TORONTO MENTAL HEALTH AND JUSTICES SERVICES - SERVICE SYSTEM ASSESSMENT

A Study Conducted for the Toronto Mental Health and Justice Coordinating Committee

February 17 to September 21, 2006

by

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Abbreviations and Terminology

ACT Team	Assertive Community Treatment Team
CAMH	Centre for Addiction and Mental Health
CCC	Criminal Code of Canada
DSM IV	Diagnostic and Statistical Manual of Mental Disorders Fourth Edition
EDP	Emotionally Disturbed Person
FACT	Forensic Assessments, Consultation and Treatment
FRMP	Forensic Risk Management Plan
HSRC	Health Services Restructuring Commission
HuDAT	Hussein Dwornik Action Team
LAMPH	Law and Mental Health Program, Centre for Addiction and Mental Health
LHIN	Local Health Integration Network
LSI-OR	Level of Service Inventory-Ontario Revision
MAG	Ministry of the Attorney General, ON
MCIT	Mobile Crisis Intervention Team
MCSCS	Ministry of Community Safety and Correctional Services, ON
MCSS	Ministry of Community and Social Services, ON
MHSIO	Mental Health Service Information Ontario
MOHLTC	Ministry of Health and Long-Term Care, ON
MOU	Memorandum of Agreement
NCR	Not Criminally Responsible
NGO	Non Government Organization
ODSP	Ontario Disability Support Program
OMA	Ontario Medical Association
ORB	Ontario Review Board
PHIPPA	Personal Health Information and Protection of Privacy Act
RFP	Request for Proposal
Unfit	Unfit to Stand Trial
YCJA	Youth Criminal Justice Act of Canada

Forensic Client: "person who suffers from a major mental disorder, is in conflict with the law and is being dealt with by the courts or the Ontario Review Board under Part XX.I -Mental Disorder of the Criminal Code (Canada)". (The Forensic Services Expert Advisory Panel)

Common Client: "clients of police, courts, correctional facilities, hospitals and community agencies who have mental health issues as well as issues with the judicial system and are in need of care or intervention". (Human Services and Justice Coordination Project)

Seriously mentally ill *: includes Axis I (DSM IV) diagnostic categories of schizophrenia, schizoaffective disorder, bipolar and affective disorders.

Moderately mentally ill: focuses on Axis II & III (DSM IV) diagnostic categories of less serious mental illness and including personality disorders, developmental disability, depression and anxiety disorders.

Concurrent Disorder: mental illness and substance abuse

Dual Diagnosis: mental illness and developmental disability

Class 1 Offence: A list of offences under the Ministry of the Attorney General Mental Disorder Diversion Policy that are presumed to be eligible for diversion depending on the circumstances of the offender and the offence; e.g. theft, mischief, causing a disturbance

Class 2 Offence: A list of offences not included in Class I or III, many are presumptively considered for diversion except those committed in circumstances of violence and any offences in which a weapon is used; e.g. minor assaults

Class 3 Offence: Those offences that are not considered for diversion regardless of the circumstances of the offence or offender; e.g. murder, sexual assaults, spousal-partner offences

***** *often includes those with concurrent disorders and dual diagnosis*

1. ACKNOWLEDGEMENTS

We would like to thank everyone who participated in this study for their involvement in responding to the questionnaires, participating in the focus groups, consultations and interviews.

We owe a special thank you to the mental health and justice clients who graciously agreed to be interviewed and provided us with insight to the developing network of services under the Service Enhancement Initiative.

The members of the Steering Committee were extremely helpful to the consultants and provided support and guidance as the study progressed. We would particularly like to express our appreciation to Steve Lurie, Chair of the Toronto Mental Health and Justice Coordinating Committee and Executive Director of the Canadian Mental Health Association of Toronto, for ensuring that we were apprised of new studies and research that was pertinent to the study , and for following up on the numerous questions we asked. We also want to express our appreciation to Frank Sirotich, Manager of the Court Support Programs for the Canadian Mental Health Association of Toronto at the Scarborough and Etobicoke courts for the information he provided us on the court support programs and the database maintained at these two courts.

We want to commend the agencies and staff who are providing services to the mental health and justice clients under the Service Enhancement Initiative. We consistently saw examples of their dedication and commitment to providing services to the client population.

Finally, we want to recognize and commend Robin Daly, Mental Health Consultant with the Ministry of Health and Long-Term Care for her exemplary work in planning and facilitating programs across systems. Her strategic leadership and ongoing support of the developing networks has enabled emerging best practices to start to develop in this important new field.

2. EXECUTIVE SUMMARY

This study was initiated by the Toronto Mental Health and Justice Coordinating Committee through a Request for Proposal (RFP) process in December 2005 and awarded to PublicPartner Inc. and Glenn Thompson Consulting Services in February 2006. The purpose of this study was to map the services that are provided in Toronto under the Service Enhancement Initiative and to produce a final report:

- "with a stress on a systems design and mapping for the service system in a better integrated design

- identifying the adjustments to service systems to better meet the needs of clients

- identifying the role the HSJCC can provide in sector coordination & communication, & in joint problem solving & planning efforts between health & criminal justice service organizations within the Toronto Region

- recommendations will include identification of several steps towards a different alignment of services"[1]

The study also was intended to take into consideration the new Local Health Integration Network (LHIN) structure that is being phased in by the Ministry of Health and Long-Term Care (MOHLTC) and to identify the linkages that need to be in place for the human services and justice sector to relate appropriately to the five Toronto LHINs.

The timing of this examination was excellent. While most of the Service Enhancement Initiative programs are in their infancy, agencies have achieved considerable success in the development of these programs and in establishing service networks that laid the foundation for the 2006-07 funding. This experience will enable the agencies not only to plan for additional services, but also to continue to develop the existing programs into recognized best practices.

The Service Enhancement Initiative is specifically focused on providing services to mental health and justice clients. This client group, often referred to as "common clients", experience difficultly in accessing mental health services. When community agencies and hospitals discover that potential clients are involved in the justice system they often end up at the "back of the line', waiting for services that may never quite reach them. These clients are sometimes difficult to serve and often present with complex needs, frequently cycling through a revolving door that involves many stops in the mental health and justice systems.

We approached this study by employing a number of methodologies to obtain both qualitative and quantitative data. These included:

- developing and distributing questionnaires to three primary groups that provide services to the client population; service providers, mental health court support programs and hospitals that provide Schedule 1 psychiatric services

- conducting semi-structured interviews with 20 mental health and justice clients

[1] Letter of engagement: February 17, 2006

- conducting 19 focus groups with:
    - agencies funded by the Service Enhancement Initiative and the networks that have been developed to coordinate their work across the city
    - agencies that deliver programs to the client group that were not funded under the Service Enhancement Initiative
    - justice services including the police, judges, crowns, probation and parole service staff and senior staff in correctional institutions
- conducting 26 individual consultations with senior level staff from both government and non-government sectors
- accessing a number of data bases in order to obtain information on the client population
- obtaining client vignettes from service providers to illustrate the impact of the Service Enhancement Initiatives

The MOHLTC has provided significant funding for mental health services to assist people with mental illness to stay out of the justice and correctional systems. A total of $50 million was announced by the Minister of Health and Long-Term Care for service enhancement for community mental health and justice programs, with the funding divided into two phases. The first phase $27.5 million was announced in January 2005 for the 2005-06 fiscal year, and the second phase $22.5 million was announced in May 2006 for the 2006-07 fiscal year.

We applaud the Ontario government for providing this funding to community mental health programs, the first significant funding for mental health and justice clients. The Service Enhancement Initiative builds upon earlier investments in the court support program initiated in 1998. While the service providers identified this funding as enabling, "*a footprint of service to be made available across Toronto*", many indicate that it will essentially provide for a much needed catch up process. It is, however, a welcome enhancement to a seriously under funded area.

We mapped the services that were funded in the first phase of the Service Enhancement Initiative, and have provided a very preliminary mapping of these services for 2006-07, as the announcement for the second year of funding was just released as we concluded this report. The funding in Toronto for the first year was allocated to community mental health agencies with a track record of providing services to clients that were in conflict with the law, and was focused on service provision in each of the south, east, west and north quadrants of the city. The Mental Health Consultant with the MOHLTC Regional Office was primarily responsible for the strategic allocation of the funding across the city and nurturing the network of agencies that has developed to implement the services.

We are very impressed by the early steps the community mental health agencies, their boards and staff have made in this relatively new service terrain. We recognized the many additional hours that they have contributed to make both the services and the networks operate efficiently.

The questionnaires provided information regarding the range of programs that are provided to this client group. As we anticipated, the agencies funded under the Service Enhancement Initiative reported that their primary client focus was persons with a serious mental illness who are also

involved with the justice system. Their entry point to these services was most frequently through the courts or probation services.

The Mental Health Court and the Mental Health Court Support Programs represent an extension of the diversion programs that include additional services to the courts as well as providing a more "client centered" mental health service for accused persons who do not qualify for diversion. A key feature is the presence of a psychiatrist in the court who provides general psychiatric assessment service, assessment for diversion and psycho-legal assessments to determine fitness to stand trial. Unfortunately, these psychiatrists are not available every day in each court. The mental health court workers act as "brokers" and "boundary spanners" linking mental health services to the needs of the clients.

The data provided by the Scarborough and Finch West court programs identified the typical mental health and justice client as predominantly male, aged 25-34 years, with a primary diagnosis of schizophrenia. Most clients are facing a Class 1 or Class 2 charge that may also include failure to appear and/or comply, and awaiting bail or trial. A significant portion have also been charged with Class 3 offences.

The profile of the mental health and justice clients identified by the court data was also consistent with the clients we interviewed, who were primarily aged 25-34 years and predominantly male. These clients were either living in their own homes or with parents and they were primarily referred to the programs by duty counsel or defense counsel. The majority of the clients pointed to the fear of rejection, including the negative reaction of family and friends and general discrimination, associated with their mental illness as the prime reason that they had not sought help earlier. For this group of clients, increased awareness of mental illness as well as public knowledge of existing programs that are available for those involved in the justice system were perceived as going a long way to closing some of the gaps that they saw in the current system.

We examined service gaps for the programs along the following axes; specific client groups; service types; human resources; service coordination and corporate systems. This examination of service gaps is not intended to minimize the very hard work, over a short time frame, that the community mental health agencies and their justice partners have made to develop these new services. It is instead intended to identify where opportunities remain to move these programs along the continuum toward best practices as they mature.

The gaps in services for specific clients, in particular dual diagnosis and concurrent disorders, had already been recognized by both the MOHLTC and the service providers and additional funding was allocated in 2006/07 to deal with some of these needs. Similarly, significant funding has been allocated for release planning and transition to the community for offenders with a mental illness that are released from correctional institutions.

We suggest that it would be prudent to conduct a similar mapping and gap identification review in mid-2008/09 as the programs mature, and following the completion of the evaluation of the Service Enhancement Initiative.

We were asked to identify "the options available to organize and deliver existing and justice system components in a coordinated fashion." Services for this population have expanded greatly in large measure because of the very significant infusion of funds by the MOHLTC through the Service Enhancement Initiative. This rapid increase in service provision by the community mental health sector, in conjunction with the courts and crown attorneys, has placed new system coordination pressures on an already rapidly expanding community mental health system in

Ontario and, because of its very large and complex population demographic, this impact is heightened in Toronto.

Community agencies often focus their attention on service delivery to clients before they attend to the overall structuring of a delivery system, and the mental health and justice programs are no exception. As the Toronto Mental Health and Justice Coordinating Committee has recognized in commissioning this study, it is essential to ensure a system structure that can provide robust coordination and management for these substantial sums of money. In addition, it is essential to assure the funder that the agencies and the court services use their energies to the best advantage of persons with mental illness who are so in need of their services.

The need to examine system design has become all the more urgent in the light of the major restructuring of the MOHLTC that has created fourteen LHINs across Ontario, five of which will soon have funding responsibility for the very programs that are the subject of this study.

It does not seem practical to attempt to align the geographic boundaries of the mental health and justice related services to the boundaries of the five Toronto LHINs, even though in the future the five Toronto related LHINs each will fund such programs in their geographic area.

The LHINs boundaries were designed to follow the flow patterns of patients requiring physical care in the health system and the mentally ill and other groups who encounter the justice system flow quite differently and in a way which relates to the boundaries for police services and the courts. For a time, the justice system becomes the predominant service system for these individuals.

It will be essential for the five Toronto area LHINs to plan their full spectrum of community mental health programs and funding in a fully coordinated manner, even though the flow of funds will occur from each separate LHIN budget to the service delivery organizations in its area.

It is for the foregoing reasons that we have proposed a strengthening of all of the leadership components in the human service and justice system. It is proposed that the current Toronto Mental Health and Justice Coordinating Committee become the Toronto Human Services and Justice Steering Committee with much more clout to assure coordination and integration of service delivery for the wider human services and justice client population including various groups such as: mentally ill; dually diagnosed; acquired brain injury; substance abuse; dangerous fire setters and fetal alcohol syndrome. This Steering Committee with this broad spectrum of client responsibilities would report to what we suggest should be a much stronger and well integrated Ministry level leadership authority.

The strengthened regional Toronto Human Services and Justice Steering Committee would provide leadership to various sector groups representing service delivery agencies. Fortunately, the Toronto Mental Health Network is very well developed and could readily provide leadership as a Sector Network structure and be a primary body for liaison to the five Toronto LHINs on Toronto- wide mental health and justice issues.

We suggest, as well, that the four current quadrants be recognized as the appropriate local service coordination areas for Toronto. The service delivery centre for the human services and justice sector should continue to be the court or courts in each quadrant. We propose that each quadrant have a District Human Services and Justice Coordinating Committee.

The Toronto Regional and the four District Committees would require modest staffing in the areas of planning, information system development, training, research and information dissemination.

We believe that such a strengthening of the leadership bodies at all levels will create a much stronger system of coordination and management that should assure that the current and still much needed additional funding will be prudently spent on clients with the greatest need. There is little doubt that a well led system will greatly enhance the effective and efficient use of provincial funds.

SUMMARY OF RECOMMENDATIONS

10.1.1 Dual Diagnosis

Recommendation 1 : *We recommend that the funding requested by the Toronto Mental Health and Justice Coordinating Committee for the dually diagnosed that are involved in the justice system to provide transitional /crisis beds and additional supportive housing units be approved should additional funding become available. This may be most economically provided by identifying specialized housing in the form of a small apartment block with specific dedicated resources such as behavioural therapists, additional support workers skilled in providing services to dual diagnosed clients and clinical back-up to the support workers. Consideration should also be given to seeking sufficient funding for support to enable dual diagnosis clients that are fire setters and minor sex offenders who are currently unable to find appropriate housing in the community, to be fully supported.*

In the interim, we recommend that the Toronto Mental Health and Justice Coordinating Committee work to improve the coordination of support services between the MOHLTC and the MCSS. Planning is required to identify how the dually diagnosed can obtain access to the existing housing units provided through the Service Enhancement Initiative; recognizing that these clients require more support services than are currently being funded by MOHLTC to live safely and independently in the community.

