A Needs Assessment Regarding Pre-charge Diversion for Persons with a Mental Illness in Toronto

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June 24, 2005

Executive Summary

In January, 2005, the Ministry of Health and Long Term Care allocated funds to the Mental Health and Justice Initiative. These enhancements are intended to provide people with a mental illness the support they need in their own communities to reduce contact with the criminal justice system. Four Toronto agencies (COTA in the North quadrant, Canadian Mental Health Association – Toronto Branch in the East quadrant, Sound Times in the South quadrant and Reconnect Mental Health Services in the West quadrant) received funds for a new program called the Pre-charge Diversion Project (PDP). Funds received by these agencies are to be used to create full-time staff positions to support persons with a mental illness and divert them away from the criminal justice system.

In April, 2005, the Toronto Pre-charge Diversion Planning Committee comprised of the four funded agencies plus representatives from: the Toronto Police Service, Court Support, the Centre for Addiction and Mental Health's (CAMH) Law and Mental Health Program, the Ministry of the Attorney General, and the Ministry of Health and Long Term Care commissioned the Community Research, Planning and Evaluation Team (CRPET) of the Community Support and Research Unit (CSRU) at CAMH to assist with the development of the PDP. CRPET conducted a needs assessment to assist with program development that reflects best practice models and incorporates feedback from key stakeholders.

Needs Assessment Objectives

- To identify similarities and differences in local service delivery needs within the four quadrants of Toronto;
- To assist the four funded agencies in refining the program logic model for each quadrant;
- To identify best practices in diversion program models; and
- To facilitate the future evaluation of the program.

Key Activities

- Literature search and review pertaining to
    - The principles of diversion
    - The general goals and objectives of diversion programs
    - The impacts of diversion programs as assessed through evaluation studies
    - The views of consumer/survivors concerning traditional mental health service delivery
    - The nature and impact of peer support for consumer/survivors

- Consultation process
    - Interviews (in person, phone or email) and focus groups with 59 stakeholders including consumers, family members, mental health professionals, police officers and other justice sector representatives

- Mapping of other mental health services in Toronto

- Creation of an inventory of American and Canadian diversion programs

- Suggested modifications to the PDP Logic Model (Form D) in light of the Ministry's new *Crisis Response Service Standards*

- Summary of information related to Goal Attainment Scaling

- Creation of a User Satisfaction Survey

Recommendations

1. *That a written memorandum of understanding be created between the four funded agencies and key referral sources*

A written agreement could address: eligibility criteria, referral processes, Reconnect's responsibilities as the lead agency, information sharing and mechanisms to facilitate evaluation.

2. *That there is one access number for the PDP*

Eventually the PDP should have one referral number. While the program is in its infancy, however, and the funded agencies are implementing distinct programs, the main telephone numbers of those agencies may need to be used.

3. *That the program operate during afternoons and evenings*

Both the consultation process and the hours of operation for existing mental health services support the contention that the program should be offered during afternoons and evenings. Service demands during and outside of regular business hours should be tracked and monitored.

4. *That a multi-phasic approach to implementation be adopted*

Additional resources may be sought to facilitate program integration and expansion, to facilitate the development of other modes of delivery such as

telephone support, to provide information and education related to the PDP and to facilitate its evaluation.

5. *That an education package for the program be created*

Numerous agencies and organizations should be informed about the PDP. This notification and linkage development process is likely to occupy a considerable amount of the time of PDP staff during the early stages of implementation. Pooling resources across the four funded agencies to develop and implement a coordinate education package about the PDP would be a cost-effective means of promoting it.

6. *That the PDP be evaluated in terms of both process and outcomes*

The impact of the PDP should be evaluated in terms of both its process and outcomes. A formative evaluation should be undertaken within the next 12 to 18 months and consider both unintended and intended benefits and drawbacks of implementation. An outcome evaluation should follow at some point after 24 months of implementation. Client outcomes can be assessed through the use of Goal Attainment Scaling in the context of the Ministry's new *Crisis Response Service Standards*. Justice system impacts may also be measured.

7. *That user satisfaction data be an integral part of any evaluation undertaken in relation to the PDP*

Client outcome data could be complemented through an examination of user satisfaction data. In this case, users would include not just persons served by the program (persons with a mental illness and, where appropriate, family members) but also referral sources.

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1. CONTEXT

In January, 2005, the Ministry of Health and Long Term Care allocated funds to the **Mental Health and Justice Initiative**. These enhancements are intended to provide people with a mental illness the support they need in their own communities to reduce contact with the criminal justice system. More specifically, the target population is persons presenting with behaviours that indicate a serious mental health issue with possible co-occurring disabilities who are: 1) at significant risk of criminal charges; 2) at significant risk of incurring further charges; or 3) at significant risk for apprehension by the police as emotionally disturbed persons.

One of the services funded through this initiative is a new program called the Pre-charge Diversion Project (PDP). Four Toronto agencies received funds for the PDP: COTA in the North quadrant, Canadian Mental Health Association – Toronto Branch in the East quadrant, Sound Times in the South quadrant and Reconnect Mental Health Services in the West quadrant. Funds received by these agencies are to be used to create full-time staff positions to support persons with a mental illness and divert them away from the criminal justice system.

In April, 2005, the Toronto Pre-charge Diversion Planning Committee comprised of the four funded agencies plus representatives from: the Toronto Police Service, Court Support, the Centre for Addiction and Mental Health's (CAMH) Law and Mental Health Program, the Ministry of the Attorney General, and the Ministry of Health and Long Term Care commissioned the Community Research, Planning and Evaluation Team (CRPET) of the Community Support and Research Unit (CSRU) at CAMH to assist with the development of the PDP. CRPET conducted a needs assessment to assist with program development that reflects best practice models and incorporates feedback from key stakeholders.

The overall aims of the needs assessment were:

- To identify similarities and differences in local service delivery needs within the four quadrants of Toronto;
- To assist the Committee in refining the program logic model for each quadrant;
- To identify best practices in diversion program models; and
- To facilitate the future evaluation of the program.

An initial document[1] reported preliminary findings of a literature review. The intent in sharing this preliminary literature review was to:

- Facilitate the development of questions for focus groups and interviews with key informants;
- Ensure that the proposed goals and objectives common across all four quadrants and presented in reports to the Ministry (i.e., Form Ds) were

consistent with best practices for diversion for persons with a mental illness;
- To identify strategies for enhancing the likelihood of program success so that such factors could be taken into account during the planning of services; and
- To identify potential performance indicators for the initiative.

2. LITERATURE REVIEW

2.1. Objectives and Method

The literature review had five objectives:

1. To identify the principles of diversion;
2. To identify the general goals and objectives of diversion programs;
3. To identify impacts of diversion programs as assessed through evaluation studies;
4. To provide information regarding the views of consumer/survivors concerning traditional mental health service delivery; and
5. To identify the nature and impact of peer support for consumer/survivors.

Because the PDP will be limited to individuals who are sixteen (16) years of age and older, the literature review was limited to diversion for adults. The literature review included both pre-charge and post-charge programs as there is not always a clear and concise distinction between these in the literature. Therefore, the review focused on literature related to programs at the pre-justice system involvement level and excluded diversion programs that occur at sentencing. The literature review pertained to diversion for persons with a mental illness, as well as diversion for persons with or without co-occurring substance use concerns.

The literature review was comprised of three parts:

- A search for both published and unpublished research materials relating to diversion that consisted of:
    - Searching indexed databases: MedLine, PsycInfo, SocioFile, and Dissertation Abstracts;
    - Searching the website of the British Home Office;
    - Contacting members of the Ontario Association of Law Enforcement Planners to identify relevant materials;
    - Conducting a general web-search for jail diversion and mental illness; and
    - Conducting a review of bibliographies of preceding materials for additional sources;
- A web-based search for program descriptions of diversion programs; and

- A search for materials pertaining to consumer perspectives of mental health service delivery that consisted of:
    - Searching indexed databases: MedLine and PsycInfo,
    - Conducting a general web-search for consumer/survivor perspectives,
    - Employing these two methods to focus on:
        - Articles by well published authors in the field,
        - Articles published by leaders of consumer/survivor initiatives and empowerment initiatives,
        - Material published by authors who self-identify as consumer/survivors, and
        - Authors and resources readily identified by consumers.

The literature review findings are organized with reference to the five literature review objectives specified above.

2.2. Principles of Diversion

Our review of the literature revealed four categories relating to principles of diversion: collaboration, training and education, program operations, and research and reporting.

2.2.1. Collaboration

All phases of any diversion project should involve collaboration between mental health agencies, justice agencies, consumers and family members.

The design, implementation, administration and evaluation of any diversion project should be an ongoing collaborative effort among mental health, social and community services, emergency services, law enforcement and other criminal justice sector stakeholders, consumers, family members and related consumer groups [2-21]. This team approach should be adopted early in the process [5, 22-25] and ensure that consumers, family members and related consumer groups are involved in all stages of the process [13, 26].

The interests and concerns of both criminal justice and mental health stakeholders need to be taken into consideration as they may be guided by different philosophies, structures, functions, languages, social roles, constituencies and priorities [9, 17, 27-29]. The design phase should involve building consensus and commitment among the stakeholder groups, ensuring the legal foundations are in place to support diversionary efforts and to gain the support of the broader community [19, 30-31]. This type of collaboration facilitates information sharing and communication among group members thereby increasing a program's ability to provide appropriate services [3, 29, 32-33]. In addition, pooling

the resources of mental health and criminal justice groups allows for the mobilization of services beyond the capability of each individual system [34].

Best practices identified for these collaborations include:

- Establishing documents of agreement between agencies [22], (see Appendix A for a sample agreement between a police service and a mental health association, and a sample memorandum of understanding between a mental health emergency services agency and a police agency regarding the disclosure of information);
- Establishing ongoing methods of contact for key personnel [8, 20, 22-23, 25, 35-37];
- Ensuring member commitment to the purpose and goals of diversion [3-4];
- Developing dispute resolution mechanisms [5]; and
- Including members that reflect the demographics of the community [7].

2.2.2. Training and Education

Police officers and mental health professionals should be provided with training and education on an ongoing basis.

The appropriate, standardized and ongoing training and education of police officers, mental health professionals and others involved in diversion is essential to program success [3-5, 10-11, 14-16, 19, 21-22, 27-29, 32, 38-46]. Consumers, mental health experts and police officers expressed overwhelming support for crisis intervention training for police [47]. Education should include cross training (between law enforcement and mental health groups) and job shadowing to increase understanding, respect and communication among team members [22, 25, 28, 31-32, 48]. Consumers can serve an essential role in training by assisting with the development of appropriate training and response procedures and sharing their experiences and opinions during training sessions [3, 32]. Research has suggested that officers who receive this type of specialized training are more confident and comfortable when responding to mental health emergencies [49].

As part of educational efforts, programs should also ensure that all groups (e.g. consumers, family members, police dispatchers, front-line officers, court staff and community members) potentially impacting the daily activities of a program are aware of its existence and mandate so that program support and utilization occurs [4, 10, 14-15, 19, 21-22, 50].

2.2.3. Program Operations

A number of best practices have been identified to facilitate the daily operations of a diversion program: provision of integrated services, effective information management, employment of a "boundary spanner" and establishment of a clear mandate.

- **Provision of integrated services**

  Effective diversion programs provide integrated and streamlined services (see section 2.3 on page 7 for more information). The provision of integrated services requires a comprehensive, accountable and responsive mental health infrastructure, as well as a variety of agencies, services and community resources for client referral [15, 28, 41, 51].

- **Effective information management**

  Diversion programs require effective information management and information sharing systems [5, 8, 14, 22, 48]. For example, a system can be established between police and mental health professionals to ensure that the latter are provided the opportunity to attend calls involving current or past clients [4].

- **Employment of a "boundary spanner"**

  Many proponents of diversion advocate for the employment of a "boundary spanner", which is an individual or agency that provides strong leadership spanning the gap and coordinating service delivery amongst different stakeholder groups [20-23, 25, 27, 33, 35, 36, 43, 52-54]. Depending on the scope and size of a diversion program, the boundary spanner may also serve as a case manager developing an appropriate plan for each individual client. This approach encourages the joint participation of various groups, ensures that clients' needs are being met and encourages program completion by clients.

- **Establishment of a clear mandate**

  Programs should establish a clear mandate comprised of common goals and a shared commitment to achieving those goals through the creation of standardized policies, procedures and protocols, that include formal case finding procedures to ensure early and equitable identification of persons with a mental illness [5, 14, 20, 22, 25, 36]. These case finding procedures include *"rapid and regular use of both the mental health and criminal justice information systems to learn more about an individual's prior criminal justice and mental health treatment histories"* [36, p.1633]. For example, some programs have developed computerized management information systems that enable staff to review an individual's treatment history [36].

2.2.4. Research and Reporting

Diversion programs should ensure appropriate research activities are conducted to evaluate program effectiveness.

Diversion programs should ensure appropriate measurement of outcomes, evaluation of program linkages, dissemination of results, [5, 15, 22, 26, 55] and continual program improvement based on results [4]. Programs should disseminate results to promote community support for current program activities and potential program expansion [4].

2.3. Goals and Objectives of Diversion Programs

Regardless of how they are framed, a common thread in articulated program goals is the aim of: diverting persons with a mental illness away from arrest and jail time, towards the provision of appropriate and integrated mental health services.

Our review of the literature revealed four categories of goals and objectives related to this aim: service provision; avoidance of arrest, jail time and injury; avoidance of hospitalization; and justice system benefits.

2.3.1. Appropriate and Integrated Service Provision

Diversion programs aim to provide clients with timely, appropriate and integrated services in the community.

One of the key goals of diversion is to provide timely, appropriate and integrated services (or linkages to services) to persons with a mental illness, including early identification [3-4, 10-11, 16, 23-26, 28, 31, 36-37, 40-41, 45, 52, 56-64]. While the focus is generally on the provision of mental health services, diversion programs may provide referral to a wide variety of services such as housing, income support, food and clothing, supported education, peer support, assistance navigating the criminal justice system, [7, 26, 30, 62, 65-67] and supports for family members and significant others [38]. Effective service provision requires timely and accurate screening and assessment [18]. Services cater to the individual needs and unique circumstances of clients [3, 32] to reduce cycling between criminal justice, mental health and substance abuse services [36, 45].

Being able to respond to individual needs requires flexibility. For example, women involved in diversion programs may be more likely to have histories of trauma, unmet medical needs, childcare needs and unstable living conditions [68]. In addition, individuals with co-occurring disorders may not respond well to traditional mental health interventions and other options may need to be considered for this group [69]. Integrated provision of services may reduce substance abuse [58], improve consumer quality of life [58], reduce homelessness [5], and decrease the intrusion and coerciveness in the lives of persons with a mental illness [5].

A number of strategies have been identified to facilitate timely, appropriate and integrated service delivery. The list of strategies below draws on the perspectives of multiple stakeholder groups and thus the importance of each strategy varies across stakeholder groups.

- Provide services in a free-standing mental health treatment facility, or a "single-point" access to services [22, 31, 40, 45].
- Provide active, nontraditional case management wherein case managers are hired primarily based on work experience in criminal justice, mental health and/or substance abuse rather than on academic credentials. Some authors argue that case managers should be culturally diverse and have a high level of involvement with each client [20, 22, 25, 36-37, 69-70].
- Streamline intake procedures to minimize police time spent accessing the diversion program [31, 45]. The Memphis diversion program, for example, has police spending an average of 30 minutes in processing time for each individual [31]. Another triage program has established a separate police entrance to reduce police time [31].
- Employ a no-refusal policy for entry into the diversion program such that diversion staff accept all police referrals [5, 12, 22, 31, 45].
- Provide services on a 24-hour basis [27, 48].
- Ensure continuity of care in terms of service provision and service providers and follow clients into the community [7, 27, 32, 60, 71].
- Provide services in the least restrictive environment [7].

2.3.2. Avoidance of Arrest, Jail Time and Injury

Diversion programs aim to avoid the arrest, jail time and additional contacts with the justice system of persons with a mental illness.

Diversion programs are intended to avoid the unnecessary arrest, jail time and criminalization of persons with a mental illness [3, 7, 14, 23, 28, 33, 39, 41, 45, 48, 52, 58, 62, 64, 72-74] and the dual stigma of being diagnosed with a mental illness and involved in the justice system [75]. More specifically, spending time in jail is likely to lead to a worsening of symptoms due to a lack of mental health treatment, lack of access to medication, the stress of the situation and an inability to adapt well to jail [3, 52]. By contrast, diversion has the potential to decrease suicides, suicide attempts and victimization while in jail [3, 14, 32, 45, 52, 63].

Avoiding jail time is beneficial to the individual consumer, while at the same time increasing the safety and cost-effectiveness and reducing the overcrowding of jails [11, 52]. It is hoped that the timely provision of mental health services will reduce repeated contacts with the police and justice system and reduce recidivism [4, 7, 23, 39, 45, 52, 58, 60]. To avoid an arrest and the creation of a criminal record, some diversion programs deal with situations on-site [3, 5] while others ensure charges are stayed [4].

Diversion programs aim to improve the outcomes of police-consumer interaction by decreasing rates of injury of consumers and police.

Diversion aims to decrease the rates of restraint, injury or death in interactions between police and persons with mental health issues [4, 5, 58, 63]. These interactions may be managed more effectively through the creation of pre-charge diversion programs thereby leading to a decrease in injuries. Evaluations of diversion programs have reported a decrease in police injuries [64, 76]. To improve the interaction between police officers and consumers during an incident, some officers involved in diversion programs consistently visit settings in which consumers regularly congregate to build familiarity and relationships with consumers [4].

2.3.3. Avoidance of Hospitalization

Diversion programs also strive to decrease rates of hospitalization of persons with a mental illness through the timely provision of mental health services [3, 7, 62, 77]. As well, diversion programs may reduce wait times and avoid unnecessary assessments [4, 77]. When diversion programs can reduce the number of persons hospitalized for assessments, these beds can be made available for other patients who require psychiatric services [32]. One diversion program in Texas was able to successfully reduce hospitalizations by 52% [3].

2.3.4. Justice System Benefits

Diversion programs aim to reduce costs within the justice system.

Diversion programs can lead to justice sector cost savings, including reduced court costs [57], reduced jail costs [28, 58], fewer court dockets [28] and less court backlogs [78]. As examples, Texas programs estimated $2 to $5 million savings [3], a program in Connecticut reported decreases in jail and hospital costs [14], programs in Los Angeles and Connecticut estimated a savings of $2,200-$2,500 per incident or diverted individual [3, 77] and programs in Illinois and New York reported savings of $19,000 and $40,000, respectively, per person [79]. While the justice sector may experience cost savings, a cost-effectiveness analysis of three diversions programs found that health care sector costs were higher for diversion, mainly due to higher mental health service delivery costs [58]. Similarly, another evaluation found that diversion programs led to lower justice system costs but higher treatment costs [80].

The informal treatment of individuals involved in diversion programs allows the criminal justice system to focus resources on individuals committing more serious offences. This re-focusing will lead to increased community safety and protection

because, for example, individuals committing more serious offences can occupy jail beds relinquished by diverted individuals [52, 73].

By collaborating with mental health professionals and agencies, police officers are able to reduce the amount of time spent processing arrests, testifying and waiting at emergency services or other treatment facilities for admission [3, 4, 28, 32, 74]. To achieve this goal, some programs employ a "drop-off" centre [3], have team members attend at hospitals with the person with a mental illness [4], or allow police to contact emergency services before their arrival to allow for a more streamlined intake process [4, 5]. As a result, police officers can return to their regular field duties, improving police responsiveness [58] and allowing the mental health professional to provide appropriate support. Programs have reported reduced time for police officers to return to patrol as a result of the implementation of diversion [64, 76].

2.3.5. Additional Considerations

Research supports the use of mandated diversion, but some proponents believe mandated programs are unnecessarily coercive.

Some diversion programs are able to encourage clients to continue their involvement with such programs by mandating their participation [11, 52, 81-82]. These programs are based on the premise that mandated services provide the leverage to improve program compliance. By contrast, non-mandated diversion may be a "disincentive" to police officers because individuals who refuse involvement in the program cannot subsequently be charged [78]. In a comparison of mandated and non-mandated jail diversion, researchers concluded that mandated programs may lead to: less time in jail, more time in the community (as opposed to jail time or hospitalization), increased time in treatment, increased provision of appropriate services, the creation of treatment linkages and a reduction in drug use [20, 81]. On the other hand, some proponents advocate for the adoption of a non-coercive and less intrusive model [69, 77]. However, a study of consumer views found that 62% of participants viewed mandated community treatment (not specific to diversion) as effective and 55% viewed it as fair [83].

2.4. Literature on the Evaluation of Diversion Programs

Much of the literature on evaluating diversion programs is descriptive.

Much of the literature evaluating or assessing the impact of diversion programs reports only descriptive information regarding planned programs or outputs for existing programs, rather than sophisticated evaluation or outcome data. In particular, there is very little information concerning the relative success of different types of diversion programs and different methods of service delivery.

Studies are mixed with regard to the impact of diversion on clients.

Studies comparing groups of diverted and non-diverted individuals are mixed with regard to the impact of diversion on clients. Some studies indicate better outcomes for diverted individuals, such as less time in jail and more time in the community [76-77, 80-81], more mental health counselling [53], higher mental health functioning [53] and greater insight into their own substance abuse [81]. By contrast, other studies show equivalent outcomes for both diverted and non-diverted individuals in terms of: arrest rates [77, 84-85]; number of days hospitalized [77]; use of emergency and inpatient substance abuse services [53]; quality of life measures [84]; levels of social support [53]; and general measures of mental health, substance use, physical health, criminality and housing [86]. Finally, some results indicate better outcomes for non-diverted individuals, such as a higher decrease in arrests [86], lower rates of hospitalization and emergency room evaluations [53, 76, 86], greater mental health and substance use improvements, greater accessibility to service, greater service utilization [84, 86] and a higher likelihood of having a "regular place to stay" [53].

Researchers have also examined long-term outcomes for diverted individuals by employing a pre-post design and report positive results: linkage to a variety of services [20, 72, 80, 87], a decrease in jail time and hospitalization time [62], an increase in mental health service utilization [85], a decrease in arrest and recidivism rates [64, 76, 88], treatment compliance over 6 months [87], drug and alcohol abstinence over 6 months [87], a decrease in homelessness rates [72], no increases in re-arrest, alcohol or drug use after 12 months [58], a decrease in nonviolent victimization [58] and an improvement in psychiatric symptoms [58].

The effectiveness of diversion programs may be related to client characteristics.

Based on program experience, one practitioner reported that certain clients were better candidates for diversion than others [67]. Specifically, successful clients had a motivation to change, fewer previous treatment failures, less previous medication noncompliance, the absence of serious substance abuse, flexibility in adjusting to limits and structure, existing social supports and the ability to adopt new skills and coping mechanisms. The author noted that for clients lacking many of these characteristics, *"a more structured, longer-term setting, though not a correctional one, would seem to be a better choice"* [67, p.270]. In addition to these characteristics, the violent nature of the offences has also been considered. One study found similar outcomes for diverted individuals with violent and non-violent charges suggesting that excluding individuals who have committed violent offences may be unwarranted even though many programs limit eligibility to non-violent offences [72, 89].

2.5. Literature Related to Consumer/Survivor Perspectives

It is important to note from the outset that although this review attempts to discuss some of the ideas raised by the consumer/survivor movement and consumer/survivors in general, *"there is no such thing as a single consumer voice"* [90, p.40].

