

SECTION 9

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SECTION 9: FORENSIC MENTAL HEALTH SERVICES

9.1 Introduction

Since the 1960's when Ontario first started to deinstitutionalize people with mental illness and close PPHs beds, the number of mentally ill individuals involved with the criminal justice system has grown considerably. Although community-based services were intended to serve people who had been previously hospitalized, the reallocation of funding was either insufficient or not targeted to appropriate services and supports for some of the most vulnerable client groups. By the 1990s it was evident the policy of deinstitutionalization in the absence of adequate services and supports in the community had resulted in the criminal justice system becoming, in times of crisis, the primary resource available to individuals with mental illness and to their families. As a result, many people with serious mental illness became trapped in the revolving door of crisis hospitalization, homelessness and involvement in the criminal justice system.

A number of factors have contributed to the influx of persons with a mental illness into the criminal justice system in addition to the downsizing of the PPHs and inadequate community-based mental health services. These include "tough on crime" legislation that tends to penalize people with serious mental illness, a lack of pre- and post-arrest intervention services and a lack of appropriate services and supports designed to reintegrate a person with serious mental illness into the community following release from jail or prison.

In recent years, some advances have been made in many areas of the province. These advances include effective diversion programs for mentally ill persons, mental health courts and more effective ways of conducting psychiatric assessment. The absence of new funding in some areas has, however, slowed this progress, with some locations such as the Northeast receiving no new funding in the past decade.

Policymakers and the public have become increasingly concerned with the plight of people with unmet mental health needs and the criminalization of these individuals. As this awareness has increased, a consensus among policymakers has emerged that the criminalization of the mentally ill is "*morally bankrupt, ineffective and a poor use of public funds.*" (*Criminal Justice Primer for State Mental Health Agencies*, 2002, p.1). Millions of dollars are spent responding to the consequences of untreated mental illness rather than efficiently and effectively addressing

the needs of adequate housing, access to treatment, effective crisis response and support and jobs for the mentally ill. The solution begins with greater cooperation and coordination between the mental health and the criminal justice systems so that no one ends up becoming criminalized because appropriate mental health care is not available.

Improving mental health care in Ontario will yield a number of positive returns, including lower criminal justice costs; healthier communities driven by a value system that sees recovery as both desirable and achievable for every person who has experienced mental illness and most importantly, a renewed hope for people who are too often viewed as a liability rather than an asset to the community.

Legislative Framework

The *Criminal Code of Canada* and the *Ontario Mental Health Act* provide the legislative framework for dealing with persons who are charged with a criminal offence and are, or may be, suffering from a mental illness.

The mental disorder provisions in the *Criminal Code* Part XX.1 Sections 672.1-672.95 provide for:

- ✓ assessment orders to determine the mental condition of the accused;
- ✓ treatment orders ;
- ✓ the determination of fitness to stand trial;
- ✓ findings of not criminally responsible on account of mental disorder (NCR); and
- ✓ the composition and function of the Ontario Review Board to make or review dispositions concerning any accused who is found not criminally responsible or unfit to stand trial.

Under the *Mental Health Act*, a judge may order a person to be remanded as a patient to a psychiatric facility for a period of not more than two months where there is reason to believe that the person suffers from a mental illness.

On December 1, 2000, the Ontario government proclaimed Bill 68 (Mental Health Legislative Reform). This legislative reform amended the *Mental Health Act* and the *Health Care Consent Act* “in keeping with the governments commitment to ensure that people with serious mental illness get the treatment they need”. The legislation includes several changes:

- The addition of community treatment order (CTO) provisions, as an option for those who require psychiatric treatment for serious, recurring mental illness.
- The addition of new grounds to the civil commitment criteria. These criteria authorize involuntary examination, assessment and detention at an earlier stage in a person's illness.
- Improved access to treatment by streamlining the hearing and appeal rules in the *Health Care and Consent Act*.

The most controversial reform is the CTO provision that was enacted to provide a person who suffers from a serious mental illness with a comprehensive plan of community-based treatment.

Mental Health Reform

In 1998, the HSRC issued a report, *Change and Transition: Planning Guidelines and Implementation Strategies for Home Care, Long Term Care, Mental Health, Rehabilitation, and Sub-acute Care*. In this report, the HSRC identified their purpose as establishing interim guidelines to achieve the MOHLTC's provincial target of 30 mental health beds per 100,000 population with a broader objective of facilitating the goals of mental health reform by moving patients and treatment from institutions to the community, providing services locally, developing a more coordinated and integrated system and balancing the range and availability of mental health resources throughout the province.

As the MOHLTC moved forward to rebalance the mental health resources by shifting the emphasis away from beds to the community, the HSRC recommended that reinvestments in community-based and other support services occur prior to the closure of any inpatient psychiatric bed closures. It also recommended that the MOHLTC continue with the process of reviewing forensic services cautioning that; "Planning undertaken to reform forensic services should be monitored closely to ensure that action is taken to increase accessibility to both inpatient and community-based forensic services".

In addition, it recommended "the work of the Human Services and Justice Coordination Project be used to guide the initial restructuring efforts in the forensic system".

In 1999, the MOHLTC published *Making it Happen: Implementation Plan for the Reformed Mental Health System* (1999) and a companion document, *Making it Happen: Operational Framework for the Delivery of Mental Health Services and Supports* (1999). These two documents provide the context for the overall reform of the mental health system in Ontario and focus on how core services will be organized and delivered within the reformed system. A critical component of this reform is that persons with mental illness will be at the centre of the mental health system and that they will be both active and valued as participants in the planning, evaluation and governance of mental health services.

In these documents, the MOHLTC recognized that the current mental health system has gaps in services for individuals that have multiple service needs and must access separate service systems, such as forensic clients. As such, the Ministry identified the need to develop a shared service model of care to provide effective treatment to these clients through:

- ✓ cross sector planning
- ✓ service agreements among sectors
- ✓ continued implementation of existing policy guidelines (e.g., Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario)

The MOHLTC confirmed its commitment to specialized regional forensic programs that are dedicated to the treatment and management of high risk/high needs clients including a regional secure program, a protected/integrated bed program and mobile forensic outreach programs. The Ministry also identified the need for the regional forensic programs to be fully integrated with the broader mental health system, so that there are avenues available for early diversion of low risk, minor offenders and access to general mental health services, including assertive community treatment programs, generic treatment and rehabilitation, as well as community services and supports that ensure a step-down services capacity to non-forensic services. (Step-down services is a system of graded services and programs based on perceived dangerousness and treatment needs that may begin with a secure restricted setting and gradually cascade down until the client is integrated in the general psychiatric stream of services or released into the community).

In addition, the MOHLTC recognized the need for participation on active Human Services and Justice Coordinating committees to enable regional/local interministry coordination between the

regional forensic service, social services and the criminal justice system, in order to make the most efficient use of available resources.

9.2 Criminal Justice System Impacts

While the MOHLTC has made significant investments in the development of community mental health services as it has moved forward with its agenda of mental health reform, the number of individuals who are continuing to fall through the gaps in the community service network and end up in the criminal justice system has escalated. Police report increasing contacts with individuals who are mentally ill and in crisis, the courts have become overwhelmed with the number of mentally ill minor offenders who are appearing before them and the correctional system has seen a significant increase in mentally ill persons in jail.

The Seaton House Annex Harm Reduction Program identified many clients who are consistently involved with community services and the criminal justice system. This involvement has had a staggering impact on community resources (court, corrections, health care, and hostel services). Furthermore, men with chronic mental health problems who have not been served by conventional models of care, also have a large economic impact on community resources. Conservative estimates place the cost of serving these persons at between \$100,000 to \$250,000 per person per year (The Harm Reduction Farm: Shirley Hoy and John Jagt Presentation, May 20, 1998).

For the Northeast, the MOHLTC shows a 29% lifetime incidence of mental disorder of the population in that region (Canadian Mental Health Association's Presentation to Branch Forum, Sept. 1999). The distance, isolation in the North and difficulties in accessing services, aggravates this problem.

Police

In times of crisis, people with a mental illness and their family members, who are unable to access community-based mental health services, frequently turn to the local police anticipating that they will be able to assist them in being admitted to the appropriate mental health programs.

While some individuals with a serious mental illness are both violent and serious offenders, the majority who break the law often commit nuisance crimes that are associated with their illness, such as trespassing, vagrancy and disturbing the peace. Police officers are frequently reluctant to take a person to a hospital when they know that custody and security is limited or that they will have to wait for several hours before a physician sees the individual. Unlike the mental health system that may question an officer's determination that the person suffers from a mental illness, the criminal justice system does not question the officer's judgment for making an arrest. Police officers, therefore, are often forced to either abandon an individual or make an arrest as the only viable option to ensure public safety.