10.1.2 Concurrent Disorders

Recommendation 2: *That the Toronto Mental Health and Justice Coordinating Committee seek to build upon the current network that includes mental health and substance abuse services and that the MOHLTC provide more funding and services suitable for integrated treatment for those with concurrent disorders..*

10.1.3 Ethnocultural Services and Programs

Recommendation 3: *While the majority of ethnocultural clients will continue to receive services in the mainstream system, access to the expertise of specialized ethnocultural services and development of additional ethno-specific agency services should be encouraged by the members of the Toronto Mental Health and Justice Coordinating Committee. Also, the Montreal Jewish General Hospital model of ethno-specific clinical consultation should be studied as it appears likely to be a more economic and expeditious solution for many agencies.(See reference re Kirmayer study)*

10.2.1 Forensic Beds for Assessment and Treatment

Recommendation 4: *That the Toronto Mental Health and Justice Coordinating Committee support and further encourage the development of additional resources to provide Fitness Assessments and Treatment Orders in correctional facilities. This should build on the functional plan previously developed by the Law and Mental Health Program and be subject to the findings of the current review of the St. Lawrence Correctional and Treatment Project.*

10.2.2.Short-Term Residential Crisis Support Beds

Recommendation 5: *That the Toronto Mental Health and Justice Coordinating Committee work with the MOHLTC and/or the LHINs to encourage the continued application of flexible criteria and more flexibility in length of stay for use of crisis beds before these persons move on to more permanent and independent housing.*

10.2.3 Housing and Support Services

Recommendation 6: *That the Toronto Mental Health and Justice Coordinating Committee work with the MOHLTC and/or the LHINs to develop more flexibility in the deployment of support services in the supportive housing program, to provide a graduated intensity of designated support staff/client ratios dependent on the individualized needs of the client. This would permit housing units to accommodate a greater range of clients with higher initial needs who can over time be safely supported with what, over the course of their care, will be a staff to client ratio of 1:8.*

10.2.4 Release Planning and Community Transition from Correctional Institutions

Recommendation 7: *That the Toronto Mental Health and Justice Coordinating Committee work with Ontario Correctional Services and funded agencies to develop a consistent job description for the newly funded release planning and community transition positions. The job descriptions should focus on maximizing the impact of providing services and linkages to other systems that these agencies will be able to provide for mental health and justice clients.*

Recommendation 8**:** *That the Toronto Mental Health and Justice Coordinating Committee develop a program that would provide training for front line personnel across the different mental health and justice service sectors involved with the Service Enhancement Initiative. This will ensure that expertise is enhanced and standardized across Toronto.*

10.3.1 Access to and Availability of Psychiatrists

Recommendation 9: *That the Toronto Mental Health and Justice Coordinating Committee work with the Toronto Schedule 1 hospitals to link the service needs of community mental health agency clients with hospital psychiatrists. This could provide much needed specialized out-patient services using the funding that has been identified for four high priority areas in the agreement between the Mental Health Funding Working Group, the Ontario Medical Association (OMA) and the MOHLTC***.**

Recommendation 10: *That the Toronto Mental Health and Justice Coordinating Committee develop strategies for funding of non OHIP billable services that will encourage Schedule 1 hospitals to work in partnership with community mental health agencies to better serve the mental health and justice clients. In the event that the priority funding is insufficient to meet current*

demands for services, alternative strategies will need to be developed including pooling and reallocation of program funds.

It is recognized that the supply of psychiatrists may not be sufficient in the foreseeable future to service the system using the current specialist service model. While psychiatrists are needed for court assessments, some services for this client group could be delegated to other mental health professionals such as nurses with psychiatric training, clinical psychologists and psychiatric social workers.

10.3.2 Access to and Availability of General Practioners

Recommendation 11: *That the Toronto Mental Health and Justice Coordinating Committee work with Family Health Teams, family practice groups in general hospitals and community health centres in various local areas to develop a "shared care" relationship for mental health and justice clients utilizing family practitioners, as well as to recommend a variety of strategies be developed including options for provision of non billable services*

10.4.1 Cross Sectoral Delivery and Involvement of the Justice System

Recommendation 12: *That the Toronto Mental Health and Justice Coordinating Committee advocate for the development of a District Mental Health Services and Justice Coordinating Committee in each of the four local areas of Toronto. These committees would be comprised of local mental health service providers and representatives from the local detention centres, probation and parole services, the police services, the crown attorney services and the local hospitals so that care can be better coordinated, barriers identified, solutions discussed and implemented.*

The structure, functions, roles and responsibilities of the District Human Service and Justice Coordinating Committee as well as other coordinating bodies we propose be created are outlined in Section 11 of this report and would address current issues that include:

- *More formal liaison with the local correctional facility to allow for comprehensive plans to be developed that will assist with preventing clients from re-offending. This would include developing protocols that will allow for designated mental health staff from community service provider agencies to have access to clients in custody, based on a similar arrangement to that which is allowed for legal counsel.*

- *Closer working relationships between housing case managers and release planners in the correctional and detention centres, to allow for easier access to housing when the client leaves the institution.*

- *The development of a "best practice" framework specifically targeted at this client group using a consistent approach to identify persons with mental illness. Clients who are incarcerated and collaborating with detention centre staff would be tracked with potential mental health providers, so that when a client moves from one correctional institution to another, the case manager responsible for the client is informed about their status.*

10.4.2 Service Agreements

Recommendation 13: *That the Toronto Mental Health and Justice Coordinating Committee work with the justice system and the member agencies of the mental health and justice network to develop service level agreements. Priority should be given to developing these agreements for the provision of crisis beds and supportive housing so that they clearly delineate the roles and responsibilities of both parties to provide services and support to the common client; identify the accountability relationship in regard to the services to be provided to the client; and set out protocols for communication and information exchange and the working relationships.*

10.4.3 Common Data Base

Recommendation 14: *That the Toronto Mental Health and Justice Coordinating Committee encourage the use of the data elements in the developing court support database to link charge and disposition to other mental health program information by all agencies that receive the Service Enhancement Initiative funding.*

Recommendation 15: *That the Toronto Mental Health and Justice Network work with its member agencies to prepare an annual report on the activities and clients served through the Service Enhancement Initiative. In addition, a review similar to this one of the progress made in this sector should be informed by the results of the provincial service enhancement study and be conducted by the end of 2007/2008.*

10.4.4 Information Sharing Across the Systems

Recommendation 16: *That the Toronto Mental Health and Justice Network work with member agencies and legal counsel to reach agreement on the sharing of information essential to the continuity of care from one system to another. It will likely be necessary to seek a regulatory change under PHIPPA (Personal Health Information and Protection of Privacy Act) to allow for the flow of information between these providers.*

10.4.5 Assessing Risk and Determining Service Needs

Recommendation 17: *That the Toronto Mental Health and Justice Coordinating Committee work with Ontario Correctional Services to coordinate training for community mental health agency staff on the use of the LSI-OR (Level of Service Inventory - Ontario Revision) and other standardized assessment tools.*

10.5.1 Performance Measures and Data Sets for Evaluation

Recommendation 18: *That the Toronto Mental Health and Justice Coordinating Committee informed by the Service Enhancement Initiative, work with MOHLTC to develop performance standards and measures that will enable the agencies to identify their successes and to document their best practices. Extra resources from MOHLTC and later from the LHINs will be critical to provide the data/information and general records upon which performance may be measured and services informed by the results of the Service Enhancement Initiative.*

10.5.2 Education and Training for the Mental Health and Justice Systems

Recommendation 19: *That the Toronto Mental Health and Justice Coordinating Committee initiate training that includes using the expertise from all member groups to ensure that both*

mental health service providers and the justice system are informed about the operations of the various service systems. The Toronto Mental Health and Justice Coordinating Committee should also consider ways and means for clients to contribute to this training.

10.5.3 Public Education

Recommendation 20: *That the Toronto Mental Health and Justice Coordinating Committee conduct open houses/information sessions in the West, North and Central quadrants, as has been done in the East quadrant, to inform local service providers about the Service Enhancement Initiatives in their communities. This would be particularly timely as the second round of funding announcements will be awarded shortly.*

11.1.1 Provincial Authority

Recommendation 21: *That the Toronto Mental Health and Justice Coordinating Committee recommend to the MOHLTC that a strengthened Provincial Authority be created for the human service and justice field. This structure should provide assertive leadership both for the forensic field and for the broad human service and justice field. Such a Provincial Authority could be separated into two closely related components, one with the responsibility for the small but very complex and demanding forensic field, and the other for the human service and justice population.*

This authority would provide much needed inter-ministry leadership and would provide much needed human services and justice information to the LHINS responsible for the Toronto area.

11.1.2 Regional Human Services and Justice Steering Committee

Recommendation 22: *That the Toronto Mental Health and Justice Coordinating Committee recommend to the MOHLTC that the regional human services and justice structure be given a more authorative role for the Toronto human services and justice field. That the name Toronto Regional Human Services and Justice Steering Committee be adopted to make evident the shift to a body with more direct influence.*

This structure and the Toronto Mental Health and Justice Network will be vital data collection and analysis locations that will provide much useful information to the LHINs. As a first step the Regional Health and Justice Coordinating Committee could begin to take on these broader responsibilities until the Regional Steering Committee is authorized, if that occurs.

11.1.3 District Human Services and Justice Coordinating Committees

Recommendation 23: *That the new Regional Human Services and Justice Steering Committee establish a District Human Services and Justice Coordinating Committee for each of the four local areas of Toronto into which it is currently divided for the Service Enhancement Initiative. These Committees would provide front-line coordination among human service and justice providers in their respective areas.*

11.1.4 Working Groups

Recommendation 24: *That inter-agency coordination of services between two or more agencies be led by "purpose built" Ad Hoc Working Group approved by either the Regional Human Services and Justice Steering Committee or the District Human Services and Justice Coordinating*

Committees.

11.1.5 Toronto Mental Health and Justice Network- A Sector Committee

Recommendation 25: *That the Regional Human Services and Justice Steering Committee authorize the creation of Sector Committees to lead service coordination across Toronto for particular client groups, such as addictions, developmental disabilities, fetal alcohol spectrum disorder, acquired brain injury, etc. The current Toronto Mental Health and Justice Network would become the Sector Committee for mental health and justice services across Toronto.*

11.1.6 LHINS: Boundary Alignment with Justice Service Areas

Recommendation 26: *That the Toronto Mental Health and Justice Coordinating Committee recommend to the MOHLTC that boundaries for the human services and justice field use the courts in Toronto as the primary focus for their service system design. That linkage to the five Toronto LHINs by the proposed Toronto Regional Human Services and Justice Steering Committee, the four District Human Services and Justice Coordinating Committees and Sector Committees should be given very high priority by all parties. These committees should serve as the key planning and integration structures for this field and advise the five Toronto LHINs.*

11.2.0 Roles, Responsibilities and Functions at each Level of Responsibility

Recommendation 27: *That the Toronto Mental Health and Justice Coordinating Committee recommend to the MOHLTC approval of the roles, responsibilities and functions of each of the proposed leadership structures as set out in the relevant sections of this report.*

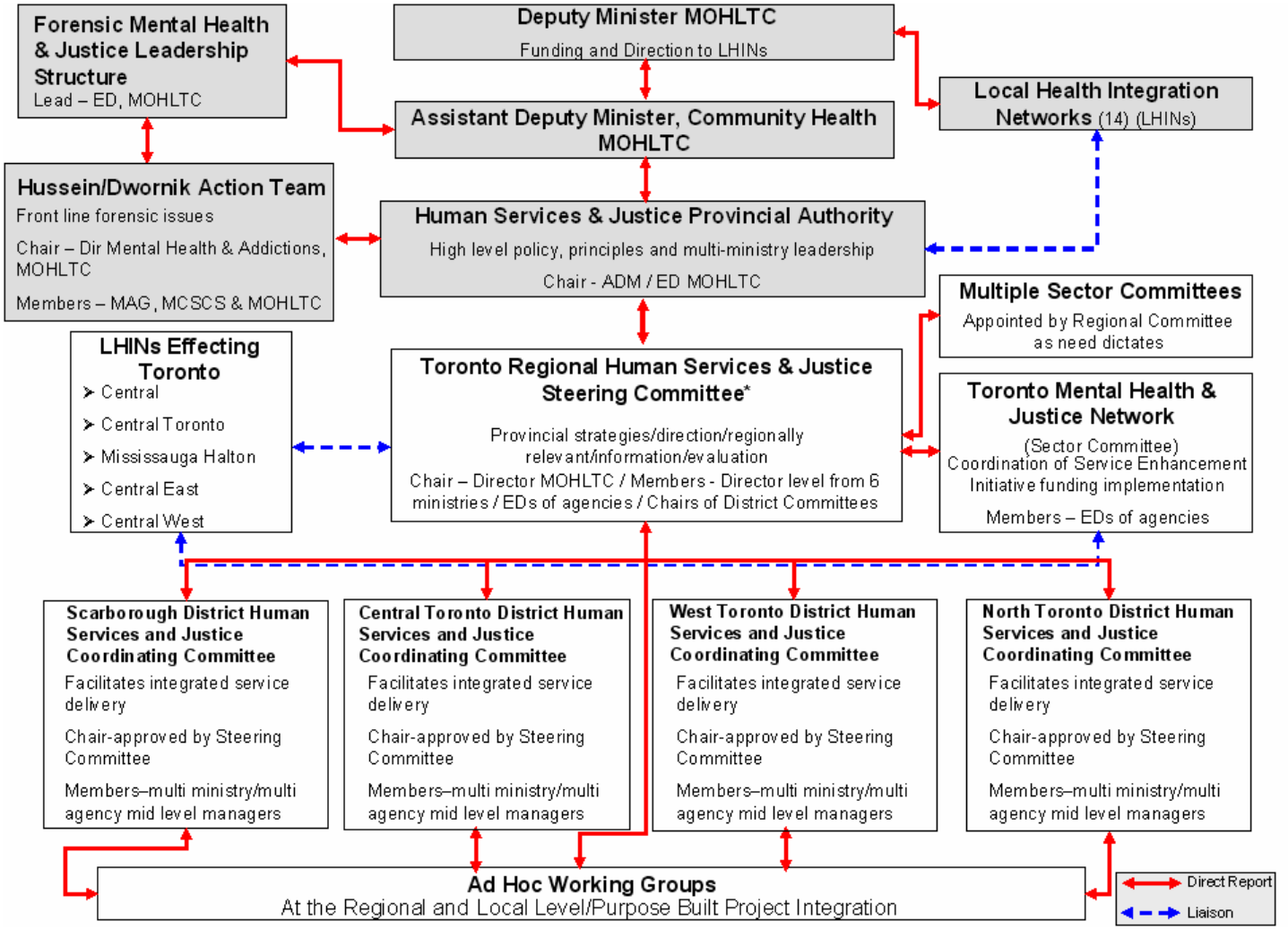
11.4.0 Relationships of the Proposed Structures to the LHINs, MOHLTC and Other Partner Ministries

Recommendation 28: *That the Toronto Mental Health and Justice Coordinating Committee meet with the leadership of the five Toronto LHINs and their committees dealing with cross jurisdictional issues, as soon as possible, to explore the development of a plan that will ensure continuity and development of services to mental health and justice clients.*

11.5.0 Funding Requirements

Recommendation 29: *That the Toronto Mental Health and Justice Coordinating Committee recommend to the MOHLTC appropriate funding for each of the proposed leadership bodies to allow them to carry out the roles and responsibilities set in recommendation 11.2.0 and 11.3.0. It is suggested that a formula such as that used in service contracts by the MOHLTC for the administrative overhead allowance in service contracts be utilized. This would mean an allocation of 3 to 5 % of the service enhancement funding allotment to staff support for the Regional Human Services and Justice Coordinating (Steering) Committee and the Mental Health and Justice Network. It is recommended that the human service and justice ministries and the Toronto area LHINS develop a pooled fund for this purpose as a pilot project for three years.*

Organizational Structure for Provincial, Regional, District and Working Group



**As a first step, the Regional Health and Justice Coordinating Committee could take on the responsibilities of the Toronto Regional Human Services and Justice Steering Committee.*

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3. INTRODUCTION

The Ontario Ministry of Health and Long-Term Care (MOHLTC) has provided funding for mental health services to assist people with mental illness to stay out of the justice and correctional systems. A total of $50 million has been announced by the Minister of Health and Long-Term Care for service enhancement for community mental health and justice programs, with the funding divided into two phases. The first phase was announced in January 2005 for 2005-06 and the second phase was announced in May 2006 for 2006-07.

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- Identifying the role the HSJCC can provide in sector coordination & communication, & in joint problem solving & planning efforts between health & criminal justice service organizations within the Toronto Region

- Recommendations will include identification of several steps towards a different alignment of services"[2]

The study was also intended to take into consideration the new Local Health Integration Network (LHIN) structure that is scheduled to be implemented by MOHLTC and to identify the linkages and new structures that need to be in place to facilitate planning, decision making, service delivery and evaluation.

At the same time as this study was getting underway, Glenn Thompson was also contracted to provide a study to determine what methods could be used to improve the coordination and management of forensic services in at the senior level of the Ontario ministries. Given the connected nature of the two studies we were mindful that they needed to be aligned wherever possible, so that the recommendations at the Ontario and Toronto levels were not inconsistent.