2.5.1. Limitations of the Medical Model

Consumer/survivors have consistently identified the limitations of the medical model.

In their critique of traditional mental health services, consumer/survivors have pointed to the limiting nature of the medical model. Individuals are labelled as "mentally ill" and oriented to in terms of their illness rather than as people and the mental illness is viewed as a permanent genetically or chemically based disorder with incurable symptoms requiring life-long medication and possibly forced treatment [90-100]. The medical model is based on a culture of control and exclusion [101-102] and promotes the stigmatization, marginalization and segregation of people living with mental illness [90-91, 98] because it facilitates viewing them as limited in their ability to cope, make decisions about their lives, undertake work, have relationships and parent [91].

2.5.2. Consumer Empowerment and Recovery

Consumer/survivors prefer to adopt a social model of mental illness.

Proponents of the consumer/survivor movement view mental illness as a social and political construct. They, therefore, prefer to adopt a social model of mental illness wherein the impact of poverty, social status and social isolation are taken into account [92] thereby foregrounding the nature and impact of the power differential between consumers and mental health service providers [92, 103].

With the adoption of a social model, consumer/survivors have shifted the focus away from illness towards recovery and wellness.

As an alternative to traditional mental health service provision, consumers have advocated for the adoption of a recovery model [94-95, 98-99, 103-105]. Recovery may be understood as *"a process, a way of life, and a way of approaching the day's challenges. It is not a perfectly linear process…The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration to live, work, and love in a community in which one makes a significant contribution"* [105, p.7]. The model focuses on many different components of recovery: empowerment (both personal and social), hope, wellness, trust, peer support, self-determination, personal responsibility, understanding, respect, meaningful and

active roles in society, advocacy and the elimination of stigma and discrimination [94, 99-100, 106-108]. Authors have also advocated for the incorporation of recovery principles into forensic programs [109]. Research demonstrates that a large proportion of individuals diagnosed with serious mental illness can recover or improve significantly [100, 108].

Consumers have advocated for their involvement in their own recovery process.

As part of this movement, consumers have advocated for their involvement in the recovery process, including *"full and complete decision making power over such fundamental questions as whether to be engaged in mental health treatment, the type(s) of treatment desired, the duration of treatment, where to live, whom to associate with, whether to go to school or to work, choices about intimate relationships, marriage, and parenting"* [92, p.11; 90, 110]. It is important to empower consumers as *partners* in the recovery process, respect their experience and view them as a heterogeneous group [90, 102, 104, 111].

Several models exist for consumer participation within mental health service delivery.

Some argue that consumers can be full partners with mental health practitioners viewing traditional mental health service provision as a choice within a broader array of options [110-112], while others focus on the value of consumer/survivor initiatives [112]. Consumer/survivor initiatives have been defined as *"self-help/mutual aid organizations that have been developed exclusively by and for people with serious mental illness"* [112, p.1]. These initiatives attempt to eliminate the power differential intrinsic in traditional service delivery by adopting a peer-support model [92].

Consumers should be involved in all phases of mental health service delivery including professional training and service design, delivery and evaluation [92-93, 102, 104]. In fact, consumers participate in the mental health system in many ways: as advocates, as case managers, as vocational and employment coaches, as peer mentors or peer support staff, as volunteers, as representatives on mental health planning boards, by serving on treatment teams and being part of consumer-operated initiatives [50, 90, 106, 110, 113-117]. A number of specialized peer training programs have been developed, including programs for Certified Peer Specialists and Forensic Peer Specialists, in the U.S. and Canada [113, 118-119].

2.5.3. Peer support in mental health service delivery

Social support from peers is important for recovery.

Within the recovery model, peer support is often viewed as a central focus [94, 96, 100-101]. *"A key element in recovery is the presence of people who offer hope,*

understanding, and support; who encourage self-determination; and who promote self-actualization" [104, p.244]. Empirical evidence suggests that for people with a mental illness, social support is a protective factor that helps to promote and maintain wellbeing, particularly as manifested in adaptive outcomes [120-122]. Thus, social support has the potential to foster recovery or improved functioning and at the very least can help to prevent further deterioration and relapse thereby maintaining a current level of functioning.

Peer support has multiple forms.

Peer support has been defined as *"a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful"* [98, p. 135]. Alternatively, it has been defined as *"social emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change"* [123, p.393]. Several forms of peer support have been identified: mutual support groups, consumer-run services, peer delivered services and peer employees [123-124].

Peer support has positive impacts on the quality of service provision, peer support users and peer support providers.

In terms of general quality of service provision, peer support related services have led to increased sensitivity, increased trust and rapport and an improved source of empowerment and role modeling [50].

It has been argued that as consumer/survivor practitioners individuals can offer hope and inspiration, share personal experiences, serve as role models and empower others to express their wishes [110, 126, 166]. A study comparing consumer and non-consumer case managers found no differences in client outcomes [166]. In addition, one study found positive impacts of combining peer social support with intensive case management for users [127]. Other studies have found additional user benefits: decreases in symptoms, hospitalizations and use of mental health and crisis services, and increases in social functioning, social support, quality of life, employment and education [30, 50, 112, 119, 123, 126, 128-129]. Furthermore, when self-help methods were compared to the use of non-peer therapists, no differences were found in outcomes [123].

Positive impacts on peer service providers have included reductions in hospitalization, improved quality of life, personal growth, increased self-esteem, "safe" employment roles, and a sense of contributing to their community and their own recovery [50, 128].

3. CONSULTATION PROCESS

3.1. Interviews and Focus Groups

Interviews (in person, phone or e-mail) and focus groups (in person) were conducted in all four quadrants of Toronto with key informants chosen by the four funded agencies or by others previously identified as key informants. This purposive sampling approach resulted in input being received from 59 people representing diverse stakeholder groups (see Table 1 in Appendix B for a breakdown by quadrant and stakeholder group membership). Six additional informants who had been referred by committee members were approached to participate; however, these stakeholders chose to decline participation. All participants were given a brief outline of the project and were asked to provide written consent to participate (see Appendix C for consent forms), informed that they were free to withdraw at any time without penalty, and assured that their responses would be kept confidential. For phone interviews, the interviewer read through the consent form and asked for verbal consent for each item on the form. Interview and focus group questions are provided in Appendix D. Consumers and family members were compensated for their time.

3.2. Approach to Qualitative Data Analysis

Detailed interview notes were taken at each interview and focus group. Where possible, direct quotes were included in the interview or focus group notes.
A content analysis of interview and focus group data was undertaken within a *grounded theory* approach, which is an inductive and iterative process of immersion in the data [130-132]. This approach was used to identify emergent themes in relation to study objectives. Because themes are grounded in the data, the coding and analysis began while other interviews were being scheduled and conducted [131, 133] and analysis continued until theoretical saturation was achieved, that is, no new themes emerged [130].

3.3. Reliability and Validity of Design and Analysis

The consultation process methodology was intended to optimize the validity and reliability of the data and analysis by: 1) obtaining data from more than the number of participants that is usually required to achieve theoretical saturation in qualitative research[1]; 2) relying on the analysis of detailed interview/focus group notes; 3) gathering information from diverse stakeholders representing different areas and through different methods [131, 135]; 4) involving multiple interviewers/focus group facilitators and multiple data analysts [135]; and 5) using other types of information, such as program documents, to corroborate

[1] Usually 20 to 30 interviews is sufficient to achieve theoretical saturation [134].

information gleaned from interviews and focus groups.

3.4. Findings From the Consultation Process

Findings from the consultation process are organized in relation to the key topics explored in interviews and focus groups. Differences across stakeholder groups and/or quadrants are noted where appropriate.

- ***Need for pre-charge diversion services***

  Participants strongly endorsed the need for a pre-charge diversion program for persons with mental health and/or substance use concerns. Many participants were interested in learning more about the PDP and in promoting it within their own organizations.

- ***Location of services***

  Some participants indicated that having a place for people to go would be helpful while others maintained that having workers who go to people would be best. Most participants indicated that the services should not be provided at a police station. Hence, if workers cannot meet officers out in the community then officers need to bring a person in crisis to the agency setting. This, however, requires consideration of the impact on other persons with mental health issues of someone in crisis being brought in to a setting. In particular, the impact on Sound Times members who might be present was raised as a concern.

- ***Accessibility/referral process***

  Participants noted that a crucial component of the PDP would be to promote it to potential referral sources particularly police officers. It was noted that if these referral sources do not know the PDP exists then they cannot access it. Furthermore, participants generally indicated that to be optimally effective in terms of access, there should be one contact number for the entire city rather than different numbers for different quadrants as this might contribute to the service being less likely to be used by prospective referral sources. On the other hand, it was observed that if the services will be distinct and not provide cross-coverage then having one phone number is of little value. A couple of participants suggested having both one number as well as quadrant specific numbers.

  The consultation process revealed support for a flexible model for accessing the PDP, that is, that referrals could come from persons with mental health and/or substance use concerns, police and other stakeholders. At the focus group in the East quadrant it was suggested that perhaps a police officer

could be dedicated to pre-charge diversion on a trial basis assuming that emergency room staff could accept persons in crisis forthwith thereby decreasing police waiting times and enabling the reallocation of an officer to diversion. It was further suggested that this could only occur if some of the Scarborough Hospital crisis workers could be based at Centenary Hospital thereby decreasing police wait times at Centenary Hospital as has been done at Scarborough Hospital. In addition, the 3 Full Time Equivalent (FTE) staff for the East quadrant would need to work closely with the hospital emergency room staff at both hospitals to accept people into the PDP.

- ***Eligibility criteria***

  Participants found the criteria to be broad. Most participants indicated that this was positive; it would allow for flexibility and for each case to be assessed on an individual basis rather than be overly restrictive as are other mental health and addiction services. Participants from all stakeholder groups noted that people with mental illnesses are particularly vulnerable to developing drug and/or alcohol addictions. Thus, eligibility criteria should be flexible enough to allow persons with concurrent disorders to access the service. If not then some people might get excluded who could benefit from diversion if criteria are too restrictive.

  On the other hand, a few participants indicated that the criteria were too vague to be useful on an operational level. Police officers and other criminal justice sector representatives, in particular, espoused this view. They maintained clarification was needed in terms of the types of offences for which pre-charge diversion could be employed arguing that broad criteria place too much responsibility on officers. Outlining criteria could be done through a service delivery agreement that is then reflected in police practices and policy.

- ***Hours of service delivery***

  There was general consensus that the program should be offered outside of regular business hours, that is, during afternoons and evenings (noon to midnight). Ideally, if resources permitted, the program should be offered on weekends as well. Participants' rationale for this was that other mental health services are available during regular business hours that can be accessed when people begin to decompensate and act in ways that beget police attention.

- ***Required linkages***

  Police having a key role was identified by many as important and that the diversion program needs to be designed in such a way as to facilitate its use by police. It was also acknowledged that police and other referral sources

would need orientation sessions to learn about the services provided in the different quadrants. Participants identified numerous other agencies and organizations that should be involved but this was typically in terms of the category or type of agency (see listing in Table 2 in Appendix E); however, some organizations were named specifically (see listing in Table 3 in Appendix F). Many participants noted that agencies that do not have as a primary mandate the provision of mental health services are often involved in supporting people with a mental illness in the community, which is reflected in the types of agencies listed in Appendices E and F.

- ***Non-mandated vs. mandated participation***

  Although the documentation for the pre-charge diversion initiative shared by the four funded agencies with the consultants indicated that the agencies wanted to offer a voluntary program, many individuals consulted expressed the need for participation in the program to be mandatory. This perspective was predominantly heard from justice sector representatives and family members arguing from a social justice perspective or a job function perspective.

- ***Infrastructure/coordination across quadrants***

  Participants inquired about the mechanism by which the staff working at the four funded agencies would be able, if at all, to share information given the mobility of clients. People may come to the attention of police and/or a hospital emergency room in a quadrant other than that in which they live raising the issue of where they should be referred. It was noted that if infrastructure support did not provide for the four agencies to coordinate service delivery across the city as a whole, this would undermine the efficiency and effectiveness of what is a relatively small service (11 FTE positions across the city). It was also noted that having an infrastructure would facilitate access to the service thereby making referrals faster and referral sources more likely to use the program and to have confidence in it.

- ***Quadrant differences in client base***

  Some participants observed that persons receiving services in the South quadrant are more likely to be adults with chronic and longer duration of mental illness than users from the other quadrants. By comparison, other quadrants were viewed as being more likely to serve younger people with less chronic illnesses who are less likely to have been diagnosed. Another way in which the potential user base in the South quadrant was viewed as different from that of the other quadrants was that the South quadrant was perceived as having more street-involved people whereas the majority of potential users in the other quadrants were perceived as more likely to live with their families thereby making family support services critical in these quadrants. Lastly,

ethnocultural diversity was mentioned in the East, North and West quadrants as an important consideration in service delivery but was not oriented to by participants in the South quadrant.

4. MAPPING OF OTHER MENTAL HEALTH SERVICES IN TORONTO

Input from the consultation process regarding differences in service delivery needs in the four quadrants was complemented by mapping out other mental health services in Toronto. In particular, we needed to gain an awareness of the relative number of mental health agencies in the four quadrants as well as the types of services they provide, catchment area, accessibility/referral information, eligibility criteria and hours of operation (see Tables 4-6 in Appendix G for a listing of agencies and summaries). One hundred and nineteen mental health agencies included in our "map" and were identified by consulting the 2004 *Blue Book*, a Google web search and the on-line version of the *Yellow Pages*. (A detailed search method is outlined in Appendix G.)

The mapping exercise revealed that the South quadrant is serviced by the highest number of mental health agencies and organizations; the vast majority of agencies and organizations do not require a professional referral; the majority of services are free; and the hours of operation for most of the agencies follow a standard business week (e.g., Monday to Friday, 9am to 5pm), although several do offer evening and weekend programming. These factors are likely to facilitate the development of linkages between the pre-charge diversion program and participating organizations by reducing the amount of administrative tasks necessary to link a diverted individual to a particular agency.

5. RECOMMENDATIONS

Based on the literature review and consultation process the following recommendations are made.

1. *That a written memorandum of understanding be created between the four funded agencies and key referral sources*

A written agreement between the four funded agencies and key referral sources such as police could address: clarification of eligibility criteria to the extent required on an operational level; the transfer of clients from one agency to another and the circumstances under which this would occur; referral processes in the different quadrants; whether an individual could access services from more than one agency simultaneously; the responsibilities Reconnect will take on as the lead agency (to avoid duplication and undue demands on Reconnect's resources relative to the other agencies); information sharing between the partner agencies; and mechanisms that will be put in place to facilitate the future evaluation of the PDP.

2. *That there is one access number for the PDP*

It was noted that referral sources, particularly police, are more likely to use the service if there is one phone number to access it. This is particularly important as police division boundaries do not correspond perfectly with quadrant boundaries initially proposed by the Toronto Pre-charge Diversion Planning Committee. Thus, eventually the PDP should have one referral number. While the program is in its infancy, however, and the funded agencies are implementing distinct programs, the main telephone numbers of those agencies may need to be used.

3. *That the program operate during afternoons and evenings*

Both the consultation process and the hours of operation for mental health services listed in Appendix G support the contention that the program should be offered during afternoons and evenings. Service demands during and outside of regular business hours should be tracked and monitored as these may contribute to a business case for additional program resources at a future date.

4. *That a multi-phasic approach to implementation be adopted*

Consistent with the aforementioned point, additional resources may be sought in the future. Additional resources could be used: to facilitate program integration and expansion, including supporting Reconnect in taking a lead role; to facilitate the development of other modes of delivery such as telephone support and to

build in peer support components to services provided in the North, East and West quadrants; to provide information and education related to the PDP; and to facilitate its evaluation.

5. *That an education package for the PDP be created*

Clearly there are numerous agencies and organizations that should be informed about the PDP. This notification and linkage development process is likely to occupy a considerable amount of the time of PDP staff during the early stages of its implementation. Pooling resources across the four funded agencies to develop and implement a coordinate education package about the PDP would be a cost-effective means of promoting it. The package could be sent to contact persons at other agencies who would then share the information with colleagues at team meetings and through other strategies.

6. *That the PDP be evaluated in terms of both process and outcomes*

The impact of the PDP should be evaluated in terms of both its process and outcomes. More specifically, a formative evaluation should be undertaken within the next 12 to 18 months to facilitate program development. The process evaluation should consider both unintended and intended benefits and drawbacks of implementation. An outcome evaluation should follow at some point after 24 months of implementation. Dividing the evaluation into these components would enable the Committee to fulfil its obligation under the new *Crisis Response Service Standards* [136], which indicate that some aspect of a program should be evaluated each year. Suggested changes to the PDP logic models for each quadrant (i.e., the Form Ds) are presented in bold italicized text in Tables 7-10 in Appendix H to foster the evaluation of the PDP in light of the new *Standards* and to provide greater clarity and continuity between logic model components (objectives, method/process, criteria for outcome, recording/reporting system). In some instances, questions or comments have been inserted to stimulate further discussion regarding a particular logic model. It is anticipated that addressing these questions or comments in the next few months will facilitate evaluation in the future.

Various outcomes or program impacts can be assessed. First, and most important, are user outcomes. It is recommended that these be assessed through the use of Goal Attainment Scaling (GAS; see Appendix I for a review of this method). On page 27 of *Crisis Response Service Standards* [136] program "effectiveness" domain indicators are listed (e.g., functional status, housing status, criminal justice involvement). Drawing on the Ministry's framework, GAS could be implemented such that goals could be developed in relation to these specific "effectiveness" indicator domains or categories. In keeping with a recovery-oriented perspective and in light of concerns raised through the

consumer/survivor movement, “consumer empowerment” could be added as an “effectiveness” domain for which each client could have a goal.

Impacts on the justice sector may also be examined. Appendix J provides a listing of American and Canadian diversion programs that includes, where available, information on evaluation. Justice sector indicators should be selected in concert with members of that sector and ideas can be gleaned from the list in Appendix J. The selection of justice sector indicators need bear in mind the goals and objectives of that sector in relation to diversion, which are not fully captured in the PDP program logic models (i.e., the Form Ds). A generic program logic model for evaluating police-mental health liaison initiatives is available to assist in this regard [137].

A final consideration with regard to the evaluation of the PDP is that quadrants may vary in the extent to which the PDP constitutes a distinct program or service within a menu of services offered by a particular agency. Sound Times is a much smaller organization than the other three funded agencies and thus its funding will be used to expand existing hours of operation thereby increasing the number of hours during which it provides services that it already provides. By contrast, the other agencies will likely look to create new and thus distinct programs within their organization’s portfolios. As a result, the boundaries between what activities constitute PDP activities as opposed to activities that are part of other services may vary across the funded agencies, which is a service delivery feature that needs to be taken into account when evaluating the PDP.

7. *That user satisfaction data be an integral part of any evaluation undertaken in relation to the PDP*

Client outcome data could be complemented through an examination of user satisfaction data. In this case, users would include not just persons served by the program (persons with a mental illness and, where appropriate, family members) but also referral sources. Such information is particularly useful in identifying strengths and weaknesses of a program. The *Crisis Response Service Standards* [136] indicate that the Ministry standard is that at least 80 % of clients must be satisfied with the program. A draft client satisfaction survey is provided in Appendix K. This survey can be adapted for different stakeholder groups, including service recipients and referral sources.

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Appendix A: Sample Documents of Agreement Between Agencies

A-1: Peterborough Pre-charge Diversion Working Group (n.d.). *Peterborough County mental health pre-charge court diversion protocol.* Received from Terry McLaren (Peterborough Chief of Police) by personal correspondence on June 7, 2005.

Peterborough County Mental Health
Pre-Charge
Court Diversion Protocol

This Protocol is Between:

The Peterborough Lakefield Community Police Service
The Ontario Provincial Police: Peterborough, Northumberland,
City of Kawartha Lakes and Haliburton Detachments
The Port Hope Police Service
The Cobourg Police Service
The City of Kawartha Lakes Police Service

And

Canadian Mental Health Association
Peterborough Branch
349 George Street
Peterborough, Ontario

Whereas it is acknowledged that the mentally disordered offenders may find themselves in conflict with the criminal justice system primarily because of their mental disorder,

And whereas the cooperation between the Canadian Mental Health Association, Peterborough Branch (C.M.H.A.) and the above mentioned police service's will permit mentally disordered arrested persons to receive a more structured environment directed toward treatment, counseling and a plan of care specific to their needs in order to reduce or minimize their contact with the criminal justice system in the future,

The purpose of the Pre-Charge Diversion Program is to assist mental health services, the judicial and police systems and persons who are primarily experiencing severe and persistent mental illness to provide effective alternative solutions to incarceration or unnecessary criminalization. The Pre-Charge Diversion Program is intended to assist individuals who are considered appropriate for diversion to access and utilize appropriate supports and services within their respective communities. Mental health diversion is an

alternative disposition or agreement resulting from the commission of an alleged offence by an individual with an identified mental illness or symptoms of mental illness. The program provides a venue for the creation of a voluntary agreement, coupled to a detailed diversion plan, which and alleged offender may voluntarily enter into with the police and the C.M.H.A. Peterborough Branch, as an alternative to receiving a criminal disposition.

Criteria:

1. A non-violent property criminal offence has been committed.
2. Accused appears to be or is known to be suffering from a mental disorder.
3. Police believe that the accused will benefit from pre-charge diversion program.
4. Accused voluntarily agrees to take part in a pre-charge program.
5. Peterborough C.M.H.A. believes the offender will benefit from the program.

Process:

1. Pre-charge diversion intake dates at the Peterborough C.M.H.A. is Monday's, Wednesday's and Friday's of each week. ***(Days??open for agreement*)**
2. Upon explanation of the program, offenders must indicate that they will attend this alternative court measure.
3. The Pre-charge Diversion form is completed by the arresting police officer.
4. A copy of the Pre-charge Diversion form is given to the offender.
5. Police agency will explain to offender's who are offered pre-charge diversion that if they do not attend the Peterborough C.M.H.A. ***(or satelite office location??)*** within 7 days, and they are determined not to be suitable for the program, criminal charges will be processed in accordance with police departmental policy.
6. If the offender fails to attend Peterborough C.M.H.A., within 7 days and/or fails to cooperate in the C.M.H.A. diversion program, appropriate criminal charges will be pursued.
7. If an offender does not cooperate or is not a suitable candidate for the diversion program, Peterborough C.M.H.A. will notify the appropriate police agency so that police can pursue a criminal prosecution.
8. The police will fax a copy of the Pre-charge Diversion Form and arrest report to the Peterborough C.M.H.A. at (705) …….
9. Should the Peterborough C.M.H.A. require additional information they will contact the police agency involved.
10. Peterborough C.M.H.A. will notify the police agency within 30 days that the offender has taken part in the diversion program so that police may close their files

This Pre-charge Diversion protocol agreement between the participating Police Service and the Peterborough Branch C.M.H.A. will continue in force in two year increments unless one of the parties, on 60 days notice, desires to terminate or amend the protocol. In such case the parties will attempt to formulate a new agreement satisfactory between the parties.

Dated this ____,day of_____, 2005.

