A Program Framework for:

Mental Health Diversion/ Court Support Services

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A Program Framework for Mental Health Diversion/Court Support Services

Preface

This document is primarily intended for use by those working in mental health diversion/court support programs funded by the Ministry of Health and Long-Term Care (MOHLTC). It provides clear direction and consistent guidelines for existing and new mental health diversion/court support services funded by MOHLTC to assist in service delivery, planning and coordination.

MOHLTC recognizes that those providing diversion/court support services interact with the mental health, health, criminal justice and social service sectors and that services involve all levels of government, which necessitates an environment of co-operation. For this reason, it is the hope that this document will also be of interest to people from across the involved service sectors (i.e., police, lawyers, etc.).

The framework reviews the literature and policy context, and identifies goals, principles, key junctures, target populations and service functions for mental health diversion/court support services.

Chapter 1: Introduction to Mental Health Diversion/Court Support Services

1.1 Introduction

In Ontario and other jurisdictions, mental health diversion and court support programs have been developed to provide mental health services and supports to adults with mental health needs who are in contact with the criminal justice system. These programs help to divert people who have a mental illness from entering the justice system, and/or provide mental health services to those in the criminal justice system.

Diversion/court support programs encompass a variety of services and supports, including crisis response/emergency services, safe beds, housing, case management, peer support, and links to social, education and employment supports, etc.

1.2 Definition

Where appropriate, mental health diversion/court support services re-direct people with a mental illness from the criminal justice system to mental health services and/or provide mental health services to those in the criminal justice system. Diversion is appropriate for people whose alleged offence is considered to be low risk and whose mental health needs can be met through services based in the community.

- **Diversion services** are provided pre or post conviction to link the person to community or institutional mental health services
- **Court support** services are provided in the courts to assist the judiciary, to support people with mental health needs and their families with the legal process, and to link people to required services.

Diversion/court support services:

- Provide linkages to a comprehensive system of mental health services and supports including crisis response/emergency services, safe beds, court support services, intensive case management, and supports to housing.
- Facilitate access to needed services and supports.
- Involve key players from the criminal justice, health and social service sectors.
- Provide referrals and consultation to those not suitable for diversion.
- Offer supports for family members/support networks.
- Improve the person's quality of life.

1.3 Potential Benefits

Although this is a relatively new field with limited outcome-based research, it has been suggested that potential benefits of diversion/court support services include:

- Improved mental health functioning/outcomes for clients;[1, 2, 3]
- Reduced recidivism and hospitalization;[4, 5, 6, 7, 8]
- Reduced pressures on the criminal justice system; and;[9]
- Increased access to mental health services.[10]

1.4 Historical Perspective

Over the past 40 years, the provision of mental health services has increasingly shifted from institutions to the community.

Although total days of inpatient care were significantly reduced in Ontario during the 1990s service demand for those with a mental illness who came into contact with the law increased in all Canadian jurisdictions.[11]

Recent Canadian research has confirmed that a substantial number of federal inmates have a mental disorder.[12] Using stringent criteria, it was found that 7.7% of federal inmates reported psychotic disorders, 21.5% reported depressive disorder and 44.1% reported anxiety disorder.[13] In the provincial corrections system, estimates of detained inmates who require some form of clinical intervention for mental disorders range from 15% to 20%.[14, i]

Since 1995 there has been a 27% increase in the number of people with a mental disorder who have been admitted to correctional facilities in Ontario.[15] The increased prevalence of people with a mental disorder coming into contact with the criminal justice system has raised concerns about policing and court resources, institutional capacity, availability and adequacy of resources and access to treatment and assessments.

Further, there are concerns about the criminalization of people with mental illness who are in contact with the criminal justice system, that is, people who are inappropriately incarcerated rather than provided with hospital or community-based mental health services and supports.[16, 17, 18]

People who have a mental illness and are incarcerated face increased risk of experiencing more severe symptoms of mental illness, are isolated from needed community services reducing the likelihood of future access to treatment, and are at increased risk of homelessness.[19] The needs of these people may be better met in community or hospital-based mental health services.

1.5 Need for the Program Framework

Over the last 10 years, Ministry of Health and Long-Term Care (MOHLTC) funded diversion/court support services have evolved with no specific MOHLTC policy framework or guidelines to support their work.

The provision of effective diversion/court support services involves the cooperation of key players from across the mental health, criminal justice and social service sectors. This program framework applies to MOHLTC funded mental health diversion/court support services; however, the need to work across involved Ministries and sectors is vital to provide people with a seamless system of appropriate diversion/court support services.

Recognizing this environment of co-operation, a framework for mental health diversion/court support services is required to provide clear direction and ensure consistent guidelines for existing and new mental health diversion/court support services funded by MOHLTC.

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[i] The criminal justice system uses the *Criminal Code of Canada* term "mental disorder": this is a broad term which encompasses, among others, mental illness, developmental disability, addictions, concurrent disorders and dual diagnosis, acquired brain injuries, and serious behavioural and anger management issues.

1.6 Purpose of the Program Framework

This document reviews the literature and policy context and presents a program framework for diversion/court support services, including identified goals, principles, and service functions.

The MOHLTC is developing a program framework for diversion and court support to:

- Provide consistent direction for services;
- Ensure that people with a mental illness who are involved with the criminal justice system receive appropriate and timely support and treatment;
- Reduce the number of people with a mental illness whose offence is considered to be low-risk who are incarcerated in correctional facilities;
- Reduce criminalization and stigmatization of people with mental illness in contact with the criminal justice system;
- Strengthen connections between the justice and mental health systems;
- Ensure that services are offered to the same standard across the province;
- Improve service quality and accountability; and
- Clarify roles and responsibilities.

The goal of the program framework is to provide ongoing, long-term direction to all Ministry of Health and Long-Term Care funded diversion/court support services.

Chapter 2: The Program Framework

2.1 Development of the Program Framework

Between November 2004 and February 2005, the ministry consulted with a stakeholder working group of community and hospital-based service providers, consumers, and representatives from the Ministries of Community Safety and Correctional Services, the Attorney General and Health and Long-Term Care. (See Appendices 1a and 1b for the Working Group's Terms of Reference and list of participants.) Using the functions and principles set out in *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* as a guide, the group defined the target population, and service goals, principles and functions. The group met again in June 2005 to review and refine the program framework.

2.2 Target Population

Policy Context

A consistent definition of a target population for mental health diversion/court support services is required to guide current and future service provision in Ontario.

Currently, definitions of target population used by diversion/court support services vary across the province. Program target population(s) have been defined in response to various factors, including government policy/funding initiatives, local need and resources, (i.e., range of services available, integration and cooperation across local health, criminal justice and social service systems), and program capacity (i.e., program mandate, staffing expertise, etc.).

Government policy, legislation and funding initiatives across the health, criminal justice and social service sectors have target populations varying from broad to very specific.

- The *Criminal Code* defines 'mental disorder' broadly as "a disease of the mind"[20]
- The 1997 Human Services and Justice and Coordination Committee Project provided a more specific definition. The Project was aimed at common clients from the mental health, developmental services and criminal justice sectors. The priority population for service provision was "common clients of mental health and/or developmental services and criminal justice sectors who have a current legal involvement or who are considered a high risk for repeat offences."[21] The Project identified 20 key juncture points between the health, developmental and criminal justice systems. It was recognized that the target population changes across junctures, especially in the preliminary stages, where it may not be possible to predict the existence or extent of disability or criminal behaviour. As a result, services in these stages must include a wider range of people.
- In 1999 the MOHLTC released *Making It Happen: Implementation Plan for Mental Health Reform* and *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports*, which provided the framework to guide mental health reform in Ontario. Based on these documents the priority population for community mental health services and supports is 'people with a serious mental illness', as defined by disability, duration, and diagnoses.[22]
- In January 2005 the Ontario MOHLTC announced an investment of $27.5 million annually in community mental health services to help people with mental illness stay out of the criminal justice and correctional systems and receive the care and support they need.[23] This Service Enhancement Strategy is specifically targeted to serving:
  - persons with mental illness who have come into conflict with the law, and
  - are at risk of being charged by the police or have been charged by the police or have been sentenced or found unfit to stand trial or not criminally responsible and
  - whose offence is considered low risk and whose mental illness can be appropriately managed through services based in the community.

Definition of the Program Framework Target Population

The goal of the Program Framework is to reflect these current variations while providing consistent direction on the target population for the future. The focus for diversion/court support services across the three key junctures (defined on pg. 8) is;

> *Adults (and where appropriate transitional aged youth)[ii] who have mental health needs[iii], and are eligible for diversion services. This means that the person is considered to be low risk, and his/her mental health needs can be appropriately met through community or hospital-based services.*

[ii] The program framework applies to adults, aged 18 and over, and youth who are involved in the adult criminal justice system. While a number of community mental health services and supports serve individuals with a mental illness aged 16 and over, when dealing with people involved in the criminal justice system, an 'adult' is defined as 18 years and over. People under the age of 18 and involved in the youth criminal justice system under the *Youth Criminal Justice Act (2002)* require special services that are not funded through MOHLTC.