[2]Letter of engagement: February 17, 2006

4. BACKGROUND

4.1 Mental Health and Justice Population

The Report *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems* (1997) expressed the view that there is a large group of individuals who are mentally ill and/or developmentally disabled and come into conflict with the law; and that these individuals need to be defined more broadly than the legal definition of a forensic client. The authors of that report identified these individuals as "common clients" since their service requirements frequently cross the mental health, social services and justice systems. They defined the common client as individuals:

"who have past or present contact with law enforcement officials (or behaviour that could have led to criminal charges) as well as past or present contact with the mental health or developmental services systems."

These common clients were also identified as exhibiting some of the following characteristics:

- experiencing problems/symptoms of disorder which affect ability to function in the community
- experiencing alcohol or drug abuse problems
- at risk of homelessness, living in poverty, and having physical health problems
- identified as a difficult, chronic, multi-problem or 'hard-to-serve' consumers, lacking skills, motivation and supports. (Human Services and Justice Coordination Project, 1997).

The priority for service provision for the common client group was identified as those individuals with a serious mental illness.

In the report *Making it Happen* (MOHLTC, 1999), an individual with multiple or complex needs was defined as:

"a person who meets the criteria for serious mental illness, has had past episodes of aggressive or violent behaviour and has one or more of the following characteristics:

- three or more psychiatric hospital admissions within the last two years
- detained in an inpatient facility for 60 or more days within this period
- subject to two or more police complaints/interventions within the last 12 months or has been incarcerated in a correctional facility for 30 or more days within this period
- recently evicted from housing, or is homeless, or living in shelters
- current problems with drugs and/or alcohol
- problems following up with recommended treatment plans." (MOHLTC, 1999).

In 2002, *The Forensic Services Expert Advisory Panel* provided what is still the accepted definition for the forensic population as follows;

A “person who suffers from a major mental disorder, is in conflict with the law and is being dealt with by the courts or the Ontario Review Board under Part XX.I -Mental Disorder of the Criminal Code (Canada)".

In addition, they also defined when a forensic client ceases to be considered forensic, which is “…when an individual is no longer subject to the proceedings pursuant to Part XX.I - Mental Disorder of the Criminal Code (Canada)".

In November 2004, the Toronto Mental Health and Justice Coordinating Committee revised the terms of reference for the committee, and this included redefining their target population. In keeping with the recommendations of the *Forensic Service Expert Advisory Panel,* forensic clients were identified as, “…only those under the legal auspices of the Forensic system either through the assessment process or as those deemed Unfit or Not Criminally Responsible maybe/can be referred to as forensic”. However, the target population for the Toronto Mental Health and Justice Coordinating Committee was recognized to also include “clients of police, courts, correctional facilities, hospitals and community agencies who have mental health issues as well as issues with the judicial system and are in need of care or intervention”. This wider population is now referred to as the “common client” population.

While it is often considered individuals that enter the forensic system via the courts have obtained a “gold card” for entrance into the best psychiatric services in Ontario, the “common clients” follow a very different route. Common clients frequently experience difficultly in accessing mental health services and when community agencies discover they are also involved in the justice system they are often assigned to the “back of the line”, waiting for services that may never quite reach them. This difficult to serve and often very problematic client with complex needs, frequently starts to cycle through a revolving door that involves many stops in the justice system. The Service Enhancement Initiative is specifically focused on providing services to this ”common client” population.

4.2 Key Reports on Mental Health and Justice

It has been argued that the process of deinstitutionalization over the past 25 years, coupled with the reduction of psychiatric beds and the failure to develop a wide spectrum, well resourced community infrastructure, has forced many formerly institutionalized mentally ill persons onto the streets, resulting in increased opportunity for crime.

Mental health reform, emphasizing a more comprehensive and coordinated response, has been promoted by numerous studies during the last 20 years.

In the 1990’s the treatment of mentally disordered offenders by the mental health and justice systems came under considerable scrutiny as a result of a number of high profile deaths and subsequent Coroner’s Inquests. These inquests identified gaps in communication and information sharing between the justice and health systems, as well as a lack of cooperation and coordination between the systems.

In 1995, Ontario began to address these gaps in service through the Human Services and Justice Coordination Project, and the development of a provincial strategy to coordinate services provided to mentally disordered offenders by the justice and health and social

services systems. This strategy identified 20 juncture points (see Appendix C) that are met by individuals as they pass through the justice system and that provide opportunities for intervention with a person that is mentally ill. In 1997 a report issued by this project, *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario,* recognized that the shared goals of safe and healthy communities is a joint responsibility of both the justice and human services systems engaged in delivering services to mentally ill persons that come into conflict with the law. It recommended the establishment of local coordinating committees to develop strategies aimed at preventing and/or mitigating the effects of mental illness and crime.

In 1998 Dan Newman, then Parliamentary Assistant to the Minister of Health, led a consultative review of the progress achieved on mental health. His report concluded that the "principles and direction of mental health reform were sound, but the government needed to take the next steps with a clearly designed implementation strategy" (Newman, 1998). The *Making It Happen, Implementation Plan for Mental Health Reform*, recognized that there are gaps in the services for clients with multiple service needs as well as access to separate service systems such as those for clients that are identified as forensic or with a dual diagnosis. The report was designed to provide a framework for implementation at the provincial, regional and local level to ensure that "services are effectively integrated and coordinated, and based on best practices" (Ontario MOHLTC, 1999).

The report of the *Forensic Services Expert Advisory Panel* (2002) endorsed and supported the two earlier reports and concluded that an effective forensic mental health system must provide a "continuum of care ranging from highly specialized inpatient services to informal community supports and must provide equitable, streamlined access to quality care and allow clients to live in the community, to the greatest extent possible".

The *Forensic Services Expert Advisory Panel* also recommended that four ministries of Health and Long-Term Care (MOHLTC), Community and Social Services (MCSS), Community Safety and Correctional Services (MCSCS) and the Attorney General (MAG) formally commit to a Provincial Coordinating Committee to support and oversee the work of the Human Services and Justice Coordinating Committees throughout the province. A Provincial Human Services and Justice Coordinating Committee was established as were Regional Committees across the province. The Provincial Committee and some of the regional committees are still operating.

While these three significant reports were well received they were not substantially implemented. Their recommendations continue to receive wide support in the field and the *Forensic Services Expert Advisory Panel* report in particular has been considered to offer a blueprint for current action.

4.3 Mental Health and Justice in the Context of Change over Ten Years

There have been many significant changes in the mental health and justice field over the past ten years, some as a result of changes to the Criminal Code of Canada (CCC). Most of these changing patterns have developed further since the 2002 *Forensic Services Expert Advisory Panel* report. It is well to take into account the developments over this decade and

especially in recent years in considering what new or different policies and structures may now be required.

1. Progressively greater public interest in and openness about mental illness.

2. A higher than usual profiling of mental health issues either through inquests or feature stories in the media adding to public awareness and greater acceptance of mental illness.

3. Continued development of a consumer movement which saw a tremendous increase in client involvement in the planning and delivery of mental health services. A less well developed family/key support person's movement.

4. Reduced detention centre programming in Ontario's Correctional Services, except for health care, with the elimination of libraries and recreation. Increased overcrowding in detention centres.

5. Consolidation of many smaller detention centres into two large capacity detention centres located in Lindsay and Penetanguishene. These were found to be too distant from many of the courts they served and were converted, in part, to longer stay multi purpose correctional complexes. The result has been the need for more detention centre capacity in Toronto and a plan to replace Toronto Jail with a larger capacity Toronto-based detention centre is being developed.

6. Remandees, inmates, lawyers and correctional staff have all felt the loss of proximity to local courts and local community linkages possible at the smaller and more widely distributed detention and correctional centres of the past

7. Dramatic and unanticipated increase in the number of persons on remand in relation to the sentenced population in Detention Centres, especially in Toronto. Between 1991/92 and 2005/06 the average length of time spent on remand increased by 85.5 %, from 18.6 to 34.5 days.

8. Apparent doubling of the forensic population in the last 10 years as a result of changes to Criminal Code of Canada.

9. New municipal boundaries in many parts of Ontario, including the merger of the smaller cities in the Greater Toronto Area into the new City of Toronto.

10. Devolution of the ten provincial psychiatric hospitals operated by the MOHLTC, except for the Mental Health Centre, Penetanguishene which provides 140 maximum and 20 minimum secure forensic beds.

11. Mental Health Implementation Task Forces studied the service needs and optional organizational structures for community agencies in each of 9 geographic areas covering all of Ontario. These very comprehensive reports were not released by the then government. The newly elected government released the reports in December, 2003, and did not act on them. Instead, a more extensive devolution of responsibility to 14 newly established Local Health Integration Networks was undertaken with most

operational health care, including mental health, to be funded by these new boards and their staff. The Implementation Task Force Report for Toronto will be of particular interest as a new structure is developed for Toronto.

12. Rapidly expanded community programs over several years led some to believe that community based care would eliminate overcrowding and other system pressures.

13. The Health Services Restructuring Commission (HSRC) and its proposal to merge many hospitals, including the four hospitals which became the Centre for Addiction and Mental Health. The community component of the HSRC's work, which would have examined the potential for consolidation in the community sector, did not materialize.

14. Introduction of Assertive Community Treatment (ACT) Teams to provide 24 hour community-based care for seriously mentally ill persons and, thereby, reduce frequent returns to psychiatric hospitals. Some ACT Teams were specifically designated to care for forensic clients.

15. Continued under emphasis of the needs of and programming for the substance abuse client group.

16. Introduction of the Toronto Mental Health Court in 1998 which has had a significant and widespread influence on judges and crowns.

17. Mainstream acceptance of the value of diversion programs for low risk offenders, including for the forensic population.

18. Dramatic increase in the use of community mental health agencies to service the mental health and justice population, especially those persons diverted by crowns and courts at the "front" of the justice process.

19. Growth in the use of telepsychiatry as a means to provide service to patients in remote areas and those with special language and ethnocultural needs. Telepsychiatry has great potential for the forensic population both to improve adequacy of service and to contain costs in so doing.

20. Opening of the St. Lawrence Valley Correctional and Treatment Centre as a hybrid institution, where security is provided by correctional staff and psychiatric care by the Royal Ottawa Hospital.

21. Revival of some Human Services and Justice Coordinating Committees as a result of the Service Enhancement Initiative and the creation of a new provincial level committee by the MOHLTC that has a province wide perspective.

22. Growing incidence of habeas corpus applications because of the inability of psychiatric hospitals to respond immediately to court referrals for assessment.

23. Continued deficiency in a variety of housing options for the forensic population, especially the diverted population, and a growing recognition that the availability of satisfactory housing is the key threshold requirement for other mental health programs to

be fully effective.

24. Service Enhancement Initiatives designed to keep people with a mental illness out of the justice system. Funding of $ 50 million provided by MOHLTC over the 2005/06 and 2006/07 years to facilitate community based care designed to remove/divert individuals with a mental illness from the justice system. Court Support services received additional funding to facilitate these diversion programs.

25. Creation of the Hussein/Dwornik Action Team (HuDAT) to develop solutions to inter organizational service pressures and conflicts in the forensic system.

26. Introduction of a major new conceptual design for the Ministry of Health and Long -Term Care, including devolution of programme leadership and funding to 14 Local Health Integration Networks (LHINs). This change necessitates that the MOHLTC assume a legislative, policy, funding, planning and evaluative role and that it identify its program and outcome expectations for the LHINs.

27. Termination of the District Health Councils in favour of the LHINs taking on many of their former regional research and planning roles.

28. LHIN boundaries apparently were based upon the normal patient flow patterns for physical illnesses but these flow patterns are not the same for the forensic population which involves the services of police, crown attorneys, judges and sometimes correctional institutions.

29. Introduction by the MOHLTC of Family Health Teams as a major new delivery scheme at the first level of the health system that should increase earlier diagnosis and referral of persons with mental illness.

30. Announcement by the Correctional Service of Canada in early 2006 of new initiatives in the mental health sector which should eventually permit federal offenders to receive improved mental health care, improved referrals on release and better supported placements in the community.

31. Planning initiated for the replacement of the Toronto Jail, perhaps to be located at the Mimico Correctional Centre site, providing an opportunity to create a significant forensic assessment unit there to serve the Toronto and area courts and the Ontario Review Board (ORB).

32. Comprehensive mental health report and recommendations released by a Senate Committee (The Kirby Report) including recommendation for a Mental Health Commission as a centerpiece.

33. Emphasis in the Ontario ministries on the need for a greater horizontal linkage in the planning and execution of programs. (horizontality).

34. May 19/06 announcement by MOHLTC of an additional infusion of $ 68.5 million for community mental health services in Ontario, intended to give service access to nearly 23,000 additional persons. The Ministry has invested over $ 90 million since 2004/05 as

part of a $185 million plan to serve 78,000 new clients by the end of 2007/08. This infusion of funds will stabilize and greatly expand services for people with mental illness.

5. METHODOLOGY

Questionnaires

Questionnaires were developed for three primary groups that provide services to the client population; these are the service providers, mental health court support programs and hospitals.

Service Providers

Questionnaires were distributed to the 13 agencies that have programs funded by the Service Enhancement Initiative and to a further 52 agencies that were identified by ConnexOntario in February 2006, on their Mental Health Service Information Ontario (MHSIO) data base that accept and/or offer specialized services for clients with legal issues and are located in the Toronto-Central LHIN Integration Network (LHIN). This data base remains a "work in progress". *(Appendix C: Questionnaire for Community Agency Service Providers)*

Mental Health Court and Mental Health Court Support Programs

Questionnaires were distributed to the 3 agencies that provide programs in the five courts in Toronto (*Appendix F: Questionnaire for Mental Health Court Support Programs*).

Hospitals

Questionnaires were distributed to 4 hospitals that provide Schedule 1 psychiatric services in Toronto *(Appendix G: Questionnaire for Hospitals).*

Interviews with Mental Health and Justice Clients

In order to include the perspective of clients in the study a total of 20 individual interviews were conducted with clients who met either of the following criteria:

- they had a mental illness and previous experience in the justice system
- they were involved as a client in one of the programs dealing with persons with mental illness in contact with the justice system

A questionnaire and consent form was prepared for the interviews (*Appendix: Interviews with Mental Health and Justice Clients and Consent Form*) and prior to each of the interviews being conducted, the purpose of the interview was explained to the individual and the consent form signed. An honorarium of $35 was paid to each participant.

These interviews were organized for the consultants by four agencies, COTA Health (8), the Law and Mental Health Program Outpatient Services at CAMH (8), CMHA Toronto (3) and CMHA Ontario (1).

Focus Groups

A total of 19 focus groups were conducted for the study during the period mid - February to mid - June 2006 (*Appendix I: Focus Groups and Consultations*). These focus groups included, agencies that are funded as part of the Service Enhancement Initiative and the network committees that have been developed to coordinate their work across the city; a number of agencies that deliver programs to the client group that were not funded under the Service Enhancement Initiative; and justice services including the police, judges, crowns, probation and parole services and senior staff from correctional institutions.

The focus groups were structured to obtain key information relevant to the participant agency/organization area of service provision and expertise. As such, they were able to serve a number of purposes for the study:

- provide information regarding the services provided by the agencies funded by the Service Enhancement Initiative
- supplement the data received from the questionnaire
- provide information on programs/services not funded by the Service Enhancement Initiative and included in the questionnaire surveys
- assist in identifying the service gaps
- inform the examination of system design
- identify recent studies, research and agreements that were pertinent to the study

Consultations

In addition to the information obtained during the focus groups, 26 individual consultations were conducted with senior level staff from both government and non-government sectors. An interview guide was used as the instrument upon which the interviews were based. *(Appendix I: Focus Groups and Consultations*)

Data Bases

A number of data bases were accessed in order to obtain information on the client population, including:

- MHISO, ConnexOntario to provide a list of all mental health services in the Toronto area
- Ontario Correctional Services data on all offenders, where offenders identified as having a mental illness are flagged on the system
- CDS and MIS data base maintained by the mental health court support programs

Client Vignettes

Client vignettes provide information on the impact of the Service Enhancement Initiative programs on the justice and mental health client population. In order to ensure confidentiality the names of the clients are fictitious, however their stories are factual. In two instances, in order to again ensure confidentiality for the clients, due to the small number of clients in this group, the stories of two clients are intertwined.