_____

Canadian Mental Health Association
Peterborough Branch

_____

Ontario Provincial Police
Peterborough County Detachment

_____

Ontario Provincial Police
Haliburton Detachment

_____

Ontario Provincial Police
City of Kawartha Lakes Detachment

_____

Ontario Provincial Police
Northumberland
Detachment

_____

Peterborough Lakefield Community
Service Police

_____

Cobourg Police Service

_____

City of Kawartha Lakes Police Service

_____

Port Hope Police Service

A-2: Canadian National Committee for Police/Mental Health Liaison. *Sample memorandum of understanding between (a mental health emergency services agency) and (a police agency) regarding the disclosure of information.* BC: Author. Retrieved on May 25, 2005 from http://www.pmhl.ca/en/download/mou.doc.

SAMPLE

MEMORANDUM OF UNDERSTANDING

BETWEEN

(A MENTAL HEALTH EMERGENCY SERVICES AGENCY)

AND

(A POLICE AGENCY)

REGARDING THE DISCLOSURE OF INFORMATION

INDEX

SECTION

MEMORANDUM OF UNDERSTANDING

BETWEEN:

A MENTAL HEALTH EMERGENCY SERVICES AGENCY

(hereinafter referred to as the "MHESA")

AND:

A POLICE DEPARTMENT

(hereinafter referred to as the "PD")

WHEREAS:

A. The Mental Health Emergency Services Agency ("MHESA") is a duly constituted program of the (Regional Body), responsible for responding to urgent mental health concerns within the community and, as a result, is authorized to collect, use and disclose information about individuals to whom such services are or have in the past been provided, in accordance with the *(British Columbia specific reference: Freedom of Information and Protection of Privacy Act R.S.B.C. 1996 c. 165)*;

B. The PD is a Police Department duly constituted in accordance with the provisions of the *(British Columbia specific reference: Police Act, R.S.B.C. 1996 c. 367),* and possess the authority to conduct law enforcement investigations within the meaning of, and to collect, use and disclose information about individuals in accordance with, the *(British Columbia specific reference: Freedom of Information and Protection of Privacy Act R.S.B.C. 1996 c. 165*);

C. From time to time, the PD has in its possession information about individuals with apparent mental disorders, relevant to enabling MHESA to provide its program services to those individuals, and MHESA has in its possession information about individuals who have an apparent mental disorder that is relevant to PD law enforcement investigations involving those individuals;

D. MHESA and the PD co-operate in a collaborative partnership through, but not limited to, the integrated *(describe program, i.e., a combined police officer and mental health worker patrol car program),* with the goal of ensuring that individuals with apparent mental disorder are recognized and may receive due consideration and relevant available services;

E. The intent of this Memorandum of Understanding is to facilitate and regulate the disclosure of Personal Information by the PD to MHESA in accordance with *(British Columbia specific references: s.33(c) and (f.1) and s. 34 of the Freedom of Information and Protection of Privacy Act),* and the collection of such

information by the MHESA under *(British Columbia specific reference: s. 26 and 27 of the Freedom of Information and Protection of Privacy Act*); and

F. The further intent of this Memorandum of Understanding is to facilitate and regulate the disclosure of Personal Information by MHESA to the the PD under *(British Columbia specific reference: s.33(c) and (n) and s. 34 of the Freedom of Information and Protection of Privacy Act*), and the collection of such information by the PD under *(British Columbia specific reference: s.26 and 27 of the Freedom of Information and Protection of Privacy Act*).

SECTION 1.0 INTERPRETATION

1.1 In this Memorandum of Understanding each of the following terms shall, unless the context otherwise requires, have the meaning set out beside it:

(a) **"Authorized Employee"** means a sworn member of the PD or an employee of the MHESA;

(b) **"Program Purpose"** in relation to Personal Information or Mental Health Information means for the purpose of delivering or carrying out an officially authorized program, service or duty;

(c) **"Mental Health Information"** means Personal Information specifically about and limited to an individual's apparent mental disorder;

(d) **"MOU"** or **"Memorandum of Understanding"** means this agreement;

(e) "**Party"** or **"Parties"** means either or both of the PD and the MHESA; and

(f) **"Personal Information"** means recorded information about an identifiable individual, including, but not limited to:

- the individual's name, address or telephone number,
- the individual's race, national or ethnic origin, colour, or religious or political beliefs or associations,
- the individual's age, sex, sexual orientation, marital status or family status,
- an identifying number, symbol or other particular assigned to the individual,
- the individual's fingerprints, blood type or inheritable characteristics,
- information about the individual's health care history, including a physical or mental disability,
- information about the individual's educational, financial, criminal or employment history,
- anyone else's opinions about the individual, and

- the individual's personal views or opinions, except if they are about someone else.

SECTION 2.0 INFORMATION SHARING GOALS

2.1 The PD agrees to share Mental Health Information and Personal Information in its possession, with the MHESA, in order to help facilitate that individuals with an apparent mental disorder, who come to the attention of the PD, may receive the services provided by the MHESA.

2.2 The MHESA agrees to share exclusively Mental Health Information in its possession, with the PD, in relation to individuals who come into contact with the PD, in order to ensure that the individuals' apparent mental disorder is recognized by the PD and may be given due consideration.

SECTION 3.0 TERMS AND CONDITIONS OF ACCESS, USE AND DISCLOSURE

3.1 The Parties may request access to Mental Health Information or Personal Information in the custody of the other Party, and may disclose such information contained in their records, in accordance with this MOU.

3.2 Mental Health Information or Personal Information may be disclosed on the initiative of the Party in possession of such information or in response to a request from an Authorized Employee of the other Party.

3.3 A Party is not required to notify or consult with the other Party in advance of using or disclosing Mental Health Information obtained from the other Party, where the disclosure is to a third party in furtherance of Program Purposes.

3.4 The Parties may disclose Mental Health Information or Personal Information to each other verbally, in the form of written records or copies thereof, or as electronic data.

3.5 Each Party shall take all reasonable steps to ensure that, only their Authorized Employees shall have access to Mental Health Information or Personal Information provided by the other Party, and that access is exclusively for Program Purposes.

3.6 The MHESA shall, from time to time and, in any event, upon request from the PD, provide the PD with a list of its Authorized Employees, and the Manager of the MHESA or a delegate shall notify the Officer in charge of … *(PD specific position holder)* as soon as practicable whenever an Authorized Employee leaves their position or duties or otherwise no longer requires access to Personal Information from the PD.

SECTION 4.0 OWNERSHIP AND MANAGEMENT OF RECORDS AND INFORMATION

4.1 All records received or obtained from a Party remain the property of the originating Party and will be immediately returned to that Party upon request.

4.2 The Parties agree to comply with any requests from the other Party in relation to the management or return of disclosed records, as necessary to comply with duties under the *(British Columbia specific reference: Freedom of Information and Protection of Privacy Act*) or other applicable laws.

4.3 In the event that a Party receives a request under the *(British Columbia specific reference: Freedom of Information and Protection of Privacy Act*) to disclose records created by or received from the other Party, the Party receiving the request shall notify the other Party of the request, and shall, as soon as practicable and in any event within 20 days of receiving the request, transfer the request and return copies of those records to the other Party, in accordance with *(British Columbia specific reference: s.11 of the Freedom of Information and Protection of Privacy Act*).

4.4 Where a Party transcribes or otherwise records Personal Information or Mental Health Information provided by the other Party, into a secondary record, that record shall be deemed to be a record belonging to the Party that created that it.

4.5 Notwithstanding subsection 4.4 above, Personal Information and Mental Health Information provided by a Party under the terms of this MOU is provided "in confidence" in accordance with *(British Columbia specific reference: s.16(1)(b) of the Freedom of Information and Protection of Privacy Act*).

SECTION 5.0 SECURITY OF RECORDS AND INFORMATION

5.1 The MHESA shall ensure that any records obtained from the PD containing Personal Information or Mental Health Information remain on the premises of the MHESA, unless such records are being transported for return to the PD.

5.2 The MHESA shall secure records provided by the PD that contain Personal Information or Mental Health Information in a locked cabinet, whenever the records are not in specific use for a Program Purpose;

5.3 The MHESA shall keep all records provided by the PD that, contain Personal Information and Mental Health Information, segregated from other documents to the extent it is practical to do so.

5.4 The MHESA shall keep the PD advised at all times of the location of premises at which the MHESA is keeping records obtained from the PD containing Personal Information or Mental Health Information.

5.5 The MHESA agrees not to permit the destruction of any records received from the PD containing Personal Information or Mental Health Information, without the prior written consent of the PD, except where required by applicable law.

SECTION 6.0 REVIEW, AMENDMENT, DISPUTE RESOLUTION AND TERMINATION

6.1 This MOU may be reviewed and discussed periodically by designated representatives of the PD and the MHESA, and can be amended at any time by mutual agreement between the PD and the *(signatory body governing the MHESA)*. All amendments shall be made in writing and signed by both parties.

6.2 Any disputes concerning the interpretation of this MOU will be resolved through consultation between the designated representatives of the signatories to this MOU.

6.3 Either party to this MOU may terminate participation in this MOU upon provision of seven (7) days written notice, or immediately if Personal Information or Mental Health Information is used or further disclosed to third parties for anything other than a legitimate Program Purpose.

6.4 This MOU will remain in full force and effect until replaced by another MOU or terminated in accordance with this section.

SECTION 7.0 ENFORCEMENT

7.1 This MOU states the wishes of the parties in relation to disclosure, use and collection of Personal Information and Mental Health Information. However, this MOU is not a legally-binding document.

SECTION 8.0 SUCCESSORSHIP

8.1 This MOU shall apply to any organization created by a restructuring or name change to the MHESA or to any successor organization that continues to respond to urgent mental health concerns in the community in cooperation with the PD and receives access to Personal Information and Mental Health Information from the PD.

SECTION 9.0 WAIVER

9.1 No action or failure to act by either party shall constitute a waiver of any right provided to that party under this MOU nor shall any such action or failure to act constitute an approval or acquiescence in any breach thereunder, except as may be specified in writing.

SECTION 10.0 FEES

10.1 The parties may negotiate the fees to cover the cost of production of documents.

SECTION 11.0 NOTICE

11.1 All notices or communications provided for in this MOU will be in writing and will be mailed or delivered. For the purposes of delivery of notice, the addresses for delivery are:

Chief Constable
( ) Police Department
( ) Street
City, Province, Postal Code
Tel. No.:
Fax No.:

Director,
MHESA
( ) Street
City, Province, Postal Code
Tel. No.:
Fax No.:

SECTION 12.0 COMING INTO FORCE

12.1 This Memorandum of Understanding shall become operational upon the signature below by the appropriate designated representative from each party.

_____ _____

Date

Chief Operating Officer
MHESA

_____ _____

Date

Chief Constable
Police Department

Appendix B:

Table 1: Breakdown of Informants by Quadrant and Stakeholder Group

Stakeholder Group	Quadrant				**TOTALS**
	North	East	South	West	
Consumer	2	2		4	**8**
Family Member	1	1		2	**4**
Mental Health Professional	7	10	9**	12	**38**
Police Officer	1	4		1	**6**
Other Justice Sector Representatives*		2		1	**3**
TOTALS	**11**	**19**	**9**	**20**	**59**

*Court Support Workers; Crown Attorneys; Probation and Parole.

**One mental health professional in the South quadrant also self-identified as a consumer.

Appendix C: Consent Forms

C-1: North Quadrant Consent Form

COTA Health
Choose Experience. Expect Results.

Declaration of Informed Consent

I give my informed consent to participate in this needs assessment of pre-charge diversion services to keep persons with a mental illness out of the criminal justice system. I understand that Joan Nandlal, Erica Procter, and Linda Yuval of the Community Support and Research Unit at the Centre for Addiction and Mental Health are conducting this independent needs assessment on behalf of CMHA – Toronto Branch, COTA, Reconnect, and Sound Times.

_____I understand that the general purpose of this needs assessment is to learn about local service delivery needs in relation to pre-charge diversion for persons with a mental illness;

_____I understand that while COTA may be aware of my participation in this study, under no circumstances will what I say be shared with COTA or the partner agencies listed above, because my responses will be kept confidential;

_____I understand that if I receive services from COTA and/or a partner agency, my participation in this project will not affect the quality or nature of those services;

_____I understand that I may skip any question that I do not wish to answer;

_____I understand that I am free to stop the interview at any time without penalty;

_____If participating in a group interview, I understand that I am to keep confidential the expressed views of the other participants unless, as a group, we agree otherwise;

_____I have been given contact information for the principal investigator (Joan Nandlal) and understand that if I have any questions or concerns about the project I can contact her.

_____
Name

_____ _____
Signature Date

C-2: East Quadrant Consent Form

Declaration of Informed Consent

I give my informed consent to participate in this needs assessment of pre-charge diversion services to keep persons with mental illness out of the criminal justice system. I understand that Joan Nandlal, Erica Procter, and Linda Yuval of the Community Support and Research Unit at the Centre for Addiction and Mental Health are conducting this independent needs assessment on behalf of CMHA – Toronto Branch, COTA, Reconnect, and Sound Times.

_____I understand that the general purpose of this needs assessment is to learn about local service delivery needs in relation to pre-charge diversion for persons with mental illness;

_____I understand that while CMHA - Toronto Branch may be aware of my participation in this study, under no circumstances will what I say be shared with CMHA or the partner agencies listed above, because my responses will be kept confidential;

_____I understand that if I receive services from CMHA - Toronto Branch or the other partner agencies, my participation in this project will not affect the quality or nature of these services;

_____I understand that I may skip any question that I do not wish to answer;

_____I understand that I am free to stop the interview at any time without any penalty;

_____If participating in a group interview, I understand that I am to keep confidential the expressed views of the other participants unless, as a group, we agree otherwise;

_____I have been given contact information for the principal investigator (Joan Nandlal) and understand that if I have any questions or concerns about the project I can contact her.

_____
Name

_____ _____
Signature Date

C-3: South Quadrant Consent Form

Declaration of Informed Consent

I give my informed consent to participate in this needs assessment of pre-charge diversion services to keep persons with mental illness out of the criminal justice system. I understand that Joan Nandlal, Erica Procter, and Linda Yuval of the Community Support and Research Unit at the Centre for Addiction and Mental Health are conducting this independent needs assessment on behalf of CMHA – Toronto Branch, COTA, Reconnect, and Sound Times.

_____I understand that the general purpose of this needs assessment is to learn about local service delivery needs in relation to pre-charge diversion for persons with mental illness;

_____I understand that while Sound Times may be aware of my participation in this study, under no circumstances will what I say be shared with Sound Times or the partner agencies listed above, because my responses will be kept confidential;

_____I understand that if I receive services from Sound Times or the other partner agencies, my participation in this project will not affect the quality or nature of these services;

_____I understand that I may skip any question that I do not wish to answer;

_____I understand that I am free to stop the interview at any time without any penalty;

_____If participating in a group interview, I understand that I am to keep confidential the expressed views of the other participants unless, as a group, we agree otherwise;

_____I have been given contact information for the principal investigator (Joan Nandlal) and understand that if I have any questions or concerns about the project I can contact her.

_____
Name

_____ _____
Signature Date

C-4: West Quadrant Consent Form

Declaration of Informed Consent

I give my informed consent to participate in this needs assessment of pre-charge diversion services to keep persons with a mental illness out of the criminal justice system. I understand that Joan Nandlal, Erica Procter, and Linda Yuval of the Community Support and Research Unit at the Centre for Addiction and Mental Health are conducting this independent needs assessment on behalf of CMHA – Toronto Branch, COTA, Reconnect, and Sound Times.

_____I understand that the general purpose of this needs assessment is to learn about local service delivery needs in relation to pre-charge diversion for persons with a mental illness;

_____I understand that if I receive services from Reconnect and/or a partner agency my participation in this project will not affect the quality or nature of those services;

_____I understand that I may skip any question that I do not wish to answer;

_____I understand that I am free to stop the interview at any time without penalty;

_____If participating in a group interview, I understand that I am to keep confidential the expressed views of the other participants unless, as a group, we agree otherwise;

_____I have been given contact information for the principal investigator (Joan Nandlal) and understand that if I have any questions or concerns about the project I can contact her.

_____
Name

_____ _____
Signature Date

Appendix D: Interview and Focus Group Questions

D-1: North Quadrant Interview Questions – Mental Health Professionals, Police Officers, and Others

1 - How can the pre-charge diversion program best compliment existing local mental health services?

2 - What are the most critical hours of service for a pre-charge diversion program?

3 - What existing local services (mental health or other) should the program be linked to?

4 - Are there any characteristics unique to your geographical area that should be taken into consideration during the development of this program (e.g. ethnocultural diversity, existing inter-agency relationships)?

5 - What steps should we take to enhance the likelihood that the service will be used by the police, mobile crisis, hospital emergency departments, etc.?

6 - What would be the most appropriate point of contact (e.g. diversion staff contacted by police, diversion staff contacted by emergency services or mobile crisis, other)?

7 - How would these individuals contact diversion staff (e.g. one phone number for all quadrants, separate phone number for each quadrant, other)?

8 - What would be the most appropriate physical location of service delivery (e.g. at COTA, in the community, at a police station)?

9 - Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?

10 – Do you have any other suggestions, comments, or concerns regarding the pre-charge diversion program?

D-2: North Quadrant Interview Questions – Consumers and Family Members

1 - How can the pre-charge diversion program best compliment existing local mental health services?

2 - What are the most critical hours of service for a pre-charge diversion program?

3 - What existing local services (mental health or other) should the program be linked to?

4 - Are there any characteristics unique to your geographical area that should be taken into consideration during the development of this program (e.g. ethnocultural diversity, existing inter-agency relationships)?

5 - What steps should we take to enhance the likelihood that the service will be used by the police, mobile crisis, hospital emergency departments, etc.? What steps should we take to enhance the likelihood that diverted individuals will participate in the program?

6 - What would be the most appropriate point of contact (e.g. diversion staff contacted by police, diversion staff contacted by emergency services or mobile crisis, other)?

7 - How would these individuals contact diversion staff (e.g. one phone number for all quadrants, separate phone number for each quadrant, other)?

8 - What would be the most appropriate physical location of service delivery (e.g. at COTA, in the community, at a police station)?

9 – What do you think about the eligibility criteria specified by the planning committee? (Who do you think would benefit from a pre-charge diversion program? Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?)

10 - What services do you think would be particularly helpful in a pre-charge diversion program?

11 - If someone you care about had contact with the police, what would you like to see happen?

12 - Would this type of program be beneficial to you? How would your life be different if a pre-charge diversion program existed?

13 – Do you have any other suggestions, comments, or concerns about the pre-charge diversion program? Is there anything that has not been mentioned that you think is important when planning a pre-charge diversion program?

D-3: East Quadrant Interview Questions – Consumers and Family Members

1 - How can the pre-charge diversion program best compliment existing local mental health services?

2 - What are the most critical hours of service for a pre-charge diversion program?

3 - What existing local services (mental health or other) should the program be linked to?

4 - Are there any characteristics unique to your geographical area that should be taken into consideration during the development of this program (e.g. ethnocultural diversity, existing inter-agency relationships)?

5 - What steps should we take to enhance the likelihood that the service will be used by the police, mobile crisis, hospital emergency departments, etc.? What steps should we take to enhance the likelihood that diverted individuals will participate in the program?

6 - What would be the most appropriate point of contact (e.g. diversion staff contacted by police, diversion staff contacted by emergency services or mobile crisis, other)?

7 - How would these individuals contact diversion staff (e.g. one phone number for all quadrants, separate phone number for each quadrant, other)?

8 - What would be the most appropriate physical location of service delivery (e.g. at CMHA, in the community, at a police station)?

9 – What do you think about the eligibility criteria specified by the planning committee? (Who do you think would benefit from a pre-charge diversion program? Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?)

10 - What services do you think would be particularly helpful in a pre-charge diversion program?

11 - If someone you care about had contact with the police, what would you like to see happen?

12 - Would this type of program be beneficial to you? How would your life be different if a pre-charge diversion program existed?

13 – Do you have any other suggestions, comments, or concerns about the pre-charge diversion program? Is there anything that has not been mentioned that you think is important when planning a pre-charge diversion program?

D-4: East Quadrant Focus Group Questions

Key Focus Groups Questions	Prompts
How can the pre-charge diversion program best compliment existing local mental health services?	What service gaps currently exist? Who would be the best candidates for this initiative? - type of offence - symptomatology Currently, what is the sequence of events that occurs when a person with a mental illness comes into contact with the police? Are you aware of any best practices of implemented diversion programs in other areas that could be adapted and applied here? What are the most critical hours of service?
What existing local services should the program be linked to?	What services are currently available in your quadrant for persons with mental health issues? Which of these services should the pre-charge diversion program be linked to? What is the current delivery structure of existing crisis, hospital emergency, and police services related responding to mentally ill persons? Are there any existing services that have a diversion component and could support this pre-charge diversion initiative? Are there any characteristics unique to your area that should be taken into consideration during the development of this program? Are there any needs of particular ethnocultural or other communities that you feel should be considered during the development and implementation of this diversion program? Are there any specific ethnocultural or other organizations that are not mental health specific but should be linked to this program?
What steps should we take to ensure that the service will be used by the police, mobile crisis, hospital emergency departments etc.?	What are the potential challenges to implementing a diversion program in your area? Do you foresee any problems with the implementation of the program or barriers to implementation based on the material presented? How can the use of diversion services be encouraged? What are the issues surrounding accessibility to police, mobile crisis, and hospital emergency services? - after hours - in person vs. phone - weekends

	What would be the most appropriate physical location of service delivery? (At CMHA, in the community, at a police station?) What do you think would be more appropriate or feasible: for a crisis worker to connect daily with the liaison officers (to follow up new EDP cases) OR to have a satellite office/desk at the police stations to facilitate communication between police and the pre-charge service? Would it be possible or appropriate for a crisis worker to work with or from the Justice and Mental Health safe bed location in Scarborough? Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?
Is there the potential for duplication of services? How can we prevent this?	What duplication of effort do you foresee when the pre-charge diversion program is implemented? What type of duplication (service to clients, duplication of responsibilities…)? How can this duplication of services be prevented?

D-5: South Quadrant Interview Questions – Mental Health Professionals, Police Officers, and Others

1 - How can the pre-charge diversion program best compliment existing local mental health services?

2 - What are the most critical hours of service for a pre-charge diversion program?

3 - What existing local services (mental health or other) should the program be linked to?

4 - Are there any characteristics unique to your geographical area that should be taken into consideration during the development of this program (e.g. ethnocultural diversity, existing inter-agency relationships)?

5 - What steps should we take to enhance the likelihood that the service will be used by the police, mobile crisis, hospital emergency departments, etc.?

6 - How would individuals contact diversion staff (e.g. one phone number for all quadrants, separate phone number for each quadrant, other)?

7 - Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?

8 – Are you familiar with Sound Times? If yes, what do you know about the services provided by Sound Times?

9 - What would be the most appropriate way of linking diverted individuals to Sound Times? [Note: question 6 used in other quadrants: What would be the most appropriate point of contact (e.g. diversion staff contacted by police, diversion staff contacted by emergency services or mobile crisis, other)?]

10 – What does the term “peer support” mean to you (in relation to mental health service provision)?

11 – How does your knowledge of Sound Times services and your understanding of peer support fit with your earlier comments regarding the pre-charge diversion program?

12 – Do you have any other suggestions, comments, or concerns regarding the pre-charge diversion program?

