders (MHD) and are unable to access the treatment or support most of the general population has access to. The lack of national policy on mental health treatment for IWID has resulted in a lack of adequate mental health services (Lunsky et al., 2013), increasing these individuals’ risk factors for criminalized behavior (Lindsay et al., 2013). A shift in responsibility in this provision of services was indicated as a strong influencing factor.

Deinstitutionalization of IWID has put an end to the segregation of people with disabilities by promoting their inclusion and place within their community. This has been a very positive shift for society as it upholds the dignity and rights of IWID. The community is working to catch up on their responsibility of service provision. This is recognized within Saskatchewan and in the broader literature as Hamdani et al. (2017), Lunsky et al. (2007), Lunsky et al. (2013), and Torr (2013) highlight within their research. With the closure of Valley View Centre, CLSD has currently transitioned 103 residents to the community and the projected date for having all residents moved is December 2019. Residential services have been built and vocational programs developed, but the main service that is lacking is specialized mental health support. Mental health services need developing for IWID and there is a need for education around what MHD looks like for IWID. Diagnostic overshadowing continues to be a large barrier impacting IWID in receiving the proper mental health treatment (Riches et al., 2006). A trend that was found within the file review was that the individual would have an increase in aggressive or
violent behaviour within the community and be taken to the emergency room. Upon assessment in the ER they often receive a medication change before or are discharged on the basis that the presenting problem was a behavioural issue and not mental health related. This cycle is documented approximately seventeen times within the files and two specific denials are noted based on the presenting problem being behavioural. Throughout this client’s life they struggled to receive the mental health supports they needed. As Riches at al. (2006) identified, mental health disorders in IWID increases their likeliness of criminalized behaviour. This was demonstrated through the client mapping as the individual’s unmet mental health needs resulted in an escalation of behaviour in the community leading to police involvement and even criminal charges. An increase in education, training, and awareness is required to better inform our service providers and ensure the needs of IWID are not being overlooked.

5.1.1 Specialization shortfall.

Across the literature are recommendations to educate and train professionals to be specialized in working with this target population. In exploring the current state of our community, this lack of specialization was found to be a common theme. Professionals from Health, Justice, Police, and Disability Programs all identified a lack of specialization within their own agency and the broader community for complex cases. Locally, we do not have appropriate mental health services for IWID nor do we have the proper programs for criminalized behaviour or recidivism. As highlighted by Cockram (2005a), specialized reoffending programs have proven to be successful for various at-risk offenders. This attention and specialization for IWID would assist in preventing a vulnerable group of individuals from incarceration, where they are at-risk for experiencing trauma and being victimized (Cockram, 2005a). Simpson et al. (2001)
recommended cross-ministry training and education as a way to increase capacity for service providers.

Cross-ministry training would allow community partners to learn about the services and supports they each offer while educating one another on their scope of practice. It was apparent that within our community many mental health services are not available to IWID and the responsibility is deferred to CLSD, the disability agency. In doing this, the client is not able to access the services they need as CLSD does not offer mental health services. The findings illustrated that part of this is caused by a lack of understanding of the roles and responsibilities of each respective agency in addition to a lack of specialized services to offer. This results in the client being denied services or having fractured care. Not only is cross-ministry training a crucial step in bringing education and awareness to these complex cases, but it will promote an integrative approach to service delivery.

5.1.2 Integrative approach to service delivery.

The local research and publications on CWSB are a strong indication that a shift to integrative service models is the most effective way to support individuals within the human services field. This was supported by the broader literature reviewed. Specifically, for complex cases, an integrative approach is required to meet the needs of the individual. Bringing together the knowledge and expertise from various agencies to work collectively towards the same goal will achieve better results for individuals with complex support needs (Simpson et al., 2001) This is the primary objective of the IACC project. The way in which services are currently being delivered within our community is not meeting the needs for IWID with MHD and criminal involvement. As a result, these individuals show high rates of recidivism, admission to acute care facilities, and experience severe disruption in their lives. The file review completed highlighted
these issues in the lifelong journey of a young client. They were admitted to acute care facilities approximately 17 times, had 4 assault charges, spent 638 days in jail, and moved a total of 23 times by the age of 34. To provide truly integrative services there needs to be an equal buy-in from all agencies along with shared ownership and fiscal responsibility (Nilson, 2018). This remains to be achieved with the IACC project. As it was stated earlier, engagement of the other team members continues to be a key focus and project objective. The research and recommendations made to the IACC on the current state and best practices will hopefully assist with engagement and collaboration among all members involved. Each recommendation and finding highlights the importance of working collectively to improve the services and supports within our community for IWID.

5.2 Models of Best Practice

The IACC team is seeking to develop a residential program and integrative service model that will better meet the needs of complex cases. The literature reviewed for models of best practice highlighted some frameworks that are successfully meeting the same identified need in various communities globally. Whether it be New South Wales, Washington State, or here in Saskatchewan the identified issues, barriers, and limitations in services for IWID have many parallels. The commonality found validates these models of best practice and strengthens the reason why they should be considered as guiding frameworks when looking to develop new services within our own province. Legislation and policy will vary but can be accommodated to fit what we are able to do within Saskatchewan.

5.2.1 Specialized services.

Two similarities between the New South Wales and Washington State models is the development of an integrative support team. This team was a crucial part of the individual’s
supports. The following recommendations were made to the IACC team for an integrative service model based on findings highlighted in Simpson et al.’s The Framework Report (2001):

- A combination of specialized residential programs along with integrative case management and community support,
- the development of a specialized community support unit comprised of a caseworker and interdisciplinary team members such as other mental health professionals, addictions workers, social workers, counselling, and outreach,
- custom training of residential staff,
- therapeutic support within the home and community, and
- cross-ministry collaboration to train and educate service providers.

These recommendations are supported in the broader literature to be strong foundations to developing an integrative service model (DSHS, 2009; Burke et al., 2012, Cockram, 2005b; Riches et al., 2006; Lindsay et al. 2006; Cockram, 2005a). In addition to the integrative support team, specialized residential programs were emphasized as necessary for complex cases, specifically for those individuals with criminalized behavior (Simpson et al., 2001).

5.2.2 Residential operationalization.

Two residential models of best practice were found within the literature reviewed. The second main objective of the IACC project is to develop a residential resource in addition to the integrated service model. Multiple attempted contacts were made to the Washington State and New South Wales programs, but unfortunately no contact was made. Specifics about the legislation, regulation, and operationalization of both residential programs was information that was not included within the articles and would have been valuable to this project. The two models were similar with their treatment focus and intensive supervision and support. A primary
difference was the level of restriction placed on the residents. Washington State was a voluntary program and New South Wales had a restrictive unit within the community. Currently in Saskatchewan we have voluntary programs. Using the models of best practice as a guide, further research was completed to look at what legislation guides residential services for IWID in Saskatchewan to explore operationalization of a new residential program for complex cases.