This program framework may apply to transitional aged youth if the person;

- is under the age of 18, but is involved with the adult criminal justice system,
- reaches the age of 18 and is transferred from the youth criminal justice system into the adult criminal justice system and therefore may be eligible for MOHLTC diversion/court support programs, or,
- reaches the age of 18, has completed his/her sentence under the youth justice system and is referred to MOHLTC community mental health programs, or
- is under the age of 18, involved in the youth criminal justice system and in contact with MOHLTC diversion/court support programs which will refer the person to appropriate services/supports or will provide with direct services, when appropriate and resources allow.

[iii] Mental health needs have been broadly defined as 'mental disorder' and include, among others, mental illness, developmental disabilities, addictions, concurrent disorders and dual diagnoses, acquired brain injuries, and serious behavioural and anger management issues.

However, the target population for community and hospital-based mental health services and supports has traditionally been people with a serious mental illness.[iv] It is recognized that a range of specialized services and supports, including community mental health services are required to provide diversion/court support services to a broader target population.

Further, a number of factors will influence the ability of diversion/court support services to serve a more broadly defined target population, including:

- Type of service and its appropriateness for the person (i.e., staff expertise, program mandate, etc.),
- Availability of program (i.e., wait list, staffing/program resources),
- Local need/local system integration,
- Availability of referral options/community resources, and
- Continued cooperation across mental health, criminal justice and social service sectors at the service provider and government levels to identify available and appropriate services and supports for referral and service provision.

To reflect the above factors, the target population for this Program Framework has been further refined for each key juncture (see Table 1). With the exception of services provided as pre-charge diversion (i.e., crisis response and safe bed services), the priority population continues to be people with a serious mental illness. The target population for pre-charge diversion services and supports is the broad target population, as at this stage it may not be possible to predict the extent or existence of a serious mental illness. Court support and post-conviction services and supports provide services to people with a serious mental illness as their priority population and provide referral services to the broader target population.

[iv] *Making It Happen* (1999) identified three dimensions that are used to identify serious mental illness;

- **Disability** refers to the fact that difficulties interfere with or severely limit the person's capacity to function in one or more activities (i.e., maintaining a household, family functioning, social or vocational-educational context).
- **Duration** refers to the acute and on-going nature of the problems and amount of services being used.
- **Diagnoses** of predominant concern are schizophrenia, mood disorders, organic brain syndrome, paranoid and other psychoses. Severe personality disorders, concurrent disorders and dual diagnosis are also included.

Table 1: Definition of Target Population by Key Juncture Point

Key Juncture	Target Population
Pre-Charge Diversion	Adults (18 and over) **who appear to have** mental health needs, who are in **contact** with the police and/or are in conflict with the criminal justice system, and who would benefit from community or hospital-based mental health services as an alternative to incarceration.
Court Support	Adults (18 and over) **with** mental health needs, who have been **charged** with a criminal offence, and who would benefit from community or hospital-based mental health services as an alternative to incarceration. The priority population for community mental health services/supports and brief service provision is people with serious mental illness. Mental health service/support providers will refer other people with mental health needs to appropriate services/supports.
Post-Conviction	Adults (18 and over) **with** mental health needs who have been **convicted** of a criminal offence, and who would benefit from community or hospital-based mental health services as an alternative to incarceration. The priority population for community mental health services/supports and brief service provision is people with serious mental illness. Mental health service/support providers will refer other people with mental health needs to appropriate services/supports.

2.3 Key Juncture Points for Diversion

Diversion occurs across a continuum of juncture points between the criminal justice and mental health systems, with the goal of:

- Linking people to appropriate community or hospital-based services to prevent incarceration or reduce the amount of time incarcerated; or
- Providing people with access to mental health services and supports while incarcerated (refer to Appendix 2 for diagram of the juncture points).

For the purpose of this framework, three key junctures have been identified:

Pre-Charge Diversion

This juncture includes adults *who appear to have* mental health needs, who are in *contact* with the police and/or are in conflict with the criminal justice system and who would benefit from community or hospital-based mental health services as an alternative to incarceration.

The person has not been charged with an offence at this point. Police may refer the person to mental health services, charge him/her, or take him/her to an emergency department for psychiatric assessment and possible hospitalization. Many mental health services work with police to develop crisis response and prevention programs.

Court Support

This juncture reflects a point of contact for adults *with* mental health needs who have been *charged* with a criminal offence, and who would benefit from community or hospital-based mental health services and supports as an alternative to incarceration. The priority population is people with serious mental illness; other people will be referred to appropriate services/supports.

Court support services assist the Court, Crown Attorney(s), Defence Counsel, and other court staff to screen and assess for diversion, link clients and their families/support networks to services and supports and assist them with the legal process. People may be referred by various sources including the Court, Crown, Defence Counsel, or Probation Officer.

Post-Conviction

This juncture reflects adults *with* mental health needs who have been *convicted* of a criminal offence, and who would benefit from community or hospital-based mental health services as an alternative to incarceration. The priority population is people with serious mental illness; other people will be referred to appropriate services/supports.

There are several points during the post-conviction phase when an person could access community mental health services, including during custody, community supervision, case management, risk assessment, release planning, conditional release and unconditional release.[24]

2.4 Goal

To re-direct people from the criminal justice and corrections systems to appropriate mental health services and supports where possible, while considering the safety and security of the person and the public.

2.5 Principles

The principles presented in this document will provide guidance in planning and development of diversion/court support services and supports and should be reflected in all aspects of service delivery.

In 1999, MOHLTC released its implementation plan and operational framework for mental health reform. These documents provide the overall context for the reformed mental health system and set out the principles and goals that underlie all mental health services and supports. (See Appendix 3 for more information on these principles.)

The court support/diversion principles were developed within the context of mental health reform and in consultation with community and hospital-based service providers, consumers and representatives from the Ministry of Community Safety and Correctional Services, the Ministry of the Attorney General, and the MOHLTC.

The following six principles provide the foundation for the development of a comprehensive system of court support/diversion services:

1. Safety and security

Balancing public safety and security with the safety and autonomy of the client is the first priority of services and supports. Safety and security are a key consideration from the initial contact and throughout service delivery. The least restrictive, intrusive and stigmatizing interventions will be used to ensure the safety of the client and the public.

2. Informed decision-making

Service providers use all relevant available information to make informed recommendations in determining when diversion is in the best interest of the client and the public. Recommendations are made in collaboration with the client and the client's support network (with client consent).

3. Recovery focused

The recovery approach underlies the delivery of mental health services and supports and emphasizes client choice, flexibility in services, individualized supports, and the importance of peers, families, significant others and communities in supporting people with mental health needs. Such an approach also considers the impact of factors such as poverty, poor housing, unemployment and stigma on people with a mental illness. (See Appendix 4 for further discussion on the Recovery approach.)

4. Accessible and appropriate services

Clients have timely access to a range of appropriate services and supports. Multi-modal and inter-disciplinary services and supports (e.g., health care, housing, and employment) will be linked and co-ordinated to streamline client access.

5. Service collaboration

Clients, service providers, government and the community collaborate in identifying services and supports that are accessible, linked and co-ordinated across and within the mental health, criminal justice and broader social service sectors.

Recognizing that responsibility should be shared across service sectors, formal partnerships between service providers will be developed whenever possible.

6. Education and support

Education and support based on evidence-based practice are available to address the needs of clients, their families and other social supports and service providers. Public education is also important to address public awareness and acceptance of clients with mental health needs involved with the criminal justice system.

Chapter 3: Service Functions based on Service Junctures

3.1 Core Functions for Mental Health Diversion/Court Support Services

Core functions have been defined for each key juncture. Identifying the core functions as a foundation for program development and enhancement aids in the delivery of consistent diversion/court support services across the province. Where appropriate, the agency will either provide the function directly or will make linkages and referrals to the required services and supports.

Diversion/court support services are part of the comprehensive continuum of mental health supports and services. In order to meet client needs and facilitate access to the range of supports and services required to provide the core functions, services and supports will be linked across and within the mental health, criminal justice, and social service systems. Eligibility criteria for mental health services will ensure that people with mental health needs who are in contact with the criminal justice system have access to required services.

The following service functions include services and supports that are provided directly to clients, i.e., crisis response services, court support, intensive case management, as well as services and supports that are not provided directly to the client, i.e., interjurisdictional co-ordination, staff training/education. The provision of both direct and indirect functions is essential in ensuring a seamless system of effective, appropriate services and supports is available as an alternative to incarceration for people with mental health needs who would benefit from them.