D-6: South Quadrant Email Interview – Mental Health Professionals

Thank you for participating as a key stakeholder in the pre-charge diversion needs assessment. Sound Times is committed to using your valuable input to shape the program. Please review the background information provided, as well as the attached consent form. Please respond to the ten questions specified below (point form is sufficient) by 9am on Tuesday, May 24th. Returning the completed interview questions indicates that you have read and understood the consent form, and consent to participate.
If you have any questions or require any clarification, please contact either myself (Erica Procter) or Joan Nandlal, the Principal Investigator.

Joan Nandlal, PhD
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Background Information:
The Ministry of Health and Long Term Care has recently allocated funds to the **Mental Health and Justice initiative**. These enhancements will provide people with mental illness the support they need in their own communities to reduce contact with the criminal justice system. One of the services funded through this initiative is a new program called **Pre-Charge Diversion**. **Reconnect (west), Sound Times (south),** and **CMHA (east)** have been funded for 3 F.T.E.s and **C.O.T.A. (north)** has been funded for 2 F.T.E.s.

Who the program will serve: Target Population
The target population is persons presenting with behaviours that indicate a serious mental health issue with possible co-occurring disabilities who are: 1) at significant risk of criminal charges; 2) at significant risk of incurring further charges; or 3) at significant risk for apprehension by the police as emotionally disturbed persons.

Program Goals and Objectives
Goal #1: To prevent and reduce people's contact with the criminal justice system.
Goal #2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice systems.
Goal #3: To ensure quality service provision.

Eligibility Criteria

- Individuals presenting with behaviours that indicate a serious mental health issue with possible co-occurring disabilities.
- Individuals who are likely to be safely and successfully supported in the community.
- Individuals who are sixteen [16] years and over.
- Individuals engaging in behaviours that are likely to lead to charges under the *Criminal Code*.

Service Components Common to all Four Funded Agencies

- Access to practical supports (i.e. food, clothing, transit, etc.)
- Assistance with or advocacy for entitlements (i.e. income support, housing and housing referrals, access to legal representation/advice, primary health care)
- Social support (i.e. housing support, educational opportunities, peer support and social and recreational opportunities).

Service Components Specific to Sound Times

- *Sound Times will provide service in the south quadrant.*
- ***Sound Times offers a location at which potential service users can receive immediate in-person service (i.e. no intake process, restrictive admission criteria or waiting list)***
- ***Service will be provided six days per week.***
- ***As a peer initiative, the services is based on the expressed needs of the individual.***
- ***Sound Times provides an opportunity for individuals to establish mutually supportive relationships with other each other to reduce social isolation and exchange strategies for meeting both the challenges and opportunities associated with being a mental health consumer or psychiatric survivor.***

Questions:

1 - How can the pre-charge diversion program best compliment existing local mental health services?

2 - What are the most critical hours of service for a pre-charge diversion program?

3 - What existing local services (mental health or other) should the program be linked to?

4 - Are there any characteristics unique to your geographical area that should be taken into consideration during the development of this program (e.g. ethnocultural diversity, existing inter-agency relationships)?

5 - What steps should we take to enhance the likelihood that the service will be used by the police, mobile crisis, hospital emergency departments, etc.?

6 - How would individuals contact diversion staff (e.g. one phone number for all quadrants, separate phone number for each quadrant, other)?

7 - Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?

8 - Are you familiar with Sound Times? If yes, what do you know about the services provided by Sound Times?

9 - What would be the most appropriate way of linking diverted individuals to Sound Times?

10 - What does the term “peer support” mean to you (in relation to mental health service provision)?

11 - How does your knowledge of Sound Times services and your understanding of peer support fit with your earlier comments regarding the pre-charge diversion program?

12 - Please add any other suggestions, comments, or concerns you have concerning the pre-charge diversion program.

D-7: West Quadrant Interview Questions – Mental Health Professionals, Police Officers and Others

1 - How can the pre-charge diversion program best compliment existing local mental health services?

2 - What are the most critical hours of service for a pre-charge diversion program?

3 - What existing local services (mental health or other) should the program be linked to?

4 - Are there any characteristics unique to your geographical area that should be taken into consideration during the development of this program (e.g. ethnocultural diversity, existing inter-agency relationships)?

5 - What steps should we take to enhance the likelihood that the service will be used by the police, mobile crisis, hospital emergency departments, etc.?

6 - What would be the most appropriate point of contact (e.g. diversion staff contacted by police, diversion staff contacted by emergency services or mobile crisis, other)?

7 - How would these individuals contact diversion staff (e.g. one phone number for all quadrants, separate phone number for each quadrant, other)?

8 - What would be the most appropriate physical location of service delivery (e.g. at Reconnect, in the community, at a police station)?

9 - Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?

10 – Do you have any other suggestions, comments, or concerns regarding the pre-charge diversion program?

D-8: West Quadrant Interview Questions – Consumers and Family Members

1 - How can the pre-charge diversion program best compliment existing local mental health services?

2 - What are the most critical hours of service for a pre-charge diversion program?

3 - What existing local services (mental health or other) should the program be linked to?

4 - Are there any characteristics unique to your geographical area that should be taken into consideration during the development of this program (e.g. ethnocultural diversity, existing inter-agency relationships)?

5 - What steps should we take to enhance the likelihood that the service will be used by the police, mobile crisis, hospital emergency departments, etc.? What steps should we take to enhance the likelihood that diverted individuals will participate in the program?

6 - What would be the most appropriate point of contact (e.g. diversion staff contacted by police, diversion staff contacted by emergency services or mobile crisis, other)?

7 - How would these individuals contact diversion staff (e.g. one phone number for all quadrants, separate phone number for each quadrant, other)?

8 - What would be the most appropriate physical location of service delivery (e.g. at Reconnect, in the community, at a police station)?

9 – What do you think about the eligibility criteria specified by the planning committee? (Who do you think would benefit from a pre-charge diversion program? Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?)

10 - What services do you think would be particularly helpful in a pre-charge diversion program?

11 - If someone you care about had contact with the police, what would you like to see happen?

12 - Would this type of program be beneficial to you? How would your life be different if a pre-charge diversion program existed?

13 – Do you have any other suggestions, comments, or concerns about the pre-charge diversion program? Is there anything that has not been mentioned that you think is important when planning a pre-charge diversion program?

D-9: West Quadrant Email Interview – Mental Health Professionals, Police Officers and Others

Thank you for participating as a key stakeholder in the pre-charge diversion needs assessment. Reconnect is committed to using your valuable input to shape the program. Please review the background information provided, as well as the attached consent form. Please respond to the ten questions specified below (point form is sufficient) by 9am on Tuesday, May 24th. Returning the completed interview questions indicates that you have read and understood the consent form, and consent to participate.
If you have any questions or require any clarification, please contact either myself (Erica Procter) or Joan Nandlal, the Principal Investigator.

Joan Nandlal, PhD
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Background Information:
The Ministry of Health and Long Term Care has recently allocated funds to the **Mental Health and Justice initiative**. These enhancements will provide people with mental illness the support they need in their own communities to reduce contact with the criminal justice system. One of the services funded through this initiative is a new program called **Pre-Charge Diversion**. **Reconnect (west), Sound Times (south),** and **CMHA (east)** have been funded for 3 F.T.E.s and **C.O.T.A. (north)** has been funded for 2 F.T.E.s.

Who the program will serve: Target Population
The target population is persons presenting with behaviours that indicate a serious mental health issue with possible co-occurring disabilities who are: 1) at significant risk of criminal charges; 2) at significant risk of incurring further charges; or 3) at significant risk for apprehension by the police as emotionally disturbed persons.

Program Goals and Objectives
Goal #1: To prevent and reduce people's contact with the criminal justice system.
Goal #2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice systems.
Goal #3: To ensure quality service provision.

Eligibility Criteria

- Individuals presenting with behaviours that indicate a serious mental health issue with possible co-occurring disabilities.
- Individuals who are likely to be safely and successfully supported in the community.
- Individuals who are sixteen [16] years and over.
- Individuals engaging in behaviours that are likely to lead to charges under the *Criminal Code*.

Service Components Common to all Four Funded Agencies

- Access to practical supports (i.e. food, clothing, transit, etc.)
- Assistance with or advocacy for entitlements (i.e. income support, housing and housing referrals, access to legal representation/advice, primary health care)
- Social support (i.e. housing support, educational opportunities, peer support and social and recreational opportunities).

Questions:

1 - How can the pre-charge diversion program best compliment existing local mental health services?

2 - What are the most critical hours of service for a pre-charge diversion program?

3 - What existing local services (mental health or other) should the program be linked to?

4 - Are there any characteristics unique to your geographical area that should be taken into consideration during the development of this program (e.g. ethnocultural diversity, existing inter-agency relationships)?

5 - What steps should we take to enhance the likelihood that the service will be used by the police, mobile crisis, hospital emergency departments, etc.?

6 - What would be the most appropriate point of contact (e.g. diversion staff contacted by police, diversion staff contacted by emergency services or mobile crisis, other)?

7 - How would these individuals contact diversion staff (e.g. one phone number for all quadrants, separate phone number for each quadrant, other)?

8 - What would be the most appropriate physical location of service delivery (e.g. at Reconnect, in the community, at a police station)?

9 - Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?

10 - Please add any other suggestions, comments, or concerns you have concerning the pre-charge diversion program.

D-10: West Quadrant Email Interview Questions – Consumers and Family Members

Thank you for agreeing to participate as a key stakeholder in the pre-charge diversion needs assessment. Reconnect is committed to using your valuable input to shape the program. Please review the background information provided, as well as the attached consent form. Please respond to the ten questions specified below (point form is sufficient) by Monday, June 6th, if possible. Returning the completed interview questions indicates that you have read and understood the consent form, and consent to participate.
If you have any questions or require any clarification, please contact either myself (Erica Procter) or Joan Nandlal, the Principal Investigator.

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Background Information:
The Ministry of Health and Long Term Care has recently allocated funds to the **Mental Health and Justice initiative**. These enhancements will provide people with mental illness the support they need in their own communities to reduce contact with the criminal justice system. One of the services funded through this initiative is a new program called **Pre-Charge Diversion**. **Reconnect (west), Sound Times (south),** and **CMHA (east)** have been funded for 3 F.T.E.s and **C.O.T.A. (north)** has been funded for 2 F.T.E.s.

Who the program will serve: Target Population
The target population is persons presenting with behaviours that indicate a serious mental health issue with possible co-occurring disabilities who are: 1) at significant risk of criminal charges; 2) at significant risk of incurring further charges; or 3) at significant risk for apprehension by the police as emotionally disturbed persons.

Program Goals and Objectives
Goal #1: To prevent and reduce people's contact with the criminal justice system.
Goal #2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice systems.
Goal #3: To ensure quality service provision.

Eligibility Criteria

- Individuals presenting with behaviours that indicate a serious mental health issue with possible co-occurring disabilities.
- Individuals who are likely to be safely and successfully supported in the community.
- Individuals who are sixteen [16] years and over.
- Individuals engaging in behaviours that are likely to lead to charges under the *Criminal Code*.

Service Components Common to all Four Funded Agencies

- Access to practical supports (i.e. food, clothing, transit, etc.)
- Assistance with or advocacy for entitlements (i.e. income support, housing and housing referrals, access to legal representation/advice, primary health care)
- Social support (i.e. housing support, educational opportunities, peer support and social and recreational opportunities).

Questions:

1 - What services do you think would be particularly helpful in a pre-charge diversion program?

2 - Are you aware of any existing programs or services that you think should be linked to the pre-charge diversion program?

3 - Have you had any positive experiences with existing programs or services (that could be linked to a pre-charge diversion program)?

4 - If you or someone you care about had contact with the police, what would you like to see happen?

5 - How would your life or the life of a loved one be different if a pre-charge diversion program existed?

6 - What are the most critical hours of service for a pre-charge diversion program?

7 - Are there any characteristics unique to your geographical area that should be taken into consideration during the development of this program?

8 - What steps should we take to enhance the likelihood that diverted individuals will participate in the pre-charge diversion program?

9 - Who do you think should be involved in the pre-charge diversion program? Do you think the eligibility criteria are appropriate?

10 - Is there anything that has not been mentioned that you think is important when planning a pre-charge diversion program? Do you have any other suggestions, comments, or concerns about the pre-charge diversion program?

D-11: West Quadrant Focus Group Questions

Key Focus Groups Questions	Prompts
How can the pre-charge diversion program best compliment existing local mental health services?	What service gaps currently exist? Who would be the best candidates for this initiative? Who would most likely benefit from a pre-charge diversion program? - type of offence - symptomatology Currently, what is the sequence of events that occurs when a person with a mental illness comes into contact with the police? Are you aware of any best practices of implemented diversion programs in other areas that could be adapted and applied here? Can you describe a situation that would lead to pre-charge intervention? What are the most critical hours of service (since there is only funding for 3 F.T.E.s in the west)?
What existing local services should the program be linked to?	What services are currently available in your quadrant for persons with mental health issues? Which of these services should the pre-charge diversion program be linked to? What is the current delivery structure of existing crisis, hospital emergency, and police services related responding to mentally ill persons? Are there any existing services that have a diversion component and could support this pre-charge diversion initiative? Are there any characteristics unique to your area that should be taken into consideration during the development of this program? Are there any needs of particular ethnocultural or other communities that you feel should be considered during the development and implementation of this diversion program? Are there any specific ethnocultural or other organizations that are not mental health specific but should be linked to this program?
What steps should we take to ensure that the service will be used by the police, mobile crisis, hospital emergency departments etc.?	What are the potential challenges to implementing a diversion program in your area? Do you foresee any problems with the implementation of the program or barriers to implementation based on the material presented? How can the use of diversion services be encouraged?

	What are the issues surrounding accessibility to police, mobile crisis, and hospital emergency services? - after hours - in person vs. phone - weekends What would be the most appropriate physical location of service delivery? (At Reconnect, in the community, at a police station?) Do you think it's appropriate for each mobile crisis, hospital emergency and police service to assign one key contact to link with, i.e. refer people to the pre-charge program? Are the eligibility criteria specified by the planning committee sufficiently clear? What are the challenges in determining the eligibility criteria? How flexible do these criteria need to be?
Is there the potential for duplication of services? How can we prevent this?	What duplication of effort do you foresee when the pre-charge diversion program is implemented? What type of duplication (service to clients, duplication of responsibilities…)? How can this duplication of services be prevented?

Appendix E:

Table 2: Types of Service Linkages Recommended by Stakeholders

Type of Service	Examples
Mental Health / Addictions	• Mental health services (Programs, mental health workers, psychiatrists, and coordinated teams) • Addictions services (Detoxification / Treatment Centres) • Crisis support • Services for individuals with developmental issues • Emergency response
Medical Support	• Hospitals • Medication support • Family Doctors • Primary Care facilities
Therapeutic Interventions	• Therapy • Case management • Generic support services • Community Support / Social Worker • Counselling • Peer support • Anger management / conflict resolution services
Outreach	• Community / multi-care centres • Drop-In programs/services • Social recreation programs • Public spaces • Homeless outreach • Mobile Services
Education System	• Universities • Education and Training • School systems
Justice System	• Liaison officers (police-students;

	• Legal Aid • Probation / Parole Officers • Court Worker • Duty Counsel offices • Police • Justice of the Peace • Forensic Services
Housing / Homelessness	• Social housing / Cooperatives • Supportive Housing programs • Boarding homes • Shelters, hostels • Pre-charge diversion beds • Short-term crisis / safe beds
Ethno-Cultural / Religious	• Language-specific services • Faith communities (synagogues, churches) • Ethno-cultural communities
Children / Youth	• Children specific services • Mental health programs for youth • Students in crisis
Socioeconomic	• Identification services • Job searching programs • Vocational training / coaching • Social assistance / Income support services
Family	• Linking to families • Day Care services
Referral services	• N/A

Appendix F:

Table 3: Specific Service Linkages Recommended by Stakeholders by Quadrant

NORTH	EAST
• Across Boundaries • Centre for Addiction and Mental Health (CAMH) - Forensic Psychiatry facility • Community Care Access Centre (CCAC) • Community Living Toronto • Community Mental Health Association (CMHA) • Community Resource Connections of Toronto (CRCT) • COSTI Immigrant Services • COTA • The Drug and Alcohol Registry of Toronto (DART) • Developmental Service Centre • Elizabeth Fry • Emergency Response • Family Association for Mental Health Everywhere (FAME) • Foodmill • Fusion of Care • George Hall Centre • Griffin Support Network • Habitat • Hospital Outreach Program • Jane-Finch Community Centre • John Howard Society • Law and Mental Health Program • The Medical and Related Sciences (MaRS) Discovery District • North York General Hospital – psychiatric unit • North York Women's Centre • Ontario Disability Support Program (ODSP) • Ontario Housing Tribunal • Ontario Works • Renaissance Centre • Salvation Army (Harbour Light) • Shared Care Team • Surrey Place • Turning Point • University of Toronto, via a liaison officer • Victim Services	• Community Treatment Order staff • John Howard Society • Scarborough Hospital

SOUTH	WEST
• ACT Team Vocational Specialist • Adelaide Women's Resource Centre • CAMH - First Episode Clinic • CMHA • College Park Mental Health Program • COTA • Dixon Hall • Don Jail staff • Dual Diagnosis Resource Service (DDRS) • Gerstein Centre • Habitat • John Howard Society • Mental Health Program @ Old City Hall • ODSP • Progress Place • Regent Park Community Centre • Ryerson University • Seaton House • Sound Times Support Services of Metropolitan Toronto • St. Jude Community Homes • St. Michael's Psychiatrist • Street Health Community Nursing Foundation • STS • Toronto Christian Resource Centre • Toronto Community Housing • Volunteer Association of Ontario • Yonge St. Mission	• Afghan Women's Centre • Airport Authority / Security Services • Bail Program • Boundaries • CAMH First Episode Program • Canadian Tamil Youth • CCAC • CMHA • Community Relations Officers • Community Resource Connections of Toronto (CRCT) • COTA • Etobicoke Hospital • Family services • Gerstein Centre • Humber College • Jamaican Canadian Association • Metro Housing • Midyanta Somali Association • New Outlook • ODSP • Operation Springboard • Polycultural Immigration Services • Public Health • Reconnect • Security Services • St. Joseph's / St. Michael's Hospital: Police Officer dedicated to mental health services • Street Health Community Nursing Foundation • Street Services • Tropicana Community Services • YouthLink

Appendix G: Mental Health Agencies in Toronto

Method of Mapping Toronto Mental Health Agencies

Information regarding the agencies and organizations listed in Table 4 was collected in three steps. First, agencies and organizations were located using the *Blue Book 2004: Directory of Community Services in Toronto*. Using the subject index contained in the *Blue Book*, those agencies and organizations that could potentially partner with the pre-charge diversion program were examined. Specifically, the following subjects were included:

- Accompaniment services (all subcategories)
- Adult day care (all subcategories)
- Adult survivors (all subcategories)
- Advocacy (all subcategories)
- Aftercare (alcoholism and drug addiction subcategories)
- Alcoholism (all subcategories)
- Anger management
- Bullying prevention
- Case management
- Counselling (all subcategories)
- Crisis intervention (all subcategories)
- Day programs
- Developmental disabilities (all subcategories)
- Drop-in centres
- Employment (mental health)
- Family Counselling (all subcategories)
- Housing facilities
- Mental health (all subcategories)
- Outreach
- Psychiatric crises
- Psychogeriatric care
- Residences
- Residential care
- Young adults
- Youth

Within each of these subject areas, specific programs were further examined by referring to their listing in the *Blue Book.* Generally (although not always), the *Blue Book* contained information related to hours of operation, catchment area, the referral process, services offered, and the target population. Websites of agencies and organizations were accessed for additional information. Second, a *Google* search was conducted using the search terms “Toronto Mental Health Agencies” and “Toronto Mental Health Organizations”. Finally, the web-based version of *The Yellow Pages* was searched for “mental health services”.

Agencies and organizations located in the following geographical areas were searched: Etobicoke, North York, Scarborough, Toronto Central - East, and Toronto Central – West.

Table 4: Toronto Mental Health Services

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Across Boundaries, An Ethnoracial Mental Health Centre www.web.ca/~accbound 416-787-3007 Hours of operation: Mon to Fri 9:30am to 4:30pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• I/R • Outreach and service planning • Counselling • Support groups • Skills building • Case management	Persons 16+ with severe mental health problems and from an ethno-racial community
Alternatives: East York Mental Health Counselling Services Agency (no website available) 416-285-7996 Hours of operation: Mon to Fri 9am to 5pm; flexible for client meetings	**ALL FOUR QUADS**	• No referral necessary • Services accessed by drop-in or by contacting program	• Community mental health program • Advocacy • Education • Supportive counselling • I/R • Case management	Persons 16+ with serious, long-standing mental health problems
Boundless Adventures Association www.boundlessadventures.org 416-658-7059 Hours of operation: not stated	**ALL FOUR QUADS**	• Group referrals only; will not accept calls from individual applicants	• Year round 5-8 day outdoor and experiential education programs at camp in Ottawa valley	Consumer/survivors of the mental health system, women, young families at risk, "the mentally challenged"
Canadian Mental Health Association, Toronto branch www.toronto.cmha.ca 416-789-7957 Hours of operation: Mon to Fri 9am to 5pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Community support services • Education • Mental health promotion services • Advocacy • Case management • Mobile services	Persons with serious mental health problems
Central Toronto Youth Services www.ctys.org 416-924-2100 Hours of operation: Mon to Fri 9am to 5pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Counselling and therapy • Advocacy • Training and education • Youth outreach • Case management • Mobile services	Youth and young adults 13 – 24
Centre for Addiction and Mental Health www.camh.net 416-535-8501 Hours of operation: varies by program	**ALL FOUR QUADS**	• Referral required for some of the programs offered	• Mental health and addiction assessment and treatment facility • Case management	People affected by addiction and mental illness
Circle of Care www.circleofcare.com 416-635-2860 Hours of operation: Mon to Fri 8:30am to 4:30pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• In-home health and support services • Counselling and support groups • Kosher Meals on Wheels • Case management	Seniors and adults with physical disabilities, cognitive impairments, or mental health problems

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Community Living Toronto www.communitylivingtoronto. ca 416-968-0650 Hours of operation: Mon to Fri 9am to 4:30pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Counselling • Coordination of services • Information and intake • Recreational programs • Job placement • Case management	Children, youth and adults with developmental disabilities
Community Resource Connections of Toronto: Mental Health Court Support Services www.crct.org 416-482-4103 Hours of operation: not stated	**ALL FOUR QUADS**	• By referral from Crown Attorney	• Assessment and treatment • Securing 'basic need' resources • Short and long-term community supports • Case management	Persons who have a serious mental health problem, who have been charged with committing low risk offence, and who accept mental health diversion (with approval of the Crown Attorney)
Consumer/Survivor Information Resource Centre of Toronto www.icomm.ca/csinfo 416-595-2882 Hours of operation: Office: Mon to Fri 9am to 5pm Drop-in: Mon to Fri 1pm to 4pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by drop-in or by contacting program	• Free literature, non-lending video and print library • I/R and outreach services	Open to anyone Priorities to persons with mental health or addiction issues
COTA: Comprehensive Rehabilitation and Mental Health Services www.cotarehab.ca 416-785-8797 Hours of operation: Mon to Fri 8:00am to 8:30pm; Sat 10am to 4pm; After hours: on call system Mon to Sun 24 hours	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Case management • Site support services • Court support services • Case management	Children and adults with physical, developmental and mental health problems
Ethiopian Association in Toronto (no website available) 416-694-1522 Hours of operation: Mon to Fri 9am to 5pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by drop-in or by contacting program	• Psychiatric crisis counselling • I/R • Case management	Open to all, with focus on Ethiopian community
Family Service Association of Toronto www.fsatoronto.com 416-595-9230 Hours of operation: Mon to Fri 9am to 5pm; evening appointments available	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Counselling and educational programs • Case management	Open to anybody Special emphasis on individuals and families who are marginalized and disadvantaged
Fresh Start Cleaning and Maintenance www.freshstartclean.com 416-504-4262 Hours of operation: Mon to Fri 9am to 5pm	**ALL FOUR QUADS**	• Drop in to fill out application	• Cleaning and maintenance company operated by psychiatric survivors	Psychiatric survivors