As mentioned earlier, residential services for adults with intellectual disabilities are in contract with CLSD and Community Based Organizations. They are regulated by The Residential Services Act (2017), The Rehabilitation Act (2014), Fire Code, and Comprehensive Personal Planning and Support Policy (CPP & SP) (2017). Any restriction that may be in place must be approved and signed off as per CLSD’s Restrictive Procedure Policy. Restrictive procedures are only approved to prevent dangerous or harmful behaviours towards clients or others. For example, if a resident has demonstrated unsafe use of knives or sharp objects, these items can be locked up within their home as a component of the client’s safety and support plan. The restrictions that are implemented are only used to prevent dangerous or harmful behaviour. This policy would not have the ability to create a restrictive home environment where doors are locked, and the residents are unable to move freely where they wish; rather minor environmental modifications are made to help ensure safety for the client such as locking the knife drawer. The community-based support unit model does enforce a level of restriction to individuals in their home with a rehabilitation and treatment focus. Being able to enforce a level of restriction within the client’s own home would allow them to avoid incarceration or hospitalization.

As is being done in New South Wales, a structured and supportive home environment paired with treatment allows these clients to be surrounded by a support team as they develop the skills and healthy connections to remain within their community (Riches et al., 2006). New
South Wales uses Guardianship Orders or orders through the court system to enforce restriction within the individual’s residence (Riches et al., 2006). Saskatchewan’s Public Guardian and Trustee office stated they do not use Guardianship Orders in this manner. More exploration on different Mental Health orders or Corrections orders would be needed to determine if they could be used to implement residential restrictions. Community Living Service Delivery has been able to rewrite their CPP & SP policy and could explore what this would look like to include a level of restriction within their residential programs. Recommendations that were made to the CLSD team were to develop an assessment tool to determine if restriction is needed, and to provide ongoing evaluation to increase or decrease restriction as part of their policy. A summary of the residential operationalizing avenues was provided to the CLSD team (Appendix M). The findings on best practices and service delivery models provide a framework and guide for the future work of the IACC project and as a community at large.
Chapter 6: Conclusion

Across the literature is the acknowledgement that further research is required in this area of focus. It appears that knowledge and awareness of the complex experiences faced by individuals with intellectual disabilities (IWID) is gaining more attention among researchers with a great deal more to learn and explore. Within Saskatchewan there is a level of acknowledgment as demonstrated in the various agency work plans reviewed for this study, specifically stating that mental health services need to be developed and made more accessible to IWID. The file review completed illustrates many of the challenges and barriers found in the literature from a personal journey experienced by a client within Saskatchewan. The relatability of the broader research to our local current state emphasizes the importance and need for Saskatchewan to make a change in our practices.

Preliminary work by the IACC project aligns with the recommendations from the literature and has great potential to shift the way services are delivered to IWID. The complex cases identified within the IACC project are some of the most vulnerable people in Saskatchewan. Raising awareness and education across ministries and various agencies is imperative in bringing the challenges and barriers of complex clients to the forefront. Creating a dialogue is the first step to making change. It is the intent of this project to be another step in starting the conversation and expanding the knowledge about the current state of Saskatchewan to improve services and supports for IWID in our community.
References


Appendices

Appendix A: Project Charter

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<th>Integrated Approach to Complex Cases</th>
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**PROJECT PARTICIPANTS AND AUTHORITY**

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<td>Project Sponsor:</td>
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<td>Business Lead:</td>
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**PROJECT DESCRIPTION**

Community Living Service Delivery (CLSD) is seeking to work with the Ministry of Justice, the Ministry of Health and the Saskatchewan Health Authority to develop a collaborative service model that will allow systems to safely support individuals with complex support needs.

There is an increasing need to develop a more appropriate and collaborative response to individuals who have complex needs (intellectual disabilities, mental health diagnosis or condition, behavioral issues and/or criminalized behavior). Complex cases are identified as those individuals who require highly specialized/ intensive/ unique services, which in their absence, could lead to serious and negative outcomes for the individual. Case management of complex cases involves multiple service providers (across multiple systems) and consumes significant time, energy and public resources. Individuals have no service options that adequately address their multidimensional support needs, or their current service options are not adequately addressing their needs. Due to lack of system collaboration/ integration, there is a significant strain on current services systems. Individuals with complex support needs experience higher levels of placement breakdown, have higher recidivism rates within the criminal justice system and repeated admissions to mental health facilities.

Within the current systems, the Ministry of Social Services, the Ministry of Health, and the Ministry of Justice and the Saskatchewan Health Authority, services tend to operate independently to serve clients; each of system acting within the restrictions of legislative mandates. Unfortunately, due to the limitations within scope and mandates, services and support systems often act in isolation. The compounding issues that surface from inappropriate responses lead to a compromised and weakened long term positive outcomes for individuals and they cycle through systems repeatedly.

**Case Example:** Mr. M is a 65 year-old male with a psychotic disorder and intermittent explosive behaviours, with a long history of involvement with the mental health system. In the past 4 years he has had involvement with the Justice system due to very violent behaviour and, due to this has been imprisoned twice. The most recent assault was on an inpatient unit staff, and he spent two years in jail and 8 months in a half-way house. There has been no community
placement that will accept him due to his history of violence and he is since been housed on the adult mental health inpatient unit at Regina General Hospital. The Regina Qu'Appelle Health Region is striving to develop a plan to eventually support him in the community.

This project will establish a cross-ministerial working group, with the Ministries of Social Services, Health and Justice and the Saskatchewan Health Authority, that will develop a collaborative approach to supporting individuals with complex needs. The key deliverables of the group are:

- a protocol that outlines how the systems will collaborate to respond with appropriate service matching for complex cases the addresses crisis events, periods of hospitalization, reintegration into a residential resource and congoing consultation and support and;
- shared data to inform a protocol;
- the development of a joint service provision framework for a shared residential resource that will provide stabilization services to clients with complex cases.

**Complex Case Background:**

- Individuals with intellectual disabilities have a prevalence of mental health disorders that is three to four times greater than the general population, yet they typically are under diagnosed and untreated\(^1\).
- CLSD's safety net is increasingly supporting individuals who require intensive complex support. However, CLSD is not always able to fully support these individuals as there is not the specialized services or authority to adequately address all the complex issues of clients such as mental health or criminal behaviors.
- Acute mental health facilities in-patient and emergency wards are treating individuals with complex needs. Often individuals with complex needs who are admitted into acute mental health facilities are either discharged without an integrated case plan or remain in short-term beds long term due to a lack of community resources.
- In 2009, the Ministry of Justice identified that an increasing number of individuals with complex support needs were either charged with an offence or were being incarcerated by default due to a lack of community resources and support.
- Incarceration does not have the same deterrent effect on individuals with intellectual disabilities and/or mental health challenges. As a result, these individuals have high rates of re-incarceration compared to the general population\(^2\).
- While incarcerated these individuals are often victimized emotionally, physically and/or sexually\(^3\).
- The costs of incarceration and/or utilizing acute mental health facilities can range from $1,200 - $3,000 per day. This cost does not account for the related system costs to process individuals which would far exceed $2,200 per day.
- In February 2009, a CDI was developed which sought to provide collaborative solutions to better support complex individuals in the community. The CDI was never presented to Cabinet and no formal action was taken.