Figure 1: Service Functions based on Service Junctures

Pre-Charge Diversion	Court Support	Post-Conviction
***Direct* Service Functions** • Crisis response/emergency services (including mobile crisis response) • Safe beds • Linkages to and protocols with: - Supports to housing - Peer support - Intensive case management - Assertive Community Treatment Teams (ACTT)	***Direct* Service Functions** • Court support • Linkages to and protocols with: - Short-term treatment/ follow-up - ACTT - Intensive case management - Supports to housing - Peer support - Client, family or joint initiatives - Social support/recreation programs	***Direct* Service Functions** • Sentencing (Post-Disposition) support • In custody, pre-release/ treatment rehabilitation support • Linkages to and protocols with: - ACTT - Intensive case management - Supports to housing - Peer support - Client, Family or Joint Initiatives - Social support/recreation programs - Supported employment programs - Supported educational programs
***Indirect* Service Functions** • Interjurisdictional coordination • Staff training/education with/ across agencies/ministries • Clinical teaching and research • Public education	***Indirect* Service Functions** • Interjurisdictional coordination • Staff training/education with/ across agencies/ministries • Clinical teaching and research • Public education	***Indirect Service Functions*** • Interjurisdictional coordination • Staff training/education with/ across agencies/ministries • Clinical teaching and research • Public education

3.2 Pre-Charge Diversion Service Functions

Table 2: *Direct* Pre-Charge Diversion Service Functions

Function	Definition
Crisis Response/ Emergency Services	• Assessment and planning in collaboration with policing services (includes assessment for diversion from criminal justice system) • Crisis support/counselling • Medical intervention • Environmental interventions and crisis stabilization • Review/follow-up referral Mobile Crisis Response - Assessment - Clinical consultation - Crisis intervention - Case management - Education - Linkages with other services
Safe Beds	• Provide clients in crisis with time-limited support in a safe, supervised, non-hospital residential setting • Clients are offered assistance to link with sources of ongoing support • Beds can be located in dedicated apartments/houses or in-home/peer support is offered
Linkages and Protocols	• Service providers are expected to develop linkages and/or protocols with the following services and supports listed below • Some services/supports may be provided by court support workers on a short-term basis until linkages with other services are established **a) Supports to Housing** • Provision of support to clients living in congregate or individual accommodation • Includes: - Up to 24 hour support to clients - Individualized assessment and planning - Assistance with activities of daily living - Ensuring a stable housing environment - Crisis management - Facilitating peer and group support and resident input - Connecting with landlords, matching people to housing, housing advocacy

Table 2: *Direct* Pre-Charge Diversion Service Functions continued

Function	Definition
	b) Peer Support • Peer support workers have direct experience with mental illness and provide unique non-clinical services and supports as part of the mental health team including: information and referral, skills training, emotional support, goal setting and attainment, advocacy, role modeling, interpersonal skills. **c) Intensive Case Management** • Outreach and client identification • Comprehensive individualized assessment and planning • Direct service provision on basis of client choice and need – intensity and/or service type may change as client needs change • Co-ordination and support • Monitoring and evaluation • Systemic advocacy and co-ordination • Outreach functions • Includes treatment, rehabilitation and support • Clients' families and other social supports are provided with services and supports where required **d) ACTT – Assertive Community Treatment Teams** • Case management (including referrals for pre-charge diversion) • Crisis assessment and intervention • Symptom assessment, management and individual supportive therapy • Medication prescription, administration, monitoring and documentation • Provision of substance abuse services • Work related services • Activities of daily living • Social, interpersonal relationship, and leisure-time skill training • Education, support and consultation to clients' family/support network • Support services

Table 3: *Indirect* Pre-Charge Service Functions

Function	Definition
Interjurisdictional Co-ordination	• Links to other services and supports across service sectors/ministries/ governments • Development and maintenance of collaborative relationships and protocols for service provision to common clients • May involve all three levels of government
Staff Training/ Education with/ across Agencies/ Ministries	• Standardized training and education for all involved service/support providers • Training and education focuses on service/support provision for people with mental health needs in contact with the criminal justice system • Issues of stigma addressed
Clinical Teaching and Research	• Clinical teaching opportunities provided by service/support providers e.g., mentorship, internships, clinical practicums • Service/support providers participate in clinical research opportunities offered by Academic Health Science Centres and/or universities
Public Education	• Focuses on addressing stigma related to criminalization and "forensic" label and recovery concept • Emphasizes that "diversion" includes access to community services and supports • Targets various audiences, including clients and their families/social supports, the general public through schools and existing public education campaigns, and community and spiritual leaders

3.3 Court Support Service Functions

Table 4: *Direct* Court Support Service Functions

Function	Definition
Court Support	• Assess appropriateness for diversion • Developing diversion plans – objectively assess and assist client and link them to services - Consult with Crown, Defence - Assist with development of sector-specific diversion protocols • Facilitate/negotiate placements for court-ordered assessment beds, where appropriate • If possible, assist with early return of clients from hospital to court • Assist client and client's family/support network to "navigate" the judicial system, whether or not client is eligible for diversion • Provide education and support to client's family/support network • Work in collaboration with bail court for clients with mental health issues to identify appropriate and available community mental health services and supports Service functions do NOT include: • Assessments: not criminally responsible (NCR), fitness, bail, sentencing, civil certification • Recommending specific terms for bail/release
Linkages and Protocols	• Service providers are expected to develop linkages and/or protocols with the following services and supports listed below • Some services/supports may be provided by court support workers on a short-term basis until linkages with other services are established **a) Short-term Treatment/Follow-up** • Provision of short-term intensive case management services until linkages are made with required services/supports **b) Assertive Community Treatment Teams (ACTT)** • Case management • Crisis assessment and intervention • Symptom assessment, management and individual supportive therapy • Medication prescription, administration, monitoring and documentation • Provision of substance abuse services • Work related services • Activities of daily living • Social, interpersonal relationship, and leisure-time skill training • Education, support and consultation to clients' family/support network • Support services

Linkages and Protocols	**c) Intensive Case Management** • Implementation of diversion plan • Outreach and client identification • Comprehensive individualized assessment and planning • Direct service provision on basis of client choice and need – intensity and/or service type may change as client needs change • Co-ordination and support • Monitoring and evaluation • Systemic advocacy and co-ordination • Outreach functions • Includes treatment, rehabilitation and support • Clients' families and other social supports are provided with services and supports where required **d) Supports to Housing** • Provision of support to clients living in congregate or individual accommodation • Includes: - Up to 24 hour support to clients - Individualized assessment and planning - Assistance with activities of daily living - Ensuring a stable housing environment - Crisis management - Facilitating peer and group support and resident input - Connecting with landlords, matching people to housing, housing advocacy **e) Peer Support** • Peer support workers have direct experience with mental illness and provide unique non-clinical services and supports as part of the mental health team including: information and referral, skills training, emotional support, goal setting and attainment, advocacy, role modeling, interpersonal skills. **f) Client, Family or Joint Initiatives** • Client and joint initiatives - Individuals receive support from others who have direct experience of what it means to be a client of the mental health system - Provide opportunities for individuals to become involved as members and/or take on leadership and decision-making roles in the planning and operations of their own organizations - Operate based on the needs and interests of clients in local areas • Family and joint initiatives - Provide support and training to enable families to adequately fulfil their roles in relationship to their family member and within the mental health system

Table 4: *Direct* Court Support Service Functions continued

Function	Definition
Linkages and Protocols	• Family and joint initiatives continued - Serve as access and co-ordination points - Reflect community needs and diversity - Work co-operatively with all other sectors in the mental health and related systems **g) Social Support/Recreation Programs** • Provide clients an opportunity to develop inter-personal, social and leadership skills and to increase involvement in the community • Programs can include social skills training, organized or individualized leisure activities, orientation to community resources and social network enhancement

Table 5: *Indirect* Court Support Service Functions

Function	Definition
Interjurisdictional Co-ordination	• Links to other services and supports across service sectors/ ministries/governments • Development and maintenance of collaborative relationships and protocols for service provision to common clients • May involved all three levels of government
Staff Training/ Education with/ across Agencies/ Ministries	• Standardized training and education for all involved service/support providers • Training and education focuses on service/support provision for people with mental health needs in contact with the criminal justice system • Issues of stigma addressed
Clinical Teaching and Research	• Clinical teaching opportunities provided by service/support providers e.g., mentorship, internships, clinical practicums • Service/support providers participate in clinical research opportunities offered by Academic Health Science Centres and/or universities
Public Education	• Focuses on addressing stigma related to criminalization and "forensic" label and recovery concept • Emphasizes that "diversion" includes access to community services and supports • Targets various audiences, including clients and their families/social supports, the general public through schools and existing public education campaigns, and community and spiritual leaders