6. MAPPING OF MENTAL HEALTH AND JUSTICE SERVICES

6.1 Service Enhancement Initiatives Funded Through the Ministry of Health and Long-Term Care: 2005-2006 and 2006-07

On January 12, 2005 the Ontario government annouced funding to assist people with mental illness to stay out of the justice and correctional systems. This funding was identifed for community mental health services to enable persons with mental illness and invovled with the law to receive "the care they need outside of hospitals or correctional facilities, and as close to home as possible." (MOHLTC, 2005). A total of $50 million annualized was announced, with the funding to be distributed over a two year period.

For 2005-06 $27.5 million was identified for community mental health agencies across the province to provide mental health services to assist non-violent offenders stay out of the justice system and correctional systems. This funding, the first comprehensive funding of its kind in Ontario, was identified to expand services in five key areas:

- Crisis response and outreach, to provide access to a range of services and supports on a 24/7 basis to individuals experiencing a mental health crisis.

- Short-term residential crisis support beds, which are often referred to as "safe beds," that can be used as an alternative to custody or hospital beds.

- Court support services, located in the courts, to assist with cases involving persons with mental illness.

- Intensive case management, to identify and provide the services required to keep people in the community with adequate supports.

- Supportive housing services, which provide longer-term housing combined with mental health services (MOHLTC, 2005).

The first year allocation of this funding was made in August 2005 and Toronto received $10,557,440.

On May 19, 2006 the Ontario government made a second announcement regarding community based mental health services to assist additional people with mental illness to stay out of the justice and correctional systems. This announcement of $22.5 million was identified for service expansion in the five key areas that had been funded in the prevoius year to strengthen the emerging network of services for mental health and justice clients. However, it also targetted transition age youth, individuals with concurrent disorders, those with a dual diagnosis, and thise requiring release planning from correctional institutions. For the second year of funding Toronto received $4,660,440. The details of this funding, including the funding allocations to agencies, became avalaible as we were concluding this report.

The funding for 2005-06 was allocated to community mental health agencies with a track record of providing services to clients that were in conflict with the law. In Toronto, the MOHLTC allocated the funding on the basis of agencies providing services to the south,

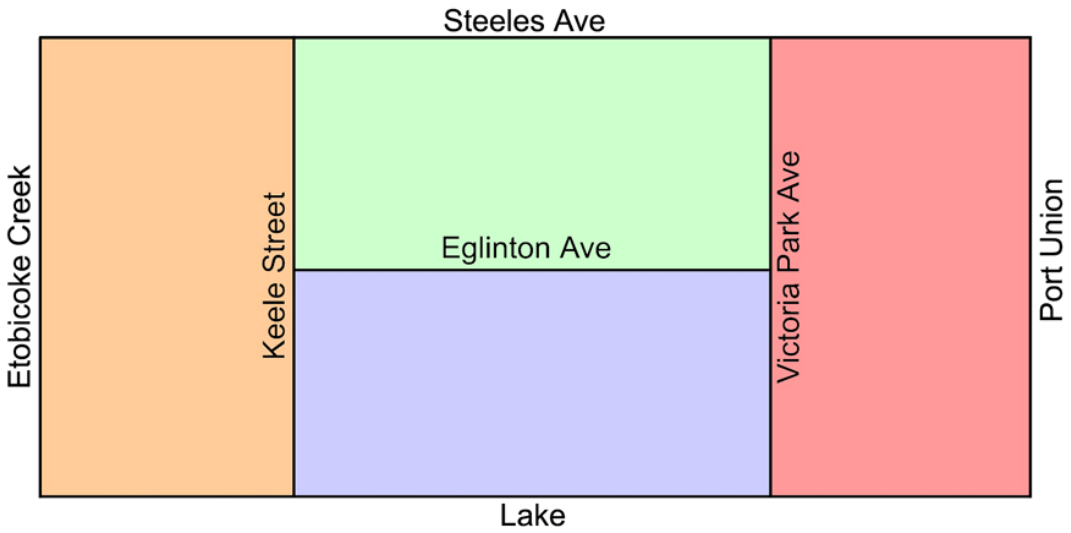
east, west and north sectors of the city. The catchment areas for these local areas or quadrants are:

South / Downtown Toronto: Victoria Park Avenue to Keele Avenue and Eglinton Avenue to Lake Ontario

East: Victoria Park Avenue to Port Union Road and Steeles Avenue to Lake Ontario

North: Victoria Park Avenue to Keele Avenue and Steeles Avenue to Eglinton Avenue

West: Keele Avenue to Etobicoke Creek and Steeles Avenue to Lake Ontario



Geographic Quadrants for Toronto Mental Health & Justice Programs and Services

By identifying a lead sponsor for the crisis response and outreach, crisis beds and four lead sponsors for supportive housing initiatives, the MOHLTC essentially created a requirement for "mandated collaboration" between the agencies. While different agencies are funded to provide services in each of the quadrants, a network has been established for each of the key program areas that coordinates access to programs from any part of the city and enables the services to appear seamless to the client. This has been achieved by way of regular meetings of the agencies and establishing registries coordinating access to housing services for both crisis beds and supportive housing. A consortium of the mental health court support service agencies was already in existence.

6.1.1 Crisis Response and Outreach

Pre-Charge Diversion

Crisis response services provide access to a range of services and supports on a 24/7 basis to individuals experiencing a mental health crisis, as well as support to families and caregivers. The funding for 2005-06 provided for community prevention programs in the

four quadrants and for police mobile crisis intervention teams. Funding in 2006-07 added to this network of services and strengthened programs that had been funded the previous year.

Agency	Service / Quadrant	New / Existing Program	2005-2006		2006-2007	
			Annualized Funding	# FTEs	Annualized Funding	# FTEs
Sound Times	South	New	$252,000			
COTA Health	North	New	$168,000			
Reconnect	West	New	$252,000		$85,200	1.0
CMHA Toronto	East	New	$252,000		$34,080	0.4
Total			**$924,000**	**11.0**	**$119,280**	**1.4**

2005-06 and 2006-07 Funding Allocation: Pre-Charge Diversion

The pre-charge diversion programs provide support in the community for persons living with mental illness who are in crisis and at significant risk of involvement or re-involvement with the justice system. These services are directed to prevent and reduce people's contact with the justice system, support people at risk of contact with the justice system and to provide mediation, advocacy and resources to consumers and families to reduce their use of the justice system.

A network committee has been developed to coordinate the work of these agencies, with Reconnect Mental Health Services identified as the lead agency.

Police Mobile Crisis Intervention Teams

Police Mobile Crisis Intervention Teams (MCIT) were initiated in direct response to concerns that had been raised regarding police response to calls involving persons with mental illness. These teams provide improved service to the community by providing appropriate and timely psychiatric assistance, with mental health workers able to triage the individual at the time of their contact with the police.

The first Police MCIT program started in November 2000 as a pilot between the Toronto Police Service, 51 Division and the St. Michael's Hospital. It was subsequently expanded to include 52 Division. The program was formalized by way of a Memorandum of Agreement (MOU) in 2004.

The 2005-06 Service Enhancement Initiative funding enabled an expansion of the existing service provided by St. Michael's Hospital/ Police MCIT and the establishment of the St. Joseph's Health Centre/ Police MCIT. At the November 2005 meeting of the Toronto Police Services Board, a MOU and the partnership with St Joseph's Health Centre for a Police MCIT covering both 11 and 14 Divisions was approved for a two year period.

Agency	Service / Quadrant	New / Existing Program	2005-2006		2006-2007	
			Annualized Funding	# FTEs	Annualized Funding	# FTEs
St. Joseph's Health Centre	West	New	$252,000	3.0		
St. Michael's Hospital	South	Existing	$130,000	1.5		
Scarborough Hospital	East	New			$255,600	3.0
Humber River Regional Hospital	North/West	New			$255,600	3.0
Total			**$382,000**	**4.5**	**$511,200**	**6.0**

2005-06 and 2006-07 Funding Allocation: Police Mobile Crisis Intervention Teams

The 2006-07 funding will enable two additional Police MCITs to be established, one in Scarborough with the Scarborough Hospital in partnership with 43 Division and the other in North/West Toronto with the Humber River Regional Hospital in partnership with the Toronto Police Service.

6.1.2 Short-Term Residential Crisis Support Beds

Crisis beds or “safe beds” are generally occupied for a period of up to 30 days, and while not all clients remain in these beds for this length of time, agencies reported that it often takes this period of time to assist the client to obtain stability, and make the appropriate linkages and referrals to other community based programs. Each of the agencies provide 24 hour on site support, as well as making connections to the community, including assisting with social assistance, housing, employment, and connecting the client to the mental health system so that they can move on to longer term housing in the community.

The 2005-06 funding provided for 16 crisis beds, with four available in each of the quadrants of the city. These beds have been operational since August 2005.

CMHA: 4 beds located in a four story building with bachelor apartments and an ensuite bathroom. Although these crisis beds are designed to be co-ed, only 2 females had used the crisis beds out of a total of 34 admissions.

Gerstein Centre: 4 beds for males located at the Maxwell Meighan Centre adjacent to the Primary Support Unit (PSU) in the downtown area of the city and operated by the Salvation Army.

COTA Health: 4 one bedroom apartments in the same building, with an office that is staffed 24 hours a day. The majority of the crisis beds are occupied by males.

Reconnect: 4 beds with 2 beds for females currently in a women's shelter and two beds for men in individual bachelor apartments. The two beds for females are being relocated from the shelter to Edwards Manor where it is anticipated they will receive greater use.

As the lead agency CMHA Toronto maintains the central bed registry and this enables access through a single contact to determine if and where a crisis support bed is available in the city.

The 2006-07 funding adds additional capacity to each of the four agencies providing services in this area to improve the bridging capacity between crisis prevention and the safe beds. Across Boundaries has received funding to provide ethno-specific services across the city. The Toronto Friendship Centre has also received funding for community services.

Agency	Service / Quadrant	New / Existing Program	2005-2006		2006-2007	
			Annualized Funding	# FTEs	Annualized Funding	# FTEs
CMHA Toronto	North	New	$350,000	4.0	$391,920	4.6
Gerstein Centre**	South	New	$350,000	4.0	$426,000	5.0
Scarborough Housing Consortium*** COTA Health Lead Agency	East	New	$350,000	4.0	$511,200	6.0
Reconnect	West	New	$350,000	4.0	$340,800	4.0
CRTC	East	New			$85,200	1.0
Sound Times	South	New			$179,162	2.1
Across Boundaries	City/focus on East & North	New			$86,478	1.015
Toronto Friendship Centre		New			$220,000	2.60
Total			**$1,400,000**	**16.0**	**$2,240,760**	**26.3**

2005-06 and 2006-07 Funding Allocation: Crisis Support Beds

** 4 beds by the Primary Support Unit (PSU) Salvation Army located at Maxwell Meighan Centre

*** Partners include COTA Health, Community Resource Connections of Toronto (CRCT), the Scarborough Hospital and CMHA Toronto

The client group includes a number of clients that are involved in the justice system for the first time as well as those who find themselves homeless for the first time. Priority referrals include the police, courts, probation, correctional institutions and the Law and Mental Health Program (LAMPH) at CAMH.

Client Vignette: *Aaron is a 42 year old male who came from Madison Housing. He was evicted for an alleged Class 3 offense (assault /bodily harm) against another resident. He had a lot of anger stemming from the charges because how it was handled and the lack of evidence surrounding the charges (no witnesses). Nonetheless, he had a lot of anxieties and fear because in the past he has blacked out during a manic phase of his illness. He has memory lapses as well He said he is aware of the symptoms when he goes into a manic phase but felt none of them on the day in question.*

Aaron is diagnosed with affective disorder. He has had several hospitalizations in the last five years. This was his first time dealing with the justice system. He did have a fear that his mental health was worsening and "what he was capable of doing" when he becomes really "sick." He liked his previous housing but felt he needed more independent living.

Aaron had difficulties settling into the PSU. His mood was low and he became increasingly agitated with the courts and housing because of how they were handled. It was also a lengthy process to be accepted into the mental health and housing initiative because of the "nature of the charges." He was with the PSU for nearly seven weeks. Houselink Community Homes accepted his application. He has been pro-active on his goals and maintained contact with the PSU and meets regularly with Houselink support staff. His mood has elevated. He loves his apartment and the surrounding areas.

The fears regarding his mental health worsening lessened and subsided when the housing and community supports were put into place, as well as supports he was receiving from his lawyer and court support worker.

He feels that he gained a lot from going through this crisis in terms of coping mechanisms and the importance of community supports in his life.

A sound working relationship has been established between the PSU and Houselink for the benefit of the client.

6.1.3 Court Support Services

The services provided to the courts have been organized on the basis of five courts that each serve a different part of Toronto. Old City Hall has a dedicated Mental Health Court and Court Support Programs are available at the courts in College Park, Etobicoke, North York and Scarborough. These programs were already well established and funding was directed in 2005-06 to supplement and support the existing services. The 2006-07 funding allocation for court support services was directed to transitional age youth and this information was unavailable to the consultants.

These programs were initially intended to assist in the diversion of individuals with a serious mental illness (DSM IV – AXIS I) who had been charged with non-violent criminal offences, many of whom were in custody, but who had not yet entered a plea before the courts. Over time these services have expanded to include consultation and support to persons who are unlikely to be diverted due to the nature of their charges or past criminal record, but are also

in need of mental health services and supports in the community when released on bail (Macfarlane, 2002)

Agency	Service / Quadrant	New / Existing Program	2005-2006	
			Annualized Funding	# FTEs
COTA Health	North York / North	Existing	$84,000	1.0
CRCT	Old City Hall & College Park / South	Existing	$168,000 $84,000	2.0 1.0
CMHA Toronto	Scarborough & Etobicoke / East & West	Existing	$168,000	2.0
Total			**$504,000**	**6.0**

2005-06 Funding Allocation: Court Support Services

Client Vignette: *Betty was in her early twenties when she was told by her husband that she was "not behaving properly." Her erratic behaviour was taking a toll on their marriage. Her first contact with the police came when she was arrested for causing a disturbance and was admitted to the psychiatric unit of a local hospital. This was her first awareness that she had a mental illness. In the following two years, her marriage broke up and she was readmitted three more times to hospital, each one precipitated by criminal charges. For each of these she had the good fortune to be represented by the same lawyer. On the occasion of her last involvement with the justice system, on a charge of assault with a weapon, she was homeless and had stopped taking her medication. With the assistance of the mental health court worker, her lawyer worked out a diversion plan which was accepted and arranged for her to stay at the shelter program. From there, the shelter worker, with the assistance of the mental health court worker was able to contact the supportive housing program, and after a two week wait she was able to move into a supportive housing unit.*

Betty acknowledges a key to her problem was her inability to accept that she had a mental illness and was in need of help. Today, the support that she needs is provided by the community support worker with whom she makes contact twice per week (phone or visit) and who attends court with her as part of the diversion plan and reports on her progress; the housing case manager with whom she meets once per month and the intensive case manger with whom she now needs to meet only every five months.

She credits her progress to having a knowledgeable and caring lawyer and a court support worker who provided information to her about her mental illness. She now works part-time and has the following goals, 1) To get back on her feet, 2) "straighten out" her life, 3) go through with her divorce and 4) stay connected to the community.

6.1.4 Intensive Case Management

Agency	Service / Quadrant	New / Existing Program	2005-2006		2006-2007	
			Annualized Funding	# FTEs	Annualized Funding	# FTEs
Scarborough Hospital JAMH Program	Release Planning: Corrections/ East	Existing	$84,000	1.0	$85,200	1,0
Homeward Mental Health Projects	Release Planning: Corrections / West	Existing	$84,000	1.0	$85,200	1.0
COTA Health	Dual Diagnosis/ City Wide	New	$84,000	1.0		
CRCT	Release Planning: LAMPH/ South	Existing	$84,000	1.0		
CRTC	Release Planning: Probation	New			$85, 200	1.0
North York General Hospital	Outpatient Court Support Program / North	Existing	$84,000	1.0		
CMHA Toronto	Transitional Aged Youth/ Finch Court, Etobicoke & Scarborough Court /East & West	Existing	$168,000	2.0		
Reconnect	Concurrent Disorders	Existing			$85,200	1.0
Sound Times	Release Planning: Corrections / South	New			$127,800	1.5
Total			**$588,000**	**7.0**	**$468,200**	**5.5**

2005-06 and 2006-07 Funding Allocation: Intensive Case Management

Both the 2005-06 and the 2006-07 Service Enhancement Initiative funding allocations provided funding for release planning and assistance with community transition from

correctional institutions in Toronto. In 2005-06 this funding provided additional funding to existing programs at the Scarborough Hospital and with Homeward Mental Health Projects, and in 2006-07 it added these services to the Toronto Jail and to probation services. Release planning and community transition services are also provided for the LAMPH at CAMH. The North York General Hospital provides case management services to mental health and justice clients that have charges before the court or are on probation. Services are provided by COTA Health across the city for individuals with a dual diagnosis, and by CMHA Toronto for transitional age youth in the courts in Scarborough and Etobicoke.