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1 Riches, Parmenter, Wiese, Stancliffe (2005, November) Intellectual disability and mental health in the NSW criminal justice system
2 Ibid
3 Ibid
### Objectives:
- Collaborate with the Ministries of Health, Justice and the Saskatchewan Health Authority to provide comprehensive, appropriate and sustainable supports to individuals who have complex needs.
- Strengthen the provincial safety net.
- Address long-term support, housing, supervision and treatment needs of individuals with complex needs.
- Reduce the amount of overall government resources spent on supporting individuals with complex needs by maximizing current resources and providing more effective, service matching.
- Protect the public and individuals with complex needs.
- Prevent inappropriate incarceration of individuals with complex needs.

### Deliverables:
- Research best practices and perform a jurisdictional scan.
- Establish a working group with representatives from Ministry of Social Service, Justice and the Saskatchewan Health Authority on individuals with complex cases.
- Engage with Indigenous communities to ensure proper understanding of specific issues facing this group and, collaborate where possible.
- Recommend a protocol that outlines how the systems will collaboratively respond to complex cases.
- Recommend a shared residential resource that includes effective stabilization units, transitional housing and long term step down residential resources to support individuals as they transition to different stages of independence.
- Create a model that can be used cross Ministries and program areas’ i.e. CFP.

### Interdependencies:
- Human Service Integration Forum
- Complex Children and Families Project (Regina)
- Mental Health and Addictions Action Plan
- Review of the Complex Case Protocol
- Provincial Disability Strategy

### Assumptions:
- The Ministry of Health, the Ministry of Justice and the Saskatchewan Health Authority will participate and make this project a priority.
- A portion of the 2018-19 Budget will be dedicated to implementing the project’s recommendations.

### Risks:
- A lack of accountability and/or commitment from ministries would make it difficult to effectively implement recommendations.
- Lack of budget to implement all recommendations.
- The collaborative nature of the project may result in budget and implementation complexities that make it difficult to enact all recommendations.
- There may be challenges associated with having no mandate to restrict individuals with complex needs.
Resources and Responsibilities:

Project Co-leads:
- Develops project charter
- Establishes key milestones/deliverables and expected timelines
- Leads/chairs the working group meetings
- Establishes communication with the Steering Committee and inform them on deliverables

Business Lead:
- Provides regular updates on progress to the Project Sponsor and Steering Committee
- Provides guidance and support to the working group

Project Sponsor:
- Approves project charter
- Provides the Business Lead with overall direction and support
- Reports to the Executive Sponsor regarding progress, risks, and pressures
- Ensures issues are escalated and resolved as necessary

Executive Sponsor:
- Approves the project charter
- Leads/chairs the Steering Committee
- Presents options to the DMO
- Provides updates on progress to the Minister’s Office
- Provides updates to leadership of participating ministries

Steering Committee
- Reviews all working group deliverables and formally approves options

Working Group:
- Researches bests practices on how to properly serve complex individuals
- Analyzes trends and best practices
- Meets bi-weekly to ensure project timelines are achieved
- Actively participates in group to achieve project deliverables
- Develops recommendations
- Provides regular updates to the Steering Committee on progress

Timelines:

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<td>Approval of project charter</td>
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<tr>
<td>ADM discussion and identification of participants (Health, Justice)</td>
<td>November 30, 2017</td>
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<tr>
<td>Establishment of multi-ministry working group</td>
<td>January, 2018</td>
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<tr>
<td>Approval of work-plan</td>
<td>September, 2018</td>
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<tr>
<td>Draft Shared Protocol</td>
<td>September, 2018</td>
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<tr>
<td>Present drafted recommendations to steering committee</td>
<td>October, 2018</td>
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<tr>
<td>Draft joint Service Provision Framework for a shared residential resource</td>
<td>November, 2018</td>
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<tr>
<td>Present drafted recommendations to steering committee</td>
<td>December, 2018</td>
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I support this Project and authorize proceeding.

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Appendix B: Complex Case Definition

Complex cases are identified as those individuals who require highly specialized/ intensive/ unique services, which in their absence, could lead to serious and negative outcomes for the individual. Case management of complex cases involves multiple service providers (across multiple systems) and consumes significant time, energy and public resources. Individuals have no service options that adequately address their multidimensional support needs, or their current service options are not adequately addressing their needs. Cases are complex due to individual life experience and system gaps.

Individuals who are identified as complex cases often share the following characteristics or life experiences. Many of these characteristics will be enduring and persistent in nature:

- Psychiatric and/or behavioural issues which require specialized treatment;
  - These require intense, individualized support strategies which require highly specialized knowledge on the part of staff (e.g. program, behavioral, health, harm reduction/risk mitigation knowledge);
- Have a history of difficulty with voluntary participation in treatment strategies or support programs;
- Present a high level of risk of harm to themselves or the community at large;
- A history with loss of placement within any or all community placements (residential and/or day programs);
- Have a mental health disorder that requires frequent acute mental health admission or ongoing mental health support. co-morbid mental health disorder
- Incarceration(s) or criminal justice involvement or ongoing contact with the justice system and have repeatedly breached probation orders;
- Have chronic addictions issues, substance abuse/dependency problems
- Lack of a natural support system and long standing dependency on government services (no family or organic support system, history of placement with CFP, youth centers, mental health facilities, correctional facilities, group homes, etc.)

Individuals may also have experienced the following system issues:

System gaps may be described as:

- Size and complexity of the systems themselves can make it difficult for this population to find out about and access needed support
- Lack of clarity about role and mandate of various systems
- Each system has its own policies and procedures. These policies can be inflexible and may exclude this group of clients
- Gaps resulting from how policies are implemented on the front line.
- Gaps experienced by youth moving into adult system
- A lack of safe and affordable housing available for those with complex needs leads to homelessness and instability
• Lack of well-resourced services: home support, case management, staff training
  • A history of failed or unsatisfactory case interventions. Require multi-system involvement and don’t "fit" the standard services in our community due to their complexity of needs, resulting in chronic homelessness, high police involvement, and frequent emergency visits;
  • Incarceration(s) or criminal justice involvement or ongoing contact with the justice system (incarnation at times due to lack of appropriate services);
  • Hard to house or homeless;
  • Conditions which are complicated by low socio-economic circumstances;
  • Require significant resources to participate in the community.
Appendix C: Shared Framework