3.4 Post-Conviction Service Functions

Table 6: *Direct* Post-Conviction Service Functions

Function	Definition
Sentencing (Post-Disposition) Support	• Provide recommendations to link client to services during sentencing process (between disposition and sentencing) – link with MCSCS court liaison officer (probation officer) • Contribute to sentencing recommendation and/or conditions of probation order (i.e., liase with Crown, act as source of information in Pre-sentence Reports, link client to services) – objectively assess and assist client and link them to services • When appropriate, consult with corrections staff when implementing sentencing (contributing to development of sentencing recommendations and probation order) • Provide education and support to client's family/support network Service functions do NOT include: • Assessments: probation/parole, civil certification
In-Custody Pre-release Treatment/ Rehabilitation	• When requested, support efforts of corrections staff, to provide in-custody treatment and rehabilitation services until client is released on parole or at discharge • When requested by parole, provide input into parole recommendations • Services may include facilitation of linkages with psychiatric services, counselling and supports to clients' family and social support network
Linkages and Protocols	• Service providers are expected to develop linkages and/or protocols with the following services and supports listed below • Some services/supports may be provided by court support workers on a short-term basis until linkages with other services are established **a) ACTT – Assertive Community Treatment Teams** • Case management • Crisis assessment and intervention • Symptom assessment, management and individual supportive therapy • Medication prescription, administration, monitoring and documentation • Provision of substance abuse services • Work related services • Activities of daily living • Social, interpersonal relationship, and leisure-time skill training • Education, support and consultation to clients' family/support network • Support services

Table 6: *Direct* Post-Conviction Service Functions continued

Function	Definition
	b) Intensive Case Management • Outreach and client identification • Comprehensive individualized assessment and planning • Direct service provision on basis of client choice and need – intensity and/or service type may change as client needs change • Co-ordination and support • Monitoring and evaluation • Systemic advocacy and co-ordination • Outreach functions • Includes treatment, rehabilitation and support • Clients' families and other social supports are provided with services and supports where required **c) Supports to Housing** • Provision of support to clients living in congregate or individual accommodation • Includes: - Up to 24 hour support to clients - Individualized assessment and planning - Assistance with activities of daily living - Ensuring a stable housing environment - Crisis management - Facilitating peer and group support and resident input - Connecting with landlords, matching people to housing, housing advocacy **d) Peer Support** • Peer support workers have direct experience with mental illness and provide unique non-clinical services and supports as part of the mental health team including: information and referral, skills training, emotional support, goal setting and attainment, advocacy, role modeling, interpersonal skills. **e) Client, Family or Joint Initiatives** • Client and joint initiatives - Individuals receive support from others who have direct experience of what it means to be a client of the mental health system - Provide opportunities for individuals to become involved as members and/or take on leadership and decision-making roles in the planning and operations of own organizations - Operate based on the needs and interests of clients in local areas

Table 6: *Direct* Post-Conviction Service Functions continued

Function	Definition
	e) Client, Family or Joint Initiatives continued • Family and joint initiatives - Provide support and training to enable families to adequately fulfil their roles in relationship to their family member and within the mental health system - Serve as access and co-ordination points - Reflect community needs and diversity - Work co-operatively with all other sectors in the mental health and related systems **f) Social Support/Recreation Programs** • Provides clients an opportunity to develop inter-personal, social and leadership skills and to increase involvement in the community • Programs can include social skills training, organized or individualized leisure activities, orientation to community resources and social network enhancement **g) Supported Employment Programs** • Provision of assistance to clients to secure paid/volunteer employment • Clients receive flexible and individualized support and training on the job as required **h) Supported Educational Programs** • Programs which prepare clients for further education or employment • Clients are integrated into educational settings and on-site support is provided

Table 7: *Indirect* Post-Conviction Service Functions

Function	Definition
Interjurisdictional Co-ordination	• Links to other services and supports across service sectors/ministries/governments • Development and maintenance of collaborative relationships and protocols for service provision to common clients • May involve all three levels of government
Staff Training/ Education with/across Agencies/ Ministries	• Standardized training and education for all involved service/support providers • Training and education focuses on service/support provision for people with mental health needs in contact with the criminal justice system • Issues of stigma addressed
Clinical Teaching and Research	• Clinical teaching opportunities provided by service/support providers e.g., mentorship, internships, clinical practicums • Service/support providers participate in clinical research opportunities offered by Academic Health Science Centres and/or universities
Public Education	• Focuses on addressing stigma related to criminalization and "forensic" label and recovery concept • Emphasizes that "diversion" includes access to community services and supports • Targets various audiences, including clients and their families/social supports, the general public through schools and existing public education campaigns, and community and spiritual leaders

Chapter 4: The Policy Context for Change

4.1 Policy Context

The provision of diversion/court support services is occurring within a broader context of health care system reform.

Diversion/court support services re-direct people from the criminal justice system into appropriate mental health services, when possible. As well, they focus on the provision of appropriate services outside of correctional facilities so people with mental health needs are able to access necessary services in their own communities, as close to home as possible.

This is consistent with the current emphasis of Ontario's health care system reform on delivering integrated, consumer-centred and appropriate health care through initiatives such as Local Health Integration Networks, Primary Care Reform, and Family Health Teams.[25]

The goals of mental health reform, including the provision of diversion/court support services, reflect similar objectives and represent an opportunity to expand system capacity through the development of linkages between broader health care reform and mental health initiatives.

The provision of diversion/court support services also represents an opportunity to partner and develop linkages with the work being done in the Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General. These ministries share similar goals of ensuring safe communities and the fair and compassionate treatment of people with a mental disorder who are involved with the criminal justice system. Diversion services reduce pressures on the criminal justice system by providing alternatives to better serve these people through access to necessary mental health services and supports.

4.2 *Making It Happen*

The Ministry of Health and Long-Term Care mental health policy framework, *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* (1999) directed that clients with mental illness, who are involved with the criminal justice system, should be integrated into general mental health services, as far as legal status and risk considerations allow. *Making It Happen* committed the ministry to:

- A hybrid system where integrated mental health services assume greater responsibility for low risk clients and regional forensic services are fully integrated with the broader mental health system. Regional forensic services are supported through activities to increase prevention, diversion and access to general mental health services.
- Provision of treatment in the context of the least restrictive alternative unless it is clear that less intrusive options are not capable of responding to the client's complex needs, or able to protect public safety.
- Linkage of mental health staff to the formal criminal justice system to help develop treatment/intervention plans at any stage of the criminal justice process i.e., diversion, bail, conditional sentence or probation.
- Continuity of mental health services so that clients' treatment, rehabilitation and discharge planning needs are met in the jail setting.[26]

4.3 Human Service and Justice Coordinating Committees

In 1997 the Human Services and Justice Coordination Project, was sponsored by the (then) Ministries of Health, Attorney General, Community and Social Services and Solicitor General and Correctional Services to better co-ordinate, resource and plan services for people with clinical needs who come into conflict with the law. It developed a policy blueprint for interministerial and ministry-specific initiatives, recognizing the joint responsibility in serving this population.[27] It also defined the roles and responsibilities of key players and identified key juncture points between the health, developmental services and criminal justice sectors.[v]

As a result of the Human Services and Justice Coordination Project, committees were established at the local, regional and provincial levels to more effectively coordinate the service planning and communications between health, criminal justice and developmental service organizations. The Human Services and Justice Coordinating Committees (HSJCC) were created to develop strategies to address service design and planning needs (i.e., prevention and crisis plans, community intervention plans, court assessment plans.)[28] The HSJCCs are currently being re-organized to position them to continue to plan and coordinate services and supports to meet the needs of adults with a mental illness or developmental disability who are involved in the criminal justice system.

4.4 Mental Health Implementation Task Forces

In 2000, the Minister of Health and Long-Term Care established nine regional Mental Health Implementation Task Forces (MHITFs). The mandate of the MHITFs was to develop implementation recommendations for regional and local mental health services. Several of the Task Forces indicated there was an insufficient range of services/response options to meet the needs of forensic clients. The Provincial Forum of MHITF Chairs recommended developing a policy framework for populations with special needs, including those receiving forensic services, as well as a policy framework for inter-ministerial linkages between MOHLTC and various ministries including the (then) Ministries of the Attorney General and Public Safety and Security.[29]

4.5 Forensic Mental Health Services Expert Advisory Panel

The Forensic Mental Health Services Expert Advisory Panel was struck in 2001 to advise the government on a provincial strategy for implementing a comprehensive forensic mental health system in the context of inter-ministerial co-ordination of forensic services. The following needs were identified by the panel:

- Guidelines on standards of practice, accountability and evaluation for mental health court support services
- Greater co-ordination between the provincial forensic system and partner ministries such as the Ministry of the Attorney General, (then) Ministry of Public Safety and Security and the (then) Ministry of Community, Family and Children's Services
- A continuum of care ranging from highly specialized inpatient services to community treatment for those who can be managed in less secure settings[30]

The Forensic Mental Health Services Expert Advisory Panel identified several barriers to policy implementation and system management, including the lack of a triage system at the court level that would enable the diversion of low risk offenders.[31] It also recognised that the lack of provincial policy direction for services to mentally ill people in the criminal courts has hindered the development of these services.