The Scarborough Hospital, Justice and Mental Health, (JAMH) Program and Homeward Mental Health Projects provide services that include release planning and community transition for offenders that are in the Special Needs Units at the Toronto Jail and Metro West Detention Centre, to link them with community mental heath services, psychiatric services and to housing supports thorough either the crisis beds or supportive housing. These services also link with the probation and parole offices to provide their clients with follow-up support and intensive case management to offenders that are living in the community. The additional funding in 2006-07 will add much needed services for the Toronto Jail and additional support to probation services.

CRCT has assigned two staff to share the responsibility of providing release planning and community transition for individuals discharged from the Law and Mental Health Program following either court ordered fitness assessments or treatment orders. These clients remain connected to the court and receive intensive case management for a period of up to six months.

The North York General Hospital has a hospital based program that provides case management services primarily to mental health and justice clients that have charges before the court or are on probation.

COTA Health provides city-wide support to individuals that are dually diagnosed and in conflict with the law.

In the 2006-07 funding allocation, Reconnect Mental Health Services received funding to partner with the Jean Tweed Centre, to assist the agency to work cooperatively with this new partner and share expertise on substance abuse and concurrent disorders.

Client Vignette: *Charlene is in her mid forties, currently living in downtown Toronto and has utilized the services of CMHA's Mental Health and Justice Program since June 2005. Over the years Charlene has experienced several episodes of homelessness as a result of her mental health issues. She has been diagnosed with a schizoaffective disorder, marked by mania and psychosis.*

Charlene has had contact with the justice system in the past and her contact with the program was initiated while she was incarcerated in the Vanier Centre for Women.

Intensive case management services were offered in mid-June to support Charlene through the court process and to assist with her eventual reintegration into the community. The initial meeting between Charlene and her case manager occurred in the interview area of the courts, following a brief court appearance. Charlene was informed that intensive case management entailed two face to face visits per week

with the client and additional support as required. Charlene immediately expressed her interest in the program and felt that the services would be appropriate, and valuable to her success/recovery.

Over the next two weeks Charlene's case manager was able to support her through a series of court appearances, ultimately resulting in a successful bail hearing. This was accomplished by meeting with Jane, her lawyer, family, and various service providers. A service plan was developed and presented to the Crown. During the bail hearing, the case manager was called upon to describe the supportive housing program and to detail the goals and strategies of the service plan. Once the plan had been accepted by the court and the bail conditions set, Charlene was released. Charlene was back in her own apartment by the end of June.

In terms of the justice involvement, Charlene's case manager has been able to supply updated information to her legal counsel, and has provided reports when needed. As a result, the court has access to information that accurately reflects Jane's progress and continued success living independently. As the legal process continues Charlene will have consistent support by the supportive housing program to enable her to continue to live independently. She has not had any additional contact with the justice system, nor has she required hospitalization.

6.1.5 Supportive Housing Services

The Service Enhancement Initiative funded four lead agencies, Houselink Community Homes, COTA Health, LOFT Community Services and CMHA Toronto to provide coordinated access to housing and support to persons with a mental illness and current involvement in the justice system. In 2005-06 these Toronto agencies received funding for 395 of the total 500 provincial housing units allocated in that year and in 2006-07 they will receive funding for an additional 116 housing units. This housing is primarily available as bachelor and one bedroom furnished apartments located across the city. The MOHLTC has also contracted with community agencies that are able to provide supportive mental health services to clients that live in these housing units. The four Lead Housing agencies have each signed individual tripartite housing agreements with their support partner agencies and the MOHLTC.

The funding provides a rent supplement that is based on the assumption that the majority of the clients would be receiving ODSP (Ontario Disability Support Program) or OW (Ontario Works) and adds to the shelter allowance they receive through these programs. A preliminary allocation of funding for 64 housing units was assigned to each of the four lead service providers.

The MOHLTC allocated the remaining beds on the basis of community agencies that were able to provide a wide spectrum of services and supports to clients i.e. mental health support, employment exploration, social skills teaching and crisis management to the housing sector. Staff was allocated on the basis of a 1:8 ratio of staff to clients, with service available five days a week, but not including overnight. This wide spectrum service requirement resulted in Across Boundaries, CRCT (Scarborough), North York General Hospital and Reconnect partnering with CMHA; CRCT downtown with Houselink; and Toronto North Support Services with LOFT.

Agency	Service / Quadrant	New / Existing Program	2005-2006		2006-2007	
			Annualized Funding	# FTEs	Annualized Funding	# FTEs
Houselink Community Homes	South	New	$1,565,090		$280,320*	2.0
COTA Health	East	New	$1,647,450		$595,680**	4.25
LOFT Community Services	West/ North	New	$1,647,450		$280,320***	2.0
CMHA Toronto	North	New	$1,647,450		$595,680****	4.25
CMHA Toronto	West	Existing			$280,320*****	2.0
Total			**$6,507,440**		**$2,032,320**	**14.5**

2005-06 and 2006-07 Funding Allocation: Supportive Housing Services

2006-07 Funding * Houselink (lead agency only)
** COTA Health (lead agency only)
*** LOFT/Toronto North Support Services
**** CMHA Toronto (lead agency only)
***** CMHA Toronto/Reconnect

As the table below indicates by September 1, 2006 all of the 395 units allocated for 2005-06 had been acquired and 320 were occupied, with full occupancy anticipated by the end of October 2006.

Agency	Units Occupied	Total Units
CMHA Toronto	132	171
COTA Health	46	64
LOFT Community Services	77	80
Houselink Community Homes	65	80
Total	320	**395**

Unit Registry - Mental Health and Justice Supportive Housing Program: September 2006

The occupancy/vacancy rate is reflective and associated with referral patterns from court support services, probation, correctional facilities, pre-charge services and the safe beds. A central registry is maintained by LOFT Community Services that provides preliminary screening and access to all of the housing units in the city. In order to be considered for

housing the client must be referred through one of the priority referral sources:

- mental health court or court support and associated case management programs
- short term residential crisis beds
- pre-charge diversion and crisis prevention
- courts/jails including probation and otherwise discharged from jail
- mental health and justice intensive case management programs
- LAMHP at CAMH and Forensic Assessments, Consultation and Treatment (FACT) Program at Whitby
-

In addition, the client must meet the following criteria:

- current involvement in the justice system
- serious mental illness
- 16 years or older
- homeless or potentially homeless
- individuals that are likely to live safely, supported in the community with minimal assistance

The first four of these criteria are assessed by the central registry on the basis of the application submitted for the client. The final criteria of being able to live safely in the community, is determined by each of the four agencies by way of an interview with the client.

Client Vignette**:** *David is a 34 year old who was diagnosed at nineteen years of age with schizophrenia, antisocial personality disorder and poly-substance abuse. He has been hospitalized at least eight times for psychiatric reasons, in Toronto and Penetanguishene. David has had significant involvement with the justice system, beginning as a minor and continuing until his most recent charges in 2003. At that time he was charged with: break and enter, theft over, threaten death, dangerous operation of a motor vehicle and failure to comply. To this date he has been incarcerated for approximately five years in total. David is currently on probation.*

In the past David has lived with family members and girlfriends, in group homes, rooming houses, supportive housing and shared accommodations. More recently David lived independently in the community for approximately four months; however he required hospitalization to manage his psychiatric symptoms and lost his housing as a result.

David became a client of the supportive housing program in May 2005. He was assessed for independent housing, and was found to have adequate skills to live on his own. David expressed his strong desire to get a fresh start and to succeed as "a regular guy". Once accepted into the program he met with his housing worker to discuss his options. David agreed that he while he preferred to live relatively close to his family and supports, he did want to fully establish his independence. He and his worker selected a few quiet residential areas not known to have high incidence levels of drugs or crime. David viewed the available units and ultimately chose a one bedroom apartment that was TTC accessible.

Of central concern to David was the fact that he had virtually no possessions of his own aside from some articles of clothing. He had difficulty accepting that all of his basic needs would be provided for through the MHJP. David was informed that by the scheduled move in date the apartment would contain brand new furniture. David has

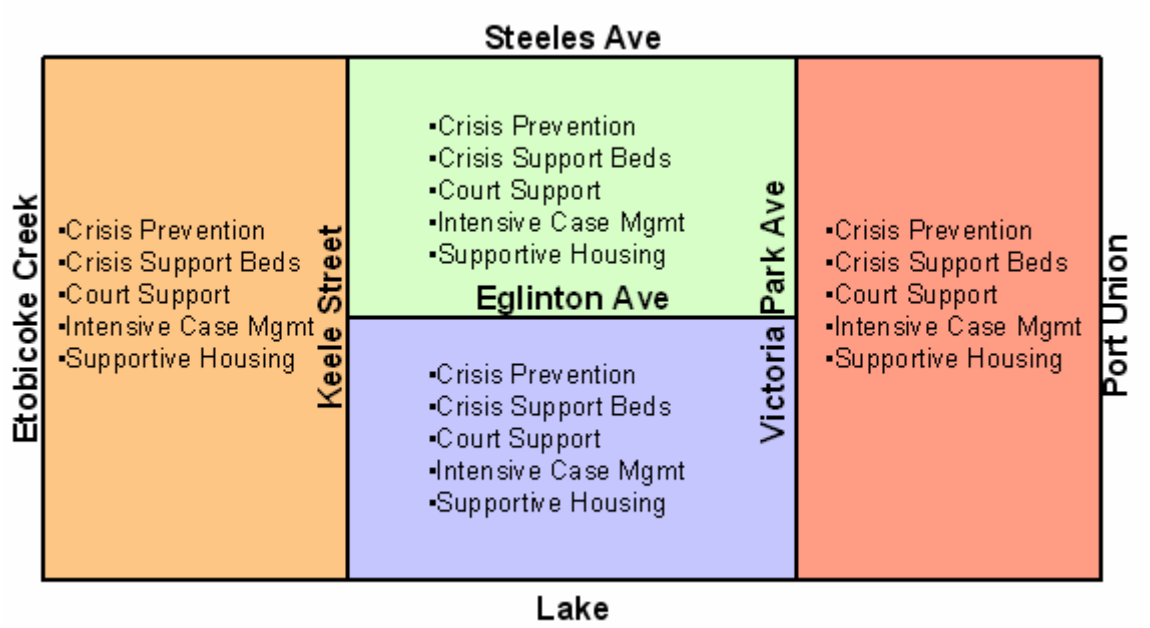
repeatedly expressed his appreciation for these items and has maintained his apartment outstandingly.

In addition to a housing worker, David was assigned a case manager through the MHJP. Initially the housing worker and case manager made home visits together twice per week. Once David was settled in his new home, the housing worker provided support as needed, while the case manager provided ongoing intensive support. Over time David was able to identify several short and long term goals for himself which formed the basis of their work. These included obtaining employment, improving interpersonal skills, literacy, better diet and abstinence from drugs. His case manager has supported him through advocacy, referrals to internal/external agencies, direct counseling and skill development. By meeting with David's psychiatrist, doctor and probation officer and maintaining that contact, the case manager has been able to objectively monitor David's progress through third party reporting. He has been fully compliant with medication and has consistently reported to probation. David feels supported by the MHJP team, and is quite candid regarding his challenges and concerns. He is fully engaged in obtaining his goals, and recognizes the many positive changes he has made in his life. David has not required hospitalization, nor has he had further contact with the justice system.

Client Vignette: *Edward came through the LAMHP at CAMH. He moved into a furnished CMHA unit through the Mental Health and Justice program on May 1, 2005. He was provided with a unit in the Scarborough area as he is being supported by the CMHA Forensic ACT Team and seen daily, seven days a week. The original assessment was held on April 27, 2005. Edward is also supported through the housing support at CMHA. His index offence is Assault Peace Officer, Assault Resist Arrest, Weapons Dangerous; Assault with a Weapon and Fail to Appear. He is diagnosed with schizophrenia. Edward has few social contacts and no family in Toronto.*

Client Vignette: *Frank came through the LAMHP at CAMH. He moved into a furnished unit provide through CMHA Toronto and the mental health and justice program on May 1, 2005. He was provided with a unit in the downtown area and he reports to the hospital once daily. He is supported through the Outpatient Team at CAMH and through the housing support services at CMHA. The original assessment was held on April 27, 2005. His index offence is manslaughter. He is diagnosed with chronic schizophrenia. Frank has had a history of hospitalization and can decompensate quickly when unwell.*

6.1.6 Map of Services



6.1.7 Service Mapping of Mental Health and Justice Programs Funded Under the Service Enhancement Initiative by Key Juncture Points of the Human Services and Justice Coordination Project

Services funded under the Service Enhancement Initiative were intended to help persons with a mental illness to stay out of the justice system and to receive the care and support they need as close to home as possible (Junctures 1,2). The Service Enhancement Initiative targets persons with a mental illness who have come into contact with the law (Junctures 3,4,5,6) and are at risk of being charged by the police or have been sentenced (Junctures 7,8,9) and then released from a correctional institution (Junctures 18.19). The overall intent was to address the problems at the front end of the justice system through prevention, appropriate intervention and diversion. The result planned was improved access to community based services, improved outcomes, to reduce reliance on costly institutional forensic facilities and reducing the stigma associated with being charged and held in a correctional institution.

In the short period since the Service Enhancement Initiative funding commenced the agencies involved have moved forward to put in place the recommended strategies for various Juncture Points of the Provincial Human Services and Justice Coordination Strategy (*Appendix K: Service Mapping of Mental Health and Justice Programs Funded Under the Service Enhancement Initiative by Key Juncture Points).*

6.1.8 Service Mapping of Mental Health and Justice Programs Funded Under the Service Enhancement Initiative by LHIN Catchment Areas

Service mapping of the mental health and justice programs that were funded by the Service Enhancement Initiative in 2005-06 is provided in *Appendix L: Service Mapping of Mental Health and Justice Programs Funded Under the Service Enhancement Initiative by LHIN Catchment Areas.*

The services are mapped by location of the agency with a LHIN area and also by service delivery by LHIN area. As this mapping indicates, there are many instances where the services delivery crosses the boundaries of the LHIN areas, and also instances where the agency is located within one LHIN and the service delivery is provided in another LHIN area.

In order to provide a seamless service to the mental health and justice clients, a Network of agencies has been established to coordinate the service delivery across Toronto. This Network of agencies is key to the continued planning and development of programs for the mental health and justice clients.

As we state later in this report the boundaries for the human services and justice field are the courts in Toronto, however this creates some difficulties in services provision given that the funding source for the Service Enhancement Initiative will shortly be from each of the five LHINs. It will be essential that as the transition to the LHIN structure in Health occurs that it does not disruption the flow of services for mental health and justice clients whose needs cross LHIN boundaries.

7. OTHER MENTAL HEALTH AND JUSTICE SERVICES

7.1.0 Mental Health Services

7.1.1 Law and Mental Health Program: Centre for Addition and Mental Health

The Law and Mental Health Program provides a forensic psychiatric services that include assessment, treatment rehabilitation, security management, community supervision, consultation and specialty services.

The medium-secure inpatient forensic unit consists of two 20-bed units, and provides a multidisciplinary forensic assessment of individuals facing a variety of charges under the Criminal Code. These assessments are predominately in relation to criminal fitness to stand trial and issues of criminal responsibility. However, the mandate of the program extends to assessing individuals convicted of various crimes and providing opinions related to pre-sentence evaluation. The program also provides limited beds for the provision of psychiatric treatment for patients deemed unfit by the judicial system and placed on judicial treatment orders. Frequently individuals falling under the jurisdiction of the Ontario Review Board (ORB) are initially admitted to the unit for stabilization or assessment prior to being transferred to longer term treatment / rehabilitation inpatient units.

The majority of patients admitted to the program are in judicially mandated custody and patients are only admitted as a result of a judicial order or an ORB disposition order.