Cross-Ministerial Framework (Shared Service) to Support Individuals with Complex Needs

Vision/Principles/ Definition and Criteria

Shared Vision

Person Centered response/ security, safety, inclusion, connectedness, interdependencies
Proactive and Reactive solutions

Partnerships

What does success look like: to inform this process we complete client service mapping to identify real life experiences of what is working and not working – Use of an appreciative inquiry process – use of harm reduction models – current partnerships i.e. HUB, PACT, SAI MHD, Phoenix home, Northern Collation, My Home
Integrated Case Management
- Referral Process
- Planning Process
  - Ministry’s Responsibility

Home/Residential/Outreach Services
- In Home crisis/treatment/stabilization
- Outreach

Training/Education/Evaluation
- Cross-Ministerial Training
- Program Evaluation

Individual and Person Centered

To start on working group goal to be done ....
Cross Ministerial Framework Development Plan

Have more folks from the different Ministry’s help with the dev of the framework – pull on expertise i.e. Ryan (service map) Chris

Section 1/Intro of Framework
Vision/ Current state/History
Definition and Criteria
Best Practice and Research Models reference
Components to framework

Chris G? linked to CM/SHA/Justice

Section 2/Integrated Case Management
Best practice
Def
How to and process

Dixie/ Brittany/

Section 3/Home Based Supports
Service provision/ treatment/ outreach
License options
restrictive procedures
Risk assessment to determine restrictions (justice)
Description of outreach worker (maybe a health staff)
Nursing

Wendy/Mark

Section 4/ Education/ evaluation
Pilot
1. 1 FTE Cupe 11?
2. FTE to help with project development and be assigned cases
3. Ask health or justice if they would provide clinical supervision?
4. Develop achievable measurable outcomes
5. Cross ministry training
target date: Jan 1st 2019 to Dec 2019 year term (location?) TBD

PE staff/ Health? Terry’s unit?

Outreach worker to be assigned when case is accepted follow through process – Case manager supervise

Pilot
Appendix D: Brief Literature Review for IACC Team

IACC Literature Review

The literature reviewed was focused on adults with intellectual disabilities (IWID) with concurrent mental health disorders (MHD) and/or criminal involvement. The primary objective was to look for models of best practice for service delivery and support for this group of complex individuals along with recommendations for future service development.

Reviewing the literature focused on IWID and MHD or criminalized behavior, there were many common issues across both topics.

- Proper community supports are not in place for IWID with complex needs. Mental health supports are not available and targeted justice prevention programs are not in place.
- There is an identified need to develop treatment services and integrative community support.
- Probation orders are difficult for IWID to follow therefore a shift is needed to allow probation officers to develop stronger relationships with the client and participate more fully in community planning with the larger support team.
- Canada does not have a national policy. Provinces must develop their own strategy and direction.
- Most provinces have started cross-ministry work by developing various policies, frameworks, or service models to support individuals with complex needs. The Government of Alberta has developed a cross-ministry policy framework for supporting adults with complex service needs.

Two models of best practice were evaluated in Washington State and New South Wales. The primary factors attributed to the success of these two models include the following:
- A combination of specialized residential along with integrative case management and community support.
- The development of a specialized community support unit comprised of a caseworker and interdisciplinary team members such as other mental health professionals, addictions workers, etc.
- Custom training of residential staff.
- Therapeutic support within the home and community.
- Cross-ministry collaboration to train and educate service providers.

In Saskatchewan there is a shift in approach to human services delivery this framework is Community Safety and Well-Being (CSWB) (Nilson, 2018). This model focuses on multi-sector collaboration and has shaped the HUB along with many other cross-ministry collaborations within Saskatchewan. Community Safety and Well-Being is a researched approach focusing on shifting service delivery to a more interdisciplinary collaborative model. This framework is in line with the recommendations and best practices identified in the broader literature. Key findings from a national scan of multi-sectoral collaboration models within criminal justice:

- Collaboration helps close service gaps
- Positively impacts clients, frontline professionals, and partner organizations
- Increases service access while reducing barriers
- Improved understanding of client needs
- Fosters shared goals, reduces duplication, and increases overall effectiveness
References


Appendix E: Community Inventory Questions

Saskatchewan Health Authority and Ministry Program Inquiry

Included is a summary of conversations that occurred with various community agencies. The purpose of the interviews was to determine what services they offered specifically for individuals with intellectual disabilities (IWID). Each person I spoke with was aware that I was calling as a graduate research student looking to learn more about their agencies programs and services.

Mental Health and Addictions Services- Adult Outreach (SHA)

Adult Outreach in Saskatoon

- Is there any specialization within your programs for individuals with intellectual disabilities (IWID)?
- Are IWID generally accepted for MH services?
- What are the main barriers to working with this group of individuals?

Mental Health and Addictions Transition Team

- Do you know if there are any initiatives or service development within mental health for IWID? I read in the mental health 10-year action plan that there are recommendations to enhance the responsiveness of services for diverse groups, including individuals with intellectual disabilities. Just curious if you know of any ongoing work around this.

Adult Community Mental Health Services

- What services and supports do you offer?
- Is there a shared case management approach when they are connected to Community Living?
- Are IWID generally accepted for MH services, specifically counselling?
- Could IWID attend your groups?
Would they be able to attend with a support person?

Is there any specialization within your programs for people with ID?

Ministry of Justice

Community Corrections

- What services are offered by adult community corrections?
- Are there any specialized caseloads, programs, or supports for IWID?
- Are the residential programs within your department? Specifically, community residential facilities?

Correctional Services Canada

Regional Headquarters

- From what I read on your website about the various community residential facilities, some are run by the government and others non-government agencies. What is the process to enter in a residential contract to operate one of the facilities?
- The website states there is a “level of control and assistance” what is the level of restriction that exists in the homes? What regulations are in place?

Guardianship and Co-decision-making for Dependent Adults

Public Guardian and Trustee Office

- Are you aware of ways in which Guardianship is used to enforce treatment? Possibly for someone with an ID and MHD who is acting in ways that are unsafe to themselves or other community members?
- In some countries guardianship orders are used for these individuals who have complex challenges are vulnerable and at risk to make decisions around their treatment and supports. Do you have any thoughts around this?
Ministry of Social Services, Community Living Service Delivery

Outreach and Prevention Services

- The crisis home operated by CLSD is not licensed, how is it operationalized?

- The models we have found of best practice in the literature have minimal to high levels of restriction, do you have any thoughts around operationalizing the new home? Possibly including a higher level of restriction?

- Cross-ministry collaboration between health, the health authority, and corrections is a strong recommendation for supporting complex clients. Has this started within your program?
Appendix F: HUB Community Program Inventory

Objective: To speak with each HUB table in the province to discuss Complex Cases and get their feedback on what resources they use in their community, what the limitations are, and recommendations of growth/future chance.

HUB is the central point where the community turns for support when standard approaches fall short. It also has ministry representatives who can offer information and insight from their area of focus.