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[v] The Human Service and Justice Coordination Project identified 20 key junctures of interaction between the health, criminal justice and developmental service sectors. For the purposes of this framework, specifically focused on mental health diversion/court support, the 20 junctures have been collapsed into the three junctures discussed in Section 2.3.

4.6 Service Enhancement Strategy and MOHLTC Investments in Community Mental Health

Community mental health services were identified by the Ontario government as part of its commitment to improving health care in Ontario.[32] The 2004 Ontario Budget committed to expanding community mental health services to serve an additional 78,600 clients annually by 2007-08 in intensive case management, crisis response and early intervention services.[33] As well, in January 2005 the Service Enhancement Strategy was announced which represents an additional investment of $27.5 million annual funding for services that divert people with mental illness away from the criminal justice system and into community mental health services.[34] Through this strategy an additional 12,000 people will receive diversion/court support services through crisis response services, safe beds, court support services, intensive case management and supportive housing services.[35]

The Service Enhancement Strategy provides specific direction and identifies clear service deliverables for those community mental health services that received funding under the initiative. The Service Enhancement Strategy fits within this broader program framework for Mental Health Diversion/Court Support Services, but has a narrower focus with specified program deliverables.

4.7 Mental Health Diversion/Court Support Services in Ontario and Other Jurisdictions

Ontario

MOHLTC funded services in Ontario provide mental health services and supports to persons with mental health needs who are involved with the criminal justice system. A range of diversion/court support services are available across Ontario and reflect the various interfaces between the mental health and criminal justice system. Examples of programs include:

Pre-Charge Services

- **The Crisis Outreach and Support Team (COAST)** in Hamilton provides crisis services including assessment, treatment, support and referral to people with mental health concerns. COAST provides mobile crisis services through a team made up of a mental health worker and police officer.[36] COAST is also planning to offer a training program to police officers based on the Crisis in Training model developed in the U.S.A. Officers apply to the program and receive additional training that provides them with the tools to more appropriately respond to the mental health population. Among other benefits, the program has been shown to link people to appropriate services, divert them from emergency rooms and the criminal justice system and provide an immediate crisis response.

Court Support Services

- **Mental Health Court Support Services (MHCSS)** provides on-site court services in five Toronto courts to people 16 years of age and older who have mental health problems and who have been charged with a criminal offence. Services include diversion, consultation for those not suitable for diversion, supports to family/significant others, and consultation/advice to the judiciary.[37] One of the courts, Court 102 at Old City Hall focuses on people with mental health concerns, and was established, in part, on the belief that the needs of people with a mental illness could be more appropriately addressed through a dedicated court. Court 102 has access to psychiatric assessments, mental health workers, a case manager, adjoining cells, special duty counsel and selected judges and crown attorneys.[38]

- **Elgin-Middlesex Court Diversion Program** was piloted in 1996 and expanded upon and implemented in 1998. The program assists people with a mental disorder, developmental disability and/or brain injury who are in contact with the law to access appropriate services through partnerships between key players in the criminal justice and mental health sectors (i.e., Crown Attorney, defence, police, mental health service providers, clients and families).[39]

Post Conviction Services

- **Windsor-Essex CMHA** has partnerships with probation and parole services to facilitate linkages to required community and psychiatric services. The person enters into a voluntary agreement with Probation and Parole Services to meet with a psychiatric nurse or community support worker at CMHA. Participation in the program is enforced through the probation office.[40]
- **CMHA – Cochrane Timiskaming** provides support and advocacy to people involved in the criminal justice system experiencing mental health, addictions and/or developmental difficulties. CMHA works with corrections and local service providers to facilitate discharge planning for inmates returning to the community from local correctional facilities.[41]

Other Canadian provinces, and territories

Each Canadian province/territory has developed diversion/court support services to differing extents. Alberta has established a cross-ministerial Provincial Diversion Committee and has produced a number of documents to guide the development of diversion/court support policies and programs.[42] British Columbia, New Brunswick, Manitoba, Nunavut and Yukon are in various stages of development of diversion/court support policies and programs. Outside of Ontario, New Brunswick is the only other province to offer a mental health court which serves people with a mental illness or intellectual disability who are involved with the criminal justice system.[43]

United States

In the United States, services are developed at the state level. As a result of legislation passed by Congress to support diversion programs (including during incarceration and upon release) through funding grants, most states offer diversion/court support programs.[44] Based on a July 2004 survey, 98 mental health courts were available across the United States.[45]

Australia

The development of diversion programs in Australia also occurs at the state level, and most currently offer or are developing diversion/court support programs. However, there are national policies to support and guide the provision of diversion/court support services. The *Guidelines for Corrections in Australia*, defined a national set of service standards for all mental health services across Australia. Standards specific to diversion services include: promoting community acceptance, prevention and promotion, service integration, access and treatment and support.[46] In addition, the document *Standard Guidelines for Corrections in Australia* is being adopted in jurisdictions across Australia and endorses the principle that imprisonment is a punishment of last resort.[47]

United Kingdom

In the United Kingdom diversion/court support services are well developed. In 2003 there were 117 criminal justice liaison or diversion services recorded across the United Kingdom.[48] The services are supported by national policies. The *National Service Framework for Mental Health* sets national service standards for all mental health services and includes specific requirements for court diversion services including that they are linked to local mental health services, provide access to comprehensive and emergency assessment, and ensure that all local agencies, including police,

have access to specialist mental health services.[49] As well, The *Home Office Circular 66/90* requires police, courts and probation to work with health and social services and encourages cooperation between agencies in the provision of diversion services.[50]

Chapter 5: Interministerial Responsibility

5.1 Interministerial Collaboration and Linkages

The provision of effective diversion/court support services crosses the mental health, criminal justice and social service sectors and involves all levels of government.

Diversion/court support services are a provincial responsibility involving the Ministries of Health and Long-Term Care (MOHLTC), Attorney General (i.e., Crown Attorneys, court services), and Community Safety and Correctional Services (i.e., police, correctional facilities, probation). In addition, the federal and provincial/territorial governments each have some responsibility for criminal justice (i.e., parole, custodial sentences based on length of sentence- federal responsibility if sentence in excess of two years). Further, responsibility is shared with the Ministry of Community and Social Services and municipalities for social services and supports (i.e., housing).

Ministries and service sectors need to continue to work collaboratively and co-operatively to ensure that a seamless system of appropriate diversion/court support services is available to the people who require it.

5.2 Ministry of the Attorney General (MAG)

While public safety is of foremost concern for the Ministry of the Attorney General, it supports the fair and compassionate treatment of people who have a mental disorder who are in contact with the criminal justice system. Its Crown Policy Manual encourages the Crown to explore alternative options when working with people who have a mental disorder.[51] MOHLTC and MAG will continue to work together and discuss mechanisms to link appropriate people to diversion/court support services, enhance knowledge of options and resources, and ensure a seamless and co-ordinated system.

5.3 Ministry of Community Safety and Correctional Services (MCSCS)

MCSCS is facing increased pressures on police and correctional services to serve people with mental disorders in the correctional system. Police are often the first contact when a person with a mental disorder is involved in an incident, and there is an increasing prevalence of people with a mental disorder who are incarcerated.

There are ongoing opportunities for MOHLTC and MCSCS to collaborate and support one another's efforts to appropriately meet the needs of people with a mental disorder through access to mental health services and supports as an alternative to incarceration. Through shared activities such as service development (i.e., crisis response/emergency services), and training and educational opportunities (i.e., to enhance awareness of available alternative, for skill/competency development) the two ministries can work collaboratively to increase the effectiveness of the system of diversion/court support services and supports.

5.4 Ministry of Community and Social Services (MCSS)

There may be some overlap in populations served by MCSS and MOHLTC. MOHLTC will continue to work with MCSS to ensure the seamless provision of services to people who are in contact with diversion/court support services and who are traditionally served through MCSS. There are opportunities for MOHLTC and MCSS to collaborate and co-operate to develop service agreements, make referrals and linkages, and develop a shared awareness of services to ensure that people have timely access to appropriate and needed services.

Chapter 6: Next Steps

6.1 Implementation Plan

Diversion/Court support services provide people with mental health needs who are in contact with the criminal justice system with alternatives to incarceration. They re-direct people to needed services and foster quality of life through the provision of appropriate services and supports.

This is a service area that is being developed in jurisdictions across Canada and internationally. Emerging research into evidence-based practices will continue to enhance the quality of diversion/court support services offered.

This program framework defines the principles, goals and essential components of diversion/court support services based on available evidence and expert advice. As this area continues to evolve, services and supports will be continually monitored and evaluated. MOHLTC is committed to the provision of accountable, quality services.