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
George Brown College of Applied Arts and Technology: Redirection Through Education www.gbrownc.on.ca 416-415-5000 ext 2315 Hours of operation: Mon to Fri 9:15am to 4pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Supported education program • College credit courses in English, general education and computers • Vocational planning • Work placements and assessments • Individual counselling • Follow-up support • Case management	Youth and adults 19+ with mental health problems
Griffin Centre www.griffin-centre.org 416-222-1153 Hours of operation: Mon to Thurs 8:30am to 8:00pm; Fri 8:30am to 5:00pm After hours: 24 hour on call service	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Counselling • Residential programs • Social/life skills training • Education and treatment • Case management • Mobile services	Youth 12 to 18 who need help in dealing with a range of mental health needs, including dually diagnosed youth and complex cases
Griffin Community Support Network www.griffin-centre.org 416-222-3563 Hours of operation: Mon to Sun 9am to 9pm After hours: Call Gerstein Centre	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Counselling • Specialized day programs • Short-term crisis supports • Case management • Mobile services	Adults 16+ dealing with a developmental disability, or a dual diagnosis (developmental disability and serious mental health needs)
Hincks-Dellcrest Centre www.hincksdellcrest.org 416-924-1164 Hours of operation: Mon to Thurs 8am to 8pm; Fri 8am to 7pm After hours: answering service for registered clients	**ALL FOUR QUADS** (Outpatient services: former City of Toronto; Residential services: current city of Toronto)	• No referral necessary • Services accessed by contacting program	• Counselling and treatment services (outpatient, day treatment and residential) • Case management	Infants, children and youth who have mental health problems
Hong Fook Mental Health Association www.hongfook.ca 416-493-4242 Hours of operation: Mon to Fri 9am to 5pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Assessment and referral • Short-term supportive counselling • English as a second language classes • Support groups • Advocacy • Housing and support for people who are homeless • Case management	Persons of Cambodian, Chinese, Korean or Vietnamese descent who are 16+, have mental health problems, and are having difficulty accessing other mental health services

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
John Howard Society of Toronto www.johnhowardtor.on.ca 416-925-4386 Hours of operation: Mon to Thurs 9am to 4:30pm; Fri 9am to 4pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Counselling • Intake and case management • Employment services • Life skills • Communication skills and anger management • Drug and alcohol counselling • Case management	Persons currently, previously or at risk of becoming in conflict with the law, and their families Persons involved with the criminal justice system
Kennedy House Youth Services www.kennedyhouse.org 416-299-3157 Hours of operation: not stated	**ALL FOUR QUADS**	• Referral via outside agency	• Secure and open custodial programs • Residential group homes • Psychiatric and psychological counselling • Anger management and problem-solving • Case management	Troubled children and youth 12-17
Loft Community Services www.loftcs.org 416-979-1994 Hours of operation: Mon to Fri 9am to 5pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by drop-in or by contacting program	• Shelter, outreach and support • Case management • Mobile services • Offers several satellite locations throughout the GTA including: - Beverly Lodge - College View Supportive Housing Services - Dunn Avenue Supportive Housing - Etobicoke Girls' Residence - John Gibson House - McEwan Housing and Support Services - St. Anne's Place - St. George House - Wilkinson Housing and Support Services	Variety of populations served, including youth, adults, and seniors with a variety of mental health issues
Muki Baum Association For the Rehabilitation of the Multi-handicapped www.mukibaum.com 416-630-2222 Hours of operation: Mon to Fri 9am to 5pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• High support residential programming • Day programs • Vocational programs • Case management	Children and adults with dual diagnosis of developmental disabilities and emotional/psychiatric disorders
Ontario Council of Alternative Businesses www.icomm.ca/ocab 416-504-1693 Hours of operation: Mon to Fri 9am to 5pm	**ALL FOUR QUADS**	• For employment opportunities, apply directly to individual businesses	• Economic development assistance to groups of psychiatric survivors	Groups of consumer/survivors of mental health services wanting to establish, develop and run survivor businesses

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Operation Springboard www.operationspringboard.on.ca 416-977-0089 Hours of operation: Mon to Fri 9am to 5pm	**ALL FOUR QUADS**	• No referral necessary* • Services accessed by contacting program *Diversion programs require referral from Crown Attorney or police	• Court diversion programs • Day programs • Residential programs • Assessment and counselling • Job training and placement • Case management	Youth and young adults who have come into conflict with the law Youth and adults who are socially or developmentally challenged
Psychiatric Patient Advocate Office www.ppao.gov.on.ca 416-327-7000 Hours of operation: Mon to Fri 8:30 to 5	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Advocacy services and rights advice • Case management	Patients (instructed and non-instructed)
Salvation Army Booth Industries (no website available) 416-255-7070 Hours of operation: Mon to Fri 8:30am to 4pm	**ALL FOUR QUADS**	• Referral by mental health professional or self-referral	• Vocational rehabilitation activity • Basic work assessments • Continuing education • Counselling • Case management	Persons with diagnosed psychiatric disabilities who are not competitively employed
Surrey Place Centre www.surreyplace.on.ca 416-925-5141 Hours of operation: Mon, Tues, Fri 8:30am to 5pm; Wed and Thurs 8:30am to 9pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Diagnosis • Counselling • Service coordination • Behaviour therapy • Case management	People living with or suspected of having a developmental disability
Toronto Community Housing Cooperation (no website available) 416-981-5500 Hours of operation: Mon to Fri 8:30am to 4:30pm	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Provides 57, 500 units of rental housing in apartments, single family dwellings, townhouses, rooming houses • Several buildings with supportive housing programs, which may include attendant care	Any Canadian citizen, landed immigrant, or refugee claimant, including persons with developmental or psychiatric disabilities
Turning Point Youth Services www.turningpoint.ca 416-925-9250 Hours of operation: Mon to Fri 9am to 4:30pm (evening therapy appointments available) Shelter Mon to Sun 24 hours	**ALL FOUR QUADS**	• No referral necessary • Services accessed by contacting program	• Counselling • Shelter and transitional housing • Substance use treatment • Diversionary services • Case management • Mobile services	Varies depending on program Age range is 12 to 24 Youth with a variety of psycho-social issues
Salvation Army Plus Program (no website available) 416-693-2116 Hours of operation: Mon to Fri 9am to 4pm	**NORTH, SOUTH and EAST** (North York, East York and Scarborough)	• Professional referral	• Vocational rehabilitation activities • Basic work assessments • Life skills • Counselling and spiritual services • Case management	Adults with mental health problems who are not competitively employable

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Toronto East General Hospital: Crisis Intervention Unit www.tegh.on.ca 416-469-6220 Hours of operation: Emergency service: Mon to Sun 24 hours Outpatient services: Mon to Fri 9am to 5pm	**NORTH, SOUTH and EAST** (South-eastern North York, East York and South-western Scarborough)	• No referral necessary • Services accessed by contacting program	• Emergency psychiatric assessment • Crisis intervention • Short-term crisis therapy and management • I/R • Case management • Mobile services	Individuals in psychiatric crisis
Toronto East General Hospital: Community Outreach Services www.tegh.on.ca 416-461-2000 Hours of Operation: Mon to Fri 9am to 5pm	**NORTH, SOUTH and EAST** (South-eastern North York, East York and South-western Scarborough)	• No referral necessary • Services accessed by contacting program	• Supportive housing • Community outreach, treatment and support • Case management • Mobile services	Adults 16+ with serious mental illness
Whitby Mental Health Centre www.wmhc2.com 905-668-5881 Crisis 1-800-263-2679 Hours of operation: Mon to Sun 24 hours Visiting Mon to Sun 9am to 9pm	**NORTH, SOUTH and EAST** (former Cities of Toronto, North York and Scarborough)	• By referral	• Range of specialized inpatient and outpatient programs • Assessment and crisis intervention services • Consultative and educational services • Case management • Mobile services	Persons with serious mental illness or emotional difficulties Adolescents 12-18 Adults 18+ Seniors 65+
Jewish Family and Child Service of Greater Toronto (no website available) 416-638-7800 Hours of operation: Mon to Thurs 9am to 8pm; Fri 9am to 4pm After hours: answering service, calls returned within 1 hour	**NORTH and SOUTH** (North York and Toronto Central)	• No referral necessary • Services accessed by contacting program	• Counselling • Life skills programs • Community outreach • Crisis response • Case management • Mobile services	Persons with social and emotional problems
Meta Centre www.metacentre.ca 416-736-0199 Hours of operation: Office: Mon to Fri 9am to 5pm Programs: Mon to Fri 9am to 3pm; Sat 10am to 4pm; also Tues to Thurs 7pm to 9pm	**NORTH and EAST** (North York, Vaughan, Richmond Hill and Scarborough)	• Contact Consumer and Family Services intake worker	• Day programs • Supported independent living program • Life skills enhancement • Employment program • Counselling • Case management	Adults 18+ with a primary diagnosis of developmental delay Also adults with a dual diagnosis (a developmental and mental health issue) or multiple disabilities
Saint Elizabeth Health Care: Integrated Community Mental Health Crisis Response Program www.saintelizabeth.com 416-498-8600 ext 2136 Crisis 416-498-0043 Hours of operation: Mon to Sun 24 hours	**NORTH and WEST** (North York and Etobicoke)	• Call crisis line	• Crisis intervention • Emergency respite housing • Follow-up • Case management • Mobile services	Adults 16+ with a serious mental illness experiencing an acute psychiatric crisis
Ontario Ministry of Children's Services, Thistletown Regional Centre for Children and Adolescents – Adolescent Services (no website available) 416-326-0600 Hours of operation: not stated	**SOUTH and WEST** (former Cities of Toronto and Etobicoke)	• Professional or self-referral	• Assessment, case consultation, and case management • Day treatment and aftercare programs • Case management	Youth 13 to 19 with histories of conduct disorders, learning disabilities, and a variety of psychiatric disturbances

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Reconnect Mental Health Services http://www.reconnect.on.ca/ 416-248-2050 Hours of operation: Mon to Fri 9am to 5pm; early evening by appointment ACTT: Mon to Fri 8am to 4pm Team available Mon to Sun 24 hours	**SOUTH and WEST** (former Cities of York and Etobicoke)	• Self, family or professional referral	• Group and individual support for skill development, problem solving, socialization • Assistance in securing and maintaining housing • Intensive mental health support • Life skills training • Case management • Mobile services	Youth and adults 16+ experiencing serious mental health problems Persons who are homeless or at imminent risk of homelessness and have a mental illness
Goodwill Toronto www.goodwill.on.ca 416-362-4711 Hours of operation: Mon to Fri 8am to 5pm	**SOUTH and EAST** (Toronto Central and Scarborough)	• No referral necessary • Services accessed by contacting program	• Employment services • Employment assessment and career counselling • Case management	Unemployed youth and adults, including those facing physical, developmental, psychiatric, vocational or social barriers to employment
Scarborough Hospital: Mobile Crisis Program www.tsh.to 416-289-2434 Hours of operation: Mon to Sun 24 hours	**SOUTH and EAST** (East York and Scarborough)	• Call crisis line	• Crisis intervention and assessment • Safe bed for dually diagnosed adults • Referrals • Case management • Mobile services	Persons 16+ with a serious mental illness experiencing a psychiatric crisis
416 Drop-in (no website available) 416-928-3334 Hours of operation: Mon to Fri 5am to 5pm; Sat 7am to 5pm; Sun 8am to 5pm	**SOUTH** (Toronto East)	• No referral necessary • Services accessed by contacting program	• Drop-in crisis • Mental health crisis intervention • Food, laundry, shower facilities • Outreach • Mobile services	Women 16+, including women who are transient, homeless, socially isolated or single mothers
416 Addiction Case Management Program (no website available) 416-964-6936 Hours of operation: Mon to Fri 8:30am to 4:30pm	**SOUTH** (Toronto East)	• No referral necessary • Call for appointment	• Counselling • Assistance in accessing and removing barriers to service • Education • Outreach throughout prison systems • Case management	Women 16+ who are unable to access or benefit from existing treatment services Emphasis on women with history of street dependent lifestyle who are: • socially isolated • working in the sex trade industry • have a history of dual disorders or long-term involvement with the mental health system • have multiple issues in addition to substance abuse
A-Way Express Courier Service www.icomm.ca/away 416-424-2266 Hours of operation: Mon to Fri 8:30am to 5:30pm	**SOUTH**	• Prospective employees: fill out application at office	• Courier service staffed and run by consumers/survivors of the mental health system • Includes full-time and part-time courier and office staff positions	Consumers/survivors of the mental health system

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Accommodation Information and Support (no website available) 416-504-3610 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (Eglinton Ave. to Lake Ontario, Victoria Park to Humber River)	• No referral necessary • Services accessed by contacting program	• Permanent affordable low support housing • Social, recreation and employment opportunities • Case management	Adults 16+ recovering from significant mental health issues and homelessness
Anduhyaun www.anduhyaun.org 416-243-7669 Crisis 416-531-0330 Hours of operation: Mon to Sun 24 hours	**SOUTH** (York Region)	• No referral necessary • Services accessed by drop-in or by contacting program	• Crisis intervention program and referrals • Emergency shelter • Counselling • Life skills program • Case management • Mobile services	Native community
Anishnawbe Health Toronto (no website available) 416-360-0486 Hours of operation: Mon to Fri 9am to 5pm After hours: answering service Mon to Sun 24 hours	**SOUTH** (Toronto East)	• No referral necessary • Services accessed by drop-in or by contacting program	• Counselling • Outreach • Health services • Case management • Mobile services	Aboriginal people, homeless individuals
Bloor-Bathurst Interchurch Gathering Spot (no website available) 416-924-5883 ext 5 Hours of operation: Drop-in program: Tues 4pm to 10pm All other times: answering machine	**SOUTH** (Toronto North)	• No referral necessary • Services accessed by drop-in or by contacting program	• Social/recreational drop-in program • Community visits, follow-up and supportive counselling geared toward referral • Monthly outings • Case management	Adults, especially persons who are socially isolated, on low incomes, or living with mental health issues
Breakaway Survivors (no website available) 416-923-6040 Hours of operation: Mon to Fri 11am to 6pm; Some eve group sessions	**SOUTH** (Toronto North)	• No referral necessary • Services accessed by contacting program	• One-on-one and peer group support • Education, advocacy and referrals • Info seminars • Case management	Psychiatric survivors
Central Neighborhood House: Homelessness and Housing Programs www.cnh.on.ca 416-368-8807 416-304-0018 Street Survivor Outreach Program 416-891-4171 Hours of operation: Mon to Sun, 24 hours	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed through drop-in or by contacting program	• Drop-in programs • Overnight shelter, free meals • I/R • Street Survivor Outreach Program • Mental health outreach program • Case management • Mobile services	Men and women 16+
Community Care East York www.ccey.org 416-422-2026 Hours of operation: not stated	**SOUTH** (East York)	• No referral necessary • Services accessed by contacting program	• Home support services • I/R, service coordination, advocacy, outreach • Crisis intervention • Counselling • Case management • Mobile services	Seniors 50+ Adults with physical disabilities, cognitive impairments, chronic mental health problems

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Community Resource Connections of Toronto: Community Support Services www.crct.org 416-482-4103 Hours of operation: not stated	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by contacting program	• Crisis intervention • Emergency housing • Skills training • I/R • Case management • Mobile services	Adults 16+ experiencing difficulties in day-to-day living as a result of severe and persistent mental health issues
Community Resource Connections of Toronto: Hostel Outreach Program www.crct.org 416-482-4103 Hours of operation: not stated	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by contacting program	• Outreach • Long-term support • Advocacy • Community service coordination • Case management • Mobile services	Homeless men and women who have significant mental health problems and difficulties functioning in the community
CORE (Centre for Opportunities, Respect, and Empowerment) (no website available) 416-340-7929 Hours of operation: Mon to Thurs 8:30am to 4:30pm; Fri 8:30am to 2pm	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by contacting program	• Work activity, socialization, recreation and nutrition programs • Community excursions	Adults with complex needs, severe behavioural problems due to mental health and/or developmental challenges
Covenant House www.covenanthouse.on.ca 416-598-4898 Crisis 416-593-4849 Hours of operation: Emergency intake Mon to Sun 24 hours	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by drop-in or by contacting program	• Emergency shelter • Crisis intervention • Community support services • Case management • Mobile services	Residential services: young men and women 16-21 Non-residential services: young men and women 16-24
Davenport Perth Neighborhood Centre: Adult Services (no website available) 416-656-8025 Hours of operation: Drop-in: Mon 12:30pm to 2:30pm; Tues, Thurs 1pm to 4pm; Wed 1pm to 3pm	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by contacting program	• Outreach, advocacy • Peer support • Mobile services	Adults 25+ who are socially isolated and have experienced addiction issues, the psychiatric system, and/or are at risk of eviction
Delisle Youth Services www.delisleyouth.org 416-482-0081 Hours of operation: not stated	**SOUTH** (Toronto North)	• No referral necessary • Services accessed by contacting program	• Counselling • Day and residential treatment • School support programs • Case management	Youth 13 – 19 experiencing social, emotional or behavioural problems
Dixon Hall www.dixonhall.org 416-863-0499 Hours of operation: Mon to Thurs 8:30am to 7:30pm; Fri 8:30am to 4:30pm	**SOUTH** (Toronto East)	• No referral necessary • Services accessed by drop-in or by contacting program	• Emergency shelter • Mental health crisis intervention • Drop-in centre • Counselling • Employment supports • Social and recreational programs • Case management • Mobile services	Varies depending on program Emphasis on homeless men and women

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
East York Residential Services www.eyrs.on.ca 416-941-9474 Crisis 416-501-4259 Hours of operation: Mon to Fri 9am to 4:30pm After hours: answering service	**SOUTH** (Toronto East)	• Referral through Children's Aid Society or Ministry of Community and Social Services	• 6 staff model group homes • social and life skills • individual and group counselling • case management	Persons 12+ with emotional problems, developmental disabilities
Elizabeth Fry Society www.efrytoronto.org 416-924-3708 Hours of operation: Mon to Fri 8:30am to 4:30pm After hours: telephone answered Mon to Sun 24 hours	**SOUTH** (Toronto East and Central)	• No referral necessary* • Services accessed by contacting program *Diversion requires referral from Crown	• Individual and group counselling • Crisis intervention • Court diversion • Release planning • Referrals • Transitional housing • Case management • Mobile services	Women and young women 18+ currently or previously in, or at risk of, conflict with the law
George Herman House www.georgehermanhouse.ca 416-924-2539 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (Toronto North)	• No referral necessary • Services accessed by contacting program	• Cooperative residential program • Emphasis on developing independent living and interpersonal skills • Case management	Women 19+ recovering from psychiatric problems or with emotional problems
Gerstein Centre www.gersteincentre.org 416-929-0149 Crisis 416-929-5200 Hours of operation: Crisis lines: Mon to Sun 24 hours	**SOUTH** (former cities of Toronto and York)	• Call crisis line	• 24 hour non-medical crisis intervention for acute psychosocial crises • support • brief stay at base facility when necessary • referrals for assistance with ongoing needs • Case management • Mobile services	Adults 16+ experiencing an acute mental health crisis
Good Shepherd Non Profit Homes (no website available) 416-869-3974 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (Toronto East)	• Contact office manager for application	• Supportive permanent housing • Life skills • Advocacy • I/R	Single men and women 16-65 who experience the effects of mental illness and are at risk of homelessness
Gothic House Residential Treatment Facility (no website available) 416-766-6069 Hours of operation: Mon to Sun 24 hours Referrals accepted Mon to Fri 10am to 6pm	**SOUTH** (Toronto West)	• Agency, medical and private referrals	• Residential treatment • Academic upgrading, life skills and job training • Individual and group counselling • Case management	Youth and adults 18+ with psychiatric, neurological or addiction problems
Habitat Services (no website available) 416-537-2721 Hours of operation: Mon to Fri 8:30am to 4:30pm	**SOUTH** (Toronto West)	• Through designated hospitals and agencies • Self-referrals accepted	• Matches potential tenants to contracted homes	Adults 16+ with mental health problems, on social assistance or low income

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Homeward www.hmward.ca 416-462-3334 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (former City of Toronto)	• No referral necessary • Services accessed by contacting program	• Clinical case management • Forensic case management • Pre-release planning case management • Case management	Adults 16+ with serious mental health issues Adults 16+ with serious mental health issues and recent involvement in the criminal justice system, or in a Toronto jail
Horizons for Youth www.horizonsforyouth.org 416-781-9898 Hours of operation: Mon to Sun 24 hours	**SOUTH** (York)	• Call first	• Emergency shelter and short-term housing • Crisis intervention • Counselling • I/R • Outreach and aftercare support • Day programs, drop-in • Case management • Mobile services	Young men and women 16-24 who are homeless or transient
Houselink Community Homes www.houselink.on.ca 416-539-0690 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (Toronto West)	• No referral necessary • Services accessed by contacting program	• Cooperative and independent housing for adults, partly self managed • Information on community services • Social and recreational programs	Psychiatric survivors with a history of some continuous psychiatric treatment
Madison Avenue Housing and Support Services http://www.mahass.on.ca 416-977-1333 Hours of operation: Mon to Fri 9am to 4:30pm	**SOUTH** (Toronto Central)	• Referrals made by agencies or professionals • Self-referrals accepted, although will need to contact other professionals working with client	• Cooperative living arrangements • Assistance with managing mental health symptoms, finding housing, improving social and community living skills • Case management	Adults with serious and persistent mental health issues
Margaret Frazer House (no website available) 416-463-1481 Hours of operation: Mon to Sun 24 hours	**SOUTH** (Toronto East)	• No referral necessary • Services accessed by contacting program	• Transitional high support residence • Counselling • Advocacy • Crisis bed available for former residents • Case management	Women 18-64 with psychiatric histories
Mount Sinai Hospital, Community Mental Health Program: ACTT, Mental Health Court Support Program www.mtsinai.on.ca 416-586-9900 Crisis 416-664-6557 Hours of operation: Office: Mon to Fri 8am to 8pm After hours: emergency pager	**SOUTH** (Toronto Central)	• By referral • Outreach	• Mental health outreach service • Court support services • Case management • Mobile services	Persons with severe and persistent mental health illness Focus on Southeast Asian, Tamil, Aboriginal and Black communities