Process:
- call each HUB chair to set up meeting
- collect information on who all sits at their table
- attend Meeting
- provide outline of Project and definition of a complex case
- ask focused questions
- share email for any follow-up discussion or questions

Questions:

1. From the definition provided, what supports and services do you have in your community for this type of client?
   a. Housing?
   b. Mental Health?
   c. Addictions?
   d. Halfway houses?

2. What has been successful in your community in supporting these clients?
3. What barriers do you see affecting these individuals? Any systemic issues flagged around this area? Any work being done by the HUB steering committee? Any data that could be shared to inform the project?

4. What vision do you have in changing services and supports to better support these individuals?
Appendix G: Hub Pre-Discussion Information Sheet

Research Project Background:
As a graduate student with the Faculty of Social Work I am currently doing a research project with the Ministry of Social Services. The project is focusing on an integrative approach to complex cases. The project task team is comprised of Ministry representatives from Disability Services, Health, Justice, and the Health Authority. We are looking to develop a protocol and process to align the services from all ministries to better respond to the needs of complex individuals in our community. Specifically, people with intellectual disabilities, mental health challenges, behavioral issues, and/or criminalized behavior. These individuals place a significant strain on each service system as they typically experience higher levels of placement breakdown and have higher recidivism rates within the criminal justice system and acute mental health facilities. This team is working to develop a collaborative service model to safely support complex individuals in the community including both residential and case management services. The HUB table often has frontline involvement with many of these complex individuals. Through the work of each agency and the HUB, there has been successes for these folks along with many challenges and barriers.

Questions & Discussion Topics:
On August 14th I will be coming to visit you all at your HUB meeting with a few key questions and areas to discuss. I am looking to hear any feedback or information you have to share from your frontline experience and involvement in the HUB.

5. From the complex cases definition attached, what supports and services are available that you know of for this type of client?
   a. Housing?
   b. Mental Health?
   c. Addictions?
   d. Halfway houses?

6. What has been successful in our community in supporting these clients?

7. What barriers do you see effecting these individuals? From the systemic issues flagged around this area, is there any work being done by the HUB steering committee at this time?

8. What vision do you have in improving services and supports to better support these individuals?
Complex Case Definition
Complex cases are identified as those individuals who require highly specialized/intensive/unique services, which in their absence, could lead to serious and negative outcomes for the individual. Case management of complex cases involves multiple service providers (across multiple systems) and consumes significant time, energy and public resources. Individuals have no service options that adequately address their multidimensional support needs, or their current service options are not adequately addressing their needs.

Cases are complex due to individual life experience and system gaps.

Individuals who are identified as complex cases often share the following characteristics or life experiences. Many of these characteristics will be enduring and persistent in nature:

- Psychiatric and/or behavioural issues which require specialized treatment;
  - These require intense, individualized support strategies which require highly specialized knowledge on the part of staff (e.g. program, behavioral, health, harm reduction/risk mitigation knowledge);
- Have a history of difficulty with voluntary participation in treatment strategies or support programs;
- Present a high level of risk of harm to themselves or the community at large;
- A history with loss of placement within any or all community placements (residential and/or day programs);
- Have a mental health disorder that requires frequent acute mental health admission or ongoing mental health support. Co-morbid mental health disorder
- Incarceration(s) or criminal justice involvement or ongoing contact with the justice system and have repeatedly breached probation orders;
- Have chronic addictions issues, substance abuse/dependency problems
- Lack of a natural support system and long-standing dependency on government services (no family or organic support system, history of placement with CFP, youth centers, mental health facilities, correctional facilities, group homes, etc.)

Individuals may also have experienced the following system issues:

System gaps may be described as:
- Size and complexity of the systems themselves can make it difficult for this population to find out about and access needed support
- Lack of clarity about role and mandate of various systems
- Each system has its own policies and procedures. These policies can be inflexible and may exclude this group of clients
- Gaps resulting from how policies are implemented on the front line.
- Gaps experienced by youth moving into adult system
- A lack of safe and affordable housing available for those with complex needs leads to homelessness and instability
- Lack of well-resourced services: home support, case management, staff training

- A history of failed or unsatisfactory case interventions. Require multi-system involvement and don’t "fit" the standard services in our community due to their complexity of needs, resulting in chronic homelessness, high police involvement, and frequent emergency visits;
- Incarceration(s) or criminal justice involvement or ongoing contact with the justice system (incarnation at times due to lack of appropriate services);
- Hard to house or homeless;
- Conditions which are complicated by low socio-economic circumstances;
- Require significant resources to participate in the community;
Appendix H: CLSD Client Consent Document

Confidential

Consent for Collection, Use and Disclosure Of Personal Information

Pursuant to the Freedom of Information and Protection of Privacy Act, or the Health Information Protection Act.

<table>
<thead>
<tr>
<th>Name of Individual:</th>
<th>Date of Birth: (dd/mm/yyyy)</th>
</tr>
</thead>
</table>

I, [myself, or legal guardian/representative] (circle) of __________________________ hereby consent to officials from the Community Living Service Delivery of the Ministry of Social Services to collect, use and disclose the following types of personal information of the above named individual for the purpose of supporting comprehensive planning to meet the needs of the above named individual.

<table>
<thead>
<tr>
<th>Type of Information: (Check those that apply)</th>
<th>Information Can be Collected From or Disclosed To: (Check those that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Social history</td>
<td>□ Social/medical professionals (eg. Psychologist, Counselor, Therapist, Physician)</td>
</tr>
<tr>
<td>□ Family history</td>
<td>□ Community Service Providers</td>
</tr>
<tr>
<td>□ Employment information</td>
<td>□ Individual’s current employer</td>
</tr>
<tr>
<td>□ Educational, psychological and psychiatric assessment(s) and evaluation(s)</td>
<td>□ Family/next-of-kin</td>
</tr>
<tr>
<td>□ Health information including medical assessments</td>
<td>□ Advocate</td>
</tr>
<tr>
<td>□ Financial information</td>
<td>□ Other</td>
</tr>
<tr>
<td>□ Legal information</td>
<td>_________________________________________________________________________</td>
</tr>
<tr>
<td>□ Other</td>
<td>_________________________________________________________________________</td>
</tr>
</tbody>
</table>

I understand that Community Living Service Delivery will:

- Collect and disclose personal information and personal health information both verbally and in writing with those who are part of service planning in order to meet the needs of myself/the above named individual.
- Only disclose as much information as is required in order to provide/coordinate services to meet the needs of the individual.
- Only disclose information in accordance with my consent and as required by law.

I understand that:
- I may refuse to sign this consent or I may revoke this consent in writing at any time.
- This form is valid for two years unless otherwise stated.