6.2 Standards/Performance Measures

The next step is the development of standards, performance outcomes and measures to monitor and enhance the provision of diversion/court support services and supports.

Developing appropriate and effective diversion/court support services requires collaboration and co-operation across services and sectors to ensure timely alternatives are available. An effective system of diversion/court support services will provide necessary services and supports to people in their own communities, decrease their involvement in the criminal justice system and improve their quality of life.

Appendices

Appendix 1a: Diversion/Court Support Working Group Terms of Reference

Name:

Diversion/Court Support Policy Working Group

Purpose:

A provincial internal/external stakeholder Working Group will advise the Mental Health and Rehabilitation Reform Branch on development of a program policy for mental health diversion/court support services consistent with the direction in *Making It Happen*.

Rationale:

- Diversion services are provided pre- or post-charge to link the person to community or institutional mental health services. Court support services are provided to clients and their families to assist the judiciary, clients and their families with the legal process, link clients to services, and provide services/supports to clients.
- Diversion and court support services have developed over the last 10 years without any policy framework or guidelines to support their work.
- Ministry policy is to integrate clients involved with the criminal justice system, as far as legal status allows, into general mental health services.
- The Mental Health Implementation Task Forces indicated there is an insufficient range of services/response options to meet the needs of forensic clients.
- The Forensic Mental Health Services Expert Advisory Panel recognized that the lack of provincial policy direction for services to mentally ill people in the criminal courts has been a hindrance to the continued development of these services.
- In 1999, the ministry released *Making It Happen* (MIH), the government's plan for reforming the mental health system. The document committed government to policy work in various areas, including development of a hybrid system where integrated mental health services assume greater responsibility for low risk forensic clients.

Deliverables will include:

- Development of values and principles for a program policy for diversion/court support services consistent with the values and principles in *Making It Happen*.
- Advice on elements of a policy framework for diversion/court support services including the identification of functions and sub-functions.
- Advice on developing program standards and mechanisms to ensure programs utilize best practices.

Parameters:

The Working Group is a time-limited group constituted to provide advice to the Ministry of Health and Long-Term Care on a policy framework for court support/diversion.

Reporting Relationship:

The Working Group will report to the Directors, Mental Health and Rehabilitation Reform Branch, and Mental Health and Addictions Branch, Ministry of Health and Long-Term Care.

Chair:

The Working Group will be chaired by the Manager, Program Policy Unit, Mental Health and Rehabilitation Reform Branch, Integrated Policy and Planning.

Composition:

Membership will reflect a range of perspectives and expertise and include representation from relevant Ministries and key external partners including:

- Clinical Director of a facility providing a forensic/law and mental health program
- Community programs providing diversion/court support services
- Ontario Review Board
- Judiciary
- Ministry of Community Safety and Correctional Services
- Crown Counsel
- Defense Attorney
- Consumer who has had contact with the forensic system
- Police services
- Mental Health and Rehabilitation Reform Branch, Integrated Policy and Planning
- Mental Health Program, Mental Health and Addictions Branch
- MOHLTC Regional Offices

Role of Members – working group members are expected to:

- Actively participate in the work of the group, including participation in sub-groups that may be created from time to time
- Bring to the table expertise in diversion/court support services and assist in developing, communicating and promoting the group's work with their constituencies.

Time frame:

November 2004 – February 2005

Appendix 1b: Diversion/Court Support Working Group Membership

Joe Wright
Legal Counsel
Ontario Review Board

Dr. Susan Adams
Chief of Staff
North Bay Psychiatric Hospital

Dr. Maurice Siu
Center for Addiction and Mental Health
Clarke Site

Karen Gignac
Manager, Resource Centre and
Prevention Services
CMHA Windsor-Essex County Branch

Roberta Jarecsni
Director of Operations
CMHA Windsor-Essex County Branch

Theresa Claxton
Chair
Ontario Association of Patient Councils

Mike Donnelly
Toronto Police Service

Jim Leveque
Regional Director, Forensic Services
Mental Health Centre Penetanguishene

Dennis DeSalvo
Mental Health Court Support Services
CMHA Hamilton-Wentworth

Liz DiTullio
Court Outreach Program
CMHA Cochrane-Timiskaming

Terry McGuirk
Crisis Outreach and Support Team (COAST)

Anthony Balka
Lawyer

Michael Feindel
Ministry of the Attorney General

Christopher Chorney
Ministry of the Attorney General

Diana Sepejak
Ministry of Community Safety and
Correctional Services

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Katherine Barry
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East Region, MOHLTC

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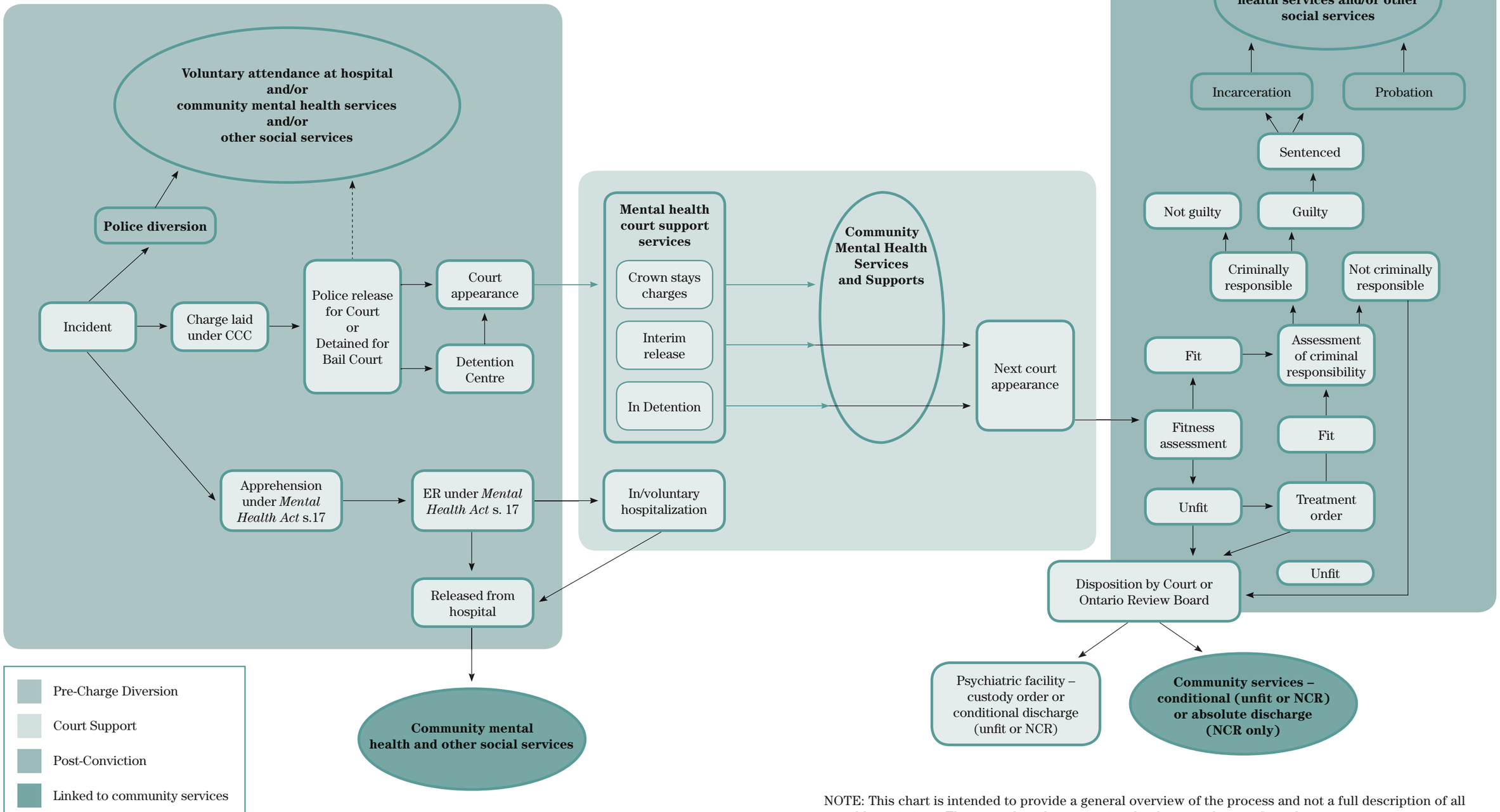
Staff Support
Ruth Stoddart
Nancy Douglas
Minghao Her
Aimee Watson
Mental Health and Rehabilitation Policy Unit,
Integrated Policy and Planning Division,
MOHLTC

Appendix 2: Key Junctures Between the Criminal Justice and Mental Health Systems



NOTE: This chart is intended to provide a general overview of the process and not a full description of all possible variations. There may be other scenarios that have not been reflected.