The Brief Assessment Unit provides a consultative, time-limited psychiatric competency assessment, usually related to forensic fitness issues for adult offenders. Its primary referral sources are suburban courts in Toronto that are not otherwise served by mental health forensic resources. A limited capacity is available for the provision of forensic psychiatric assessments of individuals facing charges under the Youth Criminal Justice Act (YCJA).

Psychiatrists also provide brief assessments of fitness for accused appearing at the mental health court at Old City Hall and the court support programs at Scarborough, College Park, North York and Etobicoke. Verbal opinions regarding forensic issues and fitness such as Unfit to Stand Trial, treatment orders and any other matter for which the court requires an opinion are presented in the court following the psychiatric assessment.

The Outpatient Service provides clinical treatment and management of individuals who are under the jurisdiction of the ORB with disposition orders that support living in the community. The program attempts to reintegrate forensic patients into the community while managing the risk that these individuals present to public safety.

7.1.2 Forensic Assertive Community Treatment Teams

In May 1999 the MOHLTC announced funding for 13 Assertive Community Treatment (ACT) teams in Toronto. ACT teams provide community-based services, to persons with a serious, long term mental illness. Five of these teams were designated as forensic teams to meet the special needs of clients who have a serious mental illness and are involved in the justice system, or under the jurisdiction of the ORB. Service is provided by a multi-disciplinary

team, with “treatment, rehabilitation and support given in the community and combines skill teaching with clinical care and case management” (*Appendix L: Agreement: St. Joseph’s Health Centre and Centre for Addiction and Mental Health*).

One of the conditions of funding the forensic ACT teams was that each team would accept referrals from the LAMPH at CAMH, where patients have been found Not Criminally Responsible (NCR) for their offence due to their mental disorder. Three of the ACT teams are sponsored by hospitals, St. Joseph’s, Toronto East General and North York General; the other two ACT teams are sponsored by the CMHA Toronto and located in the east and west quadrants of the city. The teams are available 24/7 days a week.

ACT team standards were established by the MOHLTC in 2002, and based on a US model that was first put in place in Wisconsin. These standards initially had a staff to client ratio of 1:10, but were subsequently revised to 1:8 based on experience in dealing with the client group.

Key to the provision of the services to the ORB clients by the forensic ACT teams is a formal agreement between each of the teams and CAMH that defines the relationship and facilitates the ”safe reintegration of the client into the community” (*Appendix K*). This agreement clarifies the roles and responsibilities of the ACT team and CAMH; defines the accountability relationship in regard to the services to the client; sets out the protocols for communication and information exchange and the working relationships.

Only forensic clients that have been assessed to present a low or moderate risk of violent reoffending may be referred to the ACT team, although in practice it appears that the clients are primarily in the low risk category. The agreement also acknowledges that the referral and placement of forensic clients with the ACT teams is a matter of shared jurisdiction or “shared care”. This shared care model requires that both the hospital and the ACT team share both the care and risk management of the client. In order to clearly identify the responsibilities of each party, a Forensic Risk Management Plan (FRMP) is jointly developed for each client. This document includes:

- a risk assessment of the client
- a list of obligations for the client and CAMH under the ORB disposition order
- a list of obligations of CAMH to the ACT team
- detailed reporting requirements between CAMH and the ACT team
- protocols for dealing with non-compliance and re-admission of the client to the
- Law and Mental Health Program

This agreement has generated a great deal of trust between the parties and reduced the concerns of the ACT teams in regard to managing the risk presented by the clients.

Approximately 29 (10%) of the client population of 280 attached to the LAMPH were being served by the ACT teams at the time of the study. The two forensic teams sponsored by CMHA Toronto primarily share responsibility for ORB clients and they represent approximately 20% of the case loads of each of these teams.

The LAMHP Outpatient program operates very similar to the ACT teams. The clients that are seen by this program are generally considered to be a higher risk and remain with the

hospital due to their increased capacity as a result of the inpatient program and the intensive case management which is possible through 24/7 service availability .

Both the ACT Teams and the LAMPH reported that 90 per cent of the forensic clients placed with the ACT teams are able to abide by the conditions placed on them for residing in the community. The remaining 10 per cent move back and forth between the hospital and the community, before they are able to be sufficiently assisted and supported to become stable in the community. A number of clients that have received an absolute discharge from the ORB have remained with their ACT team.

7.2.0 Criminal Justice Services

7.2.1 Police Services

The Toronto Police Service captures information on individuals who appear to have a mental illness that they come into contact with by way of the Emotionally Disturbed Person (EDP) Information Form. The police, however, indicated that this form only captures a limited number of the individuals that they decide to proceed with under the Mental Health Act, and it does not identify those individuals who have a mental illness and are charged with a crime, or those that are later identified as suffering from a mental illness. In an effort to improve the accuracy of these numbers, the police have in some instances also included data on individuals identified with non professional depictions such as “person berserk”, “threaten suicide”, “overdose”, “attempt suicide”, “elope” and “jumper”.

The primary concern for the police when they come into contact with an individual that appears to be suffering from a mental illness is to be able to manage the situation in a safe manner for both the police officer and the individual. Many of the police officers will take the individual to a community agency, but if services are not immediately available the police will either drive the person to a hospital or the jail.

7.2.2 Ministry of the Attorney General

The Mental Disorder Crown Advisory Committee was formed in 1994 following the recommendations of a Corner’s inquest into the death of a person with mental illness at the hands of another accused who was at that time found Not Guilty by Reason of Insanity (now Not Criminally Responsible). The committee meets monthly and is comprised of senior crown attorneys drawn from across the province and a mental health consultant. The senior assistant crown attorney from across the mental health court (102 Court) is on this committee.

The terms of reference for this committee includes improved coordination between crown attorneys in their involvement with mentally ill persons before the court and those under the jurisdiction of the Ontario Review Board; developing and facilitating an annual specialist training program for crowns on mental disorder; participating in and providing support for inter-ministerial institutions; providing advice to the ministry on legislative and policy changes and problem solving on issues brought before it.

7.2.3 Probation and Parole Services

Probation and parole services are provided for provincial offenders in Toronto in the nine probation and parole areas at 18 offices, including six offices that are maintained in the courts. Contact with mental health services is provided by the availability of contracted psychiatrists in some offices and through the release planning and community transition services provided by the Scarborough General Hospital and Homeward programs.

7.2.4 Correctional Institutions

In Toronto two correctional facilities provide special needs units for remanded offenders that are defined as “acutely needy offenders with severe mental illness”. These units are at the Toronto West Detention Centre which has a 40 bed unit and the Toronto Jail which has a 72 bed unit that includes a 36 bed step-down unit that is often used to manage problematic behaviour as well as mental illness. A study that is currently being conducted by Nipissing University is indicating, in its preliminary results, that the number of persons with mental illness that are being incarcerated has more than doubled in the last ten years.

8. RESPONSES TO QUESTIONNAIRES

Questionnaires were sent to all of the Service Enhancement Initiative funded agencies (n =13), for a total of 23 programs. Responses were received from eleven (11) agencies and twenty (20) programs representing the following service areas:

PROGRAM AREA/SEI FUNDED AGENCIES		Responded
	CRISIS RESPONSE/ PRE-CHARGE DIVERSION	
1	Sound Times Support Services	-
2	COTA Health	X
3	Reconnect Mental Health Services	X
4	Canadian Mental Health Association (CMHA) Toronto	X
	POLICE MOBILE CRISIS INTERVENTION TEAMS	
5	St. Michael's Hospital	X
6	St. Joseph's Health Centre Toronto	-
	SHORT TERM CRISIS SUPPORT BEDS	
7	Gerstein Centre / Maxwell Meighan Centre Salvation Army	X
8	COTA Health	X
9	Reconnect Mental Health Services	X
10	Canadian Mental Health Association (CMHA) Toronto	X
	COURT SUPPORT SERVICES	
11	COTA Health**	X
12	Community Resource Connections of Toronto (CRCT)**	X
13	Canadian Mental Health Association (CMHA) Toronto**	X
	INTENSIVE CASE MANAGEMENT	
14	Homeward Mental Health Projects of Toronto	X
15	Scarborough Hospital JAMH*	X
16	Community Resource Connections of Toronto (CRCT)	-
17	COTA Health	X
18	Canadian Mental Health Association (CMHA) Toronto**	X
19	North York General Hospital Adult Mental Health Service	X
	SUPPORTIVE HOUSING SERVICES	
20	Houselink Community Homes	X
21	Scarborough Housing Consortium /COTA Health	X
22	LOFT Community Services	X
23	Canadian Mental Health Association (CMHA) Toronto	X
Total Responses		**20**

** Verbal Response*
***Newly funded court support services are combined with existing court programs for analysis*

Fifty-two (52) questionnaires were also sent to all community mental health agencies that were not funded under the Service Enhancement Initiative but listed as providing mental health services to the target population. This list was obtained from the ConnexOntario data base and was corroborated by a list of agencies that is maintained at the Toronto Regional Office of the MOHLTC.

ConnexOntario is a Health Care Information System of which the Mental Health Service Information Ontario (MHSIO) is a new and developing data base. MHSIO lists all the organizations in the province providing mental health services, as well as the programs and supports they provide to clients. These include, in part, case management, crisis intervention, counseling, treatment, vocational and employment services, early intervention, diversion and court support services as well as programs for substance abusers.

A separate questionnaire was sent to the five courts where a mental health court or court support program operate in Toronto. A response was received from the three agencies that operate these programs.

A further questionnaire was sent to the four psychiatric units of the General Hospitals, two of which were funded to provide Police MCIT's and two were funded for Out-Patient Intensive Case Management Programs.

In summary, responses were received from the following:

- Service Enhancement Initiative Programs: 20 of the 23 funded programs

- Other Mental Health and Justice Services: 21 (see *Appendix E: Types of Services for Mental Health Clients in the Justice System Provided by Agencies Not Funded by the Service Enhancement Initiative)* for list of agencies included in the distribution of the questionnaire to service providers

- Mental Health Court and Mental Health Court Support Programs - 5 this included 2 newly funded programs

- Hospitals - 3 including 1 Police MCIT

8.1.0 Service Providers

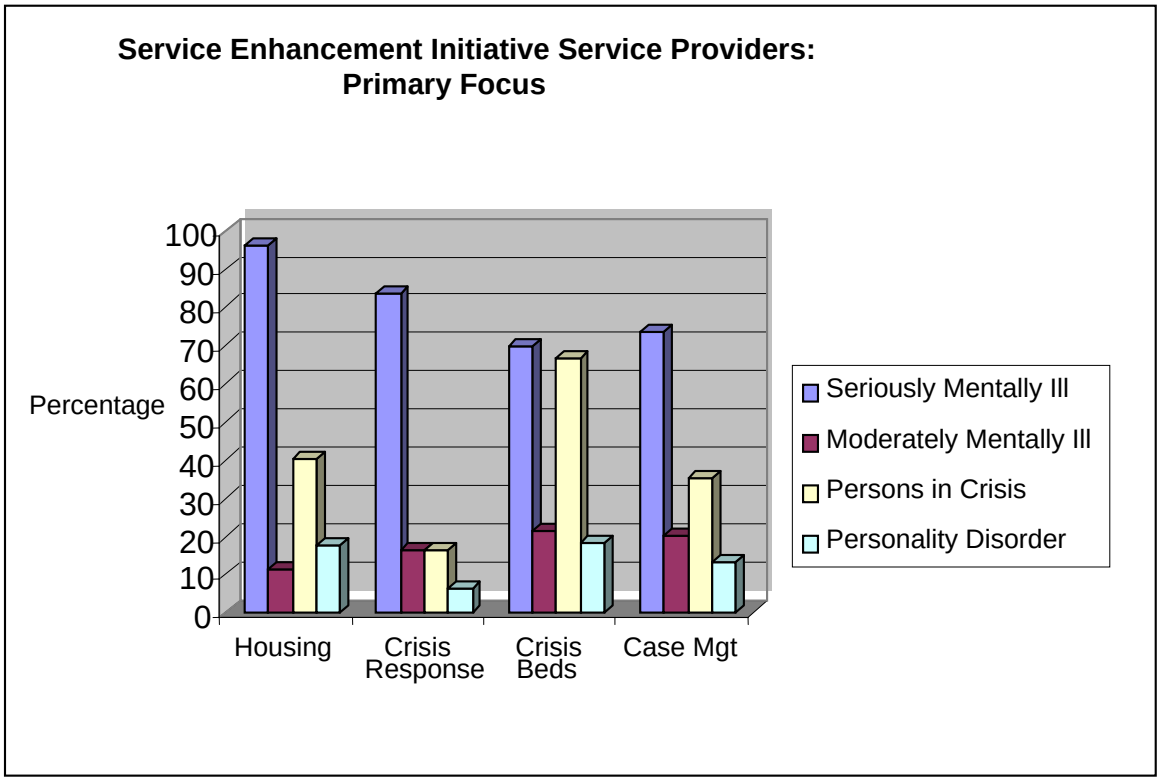
8.1.1 Mental Health and Justice Services

The questionnaires were intended to identify the range of the services provided under the Service Enhancement Initiative, the extent to which they focus on the initial and release planning stages of the mental health and justice system (Juncture Points 1-7 and 18- 20), to identify the types of services provided and the entry points of common clients coming from the justice system to the mental health system (*Appendix B: Provincial Strategy to*

Coordinate Human Services and Justice Systems: Coordinating Protocols at Key Junctures Points).

All of the services provided were directed at persons with a mental illness who are at risk of becoming criminalized or who are already a client of the justice system.

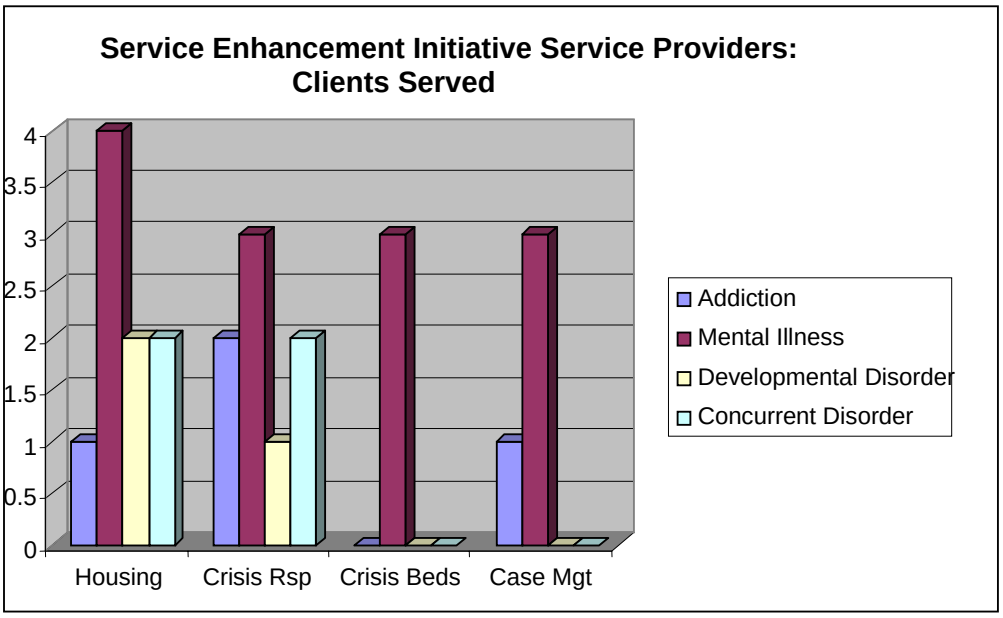
All services that reported indicated that they had a primary focus on persons who were seriously mentally ill.



It must be noted here that when the court or crown refers a client to the mental health court support program, they do not differentiate their referrals in terms of diagnosis or severity of their illness. As such, this population of clients includes those who are seriously mentally ill, as well as persons in crisis (58.5%), those who are moderately mentally ill (22%) and present with needs that can be met by the program, as well as those considered “at risk” but not severely mentally ill.

The service providers indicated that they provided a wide range of services to clients with case management and crisis response intervention as their primary focuses, followed by assessment services, relapse prevention, life skills, release planning and finally rehabilitation.

Clients had access to these services primarily through diversion programs and probation services, followed by those being referred from bail programs, other justice officials including the police and a small number as a condition of their sentence or referral from hospital.