COMMENTS:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature of Individual and/or Legal Guardian/Representative
Printed name and relationship to Individual

________________________________________________________________________
Signature of Witness/Other

Date: ____________________________

<table>
<thead>
<tr>
<th>For Office Use Only:</th>
<th>(Staff initials)</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Legal authorization of Guardian/Representative verified.</td>
<td></td>
</tr>
<tr>
<td>___ Consent withheld by individual and/or legal guardian/representative</td>
<td></td>
</tr>
</tbody>
</table>
Appendix I: Client Letter for Consent

Dear Client Name,

My name is Brittany McFadden. I am a graduate student with the Faculty of Social Work working on a research project with Community Living Service Delivery. My research is looking to find a way to better support clients like yourself. I am seeking your consent to allow me to review your file information to inform my research. No identifying information will be included in my paper such as your name, place of residence, or other agencies you are attached to. Information that will be included will be general themes of your experiences. If you have any further questions or would like to talk to me regarding my project, please let your CLSD case worker know.

Please know that at any time you can retract or cancel your consent for my project and I will not include your file information in my research.

Thank you,

Brittany McFadden
MSW Practicum Student
Program Design & Operational Policy Branch
Disability Programs
Ministry of Social Services
306-933-5808
Appendix J: Hub Non-Disclosure Agreement

Terms of Reference - Saskatoon Hub Steering Committee and Hub Table

Appendix 3

Hub Participant Non-Disclosure Agreement

Participant’s Name: Brittany McFadden

(Print)

Company / Position: Community Living Service Delivery - MSW practicum Student.

Phone Number: 306-933-5808

Email Address: brittany.mcFadden@gov.sk.ca

1. I acknowledge that I will be given access to confidential information presented during Hub proceedings or as a result of my access to the Saskatoon Hub premises.

2. I understand and acknowledge that all information presented will be held in the strictest of confidence. I will not disclose this information or knowledge to anyone outside of the Hub, unless it is required to provide services by my home agency. This information will be used in good faith and in consideration of the best interest of my client.

3. I promise to only take notes on a need-to-know basis and only if the agencies participating in the Hub discussion identified my respectful home agency to be directly involved in the situation the information pertains to. I promise to only take notes if the note taking is lawful.

4. Conflict of Interest Policy: A conflict of interest is a situation in which a person has a private or personal interest sufficient to appear to influence the objective exercise of his/her official duties.

If I am in a Conflict of Interest with a situation discussed at Hub, I will immediately disclose my conflict of interest to the Chair and the agency representatives. I will not take part in the discussion and remove myself from the entire discussion.

5. I agree to adhere to the above conditions as well as to the policies regarding confidentiality set out by my respective home agency.

6. Academic Research: I will use data and information provided to me from the Hub and MSS for the sole purpose of academic research within the scope I have identified to MSS. I will not disclose the data or information to any person, except as may be necessary for the purpose of academic research. I acknowledge and agree to abide by the following terms:
   - Data about the Hub may be provided in electronic or written format. The data is confidential, and appropriate measures shall be taken to ensure the data is securely stored at all times and not accessible to any other person.
   - Data may not be transferred to any other person.
   - Following completion of academic research, all data will be deleted or destroyed.

Participant Signature: Brittany McFadden
Witness Signature: Euni Jaceelle
Date: July 26, 2019
Appendix K: Community Inventory Responses

Saskatchewan Health Authority and Ministry Program Inquiry

Included is a summary of conversations that occurred with various community agencies. The purpose of the interviews was to determine what services they offered specifically for individuals with intellectual disabilities (IWID). Each person I spoke with was aware that I was calling as a graduate research student looking to learn more about their agency’s programs and services.

**Mental Health and Addictions Services - Adult Outreach (SHA)**

**Adult Outreach in Saskatoon**

*Is there any specialization within your programs for individuals with intellectual disabilities (IWID)*?

- No specialization.
- Services serve the general population.
- The client must also have an addictions issue meet criteria; mental health alone does not meet criteria for outreach services.
- The team is currently comprised of 3 full time addictions workers and 2 case managers.
- The focus of the outreach work is to get individuals into treatment.

*Are IWID generally accepted for MH services?*

- IWID are often not accepted for other MH services because they can’t access counselling services without goal setting.
- Criteria for the MH counselling services is to set treatment goals, this is something IWID are often unable to do.
- IWID need to find the right fit for counselling and treatment.
- There are currently no treatment center’s or programs for IWID.

*What are the main barriers to working with this group of individuals?*

- We need to set up programs and services differently for IWID.
- Modification is needed in programs.
- Sheer numbers and high volume for MH services is just too high.
- We did have 1 trained/specialized staff, they came to us with special training, and is no longer with the program.
Mental Health and Addictions Transition Team

Do you know if there are any initiatives or service development within mental health for IWID? I read in the mental health 10-year action plan that there are recommendations to enhance the responsiveness of services for diverse groups, including individuals with intellectual disabilities. Just curious if you know of any ongoing work around this.

“There isn’t a lot currently. It’s either for mental health or for intellectual disabilities. That’s often where mental health falls short. Concurrent or comorbid Dx (diagnosis) is considered “complex” and our system still like “main stream” patients. Unfortunately, that’s not how humans operate.”

Adult Community Mental Health Services

What services and supports do you offer?

- Social workers, case managers, peer support, counselling, community mental health nurses (CMHN).
- We complete referrals to Mental Health homes.
- CMHN will do both therapy and medication management.
- They could be connected to other services, such as Community Living as well.

Is there a shared case management approach when they are connected to Community Living?

- No, we just default to CLSD.

Are IWID generally accepted for MH services, specifically counselling?

- There is no discrimination for IWID.
- Clients need to have a goal to be accepted for our services, it is a goal driven program.

Could IWID attend your groups?

- Yes, if it was appropriate and they could work in a group setting.

Would they be able to attend with a support person?

- No, it is a closed group.

Is there any specialization within your programs for people with ID?

- No, we accommodate what we can.
- The client must be able to articulate a goal of change for them to work with our counsellors.
- Counsellors modify their approach, there is no specific training that we have for IWID.
Ministry of Justice
Community Corrections

What services are offered by adult community corrections?
-Probations officers.
-Programming with the P.O.
  ~Living without violence group
  ~Domestic Violence education group

Are there any specialized caseloads, programs, or supports for IWID?
-No, but it is definitely needed.
-We have PO specialized in DV or Sex Offender.
-We also have special programs and treatment for these individuals, but nothing for people with ID.
-We have partnerships with the police and mental health services for some of our programs, specifically the Serious Habitual Offender Program and our Serious Violent Offender Response.

Are the residential programs within your department? Specifically, community residential facilities?
-That is in a different division.

Correctional Services Canada
Regional Headquarters

From what I read on your website about the various community residential facilities, some are run by the government and others non-government agencies. What is the process to enter in a residential contract to operate one of the facilities?
-Could not share information.