A study conducted by Heslop and colleagues (2002) examined the changes in the pattern of contacts between the London Police Service and people with serious mental illness and found that the number of police contacts had increased from 1998 to 2001. The study reported that there had been a 21% increase in the number of nuisance type charges laid against individuals identified with a "definite serious mental illness" from 1998 to 2000 and that these individuals were more likely to spend time in custody. In addition, the study found substantial increases in the time police spent in direct response to all seriously mentally ill individuals. However, in a study by Cotton and Zanibbi (2001) regarding police officers' knowledge about mental illness, they found that the overall level of knowledge about mental illness was extremely variable and not necessarily any higher than that of the general public.

Metropolitan Toronto Police Services report a significant increase in contacts with mentally ill individuals over the past few years. Reports from other police jurisdictions, e.g., London and Sudbury, show similar increases. A police representative on the North Bay Human Services and Justice Coordination Committee describes the situation as follows: "Even though the number of arrests are down, the time spent with the mentally ill and others with whom we come in contact takes up so much of our time that we usually have to limit these contacts."

Courts

With the increasing numbers of mentally ill and developmentally disabled individuals appearing before the court, there emerges additional pressure on that institution to blend the administration of justice with a humane consideration of the needs of the persons before it. By and large, the court officials have responded and their utilization of a "therapeutic jurisprudence" approach reflects the ability of the court to react in a helpful, problem-solving manner. The

court, though, is under pressure to find solutions to the many problems that it faces, chief of which is the access to hospital beds, to have an understanding of the mental health system and the resources available so as not to make inappropriate disposition orders. Where mental health service providers have responded, in assisting the courts, judges need to be aware of the limits of their authority over these resources and use them in a way that focuses on what is best for the mentally ill accused. Mental health courts have flowed from the diversion initiative in Ontario. These courts deal with mental health matters with dedicated and trained justice and mental health workers.

Correctional Services

At the end of the criminal justice system, those individuals who are not diverted to the community or into the forensic mental health system end up in correctional institutions. In Ontario, a number of one-day snap shots taken during the mid 1980-90's estimated between 12-15% of the total inmate population were mentally ill and that 7-9% were seriously mentally ill.

However, as the mental health safety net has increasingly failed to make available services and supports in the community for individuals who are perceived to be hard-to-serve and/or potentially violent during the acute phase of their illness, the number of seriously mentally ill in jails and detention centres on remand or serving short sentences has risen dramatically. In some parts of the province, jails and detention centres are reporting that as many as 23% of the inmate population has a serious mental illness. Many of these individuals are incarcerated awaiting psychiatric assessments, a hospital bed for treatment or a court appearance.

Once incarcerated, individuals are unlikely to receive adequate treatment for their mental illness. This is because the correctional services system lacks the capacity to deliver comprehensive mental health services.

In the community, there are increasing numbers of individuals with a serious mental illness that are being placed on probation either as a sentence in itself or to follow a period of incarceration. Once a person has been identified with the criminal justice system, many community mental health providers often refuse to provide services to these individuals or place them at the end of lengthy waiting lists for services to which they may never gain access.

Probation officers frequently experience considerable challenges in obtaining ongoing care for clients under their supervision, who are mandated by the court to receive treatment as a condition of their probation. Where treatment is available, probation officers report having to expend considerable time and energy in order to link clients to services and supports.

Where the client is admitted to a treatment program, probation officers often report working in a void as they are denied information that would satisfy them that their clients are participating in, and benefiting from, the treatment. In many of these cases, they will refuse to sign the required Form 14 under the Mental Health Act that will allow the service provider to release the necessary information to the probation officer.

9.3 A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario

Policy Framework

In the early 1990's, the treatment of seriously mentally ill offenders by the health and justice systems came under considerable scrutiny by the media and the general public. This was due primarily to a number of high profile incidents and subsequent coroner's inquests. In response to these high profile incidents, the Human Services and Justice Coordination Project was established in 1994 to improve the coordination, resource and planning for people who were mentally ill and in conflict with the law.

This project was an interministerial initiative that brought together policing services, courts services, correctional services, mental health services and developmental services¹. The Ministries recognized they shared a "common client" that was mentally disordered and/or developmentally disabled and in conflict with the law. They also recognized that they had a joint responsibility to improve and integrate service delivery more effectively for these common clients so that fewer individuals fell through the service gaps in the system. Public safety was also a key concern.

A 1997 survey estimated that there were between 4,300 and 7,300 common clients in provincial facilities or in the community, with 1200 of these clients in facilities and the remaining 3,100 to

¹ Developmental services added to the project in 1996.

5,200 in the community. The estimated costs associated with providing services to this client group exceeded \$200 million annually.

A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems is the government's policy blueprint for inter-ministerial and Ministry-specific operational and policy initiatives for this common client. The policy is intended to lead the change process for reshaping programs and improving the quality of services provided to the common client; consistent with the government priorities to rationalize programs, to reintegrate clients into the community, to enhance public safety and to focus on serious crime.

The provincial strategy identifies twenty key juncture points in relation to the progress of a mentally ill and/or developmentally disabled person through the criminal justice system (see Appendix 9.1 for Flow Chart for the Provincial Strategy). These juncture points start with prevention and incident response through increasingly more serious interventions that include diversion, pre-trial remand, psychiatric assessment and transfer to a psychiatric facility; sentencing and custody in a correctional institution system and finally released back into the community. The policy identifies Ministry-specific responsibilities for the common client. It also provides opportunities for more effective coordination between the mental health, developmental services and criminal justice systems that will ensure an appropriate mix of services and supports, address the gaps in service provisions and reduce the duplication of efforts by service providers to the common client.

The strategies identified included:

- Mental health services will offer community support and prevention programs (e.g. case management, assertive community treatment), as well as develop crisis response networks that minimize police involvement in minor incidents.
- Police will receive appropriate training and have access to assistance from mental health services in responding to incidents. Linkages to mental health and social service agencies will facilitate pre-arrest diversion. Only individuals who commit serious, violent, repetitive crimes will be arrested.

- Crown attorneys will divert minor offenders. Court outreach workers and linkages to mental health and social service agencies will facilitate court diversion.
- Court linkages to mental health and social service agencies, together with community assessment and treatment planning capacity, will facilitate an offender's community release through diversion, bail, probation or Review Board supervision.
- Local court-based clinical assessments and linkages to regional forensic services will facilitate the timely transfer of unfit or NCR clients from court to appropriate community or institutional forensic services.
- High risk incarcerated offenders with clinical needs will receive appropriate treatment within correctional institutions.

At the conclusion of the Human Services and Justice Coordination Project, the MOHLTC assumed the lead role for implementation.

Human Services and Justice Coordinating Committees

One of the key initiatives to implementing the provincial strategy is the development of Human Services and Justice Coordinating Committees. These coordinating committees have been established to coordinate communication, joint problem solving and planning efforts between mental health, criminal justice and developmental services organizations within specific communities. The primary goal of these committees is to find local solutions to local problems through effective service coordination.

To enable this service coordination to occur across the mental health, developmental services and justice systems, the provincial strategy recognized the need to formalize the collaborative processes through community services agreements, interagency working agreements, information sharing protocols and joint educational initiatives. These include agreements and protocols for diversion; community release plans under bail supervision, probation, or conditional discharge; criteria for priority admissions to forensic beds; institutional treatment in correctional facilities; and risk assessment.

DHCs have played a leadership role in facilitating the establishment of coordinating committees in various locations across the province. Membership in the committees includes representatives from the judiciary, crown attorneys, police, correctional services, mental health services, developmental services and consumers.

In the Northeast, coordinating committees have been established in Timmins, North Bay, Sudbury and Sault Ste. Marie. The committees have demonstrated the effectiveness of developing a collaborative working relationship between mental health, social services and the criminal justice system. They have also developed a number of best practices with respect to providing services to common clients that includes, public education, crisis intervention protocols, fitness clinics in jails, court diversion, development of a mental health court, discharge planning and staff training. These best practices provide benchmarks for implementation of key strategies in a reformed system of mental health care for persons with serious mental health needs that are involved, or are in danger of becoming involved in, the criminal justice system.

As a key to coordination, the report suggests the development of district and regional coordinating committees which would provide cross-sector collaboration at the individual consumer, programs and system policy levels, leading to enhanced linkage, access to cross jurisdictional problem solving, joint communication and problem solving efforts. A major principle for the work of these coordination committees is to apply local solutions to local problems.