Ten (10) agencies identified some exclusion criteria for their programs. These criteria are primarily concerned with determining whether a client is within the criteria established by the MOHLTC i.e. mental illness and involvement or potential involvement with the justice system. As one agency identified, "our priority referral source is from within the justice system". Exclusions are primarily related to access to supportive housing and the ability of the agency to safely support the client in the community.

Twelve (12) agencies reported that they provide services to ethno-cultural populations, and indicated that their staff is trained to provide culturally sensitive and appropriate care. However, when asked about the ability of their services to deal with ethno-cultural challenges, only six (6) responded positively and seven (7) responded no.

Only one agency responded that they had a waiting list for access to their service, and this was in relation to the provision of a supportive housing program. The agency indicated that the wait time was from three to seven days.

The primary source of referrals to the Service Enhancement Initiative programs is from the justice system. The mental health court support programs were the most likely to refer clients, followed by probation services, police, detention centres or other court personnel. A smaller number were self referred or referred by a family member. There were also referrals identified from medical therapists and hospitals.

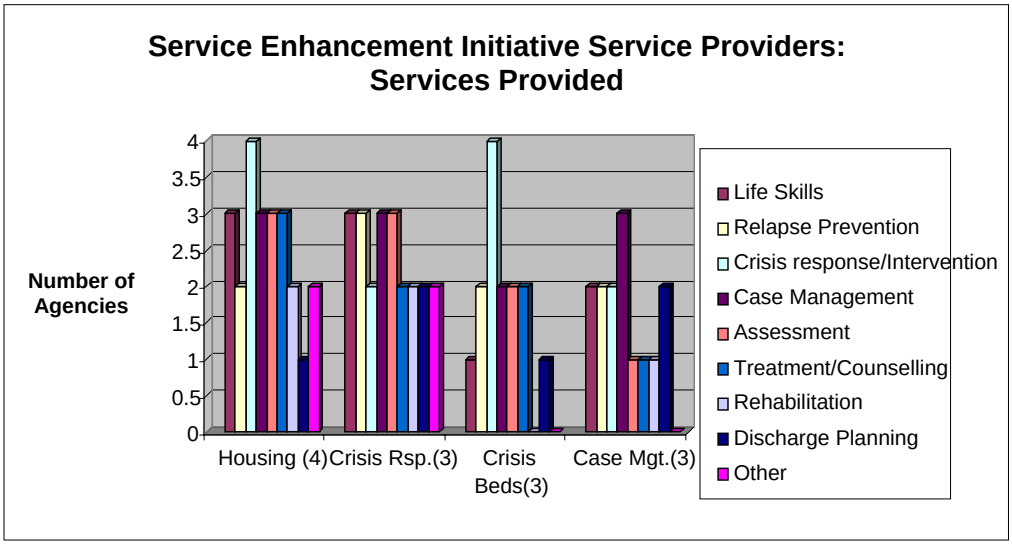
Service providers were asked to indicate the number of clients that they had seen over the past year. It must be noted that the majority of these programs have been in operation for less than one year, and we did not receive a response from all of the Service Enhancement Initiative programs. This data therefore provides an incomplete picture of the clients that would normally receive services in a full operational year.

However, the responses indicate a total of 1133 clients were served by the agencies that replied to the survey, which breaks down as follows:

- Intensive Care Management 85
- Supportive Housing 231
- Crisis Response/Outreach 75
- Crisis Beds 171
- Police MCIT 520

TOTAL 1133[3]

Of these service providers, four (4) had specific services for concurrent disorders, five (5) for persons with a dual diagnosis and three (3) for transitional age youth.



Four (4) of the service providers had formal agreements with the justice system and other mental health service providers.

Thirteen (13) programs had services available for released offenders with a mental illness, and five (5) programs reported accepting clients from the federal penitentiaries. These services were primarily crisis beds and housing support programs. Of the agencies involved in accepting clients from the provincial detention centres, only a limited number are involved in the release planning and transitional community support for inmates.

Service providers generally responded that they did not consider that the inmate population was being served adequately, with nine (9) responding no and three (3) yes. The majority considered the lack of available housing and insufficient funding as a primary barrier, while others cited the lack of connections between the mental health and justice systems, insufficiently trained staff, and a lack of coordination between service providers and the justice personnel as factors.

Many of the respondents commented on the need to improve the relationship with justice partners and, in particular, with the correctional institutions. Despite diversion strategies

[3] A number of these clients may have received services from more than one program and therefore may be counted in this data more than once.

persons with mental illness will continue to be held in jail during remand and or sentenced to periods of incarceration. While a number of responses pointed to the success of the present structure in Toronto in putting the client in the centre of care, they stated that a major disconnect in the continuity of care and support was occurring when individuals are admitted to the correctional system. They proposed:

- A joint local forum for each quadrant comprised of mental health service providers and representatives from the local detention centre, probation and parole, the police and the local hospital so that care can be better coordinated, barriers identified, solutions discussed and implemented.

- More formal liaison with the local correctional institution to allow for comprehensive plans to be developed that will assist with preventing clients from re-offending. This could include developing protocols that will allow for designated mental health staff from community service agencies to have access to clients who may be in distress, on a similar arrangement to that currently allowed for legal counsel.

- Closer working relationships between housing case managers and release planners in the detention centres to enable easier access to housing when the inmate is released from the institution.

- The development of a 'best practice' framework specifically targeted for this client group using a consistent approach to identify persons with mental illness who are incarcerated and collaborating with staff so that when clients move from one correctional institution to another, case managers of clients are informed about their status.

Access to psychiatric services was by far the most common gap identified by the service providers. They identified two major challenges; the first being that many clients who would benefit from clinical intervention are reluctant to participate, and secondly the stigma associated with being a person with mental illness who is involved with the law. That stigma creates additional barriers to effective treatment particularly in the area of diagnostic assessments, appropriate prescribing, monitoring of medication use and admission to hospital when the need exists.

Many of the service providers highlighted the recent successes in Toronto in bringing service providers and agencies together to work collaboratively. They pointed to the recent Service Enhancement Initiative and the need for time to have the services fully in place before any major changes are contemplated. The majority of their comments proposed that Toronto continue to build upon the system that is currently in place.

As part of the strengthening of this developing service system they indicted:

- A need for greater collaboration between the crisis beds and crisis prevention programs so that clients brought to the crisis beds by the police for an overnight stay could be directed to the crisis prevention programs for community support the next day, rather than emergency housing.

- The need for a Police MCIT that will respond to Emotionally Disturbed Person (EDP) calls with the police, conduct assessments and in situations where hospitalization is not deemed necessary ensure that the client is linked to the crisis prevention program which could provide follow-up or referral to the appropriate program.

- The need for improved access to a psychiatrist for the purpose of treatment and assessment.

- The need for additional programs that include the following:
    - anger management
    - risk management
    - life skills training
    - programs for substance abuse
    - culturally specific programs

- A greater mix of independent and congregate housing that would accommodate those that can be safely managed in the community, but require additional support.

- Identification of ethnocultural resources that are specific to the mental health and justice systems that can be shared by various agencies with a need for such services i.e. a list of ethno-cultural staff that could be available to assist with translation, etc. across agencies.

- A plan of advocacy for employment support and accommodation to the workplace by employers for mentally ill clients.

- Ongoing joint educational activities between the mental health and justice systems.

8.1.2 Other Mental Health and Justice Services

In addition to the agencies funded under the Service Enhancement Initiative, questionnaires were also sent to seventy five (75) additional mental health agencies in Toronto. These were listed on MHSIO, the ConnexOntario data base, as agencies that accept and/or provide specialized services for clients with legal issues. These services ranged from pre and post charge diversion and support during trial to services for released mentally ill from both the federal and provincial corrections systems.

All the agencies indicated that they provide services to people with a mental illness who are at risk of becoming criminalized or are already a client of the justice system. The breakdown of clients served by these agencies indicated that sixty three per cent (63%) of the population served was seriously mentally ill.

- Seriously Mentally Ill 63%
- Moderately Mentally Ill 21%
- Persons in Crisis 37%
- Personality Disordered 15%

Forty-eight percent (48%) of the non funded agencies do not have funds dedicated to the common client, and fifty-two percent (52%) indicated that they were funded to do so. The portion of the agency budget allocation specifically targeted to the common client ranged from a low of 1-10% (3 agencies), to 10-50% (5 agencies), to over 50% (3 agencies). A wide range of services are provided by these agencies ranging in order of frequency of usage from case management, crisis response, life skills, assessments, release planning to vocational and supportive housing.

The primary mode of access to these services was through the court diversion program, followed by referral from justice officials such as the police, probation and parole staff or as a condition of sentencing. A small number were self-referred and/or referred by other mental health services.

The presence of a mental Illness was the main criteria for admission to the programs, followed by concurrent disorder, developmental disability and addictions. Eighteen (18) of the twenty one (21) respondent agencies had conditions of exclusion from their programs. These ranged from a history of violent behaviour that might create potential safety issues for other clients and/or staff, to programs with an ethno-specific or gender based bias. Other exclusions noted were substance abuse, actively suicidal or the client declining the service.

Twenty (20) provided services to ethnocultural clients, but a majority responded that their services were not designed to deal with ethnocultural challenges even though training to provide culturally sensitive and appropriate care was reported to have been provided by nineteen (19) of the twenty-one (21) respondents.

Ten (10) agencies reported a waiting time for clients to access their service and eleven (11) did not. Of those with waiting periods, these ran from two to three (2-3) days (1 agency) to over sixty (60) days (8 agencies).

The majority of clients referred to these agencies came from correctional services (probation, parole and detention centres), followed by the mental health court support program. Other referrals came from hospitals, self, family, shelters, etc. The agencies reported having the following specialized programs, clients with concurrent disorders (7 agencies), dual diagnosis (7 agencies) and transitional age youth (4 agencies).

A number of agencies reported having formal agreements in place. These ranged from agreements with ministries for specific programs, agreements with local hospitals, to interagency agreements regarding service.

As noted earlier a majority of clients came from the correctional system. Thirteen (13) agencies reported providing services to released inmates from the federal penitentiary (4 agencies), provincial correctional facilities (9 agencies) and detention centres/jails (4 agencies). Of those, three (3) agencies were involved with release planning in the federal penitentiary system, six (6) agencies in provincial correctional facilities and eight (8) agencies in detention centres.

Ten (10) agencies felt that this population was adequately served. Those who responded in the negative pointed to a lack of funding, lack of housing, training needs of staff and a need for improved connection between the mental health and justice system as existing gaps.

In response to being asked what additional service/programs are required by their existing services the following were provided:

- additional treatment programs and training of staff to support clients with concurrent disorders
- adding an addiction worker to be connected to the court support program
- access to psychiatric services
- access to culturally specific services
- training of staff to deal with ethnocultural challenges
- more system coordination at the local level
- evidence of cooperation and coordination at the ministerial level
- improved relationship with corrections at the institutional level
- removal of city zoning barriers
- enhanced public awareness of services in Toronto

When asked about additional services needed within the mental health system, the following responses were provided in ranked order:

- increased housing
- more case management programs
- employment services
- access to medical/psychiatric services
- education and training
- ethnocultural resources
- treatment programs for addiction and concurrent disorders
- improved access and linkages with the jails for purpose of ongoing support
- release planning
- vocational training and employment support

In response to how agencies would change the justice and mental health system to better meet the needs for clients, the following was suggested:

- system coordination
- improved linkages between corrections and the community agencies
- inter-ministerial coordination
- better communication
- information sharing about a client's movement from one system to another
- improved relationships with the police that would allow for pre-charge diversion to occur
- generally easier access to service

8.2.0 The Mental Health Court and Mental Health Court Support Programs

The term Mental Health Court is used to describe a specialized court dedicated to dealing with accused persons with a mental illness that employs a process distinct from the traditional court proceedings. Some of the characteristics of the court are: a focus on mental health issues, having dedicated staff (crown attorneys, judges, duty counsel,

psychiatrists and mental health court worker s), operating five days per week and occupying a permanent courtroom site (e.g.102 Court at Old City Hall).

Mental Health Court Support Programs on the other hand represent an extension of diversion programs, which include both additional services to the courts as well as a more 'client centered' mental health service for mentally ill accused who do not qualify for diversion. A key feature of the latter approach is the presence of one or more psychiatrists in the court for one to three occasions per week. (Scarborough, North York, Etobicoke and Finch Courts)[4] At a minimum it is felt that there should be two psychiatrists in court to minimize the delay in clients being seen. Some agencies provide their own psychiatrist to augment those provided through the Ministry of the Attorney General.

In addition to a psychiatrist, these programs are staffed by mental health court worker s and case managers funded by the MOHLTC through transfer payments to the following four (4) community agencies; Canadian Mental Health Association, Toronto Branch, COTA Health, and Community Resource Consultants of Toronto (CRCT).

Further to the above, support for ethnocultural persons with mental illness appearing in the Mental Health Court (102) is provided through an arrangement with Mt. Sinai Hospital. The Mental Health Court Support Programs provide voluntary mental health supports to persons with a mental illness who are charged with a criminal offense and are before the courts. Unlike the Mental Health Court (102) with its dedicated courtroom and staff, Mental Health Court Support Programs may differ from site to site depending on the agreed upon process to be used. In some courts, the psychiatrist, after reviewing the files and interviewing the accused will follow him/her to the courtroom in which the matter is being heard. In others, all matters involving mentally ill accused are dealt with on the day that the psychiatrist is present. All Mental Health Court Support Programs in the Toronto have a common policy manual, but different processes appear to exist in terms of the role of and functioning of the people associated with some programs.

Responses to the survey were received from all the five courts in the Toronto area including the two (2) newly funded programs. However incomplete data was received from two courts. Additional data on the population served was received from the two courts in Scarborough and Etobicoke. This data included a detailed print-out and provided the basis of a more detailed review of the population.

The number of persons with mental illness who came into contact with the mental health court workers in 2005 and who applied for diversion were reported as follows:

	CONTACTS	DIVERSION
Old City Hall (102 Court) and College Park	1300	800*
Metro North 1000 Finch	287	80
Etobicoke	349	107
Scarborough	308	77

*combined numbers for Old City Hall and College Park Court

[4] Definition used by Court Services, Division Ministry of the Attorney General, 2006

The mental health court workers have acted as brokers and boundary spanners linking mental health and social services to justice clients. Individuals that are seen in the mental health court/programs are referred to a number of community services. These include the following which are listed in order of frequency of referrals:

- Case Management Programs
- Psychiatrists
- Community Support Programs
- Community Mental Health Services
- Group Homes
- Others include ACT Teams, Long Term Housing and General Practitioners

Responses to the nature of the illnesses presenting to the mental health court workers was as follows:

- Seriously Mentally Ill 64%
- Moderately Mentally Ill 32.8%
- Persons in Crisis 10%
- Personality Disorders 10%
- Concurrent Disorders 21%
- Dual Diagnosis 15%

As a result of multiple diagnoses the total exceeds 100 per cent.

The services most often needed by clients were identified as:

- Prevention from Criminal Involvement 100%
- Release from Custody/Service Planning 59.6%
- Case Management 49%
- Assessment 43%
- Treatment 39%
- Housing 25.3%

The additional data received from the two suburban Mental Health Court Support Programs enabled us to develop a more comprehensive profile of persons with mental illness who are in conflict with the law. In terms of age, the largest cluster is in the 25-34 age group, followed by the 18-24 age group and then the 34-45 age group.

83.5% of the clients were male and 16.5% were female. Ten per cent (10%) identified themselves as married, while sixty four per cent (64%) reported they were not married, with the remainder reporting a miscellaneous range of relationships, including some that were identified as unknown.

The majority of the referrals to the program were made by Duty Counsel (48%) followed by Defense Counsel (21.3%). Crown Counsel referred 4.5% of cases, family members accounted for 5%, with the remaining clients (12%) being referred from other sources.

The data provided indicated that the majority of clients lived in their own homes or with parents, with approximately ten per cent (10%) recorded as homeless.

In terms of their legal status on referral, the majority were awaiting bail or trial.
The primary presenting diagnosis was schizophrenia (56%), followed by affective disorder (37%), personality disorder (15%), substance abuse (27%) and developmental disability (2%).