The website states there is a “level of control and assistance” what is the level of restriction that exists in the homes? What regulations are in place?
-Could not share information.
-If you want to access information, you need to submit an access to information request which is $5 per request.
-Any information beyond what is posted on the website requires an access request.
I will pass your number to a colleague who is more involved in this area (*there was no follow-up from anyone).

-You need to go through the “proper channels”.

**Guardianship and Co-decision-making for Dependent Adults**

**Public Guardian and Trustee Office**

*Are you aware of ways in which Guardianship is used to enforce treatment? Possibly for someone with an ID and MHD who is acting in ways that are unsafe to themselves or other community members?*

-No.

-The primary function we use it for is to ensure a person’s assets are protected.

-You can seek a personal guardianship order through the public guardian that allows a person to decide where someone lives, who they speak to, who they see, etc.

*In some countries guardianship orders are used for these individuals who have complex challenges are vulnerable and at risk to make decisions around their treatment and supports. Do you have any thoughts around this?*

-We do see a role for guardians for more vulnerable individuals, we are just not there yet.

-Our office primarily deals with finances and assets.

**Ministry of Social Services, Community Living Service Delivery**

**Outreach and Prevention Services**

*The crisis home operated by CLSD is not licensed, how is it operationalized?*

-The homes are owned by Central Services who have regulations we follow.

-Fire code is a large piece of the safety measures.

-Cost is often barrier for CBO’s to have things we do in our home, specifically maglocks or cameras.

-The use of a camera is not a restrictive procedure.

-All programmatic restrictions are guided by our Comprehensive Personal Planning & Support Policy.

-The house staff are training in crisis intervention and we review and audit if any physical restriction is used.
The models we have found of best practice in the literature have minimal to high levels of restriction, do you have any thoughts around operationalizing the new home? Possibly including a higher level of restriction?

- CLSD should have a second stream of services.
- We currently are voluntary but work with individuals who are complex or even deemed they "cannot stand trial" due to mental capacity.
- For these clients we need a closed service system which could be in collaboration with correctional building code, social services staff, and mental health services (medication, psychology, counselling) to offer a full array of services and supports for this group of clients.
- This way we can offer community safety and adequately support people who don’t fit within our voluntary programs.
- If we could look at incorporating capacity assessment as an avenue to look at different restrictions.
- Our residential services are guided by the Residential Services Act, if there is nothing in there specifically around restriction, we would just need to write it into our policy.

Cross-ministry collaboration between health, the health authority, and corrections is a strong recommendation for supporting complex clients. Has this started within your program?
- The ISP tool works well for coordinating.
- The North Battleford office with working with Saskatchewan Hospital North Battleford to develop a shared tool to look at meeting therapeutic and clinical need of the clients collaboratively.
- Community Living Skills Project 2001; a 3-way project for clients with offending HX.
- Therapeutic counselling and training was offered, an offender treatment program was piloted for 3 years (Assessment Driven Treatment Interventions for Men with ID who have committed sexual offences). *They did not have access to the final report to share any outcomes or evaluation or this earlier work
Appendix L: Client Mapping File Review

Complex Case Client Mapping File Review

1. Outline
   a. 0-6 (1983-1990)
      - 12 residential placements (5 emergency placements where he was returned home shortly after, 5 foster home (FH) placements, 1 permanent placement with his maternal aunt)
      - First removed from home at 9 months old
      - Protection concerns included: severe neglect, physical abuse, sexual abuse, unsanitary living, lack of supervision, no food in the house, and mom suffered from severe epilepsy
      - Separated from siblings
      - Tenuous relationship with mom
      - Numerous hospital admissions for health reasons
      - High Child and Family Programs (CFP) contact and involvement
      - Youth Support Worker (YSW), provided in home support once resided with Aunt

   b. 6-12 (1990-1996)
      - Permanent Ward, CFP
      - Maintained placement with Aunt
      - High level of in-home support from the YSW
      - Inconsistent supervised visits with mom and siblings (generally a stressor for client)
      - Connected to Child Psychiatrist
      - Connected to Neurologist
      - Receiving Speech and Language Therapy at School
      - First hospital admission at the age of 12 for a medication change (12 days)

      - Moved to a therapeutic foster home as behavioral and support needs exceeded Aunt’s capacity
      - Attended a boarding school from 1997-2000 (discharged due to behavior; aggression and inappropriate sexualized behavior towards students and staff)
      - YSW provided support before and after school and on the weekends at home
      - Weekly meetings with the school Social Worker for mental health support
      - Attended mainstream school following discharge
      - Psychiatry appointments every 4 months
      - Significant decrease in family contact, primarily phone calls only
• Mom moved Provinces for a short period of time

d. 18-24 (2002-2008)
• Community Living Service Delivery (CLSD) involvement
• CFP file closed in 2003
• Transitions to adult services and residential placement with adult group home
• 3 placements within the agency to find the right fit
• Agency documents high levels of violent and aggressive behavior which resulted in police being called and hospital admission
• Transitioned from School to community supported employment in grade 12
• Assault Charge- court ordered 30 day assessment *charges dropped and 9m probation order in place
• 5 separate mental health admissions (65 days)
• Psychiatry appointments every 3-4 months
• Agency discharge due to assault
• Move to CLSD residence, and resided from 2004-2009
• Total 4 moves

e. 24-30 (2008-2014)
• Move to another CLSD home
• Assault, charges, mental health admissions
• 94 days in jail (due to no residential placement)
• 4 total admissions
• 4 moves to 4 different cities
• 1-year residence at CLSD crisis home
• Increase in police involvement
• Maintained connection with Neurology and Psychiatry
• Ongoing medication review and management
• Very little family contact/involvement
• High involvement from CLSD programmatic team (Incident report documentation, tracking and hypothesis to develop a support plan with consistent approaches, safety plans, and activity scheduling)

f. 30-34 (2014-August 2018)
• Remanded 2 times
• 5 charges (4 assault and 1 mischief)
• 11 mental health admissions, 3 fitness assessments
• 511 total days in jail
• Disclosed sexually assaulted while incarcerated
• Moved to a new agency, resided in his new home approximately 3 weeks before police were called due to aggression in the home
• Acute mental health admission, returned home, police called again, charges laid, placed in jail
• Currently no residential placement and in high cost resource

2. Environmental supports
   • Youth Support workers while in Foster Care and at boarding School
   • Alarms on his bed
   • Structured 1:1 school support
   • 1:1 and 2:1 staffing in adult residential placements and vocational programming
   • Program plans with safety planning, consistent approaches, and schedules
   • Occupational therapy assessments
   • Mental health fitness assessments

3. Family
   • Supervised visits with mon in younger years, not consistent
   • Aunt decreased support or contact after placement
   • Phone contact with sisters, although they also find phone conversations also to be stressful, the frequency significantly decreases over time
   • Limited to no maintained contact with old foster parents