The following core service activities are expected of coordinating committees:

- Joint Sector Involvement
 - a) shared cooperative planning and exchange process with respect to common client placement, discharge and access to treatment, including hard to service planning mechanisms
 - b) multi-ministry/multi-agency case management for clients involved in more than one system
 - c) continuity of care mechanism within each service system as well as common procedures to identify clients to assess risks and clinical needs
 - d) core service clinical teams located in the provincial correctional system
 - e) supplementary local services for assessment, court diversion and treatment planning

- Health Sector
 - a) linkages to the integrated mental health agency and to the MOHLTC Regional Office
 - b) linkages to other institutional and community mental health programs including addiction, ACT teams, CTOs and housing coordinators, crisis intervention teams and residential supports

- Developmental Sector
 - a) linkages to the developmental service sector
 - b) other community and institutional programs for developmentally disabled

- Police Sector
 - a) training of police officers in mental health issues
 - b) protocols to minimize police wait time
 - c) facilitate police diversion of mentally ill persons

- Court Sector
 - a) court-based diversion
 - b) best advice on non-custodial disposition
 - c) limited case management for persons before the court

- Correctional Services Sector
 - a) general treatment, rehabilitation, training and discharge planning and community linkages for sentenced inmates
 - b) institutional case management services for all incarcerated offenders
 - c) service linkages and case coordination to released offenders through the probation parole system

- General Outcomes for coordinating committees
 - a) identify and respond to gaps in service delivery between Ministries
 - b) identify and respond to deficiencies in understanding that hampers service provision
 - c) identify and make recommendations to improve in-house ministry services that need improvement

With the following general outcomes:

- create innovative and effective responses to client needs
- improvement in information sharing and assessments allowing for earlier identification and treatment of problems.
- rapid identification and diversion away from criminal processes to the community
- providing for a synchronized and cost-effective use of provincial resources
- creation of a system of linked community services
- improved system of community services allowing for successful post-release placements
- prevention of mentally ill persons coming to the attention of the police and courts through the existence of an effective service delivery model
- uninterrupted movement of mentally disordered offenders through key junctures in the criminal justice and health services process

Interministerial Agreements

The Human Services and Justice Coordination Project developed four interministerial operating agreements as part of a series of agreements between Ministries to implement key components of the provincial strategy. The four agreements are:

- *Identification of Common Clients Agreement*: to develop a consistent approach with respect to definitions, identification, and assessment of common clients.
- *Court-Ordered Assessments Agreement*: to ensure court-ordered assessments are performed on a consistent basis across the province.
- *Information Sharing Agreement*: to share all appropriate information that is legally permissible and necessary in the interests of effective and safe client care.
- *Shared Planning and Service Delivery Agreement*: that addresses case management, shared treatment and placement planning, interministerial-shared service delivery and high risk services for common clients.

These agreements provide a basis for the development of local community service agreements.

9.4 Forensic Population Flow

In addition to increasing the mentally ill population in communities, the twin process of deinstitutionalization and restructuring, allied with a host of social factors such as homelessness, substance abuse, lack of employment opportunities and difficulties in accessing care, have created a flow or road map for persons with a mental illness who become involved with the law. The movement of these individuals from hospital to court, jail and the community, has been well documented over the years. The added stigma of criminalization results in a 'forensic' label with a perception of dangerousness thus adding further barriers to accessing care. Added to the foregoing is the movement of mental health services from an institutionalized focus to a community-centered one in the past three to four decades. This has resulted in the justice sector becoming the recipient of a large number of mentally ill who must be cared for and managed through that system. Since these individuals are not managed by a single organization, there is a false economic sense of their cost to the system overall, i.e., each segment of the mental health and justice systems being aware only of their individual costs.

In order to administer justice, the courts must be assured of access to services for psychiatric assessment (Fitness and NCR) and treatment for those persons for whom there is a treatment order under the *Criminal Code*. The majority of these individuals do not require a treatment bed but judges must be assured that where a non-custodial order is made, that the mentally ill accused is adequately linked to community services. One of the downsides to the use of the court to expedite the admission of mentally ill persons to institutional and community services, is that it places them at the front of the line, ahead of many who have been awaiting voluntary admission.

The following shows the number of correctional inmates in the four major institutions in the Northeast for the years 2001/2002:

Monteith Jail		Sault Ste. Marie	
Remand	277	Remand	191
Sentenced	456	Sentenced	313
Other	4	Other	18

North Bay Jail

Remand	322
Sentenced	396
Other	7

Sudbury Jail

Remand	653
Sentenced	551
Other	27

No accurate data on the number of mentally ill exist, although Correctional Services is making every effort to update its management information system so that mentally ill persons can be identified and flagged (Ministry of Public Safety and Security, data generated from OTIS database).

Correctional Services has identified some areas of specific need, which require greater coordination and cooperation.

- Remand - Crisis intervention and support to mentally ill and developmentally disabled incarcerated in jails and detention centres. Across the province, not only is the remand count increasing, but also the number of days spent in remand has increased significantly. The average daily population of remanded adult offenders in Ontario's correctional facilities has more than doubled in the past 15 years. In the North, from 1991/1992 – 1999/2000, the remand stay in the North went from 15.5 days to 22.5 days.
- Fitness Clinics in Jail - Many of the mentally ill on remand are often awaiting a psychiatric assessment. Traditionally, a mentally ill person would be sent from (for example) Timmins to North Bay, where the forensic unit exists for a fitness assessment. This is done at an enormous cost in transportation and waiting time (with 60 - 70% being returned as fit). The Human Services and Justice Coordination Project recommended fitness clinics in the jails, where such service could be provided within a 2-day turn around. Where the fitness clinics exist in the province, they provide prompt and effective services to the court, expediting the justice process and a determination of what is best for the client.

System Considerations

Mental Health and Criminal Justice legislation divides the responsibility for mentally disordered offenders according to what has been seen as an artificially rigid and unworkable understanding

of criminal behaviour, mental disorder and their relationships. What is desirable is a cohesive system dealing with the particular condition of each mentally disordered offender and aligning services and accommodation to match the needs and risk. When the justice system no longer has an interest, then such a system must be sufficiently flexible to allow the client back into the psychiatric mainstream of services.

The Provincial Strategy to Coordinate Human Services and the Criminal Justice System

proposed a model of shared responsibility and accountability to deal with this specialized group of clients. The vision that was outlined saw clients and their families, service providers, police, court and correctional officials, as well as community representatives, involved in designing creative solutions that contribute to the shared goals of achieving healthy and safe communities. Any change process will require changes in knowledge, attitudes and behaviour: knowledge for effective job promotion and service provision; attitude changes that will allow for creativity, flexibility, responsiveness and cooperation; and behavioural changes that would result in better coordination and cooperation.

Coordination between Ministries, particularly in the area of joint funding, provides an effective approach to closing the gaps between different points in the system. Combining the funding for psychiatric services to the court with that of services to the jail through a single organization or psychiatrist allows for a continuity of care that begins at court and continues through incarceration.

Current Forensic Services In The Northeast

Within the limits of existing resources, the Northeast region has moved to respond to the needs of mentally ill accused with the following forensic services being currently available:

- ✓ fifty-two forensic beds in the North Bay Psychiatric Hospital
- ✓ four Forensic Coordinating committees located in Sault Ste. Marie, Sudbury, Timmins and North Bay
- ✓ active court-based diversion programs in each of the above sites
- ✓ mental health court worker in each of the above in addition to Manitoulin Island
- ✓ police protocol with local hospitals in Sudbury to reduce waiting time
- ✓ jail clinic for fitness in North Bay with one proposed in the remand center in the recently built remand center in Sault Ste. Marie

- ✓ a mental health court in Sudbury
- ✓ volunteer mental health workers attending at local jails in Sault Ste. Marie, Timmins and North Bay.

Gaps and Forensic Service Needs

Resources

- The maintaining of existing resources and attracting new ones, particularly forensic psychiatric and forensic psychology, has been and continues to be a challenge for the Northeast. Some of the strategies could entail joint shared recruitment between MOHLTC and MPSS, a combination of job and work enhancement, partnership with universities that will offer senior psychiatric residents their final year of training in the North, overseas recruitment once the government lifts the moratorium on foreign trained doctors, and longer term addition of a faculty of psychiatry to the proposed medical college being proposed.
- Adding mental health case managers in the following areas:
 - a) To assist the mental health court workers with case management and mental health linkage needs.
 - b) To assist with discharge planning and community linkages in the jails.
 - c) To expand the jail fitness clinic in North Bay (given the new correctional facility to be built there).