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Native Child and Family Services of Toronto www.nativechild.org 416-969-8510 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by drop-in or by contacting program	• Individual and family counselling • Youth outreach • Crisis intervention • Drop-in • Advocacy • I/R • Case management • Mobile services	All self-declared native people
Native Women's Resource Centre of Toronto www.nativewomenscentre.org 416-963-9963 Hours of operation: Mon to Fri 9am to 5pm Some evening and weekend workshops	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by drop-in or by contacting program	• Crisis intervention • I/R • Advocacy • Community outreach • Literacy and basic skills • Homelessness initiatives • Case management • Mobile services	Women of Aboriginal ancestry or women with children of Aboriginal ancestry
Oolagen www.oolagen.org 416-395-0660 Hours of operation: Mon 9am to 7pm; Tues, Thurs 9am to 8pm; Fri 9am to 5pm	**SOUTH** (Toronto Central and North)	• No referral necessary • Services accessed by contacting program	• Assessments • Advocacy • Counselling and consultation • Referral • Follow-up • Residential and school-based programs • Case management • Mobile services	Youth 13-18 with a variety of mental health issues (can work with youth up to 25)
Our Place www.our-place.ca 905-238-1383 Hours of operation: Tues to Sat 2:30pm to 10pm	**SOUTH** (Toronto Central)	• Membership by referral	• Psychosocial recreation centre • Drop-in social program • Recreational activities	Persons who are receiving psychiatric care, or experiencing mental health issues
Parkdale Activity-Recreation Centre (PARC) (no website available) Administration 416-537-2262 Drop-in 416-537-2591 Outreach 416-588-0173 Hours of operation: Office and outreach: Mon to Fri 9am to 5pm Drop-in: Mon, Wed-Thurs 9:30am to 3pm; Tues 9:30am to 1pm; Fri 9:30am to 5pm	**SOUTH** (Toronto West)	• No referral necessary • Services accessed by drop-in or by contacting program	• Peer support networks • Educational, recreational, and social programs • Emergency medical and housing referrals • Crisis intervention • Case management • Mobile services	Psychiatric survivors, homeless persons and socially isolated adults 16+
Parkdale Community Health Centre: Street Health Program (no website available) 416-537-2455 Hours of operation: Mon, Tues, Thurs 9am to 8pm; Wed 9am to 6pm; Fri 9am to 5pm After hours: answering service, doctor on call Mon to Sun 24 hours for patients of the centre	**SOUTH** (Bloor St W to Lake Ontario; Dovercourt Rd to Parkside Dr)	• Outreach	• Health care and outreach • Needle exchange, drug addiction treatment program • Mobile services	Street involved men and women including persons with psychiatric problems or drug addictions, and sex trade workers

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Parkdale Golden Age Foundation www.pgaf.ca 416-536-6077 Hours of operation: Mon to Fri 9am to 4:30pm	**SOUTH** (primarily Bloor St W. to Lake Ontario; GTA for many programs)	• No referral necessary • Services accessed by contacting program	• Social and recreational activities • Home care, respite care, friendly visiting • Case management	Seniors 60+ Adults with disabilities
Passages (part of Community Mental Health Centre – North York) (no website available) 416-922-2672 ext 444 Hours of operation: Mon to Fri 8:30am to 4:30pm	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by contacting program	• Assistance with basic needs • Counselling • Case management	French speaking persons 16-65 with severe mental illness
Pegasus Community Project for Adults with Special Needs (no website available) 416-691-5651 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (Toronto East)	• No referral necessary • Services accessed by contacting program	• Day activities • Social, recreational and fitness activities • General skill development	Young adults 21+ with developmental disabilities
Poverello Charities Ontario (no website available) 416-366-2952 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (Toronto East)	• No referral necessary • Services accessed by contacting program	• Housing • Street outreach • Mobile services	Long-term consumers/survivors of the mental illness system
Progress Place www.progressplace.org 416-323-0223 Hours of operation: Mon to Fri 8am to 8pm; Sat, Sun 4pm to 8pm	**SOUTH** (Toronto Central)	• Professional or self-referral • Intake interview • Membership required	• Community-based psychosocial rehab centre based on the clubhouse approach • Peer and staff support • Transitional job training and placement • Affordable housing • Peer support chat line	Adults with serious mental health problems
Regeneration Housing and Support Services www.regenerationhouse.com 416-703-9645 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (Toronto West)	• No referral necessary • Services accessed by contacting program	• Supported housing program • Homelessness initiatives • Employment training • Social/recreational, educational programs • Case management	Men and women 16+ with a history of long-term mental health problems (focus on prolonged histories of schizophrenia)
St. Jude Community Homes (no website available) 416-359-9241 Hours of operation: Mon to Fri 9:30am to 5:30pm	**SOUTH** (Toronto East)	• Referral from mental health worker • Joint interview by staff and residents	• Supportive housing • Community meal program • Social and recreational activities	Single adults with psychiatric disabilities who require support services
St. Michael's Hospital: Mobile Crisis Intervention Team www.stmichaelshospital.com 416-864-5346 Hours of operation: Mon to Sun 24 hours	**SOUTH** (primarily Former City of Toronto, Southeast area)	• Call crisis line	• Crisis intervention • Mobile services	Psychiatric emergencies

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
St. Michael's Hospital: CONTACT Mental Health Outreach Service; Community Connection Case Management Program www.stmichaelshospital.com 416-864-3095 Hours of operation: not stated	**SOUTH** (Downtown and Southeast part of Former City of Toronto)	• Outreach	• Intensive support, home visits, treatment • Case management	Persons who have a major mental illness along with a substance use disorder, homelessness or other complex problem
Salvation Army Dufferin Residence (no website available) 416-531-3523 Hours of operation: Mon to Fri 9am to 4pm	**SOUTH** (Toronto West)	• Contact telephone intake worker • Professional referral required	• 2-phase residential rehab program • 24 hour support • in-house chores, life skills program, social and recreational activities • case management	Persons 21+ with psychiatric diagnosis
Salvation Army Evangeline Residence (no website available) 416-762-9636 Hours of operation: Mon to Sun 24 hours	**SOUTH** (Toronto West)	• Call for details on vacancies and admission procedures	• Emergency shelter • Mobile services	Women 16+ Homeless women experiencing emotional or mental health difficulties
Salvation Army Harbour Light Centre www.harbourlight.org 416-636-5496 Hours of operation: Admissions Mon to Thurs 8am to 4pm Walk-in information Mon to Sun 24 hours	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by drop-in or by contacting program	• Residential treatment program • Day treatment and counselling • Drop-in centre • Counselling • Referrals • Outreach • Social, recreation and therapeutic programs • Case management • Mobile services	Men 18+ who are alcohol or chemical dependent Includes dual diagnosis of addiction and psychiatric disorders
Salvation Army Maxwell Meighen Centre: Primary Support Unit www.sa-mmc.org 416-366-2733 Hours of operation: Hostel: Mon to Sun 24 hours	**SOUTH** (Toronto East)	• No referral necessary • Services accessed by drop-in or by contacting program	• Respite, crisis stabilization and 24 hour support • Short term hostel services • Medical and psychiatric consultations • Assistance in pursuing identified goals • Case management • Mobile services	Homeless men experiencing difficulties related to emotional or mental health
Sistering – A Women's Place www.sistering.org 416-926-9762 Hours of operation: Mon to Fri 9am to 4:30pm	**SOUTH** (Toronto West)	• No referral necessary • Services accessed by drop-in or by contacting program	• Drop-in centre • Outreach program • Arts and crafts program • Case management • Mobile services	Women 16+ who are homeless, socially isolated, or have low incomes
Sound Times Support Services of Metropolitan Toronto www.soundtimes.com 416-979-1700 Hours of operation: Mon to Thurs 11am to 5pm	**SOUTH** (Toronto East)	• No referral necessary • Services accessed by drop-in or by contacting program	• Social support and recreational activities • Opportunities to learn and use computer skills • Education and information workshops • Community excursions • Case management	Consumer/survivors of the mental health system

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Street Haven at the Crossroads www.streethaven.com 416-967-6060 Hours of operation: Hostel: Mon to Sun 24 hours Drop-in: Mon to Fri 12pm to 8pm	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by drop-in or by contacting program	• Counselling and crisis intervention • Court assistance • Life skills • Medical and psychiatric referrals • Case management • Mobile services	Women 16+ who are in crisis, including homelessness, addiction, abuse issues or mental illness
Street Health Community Nursing Foundation: Mental Health Outreach Program www.streethealth.ca 416-921-8668 Hours of operation: irregular	**SOUTH** (Toronto East)	• Outreach	• Support, crisis intervention • Case management • Mobile services	Homeless and under-housed persons with mental health issues
Toronto East Counselling and Support Service www.tecss.com 416-462-0461 Hours of operation: Mon to Fri 9:30am to 5pm	**SOUTH** (Mortimer Ave to Lake Ontario; Victoria Park to Yonge St)	• No referral necessary • Services accessed by contacting program	• Counselling • Advocacy • Life skills development • Liaison and referral • Crisis prevention and intervention • Outreach • Accompaniment • I/R • Case management • Mobile services	Adults 18-60 who have interacted with the mental health system
Touchstone Youth Centre www.touchstoneyc.com 416-696-6932 Hours of operation: Shelter: Mon to Sun 24 hours Drop-in centre: Mon to Fri 1pm to 9pm	**SOUTH** (East York)	• Call for details on vacancies and admission procedure	• Emergency shelter and short-term housing • Crisis counselling • I/R • Education, health and housing support • Outreach • Case management • Mobile services	Homeless youth 16 to 24, and ex-residents 21-24
Trinity Square Enterprises (no website available) 416-599-9315 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (Toronto Central)	• No referral necessary • Services accessed by contacting program	• Work orientation and training • Workshops • Internship programs	Psychiatric consumers/survivors 16+
Woodgreen Community Centre of Toronto: Mental Health and Development Services www.woodgreen.org 416-469-5211 Hours of operation: Mon to Fri 9am to 5pm	**SOUTH** (former City of Toronto northern limits to Lake Ontario, Victoria Park Ave to Sherbourne)	• No referral necessary • Services accessed by contacting program	• Counselling • Social and recreational groups • Housing program • Case management	Persons with disabilities or developmental delays Persons who are socially isolated or have a history of mental illness
Wychwood Open Door (no website available) 416-652-0857 Hours of operation: Mon, Wed, Fri 8:30am to 3pm	**SOUTH** (Toronto West)	• Drop-in	• Social and recreational programs • Trips • Life skills • Community and health information • Help with housing, legal and health issues	Socially isolated persons, persons who are homeless and discharged psychiatric patients

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
York Community Services: Community Health Centre (no website available) 416-653-5400 Hours of operation: Mon, Wed 9am to 9pm; Tues, Thurs, Fri 9am to 5pm After hours: answering service	**SOUTH** (Former City of York)	• Appointment required for most services – call ahead	• Community mental health program • Housing help centre • Case management	Focus on families at risk, frail seniors, newcomer, refugees, people with mental health issues and adults with developmental disabilities
York Support Services Network: Community Crisis Response Service www.yssn.ca 905-953-5402 Hours of operation: Mon to Sun 7am to 4am	**SOUTH** (Former City of York)	• Call crisis line	• Telephone support and assistance • I/R • Mobile response as required	Anyone experiencing an emotional or psychosocial crisis
Youthdale Treatment Centres www.youthdale.ca 416-368-4896 Crisis 416-363-9990 Hours of operation: Mon to Fri 9am to 5pm Psychiatric crisis service: Mon to Sun 24 hours	**SOUTH** (Toronto Central and York Region)	• No referral necessary • Services accessed by contacting program	• Residential treatment centres • Outpatient counselling and assessments • Crisis service • Case management • Mobile services	Youth 12-18 with emotional, behavioural and adjustment difficulties
Community Mental Health Centre, North York (no website available) 416-499-5969 Hours of operation: Mon to Fri 10am to 4:30pm	**NORTH** (North York)	• Referral by telephone, mail or fax	• Assistance with basic needs (e.g., securing stable income, finding and maintaining housing • Educational, vocational and social activities • Developing community supports • Case management	Persons 16+ with long standing psychiatric disabilities, including homeless persons
Mens Sana, Families for Mental Health (no website available) 416-747-6018 Hours of operation: Mon to Fri 9am to 4pm Day program and drop-in centre Mon to Fri 10am to 3pm	**NORTH** (North York)	• No referral necessary • Services accessed by drop-in or by contacting program	• I/R • Weekly support group • Assistance with housing and financial issues • Day program drop-in • Residential home • Case management	Anyone identifying with mental health issues, including schizophrenia
Reena www.reena.org 905-889-6484 Hours of operation: Mon to Thurs 9am to 5pm; Fri 8:30am to 4pm Some programs after hours	**NORTH** (North York)	• No referral necessary • Services accessed by contacting program	• Assessment, treatment and ongoing support • Jewish environment • Family support • Day and evening programs, residential services • Case management	Persons diagnosed with a developmental disability or dual diagnosis, and their families

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Regional Geriatric Program of Toronto www.RGP.toronto.on.ca 416-480-6026 Hours of operation: not stated	**NORTH** (North York)	• Call for connection with appropriate local geriatric service	• Outreach assessments • Short-term treatment and rehabilitation • I/R • Assistance with remaining in or returning to the community • Case management • Mobile services	Elderly persons, living in community or institutions, with complex and multiple health and social problems
Salvation Army Transitional Employment Program (no website available) 416-693-2116 Hours of operation: Mon to Fri 8am to 4pm	**NORTH** (North York)	• No referral necessary • Services accessed by contacting program	• Job training program • Counselling towards reintegration into society • Case management	Persons with diagnosed psychiatric disabilities and demonstrated appropriate work skills
Seneca College of Applied Arts and Technology: Redirection through Education www.seneca.on.ca 416-491-5050 ext 2920 Hours of operation: Mon to Fri 8:30am to 4:30pm After hours: by appointment	**NORTH** (North York)	• By professional referral only	• Academic and vocational skills assessment and upgrading • Establishes personal and career goals • Develop social skills and recreational interests • Case management	Adults 18+ who have undergone psychiatric treatment
Seneca College of Applied Arts and Technology: Work on Track www.seneca.on.ca 416-491-5050 ext 4741 Hours of operation: Mon to Fri 8am to 5pm	**NORTH** (North York)	• No referral necessary • Services accessed by contacting program	• Employment program including intake and assessment, skills training, and work experience/job development • Case management	Individuals who have experienced barriers to employment due to mental health issues
Street Outreach (part of Community Mental Health Centre – North York) (no website available) 416-499-5969 Mobile phone 416-990-3317 Hours of operation: Mon to Sun 9:30am to 5:30pm	**NORTH** (North York)	• No referral necessary • Services accessed by drop-in or by contacting program	• Supportive outreach • Short and long-term monitoring, referral, assessments • Case management • Mobile services	Not stated
Youth Clinical Services www.youthclinicalservices.org 416-742-2514 Hours of operation: Mon, Wed, Fri 9am to 5pm; Tues 9am to 8pm; Thurs 9am to 7pm	**NORTH** (North York)	• Advance appointments encouraged	• Counselling • Youth employment services • Case management	Youth 13 to 29
Agincourt Community Services Association: Homeless Drop-in; Street Outreach program www.agincourtacsa.info 416-321-6912 Mobile services 416-684-6350 Hours of operation: Mon to Fri 9am to 5pm Street outreach Mon to Sun 10am to 6pm	**EAST** (Scarborough)	• No referral necessary • Services accessed by drop-in or by contacting program	• Homeless drop-in • Street outreach • Case management • Mobile services	Individuals who are homeless or at risk of becoming homeless

Name of Organization	Catchment Area	Referral Process/ Point of Access	Type of Services Offered	Target Population
Colborne Community Services: Crisis Services www.colborneservices.com 905-666-0831 Crisis 905-666-0483 Mobile crisis 905-665-6932 Hours of operation: Mon to Sun 24 hours	**EAST** (Durham Region)	• Call crisis line	• Crisis beds • Community visits • Follow-up support • Linkage and referral to other community supports • Case management • Mobile services	Men and women 16+ experiencing an emotional or psychosocial crisis
East Metro Youth Services www.emys.on.ca 416-438-3697 Hours of operation: Mon to Thurs 9am to 8pm; Fri 9am to 5pm	**EAST** (Scarborough)	• No referral necessary • Services accessed by contacting program	• Counselling • Support groups • Residential treatment • Case management	Youth 12 –18 with emotional, social and behavioural issues affecting their ability to function in school
Second Base (Scarborough) Youth Shelter www.secondbaseyouthshelter.org 416-261-2733 Hours of operation: Mon to Sun 24 hours Drop-in: Mon to Fri 9am to 5pm	**EAST** (Scarborough)	• Shelter: call for details on vacancies and admission procedure • Outreach program: drop in	• Emergency shelter • Crisis intervention • Assistance with school, finding employment, housing • I/R • Seminars and workshops • Case management • Mobile services	Men and women 16-21
Friends and Advocates Centre Etobicoke (no website available) 416-234-9245 Hours of operation: Mon to Fri 9am to 5pm	**WEST** (Etobicoke)	• No referral necessary • Services accessed by contacting program	• Life skills training • Discussion groups • I/R • Advocacy • Counselling and crisis intervention • Case management • Mobile services	Adults 16+ who are psychiatric consumers/survivors
Lakeshore Area Multiservice Project (LAMP): Satellite Program – Among Friends (no website available) 416-252-6471 Hours of operation: Mon to Fri 9am to 5pm	**WEST** (Etobicoke)	• No referral necessary • Services accessed by contacting program	• Education workshops promoting mental, physical and social health • I/R • Volunteer opportunities	Adults 18+ with recurring or persistent mental health problems
Mobile Crisis of Peel (no website available) 905-275-7646 ext 227 Crisis 905-278-9036 Hours of operation: Mon to Sun 24 hours	**WEST** (Peel Region)	• Call crisis line	• Crisis intervention • Emergency respite housing • Follow-up support • Case management • Mobile services	Individuals 16+, their friends, family members or case workers who want assistance managing current or potential mental health crises
Storefront Humber www.storefronthumber.ca 416-259-4207 Hours of operation: Mon to Fri 8:30am to 4:30pm Services available Mon to Sun 24 hours	**WEST** (Etobicoke)	• Home visit and assessment	• Home support services • Supportive housing program • Crisis intervention • Case management • Mobile services	Adults 18+ with physical or mental disabilities

Table 5: Number and Percentage of Toronto Mental Health Agencies and Organizations Broken Down by Catchment Area

Catchment Area	Number of Organizations	%
All 4 quadrants	30	25.2
North, South and East	4	3.4
North and East	1	0.8
North and South	1	0.8
North and West	1	0.8
East and South	2	1.7
South and West	2	1.7
South	61	51.3
North	9	7.6
East	4	3.4
West	4	3.4
TOTAL	119	100

Table 6: Summary of Referral Requirements for Toronto Mental Health Agencies and Organizations Broken Down by Catchment Area

	Referral required?	
Catchment Area	Yes	No
All 4 quads	4	26
North, East and South	2	2
North and East	0	1
North and South	0	1
North and West	0	1
East and South	0	2
South and West	0	2
South	5	56
North	1	8
East	0	4
West	0	4
TOTAL	12	107

Appendix H: Suggested Changes to the PDP Logic Model (Form D)

Table 7: PDP Logic Model for the North Quadrant

GOAL 1: To prevent and reduce people's contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1a) To identify and assess peoples' need for service. ***To determine quadrant needs in regard to pre-charge diversion program components. (change)*** 1b) To provide strategies to criminal charges being laid. 1c) To link people to the services they need. ***To provide alternatives to criminal charges being laid by providing crisis support and linking people to the services and supports they need (combining Objectives 1b and 1c).*** 1d) To advocate for systems change based on identified gaps/barriers in the system.	1a) Introduce and consult with relevant stakeholders in the North York area and develop a program model. 1b) Provide a location where individuals can be accompanied or self refer and receive immediate service and support 1c) Develop an intake and assessment process to provide one-to-one support for individuals at risk to assist them with access to entitlements and resources 1d) Establish appropriate community linkages/partnerships ***Perhaps change to Reconnect wording: Establish community linkages and partnerships to mental health and justice services to advocate for systems change*** 1e) Explore other linkages to programs in North York 1f) Participate in system planning opportunities (i.e. North end mental Health quadrant).	1a) Consultations completed and feedback implemented into program model ***Needs identified through consultation (addition)*** 1b) Location secured and operational by June 30/05. 1c) Service provided to a minimum of 30 clients. 1d) Individuals successfully diverted from criminal charges and linked to necessary community resources also ongoing telephone support provided 1e) Actively participate in system planning groups. 1f) At lease 5 community links and partners are established. ***1g)*** Attend regular meetings with Pre-charge group. (***Pre-charge Diversion Committee)*** *1h)* Provide updates to the MH & Justice	**1.** MIS reporting requirements **2.** Number and source of referrals **3.** Individual client files **4.** Team meeting minutes **5.** Client data base ***Consultant Report (addition)*** ***Memorandums of Understanding created and maintained***

GOAL 1: To prevent and reduce people's contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	Add item that discusses provision of service (to link with "service provided to a minimum of 30 clients").	committee	

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
2a) To provide resource information to consumers, families, mental health service providers and criminal justice officials. 2b) To identify system barriers/gaps and advocate for change. 2c) To disseminate information about program evaluation findings.	2a) Develop written brochure and resource material 2b) Record system barriers and gaps. ***Standard for this method/process not stated in criteria column.*** 2c) To provide information about Pre-charge program on our web site. 2d) Participate in North Quadrant … ***Method not complete*** ***<u>Information, Liaison, Advocacy, and Consultation/Collaboration</u>*** ***Develop and conduct a program evaluation that measures the following:*** ***1. mental health spending per capita*** ***2. proportion of staff funding spent***	2a) 200 brochures printed and distributed to various stake holders, partners and community resources. 2b) # of hits to that page. ***Create page on website about pre-charge program*** 2c) Involvement in system wide mental health and justice committee and working groups. ***<u>Information, Liaison, Advocacy, and Consultation/Collaboration</u>*** ***<u>Advocacy</u>*** ***Ministry standard: " Service providers must identify gaps in service and develop means for collaboration with other relevant community resources in order to meet unmet needs"***	2a) Brochures 2b) Agency program reports 2c) Agency MIS reports ***# of hits to that page*** ***<u>Information, Liaison, Advocacy, and Consultation/Collaboration</u>*** ***<u>Advocacy</u>*** ***Needs assessment*** ***Program evaluation*** ***Steering committees*** ***Community forums***

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	on administration and support ***Consult and collaborate with other service providers on service gaps, and the methods for reducing them (through steering committees, community forums, needs assessments, etc.)*** ***Develop needs based allocation strategy based on evaluation/consultation*** ***Identify community linkages through needs assessment, steering committees etc.*** • ***highlight both areas where strong partnerships exist and where partnerships could be further developed*** ***Identify relevant and accessible services*** ***Assess crisis workers' level of knowledge regarding these services (e.g., through survey, interview)*** ***Assess crisis workers' ability to connect consumer with these services (e.g., timeliness, appropriateness etc.)*** ***Process evaluation regarding training resources, on-the-job development and continuous learning for staff:***	***Ministry standard: "Crisis worker must be knowledgeable about services that are accessible and relevant to consumer interests in order to provide up-to-date information"***	***Needs assessment*** ***Program evaluation*** ***Steering committees*** ***Community forums*** ***Surveys*** ***Interviews*** ***Training and workshops***

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	• ***crisis worker survey regarding satisfaction, availability of accessible and relevant surveys*** • ***identify gaps, barriers to service*** ***Provide training, workshops to address identified gaps in knowledge***		