4. System involvement
   • CFP 1984-2003
   • CLSD 2002-current
   • Adult Mental Health- Psychiatry 2004-current
   • Community Corrections/Probations: in and out from 2004-current
   • HUB 2018
   • PACT 2017-current
   • Counselling: Catholic Family Services (Briefly in 2013)

5. Personal successes
   • Special Olympics participation in 2003/2004
   • Supportive Therapeutic Foster home from 1996-2003
   • Resided in CLSD home from 2004-2009
   • No correctional involvement/charges from September 2010-May 2015 or Jan 2016-June 2017
   • Developed the skills and ability to express self, show self-regulation, work through problems, and engage in positive programming
   • Developed strong relationships with various support providers and workers

6. Systems successes
   • Transition to CLSD from CFP
• Collaboration and open communication with community Psychiatrist and Neurologist
• High medical involvement and ongoing medication review
• PACT team involvement, working with CLSD to avoid further criminal charges
• Advocacy in community for Mental Health support, admissions, assessments, and community support

7. Challenges – gaps
• Denied hospital admissions due to bed numbers or history of previous admissions
• High medication focus for all admissions
• Inconsistent or complete lack of community mental health support for non-medication reasons (counselling or therapeutic support)
• High police involvement due to aggression and destruction
• Agencies burning out due to difficult and persisting challenging behavior
• Extended incarceration due to no community placements
• Labelled with challenges being “behavioral” not mental health
• Lack of support for trauma, anger, sexualized behavior, and social boundaries

8. Traumatic events

Youth
• Removed from his mom 9 times before the age of 5 (removed to emergency placement, then returned home 9 times)
• Physical abuse, sexual abuse, neglect, unsanitary living, lack of supervision
• Mom had severe health problems
• Apprehended; 3 different foster home placements, then returned home
• Apprehended; 1 foster home placement, then placement with maternal aunt
• Placement breakdown with Aunt, moved to Therapeutic Foster Home
• Attended boarding school, home every second weekend due to behavioral challenges
• Hospitalization at age of 12 for medication review
• Mom moved away to Manitoba for short period
• Inconsistent visits or phone calls with mom and sisters

Adult
• 3 moves in 1 year after leaving Therapeutic FH
• Approximately 20 MH admissions total 126 days for medication review, behavior, or fitness assessments
• First charge at the age if 20
• Pattern of moving, police involvement, and hospital admissions beginning in 2004, escalated in frequency and severity in 2009-present
• Vulnerable during time in jail, total time served 638 days
• Traumatic assault within his home
- Was sexually assaulted in jail
- Little to no family contact as an adult
- Change in group homes, ending of relationships and connections made with various agencies and communities
Appendix M: Residential Operational Summary for IACC Team

Residential Operationalization Avenues

Goal: To develop a residential program that provides supportive transitions from acute care or correctional facilities into the community or provides intensive community treatment with the intention of preventing admissions to inappropriate placements.

Best Practice: Literature shows that IWID and complex mental health or criminalized behavior require adequate treatment in the community. For individuals being released from jail or mental health institutions, their transition to the community should come in the form of a treatment home in combination with a specialized case management support. Some level of restriction is necessary for the safety and well-being of the client and others in the home. Current models vary in range of level of restriction and voluntary/involuntary.

Local avenues to explore

Mental Health; Community Committal, Compulsory Care, Community Treatment Order

Community Committal is a legal mechanism within the Canadian Mental Health Act to enforce compliance with community services and treatment. Client must submit to treatment and attend medical appointments or else face hospitalization. *Not a measure being practiced in SK.

Compulsory Care under the adult guardianship and trustee act. This can be obtained through application through the Queen's Bench. If obtained, authority is granted to take a dependent adult to the care center named in the order; it must be designated under the Dependent Adults Regulations.

Community Treatment Order can be applied for and granted under MH services Act.

(iv) the services that the person requires in order to reside in the community so that the person will not be likely to cause harm to himself or herself or to others, or to suffer substantial mental or physical deterioration:

(d.1) if considered necessary, state that the person is required to stay at a residence specified by the psychiatrist;

CTO’s are used when an individual is not medication complainant, too unwell or unable to understand their mental health deterioration or need to be highly monitored in the community. A CTO is obtained by having 2 Psychiatrists sign 2 documents form H.3 and H.4. A CTO is valid for 6 months in the province. When a client is on a CTO they will be assigned a CMHN (Community mental health nurse) who will provide the medications and monitor them in the community. Most people who are on CTO’s are on injection (depot) anti-psychotic medications. Most CTO medications are not given orally because the nurse would have to come daily to dispense same. Should the client not follow through with their CTO treatment plan, they are legally brought back to the hospital and can potentially be certified.
* Guardianship: Guardianship orders are used differently in various regions and countries. In Saskatchewan, it is not common to use a Guardianship order or decision-maker order for a dependent adult. In speaking with the Saskatchewan Guardianship and Trustee office, they were not aware of this being a current practice locally but were aware that orders are used differently in other places.

**Disability Services**
CPP&SP along with The Residential Services Act and Rehabilitation Act guide CLSD’s residential service models.
Things to consider:
- A risk assessment tool is used to create threshold in which we determine an increase or decrease in level of restriction? Adopt our policy to be inclusive of complex clients in high risk situations. Ex. An assessment is complete showing a client at a high level of risk, therefore their level of residential restriction increases until a reassessed at a lower level.
- Could this assessment be in partnership with Mental Health orders or MH team members?
- The Residential Service Act does not make any reference to restrictive measures nor does the Rehabilitation Act
- In consultation with CLSD’s Manager of Outreach and Prevention Services, government run homes are not licensed. The homes are owned by centralized services which has regulations in place by fire code and safety.
- Any level of restriction or new way of operationalizing CLSD homes would need to be written into policy.

**Corrections**
*Community-Based Residential Facilities (CBRFs)*
A Community-Based Residential Facility (CBRF) is a half-way house. These facilities provide a bridge between the institution and the community. They work on a system of gradual, supervised release. Many offer programming for residents. This may include life skills, substance abuse, employment and/or crisis counselling. Some of these are owned and operated by non-governmental agencies (CRF). Others are owned and operated by CSC (CCC).

*Community Residential Facilities (CRFs)*
Facilities owned by non-governmental agencies sign contracts with CSC. They provide special housing, counselling and supervision. They usually deal with offenders who are on day parole. The contract sets out detailed requirements for levels of control and assistance.
CSC has approximately 200 contracts with CRFs (including Hostels, PHPs, etc) across Canada.
Community Based Sentence Order
Sentence is served in custody within the community under conditions set by the judge. These conditions can include place of residence and to abide by a treatment order as directed.

Information retrieved from:

http://www qp gov sk ca/documents/Forms/PGT/FormA pdf
http://www qp gov sk ca/documents/Forms/PGT/FormB pdf
https://sasklawcourts.ca/home/provincial-court/going-to-court