Coordination

- Determine the role of the Schedule 1 facility for the admission of certain offenders who are before the court on charges.
- Explore linkages between the integrated mental health agency and the police for crisis response involving mentally ill persons.
- Have all local police services develop protocols with the integrated mental health agency and local hospitals similar to that in Sudbury.
- Expand court-based diversion capacity to all court sites in the Northeast.
- Expand Native Court and jail-based mental health workers to respond to the needs of the Aboriginal population. Native workers though, should work collaboratively and collegially with their mainstream counterparts.

- Develop protocols between the integrated mental health agency and correctional services regarding service provision to both the institutional (jails) and community corrections (probation and parole).

9.5 Emerging Issues

The following are some issues which have not been dealt with in this document, but are emerging as requiring some future consideration because of their impact on this specialized area of forensic psychiatry.

Fetal Alcohol Syndrome (FAS) and Alcohol Related Birth Defects (ARBDs) In Aboriginal Population

Widespread substance abuse, particularly alcohol abuse, is a problem with certain Aboriginal individuals and communities. FAS is marked by pre- and postnatal growth deficiency, central nervous system (CNS) dysfunction and behavioural and cognitive problems, the latter often bringing these individuals in conflict with the law. This is further compounded by a lack of agreement within the medical community on what constitutes FAS and ARBDs and the absence of culture specific standardized tests for its identification. Many Aboriginal persons are showing up in the jails with these syndromes² and are either not diagnosed or misdiagnosed. Many are also showing up in the forensic unit of North Bay Psychiatric Hospital under the jurisdiction of the Ontario Review Board where they are held for long periods of time primarily because of the absence of treatment resources in their home community. Aboriginal communities are in need of capacity building and partnerships in order to respond to their needs within their communities. Crown attorneys are concerned about the use of the criminal process (NCR and Unfit) for all illnesses that began in utero and for which there may not be a known 'recovery'. A critical first step is identifying the presence of the syndromes.

People with FAS do not process information in the same way as others. This can lead to behavioral problems due to poor self-image, lack of inhibition, stubbornness, sullenness, teasing or bullying behaviour, truancy problems, depression, withdrawal, passivity, hyperactivity, easily over-stimulated, impulsiveness, difficulty with transitions, insatiability for intense

² Dr. L. Pestor, Staff Psychiatrist, Sault Ste. Marie Jail.

experiences, disinterest in food, fearless, and being unresponsive to verbal cautions. (Committee on Alcohol and Pregnancy, p.9).

Finally, FAS individuals can also have any of the following learning characteristics: mental retardation, reduced selective and sustained attention, need for extensive external structure, difficulty with abstractions, poor problem-solving strategies, difficulty grasping cause and effect relationships, difficulty grasping cause and effect relationships, poor organization, lack of perseverance, memory problems, spotty retention, impaired rate of learning, tactile learners, academic level highest in spelling, academic level lowest in math, visual perceptual deficits, difficulty learning from past experiences, lack of motivation, trouble generalizing behaviours and information, learning disabilities, and auditory perceptual deficits. (Committee on Alcohol and Pregnancy, p.9).

Concurrent with a program of identification is a strategy focused on education and early intervention. The intent of the education program is to teach women early in their pregnancy, or even prior to pregnancy, about the impact of alcohol on their unborn child. This approach could utilize workshops in strategic locations or have trained workers go into the Aboriginal communities. Native persons would be the preferred group of educators but where they are non-native trainers, it would be important that they understand the native culture and gain the respect and trust of the Aboriginal communities. Early intervention and support services will make a significant difference in reducing the health, emotional, and social problems that can result from FAS, providing for more productive and healthy members of society.

Youth

Services for young offenders continues to be spotty and in some cases nonexistent. There are both jurisdictional and legal issues regarding the provision of services to this age group. While it is generally agreed that a continuum of services that spans from the youthful mentally ill first offender to psychogeriatrics should be in place, bringing all of these services together, given the present system of program funding and different jurisdictions is a daunting task. Some areas in the Northeast see the court as the focus around which services for young mentally ill persons could be built. Youth Court Clinics are an expensive proposition and the more economical approach taken by the Mental Health and Drug Courts could serve as a model for problem-solving for youth. This approach would rely on the existence of local programs for youth and the

ability of the court and other service providers to access them. Across the Northeast, services to older youth 16-18 years of age are particularly problematic with many falling through the gaps that currently exist between young offenders treatment services and adult services and supports.

Developmentally Disabled / Dually Diagnosed

While services for the developmentally disabled rests with the Ministry of Community, Family and Children's Services, many of these clients that are dually diagnosed with a mental disorder as well as their disability are finding their way into the mental health system. Mental health service providers have identified an increase in the number of developmentally disabled persons accessing mental health services. A key to successful management of these clients is through coordination of services and collaboration between service providers. A number of coordinating committees in the Northeast have reported some degree of success in collaborating on service needs and joint planning for these clients.

Services required for the dually diagnosed include: assessment; diagnosis of mental health problems; community-based programs; risk assessment, prevention and treatment. They also require services to manage issues of sexual and inappropriate behaviours; abuse and prevention; collaboration on system issues (e.g., wraparound services); residential services in the community including individualized residential environments, small group homes and supportive living.

The role of developmental service agencies is to provide services and supports that will allow persons with developmental disabilities to participate in community living. They are expected to work collaboratively with justice and mental health systems at the provincial and community levels to manage the balance between risk to public safety and meeting client's needs. Their active participation in prevention, education, case management and cooperative service coordination with other sectors is strongly encouraged. As well, their leadership in spearheading services and supports that will allow for court and police diversion of appropriate low risk clients and a coordinated response to higher risk individuals will ensure the likelihood of successful, long-term community integration.

Drug and Alcohol Addiction

Corrections data indicate that a higher percentage of sentenced offenders have a substance abuse problem than those with a mental illness. The extent to which both of these conditions occur together makes it necessary that they be dealt with concurrently. This requires collaboration between the mental health and the substance abuse services. Ironically, the success of the mental health court in Sudbury is driving the need to explore a drug court with both courts working simultaneously on offender problems to find a solution that is helpful to the accused and presents the least restrictive alternative for the client. In the United States, the success of the drug courts has driven the development of mental health courts, whereas here in Ontario, it appears to be the reverse.

High Risk Offender and Community Supervision

A small number of persons who have committed serious personal injury offenses (such as sexual offenses) are released into the community after they have served their sentence. For these individuals, there are a number of post incarceration mechanisms, such as probation, parole and Section 810 Applications that provide supervision and some degree of public safety. For sex offenders, there may be treatment conditions attached to these mechanisms that are to be provided in the community. In large urban areas, this treatment is usually provided by the university-based programs funded through MOHLTC. In rural communities, the provider is usually a psychologist who, unlike a psychiatrist or physician, is unable to bill the Ontario Health Insurance Plan. So, in many communities, if funding is not available for the psychologist, no service is provided and the public safety net disappears. The identification of available resources and funding should be undertaken by the coordinating committees and submissions made to the integrated mental health agency for the appropriate financial resources.

Treatment and Housing

Improved access to services and affordable housing are cornerstones of a responsive mental health system. Too often, people with mental health problems turn to acute care hospitals as their first resort rather than their last. Many of these are people that are homeless, with their lives rotating between psychiatric hospital beds and correctional services institutions. A multifaceted and coordinated approach is required to respond to the need of this population that includes consideration of Homes for Special Care and Harm Reduction Programs that can be accessed by dually diagnosed clients.

Within the mental health, developmental service and justice sectors, there are individuals that are high risk and are in need of managed care and supervision while in the community. These include developmentally disabled youth who are prone to offending sexually and mentally ill persons who cycle between Corrections and forensic mental health services. For this clientele, consideration should be given to the development of “transition housing” (approximately a 10-12 bed unit) with a higher level of dynamic security provided by assertive case managers. Linking case managers from different systems together to form a shared case management team is an important step forward in integrating and coordinating services for these clients.

One of the barriers to service coordination is in the current system of Ministries providing dedicated or “categorical” funding to programs. This approach would target funding to specific populations, providers and services. No single system can be expected to pay for the wide array of new services required for persons who are dually diagnosed, or have a concurrent disorder; who are before the courts and require diversion, or in jail and require assessment treatment and community linkage. To develop the range of services required for a client such as this, each Ministry must bring to the table the resources they can make available for shared efforts, which includes actual dollars, staff and accommodation, as well as the commitment to work cooperatively. When collectively pooled, these resources create a synergy that can produce services well beyond the scope of what any single system can mobilize on its own, and bring together a creative blend of remunerative formulas for service providers. In Sudbury, the blend of sessional fees paid by the MOHLTC with the retainer arrangement offered by Correctional Services provide a continuum of service that goes from the court into the jail. The success of this approach will require a major shift from the present thinking of “my funds/my clients” to “our funds/our clients”.