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
3a) To develop an evaluation framework. **3b)** To evaluate the implementation and outcome of the service. ***To evaluate the implementation and outcome of the service on an ongoing basis. (change)*** **3c)** Where possible, to identify best practices. ***To identify best, innovative and emerging practices, where possible. (change)***	3a) Evaluation framework developed 3b) Implement feedback into program 3c) Present findings to key stake holders (e.g. Police, Crisis units etc…) ***<u>Consumer satisfaction</u>*** ***Develop and administer a consumer/family/agency satisfaction survey that includes questions regarding the following issues:*** ***1. satisfaction with services*** ***2. level of involvement in treatment decisions***	3a) Establish program outcomes 3b) Best practices identified ***<u>Consumer satisfaction</u>*** ***Ministry standard: "Consumer satisfaction (including consumers, families and outside agencies) must be monitored continuously, and the results used to make service improvements" – Consumer satisfaction survey will be administered on an annual basis***	3a) Consultants report 3b) Literature review ***Evaluation report (addition)*** ***<u>Consumer satisfaction</u>*** ***Administer satisfaction survey on an annual basis***

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	3. knowledge and understanding of formal complaints mechanisms ***4. knowledge and understanding of patient bill of rights*** ***5. level of involvement in service delivery and planning*** ***6. level of cultural sensitivity*** ***7. number and availability of services available*** ***8. community follow-up*** ***Conduct analyses regarding the validity and reliability of the developed survey where possible.*** ***Modify survey based on these results*** ***<u>Annual evaluation</u>*** ***Develop and annually implement a program evaluation that uses best practices and published standards regarding services/supports for persons with SMI as indicators*** ***Possible tools to include:*** ***1. survey indicated above*** ***2. interviews with consumers, family members, mental health agencies, representatives from the criminal justice system*** ***3. naturalistic observation (only if and when ethically permissible)*** ***4. consumer assessments to***	***Ministry standard: "A consumer satisfaction survey will be developed and administered on an annual basis, with a target of 80% satisfaction, to the best extent possible, given the mandate of the CRS" – Consumer satisfaction survey will demonstrate satisfaction levels of 80%*** ***<u>Annual evaluation</u>*** ***Ministry standard: " All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards"***	***<u>Annual evaluation</u>*** ***Conduct surveys, interviews, observations and consumer assessments on an annual basis***

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	measure the following: • ***clinical status*** • ***functional status*** • ***involvement in meaningful daytime activity*** • ***housing status*** • ***quality of life*** • ***physical health status*** • ***mortality***		

Table 8: PDP Logic Model for the East Quadrant

GOAL 1: To prevent and reduce people's contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1. To implement a pre-charge service. ***To determine quadrant needs in regard to pre-charge diversion program components (change)*** 2. To provide alternatives to criminal charges being laid 3. To link people to the services and supports they need ***To provide alternatives to criminal charges being laid by providing crisis support and linking people to the services and supports they need (combining Objectives 3, 4 and 5).*** 4. To advocate for systems change based on identified gaps/barriers in the system	1. Consult with relevant stakeholders re program model 2. Link to police, emergency and mobile crisis to facilitate referrals 3. Implement pre charge service of in person and telephone support 4. Established linkages to mental health and justice services (Crisis beds, housing) ***Establish community linkages and partnerships to mental health and justice services to advocate for systems change (change)*** 5. Participate in system planning opportunities. 6. Record gaps and barriers in services ***Not clear exactly how gaps/barriers will be investigated and recorded***	**1.** Consultation completed. with police, family , consumers, other mental health providers ***Needs identified through consultation (addition)*** **2.** Pre- charge services to minimum of 45 people **3.** # of Individuals diverted from the criminal justice system. **4.** # of linkages/partnerships **5.** Established Agreements and MOU's **6.** Involvement in system planning groups/committees. (pre-charge, Scarborough Quadrant, Scarborough Forensic committee)	**1.** Agency and consultant report of consultations **2.** Individual agency M.I.S. and C.D.S. reports. **3.** Client records **4.** Team meeting minutes. **5.** Pre-Charge Planning Committee Minutes. **6.** Consultant report **7.** Committee minutes ***Memorandums of Understanding created and maintained***

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1. To provide resource information to consumers, families, mental health service providers and criminal justice officials **2.** To identify system barriers/gaps and advocate for change **3.** To disseminate information about program evaluation findings **4.** To co-ordinate services with other pre-charge programs	**1.** Develop written presentation and resource material, e.g. brochure **2.** Promote pre-charge service in Scarborough **3.** Participate in Scarborough Quadrant Committees and planning groups, as well as, system wide opportunities. **4.** Quarterly meetings of pre-charge services ***Information, Liaison, Advocacy, and Consultation/Collaboration*** ***Develop and conduct a program evaluation that measures the following:*** ***1. mental health spending per capita*** ***2. proportion of staff funding spent on administration and support*** ***Consult and collaborate with other service providers on service gaps, and the methods for reducing them (through steering committees, community forums, needs***	**1.** Brochures distributed to key referrals sources (hospital, police, emergency) **2.** Contacts made with priority referral sources and key community stakeholders. **3.** Identification of referral sources **4.** Involvement in Scarborough quadrant committees and planning/implementation initiatives. **5.** Present program findings to mental health and justice committee of Toronto and mental health and justice committees/working groups. ***Information, Liaison, Advocacy, and Consultation/Collaboration Advocacy*** ***Ministry standard: " Service providers must identify gaps in service and develop means for collaboration with other relevant community resources in order to meet unmet needs"***	**1.** Brochures and other promotional material. **2.** Minutes of internal and external meetings. **3.** Agency M.I.S. and C.D.S. reports. **4.** Meeting minutes pre-charge meetings ***Information, Liaison, Advocacy, and Consultation/Collaboration Advocacy*** ***Needs assessment*** ***Program evaluation*** ***Steering committees*** ***Community forums***

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	assessments, etc.) ***Develop needs based allocation strategy based on evaluation/consultation*** ***Identify community linkages through needs assessment, steering committees etc.*** • ***highlight both areas where strong partnerships exist and where partnerships could be further developed*** ***Identify relevant and accessible services*** ***Assess crisis workers' level of knowledge regarding these services (e.g., through survey, interview)*** ***Assess crisis workers' ability to connect consumer with these services (e.g., timeliness, appropriateness etc.)*** ***Process evaluation regarding training resources, on-the-job development and continuous learning for staff:*** • ***crisis worker survey regarding satisfaction, availability of accessible and relevant surveys*** • ***identify gaps, barriers to service*** ***Provide training, workshops to address identified gaps in knowledge***	***Ministry standard: "Crisis worker must be knowledgeable about services that are accessible and relevant to consumer interests in order to provide up-to-date information"***	***Needs assessment*** ***Program evaluation*** ***Steering committees*** ***Community forums*** ***Surveys*** ***Interviews*** ***Training and workshops***

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1. To develop an evaluation framework **2.** To evaluate the implementation and outcome of the service ***To evaluate the implementation and outcome of the service on an ongoing basis.*** **3.** **T**o identify innovative and emerging practices ***To identify best, innovative and emerging practices, where possible.***	**1.** Evaluation framework developed. **2.** Conduct literature review. **3.** Regular program review with stakeholders **4.** Regular pre-charge meetings for Toronto ***<u>Consumer satisfaction</u>*** ***Develop and administer a consumer/family/agency satisfaction survey that includes questions regarding the following issues:*** ***1. satisfaction with services*** ***2. level of involvement in treatment decisions*** ***3. knowledge and understanding of formal complaints mechanisms*** ***4. knowledge and understanding of patient bill of rights*** ***5. level of involvement in service delivery and planning*** ***6. level of cultural sensitivity*** ***7. number and availability of services available*** ***8. community follow-up***	**1.** Established evaluation tools **2.** Literature review completed. **3.** Innovative practices for pre-charge diversion identified. **4.** CMHA Program review occurs bi-annually ***<u>Consumer satisfaction</u>*** ***Ministry standard: "Consumer satisfaction (including consumers, families and outside agencies) must be monitored continuously, and the results used to make service improvements" – Consumer satisfaction survey will be administered on an annual basis*** ***Ministry standard: "A consumer satisfaction survey will be developed and administered on an annual basis, with a target of 80% satisfaction, to the best extent possible, given the mandate of the CRS" – Consumer satisfaction survey will demonstrate satisfaction levels of 80%***	**1.** Evaluation tools **2.** Literature review **3.** Pre-charge Consultant's report **4.** Agency M.I.S. and C.D.S. reports **5.** Program Review Report ***<u>Consumer satisfaction</u>*** ***Administer satisfaction survey on an annual basis***

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	Conduct analyses regarding the validity and reliability of the developed survey where possible. ***Modify survey based on these results*** ***<u>Annual evaluation</u>*** ***Develop and annually implement a program evaluation that uses best practices and published standards regarding services/supports for persons with SMI as indicators*** ***Possible tools to include:*** ***1. survey indicated above*** ***2. interviews with consumers, family members, mental health agencies, representatives from the criminal justice system*** ***3. naturalistic observation (only if and when ethically permissible)*** ***4. consumer assessments to measure the following:*** • ***clinical status*** • ***functional status*** • ***involvement in meaningful daytime activity*** • ***housing status*** • ***quality of life*** • ***physical health status*** • ***mortality***	***<u>Annual evaluation</u>*** ***Ministry standard: " All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards"***	***<u>Annual evaluation</u>*** ***Conduct surveys, interviews, observations and consumer assessments on an annual basis***

Table 9: PDP Logic Model for the South Quadrant

GOAL 1: To prevent and reduce people's contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1. To identify and assess people's need for service ***To determine quadrant needs in regard to pre-charge diversion program components (change)*** ***To identify the ways in which membership at Sound Times contributes to minimizing people's contact with the criminal justice system (change)*** 2. To provide alternatives to criminal charges being laid 3. To link people to the services and supports they need ***To provide alternatives to criminal charges being laid by providing crisis support and linking people to the services and supports they need (combining Objectives 2 and 3).*** 4. To advocate for systems change based on identified gaps/barriers in the system	1. Plan and implement a participatory research study among the existing membership to assess need for service ***Plan and implement a participatory research study among the existing membership (change)*** 2. Provide a location where individuals can be accompanied or self refer and receive immediate service and support 3. Increase access to Sound Times by expanding service hours 4. Provide one-to-one support for individuals at risk to assist them with access to entitlements, resources, and the creation of individual support plans 5. Reduce social isolation by facilitating supportive relationships among the members 6. Develop partnerships and MOUs where appropriate with organizations willing to participate in supporting members	**1.** Minimum of 6 aspects of peer support, identified through 30 member interviews, that assist in reducing contact with emergency services and/or police ***Aspects of peer support that assist in reducing contact with emergency services and/or police are identified (change)*** ***Needs identified through consultation*** **2.** Service provided to 60 new members who self report a risk factor associated with arrest/incarceration ***Service provided to 60 new or existing members who self report a risk factor associated with arrest/incarceration (change)*** **3.** Service hours increased by 50% **4.** Individualized service provided to 60 new or existing members of Sound Times **5.** Visits to Sound Times increased by 50%	**1.** Research report **2.** Member database **3.** Number and source of referrals **4.** Program schedule **5.** Number of appointments for individual supports **6.** Daily attendance log **7.** Attendance at social, recreational and educational events **8.** Partnership or support service agreement and/or MOU **9.** Meeting minutes **10.** Report ~~**11.** Meeting minutes~~ ***Memorandums of Understanding created and maintained***

GOAL 1: To prevent and reduce people's contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	7. Hold regular meetings with the Precharge Diversion Committee to identify gaps and barriers in the system 8. Provide the results of the Precharge Diversion Committee findings to the MOHLTC through the MH & Justice Committee	***Percentage increase in number of visits to Sound Times (change)*** ***Increase in number of members (addition)*** **6.** Agreements negotiated and formalized with at least three organizations – preferably one housing provider and one crisis service **7.** Committee meetings held **8.** Committee findings documented **9.** Findings presented to MH & Justice Committee and tabled	

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1. To provide resource information to consumers, families, mental health service providers and criminal justice officials **2.** To identify system barriers/gaps and advocate for change	**1.** Provide access to information for members through our resource centre **2.** Promote and provide information about diversion on our website	**1.** Inventory of existing material taken and appropriate information added and/or updated **2.** Page added to website related to diversion project	**1.** Resource centre inventory and library catalogue **2.** Website hits **3.** Outreach presentation notes **4.** Brochures

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
3. To disseminate information about program evaluation findings	**3.** Present information about our service to interested groups of consumers and survivors **4.** Present information about our service to interested groups of service providers **5.** Consult with police and crisis services to develop a method for them to inform potential members of our services **6.** Participate in C/S advocacy initiatives, service provider committees and planning opportunities **7.** Decide on strategies to publish or present program evaluation findings with Precharge partners	**3.** Segment added to outreach presentation defining diversion and describing service **4.** Presentation for service providers designed **5.** Presentations to a minimum of six service organizations made **6.** Community liaison officer at 51 Division, Gerstein Centre, MCIT, Court Support, and other appropriate referral sources consulted **7.** Outreach, information and/or orientation tool for use by referral sources designed **8.** Preliminary evaluation findings, Sound Times research study findings and/or program information presented at a minimum of one C/S conference/forum **9.** Representation at MH & Justice Committee **10.** Peer support contribution included in every publication and presentation related to Precharge partnership **11.** Dissemination strategy identified and documented	**5.** Presentation notes **6.** Brochures and promotional materials **7.** Consultation report **8.** Contact card for potential clients **9.** Orientation/information tool for emergency service providers **10.** Attendance **11.** Presentation materials **12.** Committee attendance **13.** Minutes **14.** Publications **15.** Presentation materials **16.** Dissemination strategy report

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	Information, Liaison, Advocacy, and Consultation/Collaboration ***Develop and conduct a program evaluation that measures the following:*** ***3. mental health spending per capita*** ***4. proportion of staff funding spent on administration and support*** ***Consult and collaborate with other service providers on service gaps, and the methods for reducing them (through steering committees, community forums, needs assessments, etc.)*** ***Develop needs based allocation strategy based on evaluation/consultation*** ***Identify community linkages through needs assessment, steering committees etc.*** • ***highlight both areas where strong partnerships exist and where partnerships could be further developed*** ***Identify relevant and accessible services*** ***Assess crisis workers' level of***	***Information, Liaison, Advocacy, and Consultation/Collaboration Advocacy*** ***Ministry standard: " Service providers must identify gaps in service and develop means for collaboration with other relevant community resources in order to meet unmet needs"*** ***Ministry standard: "Crisis worker must be knowledgeable about services that are accessible and relevant to consumer interests in order to provide up-to-date information"***	***Information, Liaison, Advocacy, and Consultation/Collaboration Advocacy*** ***Needs assessment*** ***Program evaluation*** ***Steering committees*** ***Community forums*** ***Needs assessment*** ***Program evaluation*** ***Steering committees*** ***Community forums*** ***Surveys*** ***Interviews*** ***Training and workshops***

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	knowledge regarding these services (e.g., through survey, interview) ***Assess crisis workers' ability to connect consumer with these services (e.g., timeliness, appropriateness etc.)*** ***Process evaluation regarding training resources, on-the-job development and continuous learning for staff:*** • ***crisis worker survey regarding satisfaction, availability of accessible and relevant surveys*** • ***identify gaps, barriers to service*** ***Provide training, workshops to address identified gaps in knowledge***		

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1. To develop an evaluation framework **2.** To evaluate the implementation and outcome of the service ***To evaluate the implementation and outcome of the service on an ongoing basis. (change)***	**1.** Research evaluation frameworks that are in keeping with the philosophy and values of CSIs ***Assess user and referral source satisfaction*** **2.** Develop an evaluation tool	**1.** Established CSI evaluation tools located and provided to consultant and Precharge partners ***Specify type of tool to be employed*** ***Satisfaction ratings of 80% or higher*** **2.** CSI service provision principles and	**1.** Precharge consultant's report **2.** Evaluation tool **3.** Evaluation tool ***Annual Satisfaction Surveys***

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
3. Where possible, to identify best practices ***To identify best, innovative and emerging practices, where possible. (change)***	consistent with the principles of peer initiatives and Sound Times' values **3.** Implement evaluation tool **4.** Research other peer delivered forensic services ***<u>Consumer satisfaction</u>*** ***Develop and administer a consumer/family/agency satisfaction survey that includes questions regarding the following issues:*** ***1. satisfaction with services*** ***2. level of involvement in treatment decisions*** ***3. knowledge and understanding of formal complaints mechanisms*** ***4. knowledge and understanding of patient bill of rights*** ***5. level of involvement in service delivery and planning*** ***6. level of cultural sensitivity*** ***7. number and availability of services available*** ***8. community follow-up*** ***Conduct analyses regarding the validity and reliability of the developed survey where possible.*** ***Modify survey based on these results***	C/S defined outcome criteria included in evaluation tool **3.** Evaluation tool implemented **4.** Research conducted ***<u>Consumer satisfaction</u>*** ***Ministry standard: "Consumer satisfaction (including consumers, families and outside agencies) must be monitored continuously, and the results used to make service improvements" – Consumer satisfaction survey will be administered on an annual basis*** ***Ministry standard: "A consumer satisfaction survey will be developed and administered on an annual basis, with a target of 80% satisfaction, to the best extent possible, given the mandate of the CRS" – Consumer satisfaction survey will demonstrate satisfaction levels of 80%***	**4.** Literature review **5.** Correspondence and/or communication with peer services ***<u>Consumer satisfaction</u>*** ***Administer satisfaction survey on an annual basis***

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	Annual evaluation ***Develop and annually implement a program evaluation that uses best practices and published standards regarding services/supports for persons with SMI as indicators*** ***Possible tools to include:*** ***1. survey indicated above*** ***2. interviews with consumers, family members, mental health agencies, representatives from the criminal justice system*** ***3. naturalistic observation (only if and when ethically permissible)*** ***4. consumer assessments to measure the following:*** • ***clinical status*** • ***functional status*** • ***involvement in meaningful daytime activity*** • ***housing status*** • ***quality of life*** • ***physical health status*** • ***mortality***	***Annual evaluation*** ***Ministry standard: " All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards"***	***Annual evaluation*** ***Conduct surveys, interviews, observations and consumer assessments on an annual basis***

Table 10: PDP Logic Model for the West Quadrant

GOAL 1: To prevent and reduce people's contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1. To identify and assess people's need for service ***To determine quadrant needs in regard to pre-charge diversion program components*** 2. To provide alternatives to criminal charges being laid 3. To link people to the services and supports they need ***To provide alternatives to criminal charges being laid by providing crisis support and linking people to the services and supports they need (combining Objectives 3 and 4).*** 4. To advocate for systems change based on identified gaps/barriers in the system	**1.** GATHER FEEDBACK FROM RELEVANT STAKEHOLDERS IN WEST TORONTO RE PROGRAM MODEL **2.** RECEIVE REFERRALS FROM COMMUNITY PROVIDERS INCLUDING POLICE, EMERGENCY AND MOBILE CRISIS SERVICES **3.** IMPLEMENT A PRE-CHARGE SERVICE OF OUTREACH AND TELEPHONE SUPPORT. **4.** LINK CLIENTS TO RECONNECT'S EXISTING DROP-IN, LIFE SKILLS AND SOCIAL RECREATION PROGRAMS. **5.** ESTABLISH COMMUNITY LINKAGES AND PARTNERSHIPS TO MENTAL HEALTH AND JUSTICE SERVICES ***Establish community linkages and partnerships to mental health and justice services to advocate for systems change*** **6.** PARTICIPATE IN SYSTEM PLANNING OPPORTUNITIES.	**1.** FEEDBACK FROM CONSUMERS, FAMILY MEMBERS, POLICE AND MENTAL HEALTH PROVIDERS ANALYZED AND INCORPORATED INTO SERVICE. ***Specify number of participants to include? (clarification)*** ***Needs identified through consultation (addition)*** **2.** A MINIMUM OF FORTY-FIVE [45] CLIENTS SERVED **3.** # OF INDIVIDUALS DIVERTED FROM THE CRIMINAL JUSTICE SYSTEM. **4.** NUMBER OF CLIENTS PARTICIPATING IN EXISTING RECONNECT PROGRAMS. **5.** NUMBER OF LINKAGES/PARTNERSHIPS ***If possible, specify the numbers for #3, 4 and 5.*** **6.** INVOLVEMENT IN SYSTEM PLANNING	**1.** CONSULTANT REPORT **2.** INDIVIDUAL AGENCY M.I.S. AND C.D.S. REPORTS. **3.** INDIVIDUAL CLIENT FILES. **4.** TEAM MEETING MINUTES. **5.** PRE-CHARGE PLANNING COMMITTEE MINUTES. ***Memorandums of Understanding created and maintained***

GOAL 1: To prevent and reduce people's contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	7. IDENTIFY GAPS AND BARRIERS IN THE SERVICE SYSTEM ***Not clear exactly how gaps/barriers will be investigated and recorded***	GROUPS/COMMITTEES. ***Define level of involvement?***	

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1. To provide resource information to consumers, families, mental health service providers and criminal justice officials **2.** To identify system barriers/gaps and advocate for change **3.** To disseminate information about program evaluation findings **4.** To co-ordinate services with other pre-charge programs	**1.** DEVELOP WRITTEN PRESENTATION AND RESOURCE MATERIAL, E.G. BROCHURE, POWER POINT, ETC. **2.** PROMOTE PRE-CHARGE SERVICE IN THE WEST QUADRANT. **3.** DEVELOP A WEB BASED INVENTORY OF MENTAL HEALTH, JUSTICE SYSTEM AND OTHER RELEVANT COMMUNITY RESOURCES. **4.** PARTICIPATE IN WEST QUADRANT COMMITTEES AND PLANNING GROUPS, AS WELL AS, SYSTEM WIDE OPPORTUNITIES.	**1.** BROCHURES DISTRIBUTED TO KEY REFERRALS SOURCES (POLICE HOSPITAL EMERGENCY, MOBILE CRISIS SERVICES AND OTHER MENTAL HEALTH AND JUSTICE PROGRAMS. **2.** PRESENTATIONS TO A MINIMUM OF TEN [10] ORGANIZATIONS. **3.** CONTACTS MADE WITH PRIORITY REFERRAL SOURCES AND KEY COMMUNITY STAKEHOLDERS **4.** # OF HITS TO THE WEB SITE. **5.** REGULAR ATTENDANCE AT WEST TORONTO COMMITTEES AND PLANNING/IMPLEMENTATION INITIATIVES, E.G. THE	**1.** BROCHURES AND OTHER PROMOTIONAL MATERIAL. **2.** MINUTES OF INTERNAL AND EXTERNAL MEETINGS. **3.** AGENCY M.I.S. AND C.D.S. REPORTS. **4.** RECONNECT WEB SITE AND LINKAGES TO OTHER MENTAL **5.** HEALTH AND JUSTICE WEB SITES. **6.** PRE-CHARGE PLANNING GROUP MEETING MINUTES