Appendix 3: *Making It Happen* Principles[vi]

The following principles and goals guide how mental health services and supports are organized and delivered across the mental health system.

1. **Client at the centre of the mental health system**
   Services demonstrate sensitivity for age, gender, race, culture, ethnicity, Aboriginal communities, language, economic standing, gender identity and sexual orientation.
2. **Services tailored to client needs with a view to increased quality of life**
   Recognising legal constraints, services and supports build on the person strengths and needs of clients, addressing stigma and emphasising choice, service flexibility and client self-determination.
3. **Client choice will be improved while access to services will be streamlined**
   Consistent capacity for services and supports will be developed across the province so that there is no obvious distinction in the quality based on location.
4. **Services will be linked and co-ordinated**
   Access to services is facilitated through links with other mental health services, general health services, social services and criminal justice services. There is a co-ordinated approach to linking eligible people with required services and supports.
5. **Services will be based on best practices**
   Accountable and effective services and supports will be informed by current knowledge and evidence-based practices, clear program objectives and the evaluation of outcomes.

[vi] Ontario Ministry of Health and Long-Term Care (1999). *Making It Happen: Implementation Plan for Mental Health Reform.* p 4-5.

Appendix 4: Recovery Philosophy[vii]

The advice summarized in this document assumes an understanding of the recovery approach as it pertains to mental health. The concept of recovery should underlie a program framework for court support/diversion services, and will be referred to throughout the document in relation to all aspects of the program framework for which advice will be given. A brief description of the recovery philosophy is therefore provided here given the importance of the concept to this program framework.

The recovery concept has steadily gained momentum since the 1980's as a result of three main driving forces. First, consumers have provided a conceptual base for the recovery approach in writing of their own experiences. As well, a number of long-term outcome studies suggest that a deteriorating course for serious mental illness is not the norm (e.g., see Harding et. al., 1987).[viii] Finally, there is growing recognition of the role that stigma plays in preventing people with mental illness from moving on and achieving quality of life and the recovery approach acknowledges this and incorporates the need to understand the impact of stigma as a central focus.

Anthony (1993)[ix] states that, "Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability". Recovery does not mean cure. Recovery can occur even if the person still experiences symptoms of mental illness. Silvestri and Hallwright (2001)[x] note that "The real test for recovery is when the user feels they have recovered, that is, they see themselves as living a quality of life that is not dominated by their past situation or their current symptoms and stresses".

The recovery approach is not tied to any one service model, it can be implemented in a variety of settings and programs. There are, however, implications for programs and services in developing a recovery-oriented approach. There are implications for the role of service providers, the orientation of programs, and the involvement of the broader community in recovery. A recovery approach emphasizes consumer choice, flexibility in services, individualized supports, and the importance of families, significant others and communities in supporting people with mental illness. A recovery approach also places emphasis on considering the negative correlates of mental illness such as poverty, stigma, poor housing as well as incorporating wellness promotion, rights advice, and the attainment of basic supports such as income.

[vii] Ontario Ministry of Health and Long-Term Care. (2004). *Program Policy Framework for Early Intervention in Psychosis*. p.27.

[viii] Harding, C.M., Brooks, G.W., Asolaga, T.S., and Breier, A. (1987). The Vermont longitudinal study of persons with serious mental illness. *American Journal of Psychiatry*, 144, 718-726.

[ix] Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.

[x] Silvestri and Hallwright, (2001). The Future Approach for Community Mental Health, in *This is Madness Too*, Ross on Wye.

Appendix 5: Sampling of Key Research Findings on Diversion/Court Support Services

Pre-Charge Diversion Research Findings

Research Source	Findings
William Deane, et al. (1999). Emerging partnerships between mental health and law enforcement. *Psychiatric Services*, 50(1), 99-101	Surveyed police departments in 194 U.S. cities. Forty-five per cent of police departments who responded (n=174) had a special program to respond to people with a mental illness. Findings: • Identified three specialized program strategies: 1. police-based specialized police response (specially trained officers) 2. police-based specialized mental health response (police department hire mental health consultants) 3. mental health-based specialized mental health response (community mental health mobile crisis teams who have relationship with police) • Programs with mobile crisis teams had higher ratings of perceived effectiveness than other models. However, this difference was not significant. • Police departments with the use of a crisis 'drop-off centre' (68% of police departments) were significantly more likely than other departments to perceive selves as highly effective.
Lamb, et al. (1995). Outcomes for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services*, 46(12), 1267-71	Studied clients of SMART (System-wide Mental Assessment Response Team) in Los Angeles, CA. Team made up of at least one mental health professional and specially trained police officer. Findings: • Of the 101 clients studied, only two were taken to jail, 73 were sent to hospital, 26 were referred to community services/refused referrals/or did not receive a referral. • Of those who had six month follow-up (n=85), 24% were arrested, 42% hospitalised, 22% committed acts of violence • After six months 11% were homeless compared with 31% at time of referral Team benefited from shared access to mental health and criminal justice information for decision-making, and benefited from one another's skills (i.e., mental health professionals' knowledge of mental health services, police officers' law enforcement skills). Identified the importance of training for team members.

Pre-Charge Diversion Research Findings continued

Steadman et al. (2000) Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services*, 51, 645	Compared three pre-charge models – Memphis Model (specially trained officers), Knoxville Tennessee (mobile crisis unit), and Birmingham, Alabama (civilian police employee in community service officer team). Findings: • Proportion of calls that resulted in crisis team response, 95% (Memphis), 40% (Knoxville), 28% (Birmingham). • Resulted in low arrest rates when the team responded, 2% arrested (Memphis), 5% (Knoxville) and 13%(Birmingham). Success of programs linked to two key factors; availability of triage/drop-off centre where police can transport people in crisis, and community partnerships.

Court Support Research Findings

Research Source	Findings
Steadman, Morris & Dennis (1995). The diversion of mentally ill persons from jails to community-based services: A profile of programs. *American Journal of Public Health*, 85(12), 1630-35	Based on findings from mail surveys (n=685), telephone interviews (n=115), and site visits (127 interviews across 18 sites). Findings: • Identified six common factors in the most effective diversion programs including 1. Integrated services – co-operation, formal agreements, communications between systems, supported with resources to promote interaction 2. Regular meetings between key providers 3. Boundary spanners – to bridge systems 4. Strong leadership 5. Early identification of clients – early identification and screening, shared information on individual's history (health, jail) 6. Case management services with the following functions: - Client identification and outreach - Assessment of client service needs - Consultation to courts - Development of treatment plans - Link to aftercare services - Service delivery monitoring - Client advocacy - Direct service provision

Court Support Research Findings continued

Research Source	Findings
Lamb, et al. (1995). Outcomes for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services*, 46(12), 1267-71	Studied Los Angeles court diversion program Findings: • 46% of program participants had a good outcome (defined as not being psychiatrically hospitalised or arrested, had not committed physical violence against others or was homeless for one year after the program) • Found significantly larger proportion of subjects mandated to receive judicially monitored treatment had good outcome compared with those not mandated to receive monitored treatment • Also had better outcomes if mandated to court-monitored treatment than those referred for treatment without court monitoring.
Swaminath et al. (2002) Experiments in change: Pretrial diversion of offenders with mental illness. *Canadian Journal of Psychiatry*, 47(5), 450-58.	Studied court diversion programs in two Ontario communities (rural and urban). Findings: • Low recidivism rates of two to three percent after one year for diverted groups • Suggested the rate of diversion was low as a result of: - the Crown screening out most people with criminal histories or spousal-abuse offences - lack of resources – diversion not occur if services were unavailable - lack of awareness of diversion program among court staff Concluded that diversion is feasible in urban and rural settings, if supported by collaboration and clear policies between criminal justice and mental health sectors that favour treatment rather than prosecution.

Post-Conviction Research Findings

Research Source	Findings
Lovell, Gagliardi & Peterson (2002). Recidivism and use of services among persons with mental illness after release from prison. *Psychiatric Services*, 53, 1290-96.	Studied the post release services received, new offences committed and the factors associated with recidivism of people who had a mental illness released from Washington State prisons in 1996 and 1997. Findings: • Few received clinically meaningful levels of service during first year of release • Subjects who committed new felonies tended to receive community services later and in smaller amounts than those who did not commit new felonies, however any causal relationship cannot be determined. Suggest that quality and quantity of post-release mental health services received requires further study into its impact on recidivism.
Ventura et al. (1988) Case management and recidivism of mentally ill persons released from jail. *Psychiatric Services*, 49, 1330-37.	Tracked 261 inmates of a jail program for three years after release. The jail program links inmates with serious mental illness to case management services while in jail for community re-entry planning. Upon release, individual is linked to community-based case management. Findings: • Receipt of case management services after release was significantly associated with a lower probability of re-arrest and longer period before re-arrest • Receipt of case management while still in jail was not directly related to recidivism, but it significantly increased the possibility of receiving community-based case management. Determining causal relationship between case management and a decrease in recidivism requires further research.