Harnessing the Use of Technology in the Northeast

The use of technology is increasing in both the justice and the mental health systems. Video remand is in use within the justice system and is now considered essential in expeditiously dealing with large volumes of remanded inmates for setting court dates and for bail hearings. In the medical field, telepsychiatry, videoconferencing, and telemedicine have an established reputation for providing education and medical consultation in remote communities. The geographically dispersed population in the Northeast is ideally suited to this mode of communication and can provide potential benefits to treatment teams, mentally ill clients and their families, and to underserved areas of the region. While the participation of persons with mental illness must be guided by therapeutic discretion, its use in the forensic field for consultation between forensic psychiatric experts and justice officials as well as between mental health service providers can be extremely beneficial.

Video teleconferencing capabilities already exist in many correctional institutions and mental health agencies in the Northeast. Coordinating committees see this technology as providing an important link with remote areas in the Northeast, as a useful tool to enhance and communicate care plans, and to provide the necessary discharge linkages for jail and forensic populations.

9.6 Recommendations

The Northeast Mental Health Implementation Task Force has identified a new vision and a restructuring of the mental health services to meet the challenges facing the region. This vision, which has at its center, an integrated mental health agency structure with five mental health agencies across the Northeast, will provide the community-based foundation for mental health services and supports, and will work in close partnership with community hospitals, Schedule 1 hospitals and the Northeast Mental Health Centre. The integrated mental health agencies will be responsible for integrating services and supports within each district cluster to ensure that consumers and their families have easy access and the means to obtain appropriate mental health care.

As part of the vision of an integrated continuum of services and supports, the integrated mental health agencies must also establish a collaborative working relationship with the criminal justice

system. This will enable the development of a shared service approach to meeting the needs of individuals with serious mental illness who are in conflict with the law. It will also ensure that those individuals do not end up inappropriately in the criminal justice system because the community-based mental health system is unable or unwilling to meet their needs. The integrated mental health agencies are pivotal to the development and negotiation of protocols and service agreements with the criminal justice system that ensure equitable access to appropriate mental health services for persons with a serious mental illness who are in conflict with the law. As such, they become partners with the criminal justice system, and act together as gatekeepers in reducing the inappropriate criminalization of the mentally ill.

1. That a coordinating committee exists in each of the five locations in which an integrated mental health agency is created and that the integrated mental health agencies in the Northeast become the primary support structure for the coordinating committees.

Key to the reform strategy envisioned for the Northeast is the participation of persons with mental illness in determining the appropriate supports and services to meet client needs, as such they must participate as active members of the coordinating committees.

These committees, however, have functioned with limited support by ministries and have relied primarily on the goodwill of the individual committee members to sustain their work. The integrated mental health agencies are uniquely positioned such that they can provide the necessary support and structure to these coordinating committees. Until such time as the integrated mental health agencies are established, the District Health Council together with the MOHLTC regional mental health consultant should provide this support.

A fundamental principle inherent in the design of the coordinating committee is that it would provide local solutions to local problems. This will be a group of service providers and ministry stakeholders who, at the outset, will develop an understanding of local needs and work on these. It is not only an understanding of local services but also local hard to service clients. The awareness and understanding of the needs of that particular group, who are predominant in the justice system, will make proactive planning easier to implement and more effective. In communities where coordinating committees do not exist, the closest coordinating committee will ensure involvement and participation through membership and the creation of sub-committees.

2. Because the emerging issues identified cross jurisdictional boundaries and impact on forensic psychiatric services in the region it is recommended that coordinating committees working with key regional and local support e.g. DHC and MOHLTC regional office to assess the impact of these issues locally.

Human Services and Justice Coordinating Committees are considered the primary vehicle to facilitate cross section service coordination in response to client needs, and address such issues access to, duplication of services and new issues that impact on service availability. In addition, coordinating committees are expected to lead a multi system design and planning effort to improve service system linkages and integration to protect public safety and provide a continuum of care to common forensic clients.

3. The five integrated mental health agencies work with the criminal justice system to ensure equitable access for all individuals to community-based mental health services and supports in the Northeast, which includes cross-sector planning and the negotiation of protocols and service agreements.

In addition to a wider interest in access to mental health services, the justice sector has a direct interest in the following areas:

- Crisis response and police/mental health linkages
- Diversion processes and linkages (both police and crown)
- Option for streamlining court administration processes
- Treatment/case management programs (community, jail, hospitals)
- Implications of hospital and Social Services restructuring
- Access to services in rural versus urban areas
- Special needs population
- Broader social service sector involvement

4. The integrated mental health agencies support the addition of new resources in the following areas: police diversion and mental health crisis response with the police; case management resources to augment the mental health court workers; case management street workers tied to the police and housing programs; mental health discharge planners working with discharge planners in the jails and correctional centres.

These resources will provide support to core services provided by ministries. A number of core services have implications for shared treatment and placement planning arrangements between service sectors (i.e. shared planning and information exchange processes with respect to common clients; multi-ministry case management team for clients involved in more than one system and core services clinical teams located in provincial correctional facilities. Core service elements include the regional forensic Services, other community and mental health programs, ACT Teams and CTO coordinators and other strategies to minimize police involvement with mentally ill and developmentally disabled persons. For the courts core services include, court based case management and coordination. For Corrections core services include, general treatment, rehabilitation discharge planning and case coordination to release offenders back into the community, and case coordination for probation and parole.

It is highly desirable that the costs for these new resources be borne by all partner Ministries, but it is also recognized that the time frame in which such partnership agreements could be arrived at may be very lengthy.

5. That a coordinating committee be tasked with exploring the feasibility of a 10-12 bed “transition house” for hard to treat mentally ill and developmentally disabled person.

These difficult to serve individuals who often present with somewhat higher risk levels experience difficulties in accessing and remaining linked to existing services. They are often homeless, do not fit into any of the community housing programs, and require case management and a higher, more secure setting than what is currently available in the community. A pilot multi-ministry initiative could be instructive for other parts of the province. Such an initiative could be in the form of a hospital community agency/ landlord agreement, where the landlord provides the housing unit(s) and the clinical staffs are provided by the hospital and community agencies.

6. The integrated mental health agencies direct and support coordinating committees to develop protocols with the police to:

- Ensure that crisis interventions are linked to the agency crisis response teams, to maximize opportunities of appropriate linkages to community mental health services and support as well as connect persons with mental illness to services for longer term follow up.
- Develop protocols between the police, community service providers and schedule 1 hospitals to reduce the time police are required to wait at a hospital with a mentally ill person.

Frequently police are requested to intervene in a crisis situation involving the mentally ill. When there is a lack of community alternatives, the police may be forced to take a person to a hospital or alternatively arrest them on a minor offence and have them placed in jail. The Sudbury Coordinating Committee has developed a protocol between the police and the Schedule 1 hospital to reduce the time that police are required to wait at the hospital with a mentally ill person. These protocols have been developed in a number of cities and have proven to be effective in ensuring prompt attention for individuals in crisis who are accompanied by police officers to a hospital.

In addition, police need to be linked to crisis support workers as partners in the development of a plan where effective diversion to community supports provides an alternative to arrest for a minor offence. Police diversion is the most effective point for diversion of a mentally ill person as it ensures minimal contact with the criminal justice system and avoids the additional stigma attached to individuals who become identified as “forensic” clients.

7. Screening for fitness and routine fitness assessments should be conducted at court or at fitness clinics established in correctional institutions.

Studies indicate that two thirds of individuals that are assessed for fitness to stand trial are found fit. In the Northeast mental health court workers have been trained to screen for fitness, and a fitness clinic has been established in the North Bay Jail and one proposed to be established at the remand facility of the Northern Treatment Center in Sault Ste. Marie. This significantly reduces the number of individuals who need to be directed to a forensic bed at the North Bay Psychiatric Hospital for fitness assessment. As a matter of practice,

routine fitness assessments should be conducted either at court or in jail, reserving forensic beds for only the most complex fitness assessments.

In Sudbury a mental health court has been established modeled on 102 Court at Old City Hall in Toronto. To date a total of 99 mentally disordered accused have been assessed and diverted from the criminal justice system in the eight months period of its operation. Currently the Sudbury Coordinating Committee is considering combining the court with a drug court, given the number of mentally disordered offenders with a co-morbidity.

8. The Sudbury Coordinating Committee should continue to explore the feasibility of a combined mental health and drug court.

There are many individuals present with mental illnesses and addictions. This is known as a concurrent mental illness or co-morbidity. The approach that appears to be most promising in studies is to integrate treatment for both conditions. This integrated approach customizes treatment and considers a person's full range of problems, not only those related to the mental illness.