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
		COMMUNITY POLICING LIAISON COMMITTEE AND THE WEST QUADRANT COMMITTEE. **6.** REGUALR ATTENDANCE AT SYSTEM WIDE MENTAL HEALTH AND JUSTICE COMMITTEES/WORKING GROUPS, E.G. THE TORONTO REGION MH & JUSTICE COMMITTEE.	
	Information, Liaison, Advocacy, and Consultation/Collaboration ***Develop and conduct a program evaluation that measures the following:*** ***1. mental health spending per capita*** ***2. proportion of staff funding spent on administration and support*** ***Consult and collaborate with other service providers on service gaps, and the methods for reducing them (through steering committees, community forums, needs assessments, etc.)*** ***Develop needs based allocation strategy based on***	***Information, Liaison, Advocacy, and Consultation/Collaboration*** ***Advocacy*** ***Ministry standard: " Service providers must identify gaps in service and develop means for collaboration with other relevant community resources in order to meet unmet needs"***	***Information, Liaison, Advocacy, and Consultation/Collaboration*** ***Advocacy*** ***Needs assessment*** ***Program evaluation*** ***Steering committees*** ***Community forums***

GOAL 2: To enhance community knowledge and access to resources for people at risk of contact with the criminal justice system			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	evaluation/consultation ***Identify community linkages through needs assessment, steering committees etc.*** • ***highlight both areas where strong partnerships exist and where partnerships could be further developed*** ***Identify relevant and accessible services*** ***Assess crisis workers' level of knowledge regarding these services (e.g., through survey, interview)*** ***Assess crisis workers' ability to connect consumer with these services (e.g., timeliness, appropriateness etc.)*** ***Process evaluation regarding training resources, on-the-job development and continuous learning for staff:*** • ***crisis worker survey regarding satisfaction, availability of accessible and relevant surveys*** • ***identify gaps, barriers to service*** ***Provide training, workshops to address identified gaps in knowledge***	***Ministry standard: "Crisis worker must be knowledgeable about services that are accessible and relevant to consumer interests in order to provide up-to-date information"***	***Needs assessment*** ***Program evaluation*** ***Steering committees*** ***Community forums*** ***Surveys*** ***Interviews*** ***Training and workshops***

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
1. To develop an evaluation framework ***2.*** To evaluate the implementation and outcome of the service ***To evaluate the implementation and outcome of the service on an ongoing basis. (change)*** **3.** Where possible, to identify best practices ***To identify best, innovative and emerging practices, where possible. (change)***	**1.** EVALUATION FRAMEWORK DEVELOPED AND IMPLEMENTED. **2.** CONDUCT LITERATURE REVIEW. **3.** REGULAR PRGRAM REVIEW WITH THE PRE-CHARGE PLANNING GROUP AND OTHER STAKEHOLDERS. **4.** REGULAR PRE-CHARGE MEETING ***<u>Consumer satisfaction</u>*** ***Develop and administer a consumer/family/agency satisfaction survey that includes questions regarding the following issues:*** ***1. satisfaction with services*** ***2. level of involvement in treatment decisions*** ***3. knowledge and understanding of formal complaints mechanisms*** ***4. knowledge and understanding of patient bill of rights*** ***5. level of involvement in service delivery and planning*** ***6. level of cultural sensitivity*** ***7. number and availability of services available*** ***8. community follow-up***	**1.** EVALUATION TOOL IMPLEMENTED. ***If possible, identify the type of tool to be used*** **2.** LITERATURE REVIEW COMPLETED. **3.** BEST/INNOVATIVE PRACTICES FOR PRE-CHARGE DIVERSION IDENTIFIED. **4.** REVIEW RECONNECT PRE-CHARGE SERVICE QUARTERLY. ***<u>Consumer satisfaction</u>*** ***Ministry standard: "Consumer satisfaction (including consumers, families and outside agencies) must be monitored continuously, and the results used to make service improvements" – Consumer satisfaction survey will be administered on an annual basis*** ***Ministry standard: "A consumer satisfaction survey will be developed and administered on an annual basis, with a target of 80% satisfaction, to the best extent possible, given the mandate of the CRS" – Consumer satisfaction survey will demonstrate satisfaction levels of 80%***	**1.** LITERATURE REVIEW **2.** CONSULTANT'S REPORT **3.** EVALUATION TOOL **4.** AGENCY M.I.S. AND C.D.S. REPORTS. **5.** PROGRAM REVIEW DOCUMENT. ***<u>Consumer satisfaction</u>*** ***Administer satisfaction survey on an annual basis***

GOAL 3: To ensure quality service provision			
OBJECTIVES	**METHOD/PROCESS**	**CRITERIA FOR OUTCOME**	**RECORDING/REPORTING SYSTEM**
	Conduct analyses regarding the validity and reliability of the developed survey where possible. ***Modify survey based on these results*** ***<u>Annual evaluation</u>*** ***Develop and annually implement a program evaluation that uses best practices and published standards regarding services/supports for persons with SMI as indicators*** ***Possible tools to include:*** ***1. survey indicated above*** ***2. interviews with consumers, family members, mental health agencies, representatives from the criminal justice system*** ***3. naturalistic observation (only if and when ethically permissible)*** ***4. consumer assessments to measure the following:*** • ***clinical status*** • ***functional status*** • ***involvement in meaningful daytime activity*** • ***housing status*** • ***quality of life*** • ***physical health status*** • ***mortality***	***<u>Annual evaluation</u>*** ***Ministry standard: " All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards"***	***<u>Annual evaluation</u>*** ***Conduct surveys, interviews, observations and consumer assessments on an annual basis***

Appendix I: Goal Attainment Scaling

Goal Attainment Scaling (GAS) was designed for use in evaluating mental health programs but has been used in other contexts where individual outcomes are important [1, 2]. An advantage to using GAS is that it enables an assessment of individual client outcomes in context such that client goals are practical rather than ideal [2].

GAS typically involves a client and front-line workers selecting one to five rehabilitation goals [3]. For each goal an incremental series of realistic treatment outcomes ranging from least to most desirable is created resulting in a 5-point scale ranging from -2 through to +2 [4]. The midpoint of the scale (0) represents the most likely outcome [4]. Each possible treatment outcome needs to describe phenomena that can be observed and measured [3]. In addition, each possible outcome for a given goal must be distinct from other outcomes [5]. Hence, frequencies of events (the number or percentage of times a behaviour occurs or does not occur, as appropriate) are often used as these are discrete. Delineating the five possible outcomes for each goal is viewed by many as the most challenging aspect of GAS [6].

Weights are assigned to each of the goals based on the relative importance of the goals. After a specified time period, usually three months to one year, an outcome score is determined for each goal [2]. Then a standardized goal attainment score is calculated such that average scores for different groups of clients can be generated thereby enabling comparisons among groups of clients. The formula for calculating each client's score can be found in various sources [4, 3, 6]. Use of this formula does, however, require treating an ordinal scale (i.e., a scale of rankings that does not have an equal distance between any two consecutive points on the scale) as providing interval data (i.e., wherein the distance between two consecutive points on the scale is the same) [3].

Programs may opt to report the frequency or percentage of clients who scored 0 or higher particularly if the same number of goals are created for each client and all goals are weighted equally. This information may be sufficient from the perspective of clients, clinicians and other stakeholders as evidence of client outcomes. Where improvements are not seen, even this simplified version of GAS can assist with identifying areas of difficulty for clients [3]. Scores are readily comparable across clients when GAS is used to assess change in a given behaviour categories rather than concentrating on descriptions of outcomes [7]. Front-line service providers have been found to be highly satisfied with GAS because it dovetails with clinical decision-making [2].

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Appendix J:

Table 7: American and Canadian Diversion Programs

Title and Location of Program	Description of Program
The Bexar County Jail Diversion Program: The Center for Health Care Services, Texas	Eligibility: adult offenders with mental illness Referral: 1) pre-booking diversion by Deputy Mobile Outreach Team or Crisis Intervention Team, or 2) post-booking diversion by Pre-trial services or Mental Health Docket Services: 1) assessments 2) crisis centre admittance when necessary 3) committed or community treatment Outcome data: 1) 1,732 diverted cases for 2004 2) estimated potential avoidance in criminal justice costs of $3.8 - $5.0 million Source: www.center-for-healthcare.org/JailDiv/Policy%20Report.pdf (May 19, 2005)
Calgary Diversion Service: Mental Health and Psychiatric Services, Calgary, Alberta	Eligibility: adults 18+ suffering from a mental disorder and charged with a minor low-risk offence (must consent to participate) Referral: 1) Arrest Processing Unit 2) Crown Prosecutor's office, or 3) Remand Centre (referrals may be initiated by community services, hospital or family) Services: 1) assessments 2) linkages with community resources are established and monitored 3) report forwarded to Crown Outcome data: not indicated Source: www.calgaryhealthregion.ca/mh/diversion.htm (May 25, 2005)
Community Criminal Justice Treatment Program: Maryland (multi-agency collaboration)	Eligibility: individuals 18+ who have a serious mental illness with or without a co-occurring substance abuse disorder Referral: pre- or post-charge diversion by 1) arresting officer 2) classification officer, or 3) medical or other jail staff Services: 1) crisis intervention 2) case management 3) screening and counselling 4) community follow-up 5) emphasis on housing and services for homeless individuals Outcome data: 1) recidivism rates reduced 2) number of community-based services have increased Source: www.bazelon.org/issues/criminalization/factsheets/criminal9.htm (May 19, 2005)
Crisis Intervention Team (CIT): Albuquerque Police Department, New Mexico	Eligibility: individuals who have a mental illness and/or who are in crisis Referral: pre-charge diversion by CIT police officer Services: 1) on-site assessment 2) use of appropriate crisis intervention techniques 3) transportation to psychiatric ER Outcome data: 1) 48% CIT calls resulted in transportation to mental health facility 2) fewer than 10% of CIT calls resulted in arrest 3) little over 1% of CIT calls resulted in citizen injuries 4) SWAT call-outs decreased by 48% Source: www.fbi.gov/publications/leb/2001/feb01leb.pdf (May 26, 2005)

Title and Location of Program	Description of Program
Crisis Intervention Team (CIT): Memphis Police Department, Tennessee	Eligibility: individuals in psychiatric crisis Referral: pre-charge diversion by CIT police officer Services: 1) on-site assessment 2) use of appropriate crisis intervention techniques 3) transportation to psychiatric ER Outcome data: 1) decreased need for hostage negotiations and tactical squads 2) officer injury rate seven times higher before implementation of CIT 3) significant reduction in barricade call-outs Source: www.lib.jjay.cuny.edu/len/2000/12.31 (May 26, 2005)
Crisis Intervention Team (CIT): Seattle Police Department, King County, Seattle	Eligibility: persons with mental illness, drug/alcohol problems and developmental disabilities Referral: 1) pre-booking diversion by CIT police officer 2) post-booking diversion through mental health court Services: 1) on-site assessment 2) use of appropriate crisis intervention techniques 3) transportation to psychiatric ER Outcome data: not indicated Source: www.gainsctr.com/pdfs/program_briefs/King_County.pdf (May 26, 2005)
Framingham Jail Diversion Program: Advocates Inc/Framingham Police Department, Massachusetts	Eligibility: persons with mental illness, substance abuse, developmental disabilities and other behavioural issues Referral: pre-arrest diversion by police officer Services: 1) on-site assessment 2) rapid access to community mental health, substance abuse and psychiatry services Outcome data: in progress Source: www.consensusproject.org/programs/one?program_id=430&searchlink=%2fprogram (May 25, 2005)
Jail Diversion Program/Mental Health Linkage: Clermont County Mental Health and Recovery Board, Ohio	Eligibility: persons with mental health and/or substance abuse diagnoses Referral: post-arrest diversion, primarily through Municipal Court Services: 1) jail-screening for pre-trial referrals 2) advice to courts 3) post-sentence supervision 4) mental health treatment services 5) intensive probation monitoring Outcome data: 1) gross savings of $1.3 million by reducing county jail bed days 2) high consumer and referral source satisfaction with program 3) recidivism rate 13% lower than for general population Source: www.consensusproject.org/programs/one?program_id=236&searchlink=%2fprogram (May 25, 2005)
Jail Diversion of Mentally Ill: Tulsa County Division of Court Services, Oklahoma	Eligibility: non-violent defendants with mental illness Referral: pre- or post-charge diversion by law enforcement or courts Services: 1) screening and evaluation 2) screening for pre-trial release 3) assessments Outcome data: not indicated Source: www.consensusproject.org/programs/one?program_id=173&searchlink=%2fprogram (May 25, 2005)

Title and Location of Program	Description of Program
Jail Diversion Program: Anchorage Community Care Alternative Project, Alaska	Eligibility: people 18+ with a serious mental illness who have committed non-violent misdemeanour offences, and have been arrested and gone through the booking process Referral: post-charge diversion (referral source not indicated) Services: 1) intensive case management 2) housing support 3) psychiatric services 4) medication management 5) substance abuse counselling for dually-diagnosed consumers 6) intensive support services 7) crisis intervention Outcome data: not indicated Source: www.southcentralcounseling.org/Jail%20Diversion.htm (May 25, 2005)
Jail Diversion Program: Department of Mental Health and Addiction Services, Connecticut	Eligibility: people with mental health and co-occurring substance abuse disorders arrested on minor offences Referral: court diversion by judge, based on recommendation of diversion staff 2) referrals also taken from court personnel Services: 1) assessments 2) case management to ensure continuity of mental health care and community reintegration Outcome data: 1) individuals who participated in the program spent significantly fewer days in jails and psychiatric hospitals Source: www.consensusproject.org/programs/one?program_id=82&searchlink=%2fprogram (May 25, 2005)
Jail Diversion Program: Bernalillon County, New Mexico	Eligibility: individuals who have been placed in jail and are determined to have a mental illness Referral: 1) pre-booking diversion by CIT officer, or 2) post-booking diversion referrals from attorneys, judges, jail staff, mental health providers, family members or the police Services: 1) pre-trial assessments 2) case management 3) peer support Outcome data: 1) jail bed days reduced by 4,740 in 6 months, saving the jail $355,500 and helping to reduce over-crowding Source: www.bazelon.org/issues/criminalization/factsheets/criminal7.htm (May 25, 2005)
Jail Diversion Program: Montgomery County, Pennsylvania	Eligibility: individuals with mental health and substance abuse issues who have committed less serious offences Referral: 1) pre- and post-booking diversion 2) “co-terminous” jail diversion (offender is arrested and booked but is also delivered directly into psychiatric treatment) Services: 1) regular screening of inmates 2) community and on-site treatment 3) mobile crisis 4) case management Outcome data: not indicated Source: www.bazelon.org/issues/criminalization/factsheets/criminal7.htm (May 25, 2005)
Mental Health Diversion Program: Canadian Mental Health Association, Thunder Bay Branch, Ontario	Eligibility: mentally disordered offenders, both youth and adults Referral: post-charge diversion by the judge on a case by case basis Services: referred to a hospital, a person or the Canadian Mental Health Association to seek treatment Outcome data: not indicated Source: www.cmha-tb.on.ca/mhdiversion.htm

Title and Location of Program	Description of Program
Mental Health Diversion Program: Pima County Pre-trial Services, Arizona	Eligibility: defendants with mental illness who are charged with city court misdemeanours Referral: post-charge diversion determined by prosecutor in conjunction with the case manager Services: development, coordination, and implementation of a diversion plan Outcome data: 1) no filings for Rule 11 (competency to stand trial) resulting in great savings 2) number of misdemeanour defendants detained beyond initial appearance has decreased significantly Source: www.consensusproject.org/programs/one?program_id=90&searchlink=%2fprogram (may 25, 2005)
Mental Health Diversion Program: Louisville Metro Criminal Justice Commission, Kentucky	Eligibility: non-violent felony and misdemeanour defendants with serious mental illness Referral: court diversion by diversion staff and court system Services: 1) community-based treatment 2) case management 3) group therapy Outcome data: total jail days reduced for program participants Source: www.consensusproject.org/programs/one?program_id=80&searchlink=%2fprogram (May 25, 2005)
Mental Health Jail Diversion Program: Dallas Area NorthSTAR Authority, Texas	Eligibility: adults charged with non-violent misdemeanour offences, and certain defendants on non-violent felony probation with technical violations; must be identified as members of the priority population (schizophrenia, bipolar disorder, MDD) Referral: not specified Services: 1) temporary crisis housing 2) intensive case management 3) psychiatric evaluation 4) rehabilitation Outcome data: not indicated Source: www.consensusproject.org/programs/one?program_id=459&searchlink=%2fprogram (May 25, 2005)
Mental Health Jail Diversion Project: Mental Health Association of the Capital Region, New York	Eligibility: individuals with mental illnesses and/or co-occurring substance abuse disorders who have been arrested for non-violent offences Referral: post-booking diversion by judges, law enforcement, jail staff, district attorneys, public defenders, family members Services: 1) assessment and treatment 2) case management 3) assistance with housing, employment services, substance abuse treatment Outcome data: 1) inappropriate detainment reduced from an average of 72 days to 25 days 2) inmate with mental health needs costs $7,190, while diversion costs only $2,500 Source: www.consensusproject.org/programs/one?program_id=233&searchlink=%2fprogram (May 25, 2005)

Title and Location of Program	Description of Program
Nathaniel Project: The Center for Alternative Sentencing and Employment Services, New York City	Eligibility: people with serious mental illness who have committed felony offences, including violent Referral: post-charge diversion, primarily by defence attorney, but also from community health workers, family members, judges and prosecutors Services: 1) screening 2) residential treatment program 3) advocacy 4) counselling 5) intensive case management Outcome data: 1) participant arrests dropped from 101 down to 7 arrests in the year since intake 2) 88% retention at 6 months, 80% retention at 2 years 3) at intake 93% of participants were homeless; after one year, 79% had permanent housing Source: www.gainsctr.com/b/spotlight/nathaniel_project.asp (May 26, 2005)
The Phoenix Project: Wicomico County, Maryland	Eligibility: women 18+ with severe mental health and co-occurring substance use disorders who have committed misdemeanours or non-violent felonies Referral: 1) pre-booking diversion by mobile crisis unit or police 2) post-booking diversion by jail staff, judges, prosecutors or defence attorneys Services: 1) integrated mental health and substance abuse treatment 2) specific needs of women addressed, including issues involving children, parenting, medical services, housing, transportation, educational and vocational training, and domestic violence Outcome data: not indicated Source: www.gainsctr.com/pdfs/brochures/Needs_of_women.pdf (May 19, 2005)
Pre-Trial Services Diversion: Harris County Sheriff's Department, Houston, Texas	Eligibility: individuals with mental illness (type of offence not indicated) Referral: 1) pre-arrest diversion by CIT 2) post-arrest diversion by Pre-trial Services, booking deputies, family members, medical personnel, and/or officers of the court Services: 1) transportation to psychiatric ER 2) screening and assessment 3) case management Outcome data: not indicated Source: www.mhatexas.org/jiles.ppt (May 19, 2005)
Project Link: New York, New York	Eligibility: individuals with severe mental illnesses, previous involvement with the criminal justice system, and non-adherence to outpatient treatment; majority charged with a felony or have past felony convictions (most of them violent) Referral: post-charge diversion by police, public defenders, jails and state prisons Services: 1) mobile treatment team 2) dual diagnosis treatment residence 3) case management Outcome data: 1) high consumer satisfaction 2) decline in jail costs for clients from $672 per month to $157 3) total mental health service costs declined from $197,899 to $42, 247 4) significant reduction in number of incarcerations and average days spent in jail from 9.1 to 2.1 per month and from 107 to 46 per year 5) significant reductions in total incarcerations Source: www.bazelon.org/issues/criminalization/factsheets/criminal9.htm (May 19, 2005)
Thresholds: Chicago, Illinois	Eligibility: individuals incarcerated at the Cook County Jail who have a serious mental illness and a history of arrests Referral: post-arrest diversion by courts Services: 1) intensive case management 2) housing assistance 3) transportation/money services Outcome data: 1) 82.2% decrease in days spent in jail 2) 85.5% drop in hospitalizations 3) Cost $26/day vs. $70/day for jail Source: www.bazelon.org/issues/criminalization/factsheets/criminal7.htm (May 25, 2005)

Appendix K: Pre-charge Diversion Client Satisfaction Survey

1. Please circle the number that best represents how satisfied you are with each of the following aspects of service delivery:

    a) Availability of services [at agency name]

1……..2……3……4……5……6……7
Very Dissatisfied Very Satisfied

Comments:

    b) Number of services available at [Agency name]

1……..2……3……4……5……6……7
Very Dissatisfied Very Satisfied

Comments:

    c) Quality of services

1……..2……3……4……5……6……7
Very Dissatisfied Very Satisfied

Comments:

    d) Follow up after initial contact with [Agency name]

1……..2……3……4……5……6……7
Very Dissatisfied Very Satisfied

Comments:

e) Overall satisfaction with services at [Agency name]

1……..2……3……4……5……6……7
Very Dissatisfied — Very Satisfied

Comments:

2. Please circle the number that best represents the extent of your agreement with each statement below:

a) Program staff are knowledgeable.

1……..2……3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

b) Program staff are friendly and respectful.

1……..2……3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

c) Staff provided the right amount of support.

1……..2……3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

d) I am aware of and understand the process for making a formal complaint about the services received at [Agency name].

1……2……3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

e) I am aware of and understand my rights as a client (or a member) of [Agency name].

1……2……3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

f) Services at [Agency name] were provided in a manner that was sensitive to my ethnocultural values and beliefs.

1……2……3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

g) Services at [Agency name] were provided in a manner that was considerate of my gender/sexual orientation/identity.

1……2……3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

h) [Agency name] staff linked me to appropriate services.

1……..2……..3……4……5……6……7
Highly Highly
Disagree Agree

Comments:

i) [Agency name] staff are in tune with the needs of program users.

1……..2……..3……4……5……6……7
Highly Highly
Disagree Agree

Comments:

j) [Agency name] staff assisted me in receiving my entitlements.

1……..2……..3……4……5……6……7
Highly Highly
Disagree Agree

Comments:

k) The pre-charge diversion program offered at [Agency name] helped me to avoid further contact with the criminal justice system.

1……..2……..3……4……5……6……7
Highly Highly
Disagree Agree

Comments:

l) My involvement in the pre-charge diversion program at [Agency name] promoted my recovery.

1……..2……..3……4……5……6……7
Highly Highly
Disagree Agree

Comments:

m) At [Agency name], I was involved in making decisions that affected me.

1……..2……..3……4……5……6……7
Highly Highly
Disagree Agree

Comments:

n) The pre-charge diversion program at [Agency name] helped me to achieve the goals that I set shortly after I began the program.

1……..2……..3……4……5……6……7
Highly Highly
Disagree Agree

Comments:

o) I can count on [Agency name] staff to assist me.

1……..2……..3……4……5……6……7
Highly Highly
Disagree Agree

Comments:

p) The hours of operation at [Agency name] are convenient for me.

1……2……3……4……5……6……7
Highly

Highly
Disagree

Agree

Comments:

q) The facilities at [Agency name] were suited to the nature of the pre-charge diversion program.

1……2……3……4……5……6……7
Highly

Highly
Disagree

Agree

Comments:

r) [Agency name] staff assist me more than I need to be assisted.

1……2……3……4……5……6……7
Highly

Highly
Disagree

Agree

Comments:

s) My involvement in the pre-charge diversion program at [Agency name] helped me to avoid another crisis.

1……..2……..3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

t) My involvement in the pre-charge diversion program at [Agency name] provides me with a sense of belonging.

1……..2……..3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

u) [Agency name] staff involved my family and friends appropriately.

1……..2……..3……4……5……6……7
Highly Disagree — Highly Agree

Comments:

Do you have any other feedback that you would like to share regarding the precharge diversion program?

N.B. Appropriate demographic questions should be added depending on the user group.