Endnotes

[1] Cowell, AJ et al. (2004). The cost-effectiveness of criminal justice diversion programs for people with serious mental illness co-occurring with substance abuse. *Journal of Contemporary Criminal Justice*, 20(3), 292-315.

[2] Lamb, HR et al. (1996). Court intervention to address the mental health needs of mentally ill offenders. *Psychiatric Services*, 47(3), 275-281.

[3] Lamb, HR et al. (1995). Outcomes for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services*, 46(12), 1267-1271.

[4] Ibid.

[5] Lamb, HR et al. (1996). Court intervention to address the mental health needs of mentally ill offenders. *Psychiatric Services*, 47(3), 275-281.

[6] Swaminath, RS et al. (2002). Experiments in change: pretrial diversion of offenders with mental illness. *Canadian Journal of Psychiatry*, 47(5), 450-458.

[7] Project Link, Department of Psychiatry, University of Rochester. (1999). Prevention of jail and hospital recidivism among persons with severe mental illness. *Psychiatric Services*, 50(11), 1477-1480.

[8] Cowell, AJ et al. (2004). The cost-effectiveness of criminal justice diversion programs for people with serious mental illness co-occurring with substance abuse. *Journal of Contemporary Criminal Justice*, 20(3), 292-315.

[9] Ibid.

[10] Steadman, HJ et al. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services*, 51, 645-649.

[11] Sealy, P & Whitehead, P (2004). Forty years of deinstitutionalization of psychiatric services in Canada: An empirical assessment. *Canadian Journal of Psychiatry*, l49(4), 249-257.

[12] A health care needs assessment of federal inmates in Canada. *Canadian Journal of Public Health*, Volume 95, Supplement 1, March/April 2004.

[13] Motiuk, L & Porporino, F (1991). *The Prevalence, Nature and Severity of Mental Health Problems among Federal Male Inmates in Canadian Penitentiaries*; Research and Statistics Branch, Correctional Service Canada, September 1991. Retrieved on the World Wide Web at http://www.csc-scc.gc.ca/text/rsrch/reports/r24/r24e_e.shtml

[14] 2000 Provincial Auditor's Special Report: *Value for Money 3.04: Institutional Services and Young Offenders*. Retrieved on the World Wide Web at http://www.auditor.on.ca/english/reports/en00/304eng00.htm

[15] Ontario Government (2005) *McGuinty Government Helping People with Mental Illness Stay Out of Jail*. News release Jan 12, 2005. Retrieved on the World Wide Web on April 14, 2005 at http://ogov.newswire.ca/ontario/GPOE/2005/01/12/c2146.html?lmatch=&lang=_e.html

[16] Lamb, HR et al. (1996). Court intervention to address the mental health needs of mentally ill offenders. *Psychiatric Services*, 47(3), 275-281.

[17] Lamb, HR et al. (1995). Outcomes for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services*, 46(12), 1267-1271.

[18] Hoff RA et al. (1999). The effects of a jail diversion program on incarceration: A retrospective cohort study. *Journal of American Academy of Psychiatry Law*. 27(3), 377-386.

[19] Ibid.

[20] Criminal Code of Canada, R.S. 1985, c. C-46

[21] Human Services and Justice Coordination Project, *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario*, 1997; p. 5.

[22] Ontario Ministry of Health and Long-Term Care (1999). *Making It Happen: Implementation Plan for Mental Health Reform* and Ontario Ministry of Health and Long-Term Care (1999). *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports.*

[23] Ontario Government (2005). *McGuinty Government Helping People with Mental Illness Stay out of Jail*. Retrieved on the World Wide Web on May 16, 2005 at http://ogov.newswire.ca/ontario/GPOE/2005/01/12/c2146.html?lmatch=&lang=_e.html

[24] Human Services and Justice Coordination Project. (1998) *Innovative Practices for the Coordination of Human Services and Criminal Justice Systems in Ontario – Second Edition*. p.24-26.

[25] Ontario Ministry of Health and Long-Term Care. (2004). *Public Information – Taking Action to Improve Health Care*. Retrieved on the World Wide Web on May 16, 2005 at http://www.health.gov.on.ca/transformation/#1

[26] Ontario Ministry of Health and Long-Term Care (1999). *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports.*

[27] Human Services and Justice Coordination Project, *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario*, 1997; p. i.

[28] Ibid. p.iii.

[29] Provincial Forum of Mental Health Implementation Task Force Chairs (2002). *The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario*.

[30] Forensic Mental Health Services Expert Advisory Panel. (2002). *Assessment, Treatment and Community Reintegration of the Mentally Disordered Offender*. Ontario Ministry of Health and Long-Term Care, p. 5.

[31] Ibid. p. 25.

[32] Ontario Government (2004). *2004 Ontario Budget Backgrounder Transforming Health Care*. Retrieved on the World Wide Web on May 16, 2005 at http://www.gov.on.ca/FIN/bud04e/bke1.htm

[33] Ibid.

[34] Ibid.

[35] Ibid.

[36] Information retrieved June 1, 2005 on the World Wide Web at: http://www.coasthamilton.ca/

[37] Information retrieved June 2, 2005 on the World Wide Web at http://www.crct.org/mhc.htm

[38] Macfarlane, D. et al. (2002). *A Review of Mental Health Services in the Toronto Courts – Final Report*. Prepared for the Court Support Services Consortium.

[39] Hartford, K. (2003). Best Practices in Four Cities in Southwestern Ontario: The Interface Between People With Mental Illness and the Criminal Justice System. Report prepared for the Ontario Ministry of Health and Long-Term Care. p.25, Retrieved June 2, 2005 on the World Wide Web at http://www.ontario.cmha.ca/admin_ver2/maps/best%5Fpractices%5Fsouthwestern%5Fontario%2Epdf

[40] Ibid, p. 45

[41] Information retrieved June 2, 2005 on the World Wide Web at http://www.cmhact.ca/english/programs/courtsupport.htm

[42] Alberta's Provincial Diversion Framework Working Committee (2001). Reducing the *Criminalization of Individuals with Mental Illness*. Retrieved on September 29, 2004 at http://www.amhb.ab.ca/programs/pdfs/Provincial%20Diversion%20Framework%20-%20November%202001.pdf

Alberta's Provincial Diversion Working Committee (2002) *Proposed Implementation Plan for Reducing the Criminalization of Individuals with Mental Illness*. Retrieved on September 29, 2004 on the World Wide Web at http://www.amhb.ab.ca/programs/pdfs/Provincial%20Diversion%20Implementation%20Plan%20-%20March%202002.pdf

Alberta's Provincial Diversion Working Committee (2003) *Alberta's Diversion Program: Phase One – Implementing the Provincial Diversion Program in Alberta Communities: Guidelines and Standards*

[43] New Brunswick (2004). *Mental Health Court Canada*. Retrieved September 28, 2004 on the World Wide Web at http://www.mentalhealthcourt-sj.com/home.html

[44] United States Congress (2003). *Mentally Ill Offender Treatment & Crime Reduction Act of 2003*. Retrieved October 12, 2003 on the World Wide Web at http://www.theorator.com/bills108/hr2387.html

[45] TAPA Center for Jail Diversion (July 2004). *Survey of Mental Health Courts*. Retrieved on September 28, 2004 on the World Wide Web at http://www.mentalhealthcourtsurvey.com/

[46] Commonwealth of Australia (1996). *National Standards for Mental Health Services*. Retrieved October 20, 2004 on the World Wide Web at http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mentalhealth-mhinfo-standards-nsmhs.htm

[47] Public Health Association of Australia (2004). *Health Promotion and Imprisonment – Imprisonment as a Punishment of Last Resort*. Retrieved September 29, 2004 on the World Wide Web at http://www.phaa.net.au/Advocacy_Issues/honmichelleroberts.htm

[48] Centre for Public Mental Health. (2003). *Adult Mental Health Service Mapping Atlas 2003: Criminal Justice and Forensic Services*. Retrieved on September 29, 2004 on the World Wide Web at http://www.dur.ac.uk/service.mapping/amh/documents/Section%209%20CJS%20and%20Forensic.pdf

[49] National Health Service (1999). *National Service Framework for Mental Health: Modern Standards and Service Models*. Retrieved on September 28, 2004 on the World Wide Web at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009598&chk=jmAMLk

[50] Home Office (1990). *Provision for Mentally Disordered Offenders (Home Office Circular 66/90)*. Retrieved September 28, 2004 on the World Wide Web at http://www.homeoffice.gov.uk/docs/hocirc66.pdf

[51] Ontario Ministry of the Attorney General. (2005). *Crown Policy Manual*. Retrieved June 1, 2005 on the World Wide Web at http://www.attorneygeneral.jus.gov.on.ca/english/crim/cpm/2005/MentallyDisorderedOffenders.pdf

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