Because these two disorders are so closely interrelated, it is difficult to see a person appearing in the mental health court on account of a concurrent illness being diverted on account of his mental illness but sentenced as a result of his addiction. The dual mental health/drug court will make the addiction services more available to the court and allow for the successful diversion approach to be available to both mental health and addiction services. Sudbury has the required numbers of concurrent cases and the commitment of stakeholders to make this a success.

9. Mental health professionals must be trained to accept and treat minor offenders in the community including mentally ill individuals at the end of their sentence and those under probation supervision.

Timely access to forensic beds has been a major coordinating difficulty for both MOHLTC and Correctional Services. In some instances individuals have waited up to 8 months in jail before being transferred to a psychiatric hospital after being declared NCR. While this has not been a major problem in the Northeast, it is important that forensic beds be primarily

reserved for those who have been found NCR and are violent, dangerous or their criminal acts require that they be in a secure setting; for complex fitness assessments or court ordered treatment.

The current forensic unit at the North Bay Psychiatric Hospital will be divested to the Northeast Mental Health Centre. The new forensic unit will be purpose built and will have 52 forensic beds, which will include two wards, a 28 medium secure ward and a 24 minimum secure ward.

The forensic label carries with it a stigma that makes moving on extremely difficult. There is a need to adopt a recovery-based model so that supports and services are individualized, tailored and activated in response to a care plan that enables the person to step down from the forensic system when the intensity of service provided by this system is no longer required.

For those individuals that have been declared NCR and remain in the community it is important that they receive the least intrusive services close to their home communities, this means that they must have access to both general mental health programs and support services or specialized forensic services according to their needs. Forensic clients must not be denied services based on their legal status. The overall goal for these clients is that integration into the community is both desirable and achievable.

In order to facilitate integrating former forensic and sentenced mentally ill persons into the mainstream of general psychiatric service, it is important that these clients have access to ACT Teams and the provisions under the Mental Health Act for community certification (CTO) is so warranted.

10. Forensic beds should be reserved for those individuals who have been found NCR and are violent, dangerous or their criminal acts require that they be in a secure setting; and for complex fitness assessments or court ordered treatment.

The most expensive part of the mental health system should not be the default for all mentally ill persons entering the system with a forensic label.

In accordance with approved ministry role statements, MOHLTC will fund and ensure the provision of a seamless range of mental health services that are responsive to client needs. This will include: community-based mental health services and support such as case management, 24 hour crisis response, and client, family or joint initiatives; institutional treatment programs for all severely mentally ill offenders in need of hospital-based care (except for those offenders serving a sentence in a federal penitentiary); and programs for NCR and Unfit patients at various levels of risk.

Psychiatric hospitals, specialty hospitals and some Schedule 1 hospitals will offer a range of services including assessment, diagnosis, treatment, rehabilitating and continuing psychiatric care. A safe and secure setting will be available as a component of this service delivery system. Specific psychiatric hospitals will be identified to provide regional forensic psychiatric services which offer a continuum of care from a locked, secure setting to out-patient services to people with a mental disorder who are at risk of violent criminal re-offending and who require more intensive management or specialized treatment than is normally available through the general mental health system.

Community mental health programs will assist in improving the quality of life and level of wellness of individuals experiencing severe mental illness/severe mental health problems and increase their potential to live in their own preferred community. This is accomplished through a range of services that reduce the level of disruption that these individuals often experience on a daily basis.

Key support includes responsive crisis networks. Under mental health reform, districts are developing a community-based crisis response system. Crisis response services are useful as points of access to mental health resources. It is important that jails and detention centers be linked into this system to receive support and assistance in handling a mentally ill prisoner in crisis, as well as access to necessary hospital services or follow-up community aftercare programs. This will provide a more comprehensive and integrated crisis response.

11. Some mentally ill accused that are before the courts should have access to Schedule 1 beds, if they are in need of treatment and are suitable for admission.

There is a role for Schedule 1 hospitals to play in the process of management and treatment of mentally ill persons who come in conflict with the law. The majority of mentally ill persons who commit offenses, particularly minor nuisance offenses come from the general psychiatric stream and have the same needs as other mentally ill persons. The fact that they are now defined as mentally disordered or forensic is more often a matter of labeling.

Many Schedule 1 facilities in the Northeast do admit cases before the courts and sentenced inmates to their general psychiatric wards, but they point to the disruption that often results. They have suggested that with the proposed construction of new Schedule 1 hospitals in Sault Ste. Marie and Sudbury, it would be useful to have 3-4 psychiatric beds built with more security and set aside for these cases.

12. That the Correctional treatment services planned for the Near North be factored into the resource calculation of available services for Northeastern Ontario, and that the service be a partnership between MPSS and the Northeast Mental Health Centre.

Correctional Services is planning to build a treatment facility (Near North Treatment Centre) on the grounds of the existing North Bay Psychiatric Hospital. This jail will include 50 beds for mentally disordered offenders with the service provider being the Northeast Mental Health Centre. It will be structured similar to the St Lawrence Valley Centre in Brockville.

13. The integrated mental health agencies must ensure that individuals discharged from a forensic program or a correctional institution are linked to the appropriate level of community supports and services consistent with their needs, which includes access to generic mental health services.

While it is important to control the “front door” access to both forensic beds and incarceration in a correctional institution, it is equally important to also control the “back door” if we want to make an impact on the number of people who are caught up in the revolving door of hospitalization, homelessness and arrest.

The integrated mental health agency must ensure that they work with the discharge planners from the Northeast Mental Health Centre, the North Bay Regional Health Centre and correctional institutions to ensure that the seriously mentally ill are connected to the

appropriate level of community services to meet their mental health needs and public safety requirements prior to discharge.

Some individuals, with serious and enduring mental illness may require the continuing intensive support of ACT teams following their discharge from a forensic unit or a correctional institution. This support will include working with the client to maximize their level of functioning, increase their social networks and abilities to access a range of community resources and facilities. Key to ensuring that these individuals are able to remain in the community is assistance in obtaining accommodation and employment. It is also important, however, that where there is a potential public safety threat, that these plans include liaison with the criminal justice system.

14. The information system developed for the Northeast includes a database that is accessible and available to the criminal justice system to ensure continuity of care for the seriously mentally ill.

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APPENDIX 9.2 FORENSICS AND MENTAL HEALTH REFORM - THE "COMMON CLIENT" - A GLOSSARY OF SOME KEY TERMS

Aboriginal Client: refers to Forensic Clients who are Status and non-status Indians, Metis and Inuit Canadians. ("Agenda for First Nations and Inuit Mental Health", Health & Welfare, Canada, 1991)

Accountability Framework: is a structure that provides the foundation for objectively assessing performance and taking steps to improve results. It helps to: ensure that Forensic Clients receive the services they need, when they need them, and to reduce their involvement with the criminal justice system. Within and across sectors, it includes:

- clearly defined roles and responsibilities;
- agreements on performance expectations or goals;
- the establishment of credible reporting requirements;
- the establishment of evaluation processes, with a focus on improving performance and outcomes;
- the involvement and commitment of all partners;
- the development of mechanisms to resolve conflicts.
- the ongoing utilization of : program evaluation; evidence-based practice: literature review and research; data bases, which improve information sharing and communication, while respecting all privacy legislation and principles of accountability.
- (Working Group on Accountability and Evaluation Report", Toronto Forensic Mental Health Committee, 2001)

Best Practices: are activities and programs that are in keeping with the best possible evidence about what works. ("Making it Happen...", MOH<C, 1998). They define what one would expect to find in a reformed mental health system in terms of the types of services and supports and the infrastructure in which they are located... They provide a more general program of action that requires further specification to fit the particular circumstances in which the system of care is being implemented. ("Best Practices in Mental Health Reform", Clark Institute of Psychiatry, 1997). They are evidence based interventions that work to achieve desired outcomes ("Working Group on Accountability and Evaluation Report", Toronto Forensic Mental Health Committee, 2001)

Capacity: is defined as the right amount and mix of services and supports so that, in fact, a system can be said to exist (³e.g. the essential services in a recovery-oriented system). ("The Whole Picture: A Provincial Framework for Redesigning the Ontario Mental Health System", Canadian Mental Health Association, Ontario Division & Ontario Federation of Community Mental Health & Addiction Programs, 2001)

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Children and Youth: refers to younger persons (19 years of age or under) with mental health problems/disorders ranging from emotional and behavioral distress, depression, personality disorders, addiction, disorders of a neurological origin, and psychosis. ("Human Resources - A Plan for a Reformed Mental Health System in Southeastern Ontario", Human Resources' Committee, Mental Health Implementation Task Force, Southeastern Ontario, 2002)

Class One Offences: e.g. theft under (e.g. shoplifting); joyriding; fraud under; fraud accommodation; false statement under; possession under; mischief under; food fraud; cause disturbance; false pretences under (e.g. price tag switching). ("Post Charge Diversion Program for Special Needs Offenders", Human Service & Justice Coordination Committee, London & Middlesex County, 1998)

Class Two Offences: includes all of the offences not included in Class One and Three, e.g. uttering threats; public mischief; resisting arrest; fraud; false pretences; soliciting; secret commission; criminal breach of contract; keeping a common bawdy house; simple assault (except assault in a wife assault circumstance); dangerous driving where no bodily harm or death caused; break and enter; assault peace officer (unless a weapon is involved or there is bodily harm); advertising reward; personating a peace officer; theft; forgery; keeping a common gaming house; mischief to property; obstructing a highway; attempt to obstruct justice. ("Post Charge Diversion Program for Special Needs Offenders", Human Service & Justice Coordination Committee, London & Middlesex County, 1998)

Class Three Offences: e.g. murder; any offence involving wife assault; procuring for purposes of prostitution; assault causing bodily harm; any offence involving explosives; sexual assault; manslaughter; robbery; aggravated assault; criminal negligence; any drinking and driving offence. ("Post Charge Diversion Program for Special Needs Offenders", Human Service & Justice Coordination Committee, London & Middlesex County, 1998)

Common Client: is a Forensic Client who is in need of and / or receipt of services from the Human and Justice Services' Sectors of the Federal (Canada) and / or Provincial and / or Territorial and / or Regional (Ontario) and / or District (Ontario) and / or Municipal (Ontario) Government(s). (Forensic, Mental Health Services, Experts' Advisory Panel, 2001) - Draft, November 11, 2001. They exhibit characteristics such as, a history of contact with the criminal courts, and the mental health system, more than one hospitalization in a mental health institution, and / or contact with services for the developmentally disabled. It is estimated that between 15% to 20% of Ontario's, provincial inmates have a psychiatric illness. ("Working Group on Accountability and

Evaluation Report", Toronto Forensic Mental Health Committee, 2001)

Competency: is the ability to function, process and understand information and to make applicable, well founded decisions based on that understanding. ("Lost in the Kaleidoscope", Canadian Mental Health Association, Ontario Division, Ottawa Branch, 1999)

Concurrent Disordered Client: is a Forensic Client who is struggling with an addiction / substance abuse problem as well as a mental illness. ("Lost in the Kaleidoscope", Canadian Mental Health Association, Ontario Division, Ottawa Branch, 1999)

Conditional Release: is any release from custody that requires supervision of the offender in the community under conditions. ("A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario", Ministry of the Attorney General, et al, 1998). A release is considered successful if it was completed without a return to prison for a breach of conditions or for a new offence ("A Handbook for Criminal Justice Professionals", Solicitor General of Canada, 2001)

Conditional Sentence: if the offender does not pose a danger to the community, courts can use conditional sentences when the jail term is less than two years. Judges place certain conditions on an offender such as community service or requiring that treatment be obtained. ("Alternatives to Incarceration", Solicitor General of Canada, 2001)

Criteria for Diversion Candidacy:

- a Forensic Client who suffers from a mental disorder that has a good prognosis for improvement through established, feasible treatment or management regimens that can be provided at a designated mental health facility or community based service (i.e. schizophrenia and mood disorder, but not antisocial personality disorder);
- someone who appears to be suffering from acute psychotic symptoms (i.e. experiencing hallucinations or delusions; out of touch with reality; bizarre or paranoid behaviour). Some demonstrate symptoms of severe depression, withdrawal or suicidal behaviour or show lack of competence to care for themselves. Many have a psychiatric history;
- the designated mental health facility or community based service agrees to accept the candidate upon referral;
- individuals accused of a Class One Offence or a Class Two Offense, where the alleged offence was not committed on circumstances of violence (other than very minor assaults) or with the use of a weapon.

- ("Post Charge Diversion Program for Special Needs Offenders", Human Service & Justice Coordination Committee, London & Middlesex County, 1998)

Custody: is the holding of an accused or convicted person in a correctional or detention facility. ("You & the Justice System", Ministry of Employment & Immigration, 1983)

Dangerous Offender (D.O.): is an individual given an indeterminate sentence on the basis of a particular violent crime or pattern of serious violent offences where it is judged that the offender's behaviour is unlikely to be inhibited by normal standards of behavioral restraint. ("Corrections and Conditional Release - Statistical Overview", Solicitor General of Canada, 2001)

Disability: refers to the fact that difficulties interfere with or severely limit an individual's capacity to function in one or more major life activities. These activities include: basic living skills such as eating, bathing, or dressing; instrumental living skills such as maintaining a household, managing money, getting around the community, and appropriate use of medication; and functioning in social, family and vocational-educational contexts. ("Making it Happen...", Ministry of Health & Long Term Care, 1998)

Developmental Handicap/Disability: is a condition of mental impairment present or occurring in a person's formative years that is associated with limitations in adaptive behaviour. ("Post Charge Diversion Program for Special Needs Offenders", Human Service & Justice Coordination Committee, London & Middlesex County, 1998)

Diagnosis: of predominant concern are schizophrenia, mood disorders, organic brain syndrome, and paranoid and other psychoses. Other diagnosable disorders such as severe personality disorder, concurrent disorder and dual diagnosis are also included. ("Making it Happen...", Ministry of Health & Long Term care, 1998)

Disposition: is the punishment imposed on a person who has pled guilty or been found guilty of an offence. ("You & the Justice System", Ministry of Employment & Immigration, 1983)

Diversion: is a pre-trial procedure where Crown Counsel uses his or her discretion on a case by case basis not to prosecute a Forensic Client with criminal charges pending against him or her. ("Getting the Word Out About Forensic Clients", Canadian Mental Health Association, 1999); includes: a) the avoidance of full prosecution through a screening process which occurs after the laying of a charge; b) processes which occur prior to the laying of a charge; and c) the avoidance of more intrusive measures (such as imprisonment or parole)

revocation) following conviction. ("Diversion Programs for Adults", Solicitor General of Canada, 1997); instead of prosecution, the accused is referred to a person, service or hospital with the intent of having the accused embark upon a treatment program to address his or her particular treatment needs. ("Post Charge Diversion Program for Special Needs Offenders", Human Service & Justice Coordination Committee, London & Middlesex County, 1998)

- Dually Diagnosed Client:** is a Forensic client with a developmental handicap / disability and mental health needs. ("Lost in the Kaleidoscope", Canadian Mental Health Association, Ontario Division, Ottawa Branch, 1999)
- Earned Remission:** in a provincial institution (for sentences less than two years) an offender may be granted up to one-third off his/her sentence by actively participating in the program of the institution. ("You & the Justice System", Ministry of Employment & Immigration, 1983)
- Family:** includes parents, siblings, extended relatives, and, at times, a broad range of supportive people, who are not relatives of the person with mental illness. ("Human Resources - A Plan for a Reformed Mental Health System in Southeastern Ontario", Human Resources' Committee, Mental Health Implementation Task Force, Southeastern Ontario, 2002)
- Forensic Bed:** is a funded and staffed, hospital bed that is "designated" as such, or one that is occupied by a Forensic Client. (Forensic, Mental Health Services, Experts' Advisory Panel, 2001)
- Fitness to Stand Trial:** (pertains to mental condition at time of trial). A Forensic Client is deemed to be unfit to stand trial when he/she is unable on account of a mental disorder to conduct a defense at any stage of the proceedings. That is, he/she is unable to: a) understand the nature and object of the proceedings; b) understand the possible consequences; and c) communicate with counsel. (Section 2, Criminal Code of Canada and "Forensic Psychiatry: General Issues and Applications to Ontario", J.Arboleda-Florez, 2001)
- Forensic Client:** is a person who: is suffers from a major mental disorder; is in conflict with the law; and is being dealt with by the courts or the Ontario Review Board, under Part XX.1 / Mental Disorder of the Criminal Code (Canada). A forensic client" ceases to be "forensic" once the individual is no longer subject to proceedings pursuant to Part XX.1 - Mental Disorder of the Criminal Code (Canada). (Forensic, Mental Health Services, Experts' Advisory Panel, 2002)
- HS&JC Strategy:** is an Inter-ministerial Coordination Strategy which describes 20 "juncture" / contact points of mentally ill / developmentally disabled persons with the Justice System. Coordination protocols were developed at each stage to provide appropriate interventions and allow Forensic Clients to move

between systems and services depending on need and public safety. ("Ontario's Forensic System - An Update", Ministry of Health & Long Term Care, 2001)

Incidence: is the number of new cases of a particular illness or disease within a given population. ("Building Consensus for a National Action Plan on Mental Illness and Mental Health", Canadian Alliance on Mental Illness & Mental Health, 2000)

Inpatient: is a Forensic Client who is admitted to an inpatient unit for treatment and is assigned an inpatient bed for the duration of his / her stay. ("Balanced Scorecard", Center for Addiction & Mental Health Services, 2000)

Key Junctures: highlight the progress of a Forensic Client through the criminal justice system. They start with prevention and incident response through increasingly more serious interventions by the police, courts and the correctional system (i.e. pre-trial process; fitness and criminal responsibility; trial; and sentence) and complete with the release of the individual back into the community. The overlap between justice and human service processes are highlighted, as well as opportunities for more effective coordination and treatment of common clients. ("Working Group on Accountability and Evaluation Report", Toronto Forensic Mental Health Committee, 2001)

Mental Health Court: was established in 1998, at the Old City Hall Court House (Courtroom 102), in Toronto. MHCW's interact with 80 Crown Attorneys rotating through the court in three teams. Clients are assessed for fitness, on site and in a timely fashion, by a psychiatrist from the Center for Addiction and Mental Health Services. ("Working Group on Accountability and Evaluation Report", Toronto Forensic Mental Health Committee, 2001)

Mental Health, Court Support Services: may include: mental health diversion; consultation (court - based fitness or brief forensic assessments; and general assessments of mental capacity, treat ability, and opportunities for community support); linking Forensic Clients to short and long-term services and supports; family support and information sharing; public education; and consultation and advice to the judiciary, on cases referred for disposition. ("Mental Health Court Support Services in Toronto", COTA Comprehensive Rehabilitation and Mental Health Services et al, 1999)

Mental Health Court Worker (MHCW): assists and, at times, leads in the overall provision of mental health, court support services; is located on site at the Courts; might assist over 350 Forensic Clients each year; and provides numerous brief consultations for individuals who are not divertible. ("Working Group on Accountability and Evaluation Report", Toronto Forensic Mental Health Committee, 2001)

Mental Illness or Mental Disorder:

may be defined as a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities. Mental disorders result from biological, developmental and/or psychosocial factors, and can - in principle - be managed using prevention, diagnosis, treatment and rehabilitation approaches to care. ("Building Consensus for a National Action Plan on Mental Illness and Mental Health", Canadian Alliance on Mental Illness and Mental Health, 2000)

No Wrong Door:

means that wherever consumers or their families come into contact with the mental health system, they will either receive appropriate help or be referred to another program nearby that will meet their needs. "No-wrong-door" policies also ensure that consumers will be able to access help in a timely fashion, averting as much as is possible, harmful deterioration leading to hospitalization or possible trouble with the law. ("The Whole Picture: A Provincial Framework for Redesigning the Ontario Mental Health System", Canadian Mental Health Association and Ontario Federation of Community Mental Health & Addiction Programs, 2001)

Ontario Review Board (ORB):

is an independent, quasi-judicial tribunal established under the Criminal Code of Canada. The Code sets out the composition, mandate and powers of the Board. Appointments to the Board are made by the Lieutenant Governor in Council. The Board is funded by the Ministry of Health and Long Term Care. ("The Provincial Forensic System", Ministry of Health & Long Term Care, 1997)

ORB Mandate:

is to make disposition orders in respect of offenders found unfit to stand trial or not criminally responsible for an offence on account of a mental disorder. The Board must hold a hearing and make a disposition in accordance with the criteria set out in the Criminal Code of Canada. Hearings must be held annually. The Board has the discretion to hold an early review of the accused current disposition. ("The Provincial Forensic System", Ministry of Health & Long Term Care, 1997)

Partners:

are the stakeholders, within and across the sectors, who come in contact with or provide services to the Forensic Client and their families. Clients and their families are also considered as partners within the system. ("Working Group on Accountability and Evaluation Report", Toronto Forensic Mental Health Committee, 2001)

Preliminary Hearing:

consists of Court proceedings before a judge, at which the Crown Attorney must present its evidence against an accused in order to show that it has a reasonable case which warrants proceeding to trial. ("You & the Justice System", Ministry of Employment & Immigration, 1983)

Presentence Report:

is a report that a judge may request, prepared by a probation and parole officer on a person found guilty of an offence. The report provides information about the offender's background and personality. ("You & the Justice System", Ministry of Employment & Immigration, 1983)

Probation: is a sentencing alternative which permits a judge to order that an offender remain under the supervision of a probation officer for a specified length of time, not more than three years. ("You & the Justice System", Ministry of Employment & Immigration, 1983)

Provincial Forensic System: consists of a broad continuum of mental health services funded by the Ministry of Health & Long Term Care, ranging from secure inpatient settings to open general beds and community living. ("The Provincial Forensic System", Ministry of Health & Long Term Care, 1997)

Re-integration: is the enabling of Forensic in patients / inmates to take advantage, to the degree they are able, of opportunities and services in the community, including housing, transportation, employment, etc. The degree to which re-integration is possible is dependent upon both the patient's / inmate's functioning ability, their choice of environments and their legal restrictions. It formulates the core of their rehabilitation plan. (Ministry of Health, Psychiatric Hospitals' Branch, 1992)

Remand: to send back: accused are said to be "remanded" when they are returned to custody to await trial after a preliminary hearing. (Directory of Criminal Justice Data Terminology U.S. Dept of Justice, 1981)

Risk Assessment: is the use of clinical and situational factors together with actuarial risk information to form opinions of risk and strategies to prevent future violent or criminal conduct. ("The Provincial Forensic System: Strategic Directions", Ministry of Health & Long Term Care, 1997). Risk Assessments answer two general concerns. First, how likely is an offender to commit a new offence? Second, what can be done to decrease this likelihood? Perfect prediction is an unattainable goal. ("Approaches to Offender Risk Assessment: Static vs Dynamic", Solicitor General of Canada, 2001)

Serious Mental Illness: the three dimensions used to identify individuals with serious mental illness / serious mental health problems are: disability, anticipated duration and / or current duration, and diagnoses. The critical dimension is the extent of disability and serious risk of harm to themselves or others, related to the diagnosable disorder. ("Making it Happen: Implementation Plan for Mental Health Reform", Ministry of Health & Long Term Care, 1998)

Sex Offender: is defined as anyone who has:

- been convicted of a sex offence;
- been convicted of a sexually motivated crime;

- has admitted to a sex offence, but has not been convicted. The assessment and treatment of sex offenders focuses on identifying the nature and pattern of behaviour and developing strategies that may be influential in reducing the risk of re-offending. ("Sex Offender Program", Solicitor General of Canada, 2001)

Stigmatization: is the existence of stereotypic attitudes that result in barriers to social inclusion and access to services. ("Working Group on Accountability and Evaluation Report", Toronto Forensic Mental Health Committee, 2001)

Temporary Absences: (escorted or unescorted)
an offender may be allowed to leave the institution for short periods of time to access community services, maintain family contacts, or to access rehabilitative programs. All offenders may be considered for medical or humanitarian escorted temporary absences from the beginning of their sentences. For escorted absences, the offender is accompanied by one or more staff or by a trained volunteer from the community. ("A Handbook for Criminal Justice Professionals", Solicitor General of Canada, 2001)

The "Two Year Rule":
provides that offenders serving sentences of two years or more do so in penitentiaries, while those serving sentences under two years (hence the expression "two years less a day") do so in provincial correctional facilities (formerly, and often still, called "prisons" or "reformatories"). ("Corrections Population Growth", Solicitor General of Canada, 1996)

Violent Offences: include offences such as homicide, manslaughter, attempted murder, assault, sexual offences, abduction, robbery and weapon offences. Supervised offenders are being convicted of fewer violent offences. ("Corrections and Conditional Release - Statistical Overview", Solicitor General of Canada, 2001)

Waiting Times: are the number of consecutive, calendar days that a Forensic Client is waiting to: attend an outpatient program or be transferred to a community agency, after first contact with the Health Care Facility / Agency; or be admitted or transferred to an inpatient program, post Legal Date; or be returned to Court, after being found fit to stand trial. ("Forensic Statistics' Manual", Mental Health Facilities Branch, Ontario Ministry of Health, 1992)

Widening the Net: is a term used to describe the unintended effect of adding controls to offenders who would not have received these controls in the normal application of justice. For example, if it were not for the diversion program being available would the offenders really have gone to jail or would they have simply been given probation? Many diversion programs widen the net rather than truly divert offenders from deeper penetration into the criminal justice system. ("Adult Offender Diversion Programs", Solicitor General, Canada, 1998).