The charges laid against the clients in the two court sites indicate a total of 657 persons charged with the following offences:

- 575 Class I charges of which 273 were for failing to appear/comply
- 585 Class 2 charges
- 375 Class 3 charges

The approach to a particular mental health court program varies from one site to another. Mental health court workers have found that scheduling a court day at a particular time and place (court room) can result in efficiencies in consolidating all matters related to mental health in one court and at a designated time. Given the common service provided, the similarity of clients and the processes used in each court, it would make sense to standardize many of the procedures across all courts. This is even more important given that the psychiatrists who attend at these courts are from the LAHM Program at CAMH.

The needs of the court, judges and crowns for psycho-legal assessment, general psychiatric assessments for bail, diversion and sentencing, and the need for the LAMHP to be able to manage their bed resources effectively, should prompt a new arrangement within the Mental Health Court Support Programs.

Some suburban courts (Newmarket and Barrie) have special mental health duty counsel assigned to these courts. Where the numbers do not warrant a full time duty counsel, special training could be provided to selected duty counsel who could serve as an expert in this area when needed.

8.3.0 Hospitals

8.3.1 Hospitals with Mental Health and Justice Programs

North York General Hospital: Adult Mental Health Outpatient Court Support Program

A questionnaire response was received from the North York General Hospital Out Patient Court Support Program. This is a unique program hospital based case management service primarily focused on providing services to meet the needs of persons with psychiatric problems who are involved with the justice system. (A similar program exists in a partnership arrangement with the Scarborough Hospital, Justice and Mental Health Program). The program was initially funded in 1998 at the time when diversion programs were being expanded and in 2005 when the case management component was added. The services offer assessment, treatment and follow up on an outpatient basis to persons who are not in custody and who are referred primarily for services that include counseling, psychiatric assessments, anger management and case management. Seventy-five percent (75%) of the cases seen in this program have charges before the court with sixty five

percent (65%) being referred from the mental health court program and twenty five percent (25%) from the probation and parole service.

The program is composed of the following mix of clinical staff: consulting psychiatrists (2), nurse clinician (1), social worker (1), intensive case manager (1), housing intensive case managers (2), and an administrative assistant. While case management is a primary service, case managers also provide crisis response services as a secondary focus.

Although there are two psychiatrists attached to this program, staff identified the need for additional psychiatric services. Other gaps identified were the need for addiction programs or formal linkages to addiction services, an expanded anger management program and day treatment program to better serve clients and a remedy to the delays in the response by social welfare programs to the needs of these clients, and the need for additional police training on behavioral observation of clients.

The program has a good relationship with the police and is experimenting with a plan that will allow the police to bring clients directly to the program in lieu of being charged. The program staff raised the possibility of managing clients on treatment orders who have been stabilized and do not require a hospital bed. The staff saw their model of a case management program that is attached to a psychiatric unit of a general hospital, and in close proximity to a court, as one that could be expanded to other locations.

St. Michael's Hospital: Police MCIT Program

A questionnaire response was also received from the St. Michael's Hospital covering the activities of the Police MCIT program at the hospital.

The program began as a pilot in November 2000 between the hospital and 51 Division of the Toronto Police Service. It was formalized and expanded some years later to include 52 Division. The program was initiated in response to concerns that had been raised regarding police response to calls involving "emotionally disturbed persons" (EDP). Prior to that, a number of Coroners' inquests had recommended closer working arrangements between the Toronto Police Service and community service providers. The Police MCIT allows mental health workers to triage the individual at the scene resulting in shorter waiting periods upon attendance at the hospital, and the community benefiting by freeing up primary response police units to attend to other calls for service more quickly. The police summarized the overall effect of the programs as resulting in improved service to the community, in particular for some vulnerable members; more efficient use of financial and human resources for the Toronto Police Service and the hospital, and improved relations between police officers and hospital staff.

Under the Service Enhancement Initiative funding was provided and the program expanded to St. Joseph's Medical Centre, involving Police Divisions 11 and 14.

In the past year, the program served a total of 520 clients. Of these, thirty four per cent (34%) were apprehended pursuant to the Mental Health Act, twenty five per cent (25%) had a previous contact with the Police MCIT and twenty eight (28%) had a previous contact with the justice system. Many clients declined to provide any information regarding current or

past contact with the justice system. This is understandable as crisis situations requiring the involvement of the Police MCIT are not always conducive to providing past information. Of these less than two per cent (2%) had charges laid by the police.

In terms of disposition, fifteen per cent (15%) were admitted as an emergency to the hospital, two per cent (2%) were referred to community mental health services, and a reported four per cent (4%) refused further intervention. The outcome for the majority of this population beyond the crisis contact period is unknown as the Police MCIT has no tracking mechanism beyond what happens in the emergency department.

The services required by clients at the point of first contact with the hospital program are varied. They include case management, usually as a follow up to post MCIT intervention; crisis response and assessment, which is provided at the time of intervention; emergency treatment, which is provided in the emergency department; and treatment and follow up to the MCIT intervention. Other needed services include inpatient mental health beds, shelters and safe-beds.

The gaps identified were as follows:

- Funding to provide 24 hour/7day a week MCIT services

- Need to expand the service to other key areas in Toronto

- Lack of specialized mental health training for police dispatchers in order to enable them to identify calls that are mental health crises. This training should include the need to record situations where community agencies have called 911 to report a mental health crisis, but where the Police MCIT was not contacted.

- Lack of specialized mental health training for police in the field to allow them to be able to identify a mental health crisis and deal effectively with the person when the Police MCIT is unavailable.

In terms of improving the mental health and justice systems the implementation of an integrated mental health crisis response system that would include having both police and non-police mobile teams includes:

- Developing a central crisis line staffed by experienced professionals with the capacity to identify mental health crisis and triage to appropriate services such as police crisis team, non-police team etc.

- Shared information among mobile crisis teams, emergency departments, community and other mental health providers and the justice system

- Agreement on the use of common assessment tools

- Common cross services data collection allowing for tracking of individuals as they move across systems

- Standards of practice

- Formal linkages across mobile crisis teams, community mental health services and the justice system

8.3.2 Other Hospital Programs

Mount Sinai Hospital: Ethnocultural Mental Health Services

The Mount Sinai Hospital ACT Team is funded to provide ethno-specific services to the court at Old City Hall. The funding for this service is limited and includes a part-time manager and two part-time staff. The target population is Asian, South East Asian (Tamil), and African-Caribbean and bridges diversity needs and the mainstream systems, one of the most significant service gaps in the mental health and justice system.

The court support services are community based with short-term intensive psychosocial rehabilitation services provided for periods of six to twelve months. The program is linked to other multi-cultural programs in the community including the Hong Fook Mental Health Program and Across Boundaries, as well as to the Mount Sinai/Hong Fook ACT Team, psychiatrists and family practice doctors. There is a tremendous need for more programs of this type.

The program accepts clients primarily through court diversion (90%) with a small number being referred through probation (10%). The majority of these referrals come through duty counsel (70%) and a smaller number from the defense bar (10%). The remaining clients are referred through the mental health court support program at Old City Hall. All of the clients that are referred are on current charges and the service meets their needs through assessment, crisis response, case management, treatment and counseling.

Some of the gaps identified in services for ethno-cultural clients are:

- Culture and language barriers and the inability to find culture and linguistic experts to be available for clients during trial

- Stigmatization and discrimination, in particular of those persons whose culture does not accept mental illness

- Lack of ethno-specific psychiatric support services as well as ethno-sensitive social services

- Many of the clients lack immigration status and in the absence of proper documentation do not have access to treatment service, medication, financial support and housing services.

Client Vignette: *Gina is a 45 year old woman of Asian descent. She has made numerous visits to the emergency department at her local hospital because of psychotic agitation and suicidal attempts. She was arrested and charged twice with physical assaults with weapons and uttering verbal threats to strangers in the park. She was apparently psychotic and Unfit to Stand Trial. She was sent to the Mount Sinai Hospital program for a fitness assessment and later a treatment order was issued. She was discharged at court and is being supported in the community by the Mount Sinai court support program.*

She was seen by a psychiatrist and also received intensive psycho-social community based rehabilitation; including assistance with housing, social welfare and obtaining a drug card through the mental health court support program.

Gina complies with her treatment program and there have been reduced suicidal attempts. She is managing to maintain part-time employment, is integrated into community living and enjoying a heightened quality of life. Gina maintains regular contact with her psychiatrist and mental health court worker.

Client Vignette: *Harry was referred to the program by the Mental Health Court Support Program at Old City Hall. He was charged with public mischief. He had emigrated from China, and both he and his wife have difficulty with English and were unemployed. They have two children.*

He presented at his first interview with symptoms of major depression. He felt hopeless and helpless when his application was rejected for social welfare. He was under enormous financial strain and unable to sleep. During the second session of psychotherapy he revealed that he repeatedly thought about using a knife to kill his wife and children and then killing himself. He had even chosen his suicide spot.

Harry was admitted to CAMH. The mental health court worker continued to advocate on his behalf and presented a financial report and a letter to Ontario Works. His mental status improved with medication. His social welfare application was approved in a few weeks. He was discharged from hospital.

His mental status has been stable with both pharmacotherapy and psychosocial intervention which has also been provided to his wife.

9. INTERVIEWS WITH MENTAL HEALTH AND JUSTICE CLIENTS

In order to include the perspective of users of the mental health system in the study, a total of 20 mental health and justice clients were interviewed.

The criteria for selecting this group were:

- that they had a mental illness and previous experience in the criminal justice system
- that they were involved as a client in one of the programs dealing with persons with mental illness in contact with the justice system

These clients were drawn from the following services:

- COTA Health
- CAMH LAMHP (Outpatient Service)[5]
- CMHA Toronto
- CMHA Ontario

The purpose of the study was explained to each interviewee and a consent form signed (*Appendix H: Interviews with Mental Health and Justice Clients and Consent Form*).

The age range of the majority of the men and women (16 men and 3 women) interviewed fell in the 25-35 age bracket (45%), with the second grouping in the 36-45 age range (40%). This age range approximates the age and gender range reported in the mental health court support data. Persons seen at the court are usually in the early stages of their justice involvement, while those interviewed who were using services appear to have a longer involvement with the justice and mental health systems and therefore were somewhat older.

Information about what services are available and a good therapeutic relationship between service users and their families are key to informed problem-solving and prevention. All respondents knew where to go and who to contact if help is needed. The majority felt that needed services were readily available and cited as examples case management, shelters and hospital services.

When asked about barriers encountered when seeking care the majority of responses were: waiting list for housing, the attitude of the police and stigma associated with their illness. A few elaborated that their fear of stigmatization by family and friends prevented them from seeking treatment in a timely manner, others mentioned the denial as a factor in obtaining help, *"I did not believe I was ill or needed help*".

The charges that brought them into contact with the justice system ranged from assault with a weapon and sexual assault to mischief. Other charges included threatening, property damage, fraud, failure to comply, harassment and possession of drugs.

[5] While the Law and Mental Heath Program at CAMH is not a funded agency under the Service Enhancement Initiative, the clients that were interviewed were connected to funded housing and case management programs in the community through this Initiative

All of the interviewees were currently involved in one or more programs and these included housing, community support, anger management, socialization, sexual offenders program, medication clinics, addiction management (drugs and alcohol), and life skills programs.

When asked about the length of time in which they were involved with their particular program(s), their responses reflected a wide variation that ranged from 2 weeks to 10 years. Those interviewees that indicated their involvement in a housing program cited a time frame of less than one year, which is reflective of the start up time for the supportive housing program under the Service Enhancement Initiative.

In the years since the mental health diversion program was implemented, the members of the defense bar have come a long way toward embracing this area of law and advocacy for persons with mental illness persons before the court.

The majority of users interviewed singled out their lawyer as the person who provided the greatest assistance to them while in the justice system as well as getting them into their current program(s). This was followed by mental health court workers, family members and case managers. This perception of lawyers as "*best friend and advocate*" for the persons with mental illness before the courts is borne out by the mental health court support data that was provided to us.

One interviewee described her relationship with her lawyer who has represented her over a five year period, including her appearance in court as *"the best thing to happen to me"*. On each occasion her lawyer has worked with the mental health court worker in developing a diversion program and continues to be available and supportive even when she is not involved in the justice system.

When asked about their experience with the justice system, the following areas were singled out: For the police, the responses were mixed in that even though they described being "*roughed up"* during the police response, they described the experience as *"fine"* and that "*the police were simply doing their job.*" Many had multiple contacts with the police and over time would have acquired an appreciation of the challenges they face. One user offered the comment on one episode with the police that *"they could have been as fearful of me as I was of them.*"

The defense bar was described as *"sensitive, caring and knowledgeable,"* by an advocate who negotiated with the mental health court workers on diversion plans. The mental health court worker was seen as being respectful, empowering and an advocate. The comments on their experience with correctional services ranged from their *"worst experience to okay"*.

A common problem raised was the length of time before being seen by a corrections psychiatrist (2-4 days) in order to get restarted on medication. Many felt supported by the ongoing contact maintained with the mental health court worker or case manager while on remand or incarcerated and felt that made their jail experience "*okay*".

Clients described the mental health court support programs as the success factor in these programs. They were seen as educated, sensitive, helpful, considerate, consistently available, respectful and caring. "*They advocated for me."* Other beneficial aspects of the service provided through these programs was regularly taking medication, participating in he

program activities, help with the Ontario Disability Support Program (ODSP) and the opportunity for socialization with peers and staff.

In response to the question on whether services for persons with mental illness that are involved with the justice system have improved or stayed the same, the majority said they had improved, and they cited the following: more educated mental health staff, more services are available, an increased awareness of mental illness, as well as increased awareness of processes and services to help mentally ill persons. There was evidence that staff cared, and that they are both respectful and willing to advocate for clients.

When asked about their ideas for improving the system, the following were identified:

- Police training, particularly in their interactions with persons in crisis with mental illness. Clients represent a unique group of teachers who should be encouraged to participate and share the insights into their illnesses to bring about greater personal awareness on the part of officials with whom they must interact.

- Access to psychiatrists or general practitioners was seen as a required improvement.

- More 'connection' to society. This was associated with the perceived stigma of mental illness.

- Available life skills groups with activities such as cooking, education, nutrition and job training.

- Referral from shelters to supportive housing. Some of those interviewed accessed the supportive housing program from the shelters. They would like to see this process somewhat more streamlined.

- A number of clients suggested that there should be a process to make the public more aware of the range of services that are available in the community for the persons with mental illness. Based on their own earlier experiences, they claim that many suffer needlessly and will continue to do so unless they are aware of the services and how to access them.

- Continue with efforts to decrease stigma and exploitation of the persons with mental illness by employers. Specifically, the exploitation related to the lack of accommodation by employers to allow employees to manage their mental illness and keep their jobs. A small number of interviewees who worked on a part time basis commented on how important this was to their sense of well being.

- Housing was seen as an important empowerment for the users interviewed. Providing more housing for those persons with mental illness who are homeless was seen as an important and urgent need.

- Of the twenty (20) interviewed, six (6) were from visible minorities. All but one person spoke English fluently and all expressed the need to have increased ethnocultural awareness and programs that are sensitive to the cultural differences that exist. To the extent possible, this should also extend to the courts where it may

be necessary not only to have interpreters but also to be represented by counsel who speak the language and understand the culture.

10. SERVICES GAPS AND CURRENT ISSUES IN THE MENTAL HEALTH AND JUSTICE SYSTEMS AND RECOMMENDATIONS

10.1.0 Gaps in Services for Specific Client Groups

10.1.1 Dual Diagnosis (Mental Illness and Developmental Disability)

We were extremely impressed with the organization and the sophisticated networking that we found in the service provisions for the dually diagnosed. Their client centred approach enables service providers to "wrap the service around the client" to meet their needs. In particular, we applaud the work of the small team who work in the Dual Diagnosis and Developmental Services Unit at COTA Health which provides community based services for clients who are also in involved with the justice system.

In the first year of the operation of the Service Enhancement Initiative COTA Health has developed good relationships with the justice system and the agencies that are funded for pre-charge and prevention programs. They are also working with these services to identify and connect them with individual clients that are able to benefit from their specialized services.

A major service gap for these clients, however, has been access to supportive housing. While dual diagnosis clients are not excluded from supportive housing provided under this Initiative, none of the client applications have been accepted during the first year of their operation. The reason for the rejections have been primarily related to their support needs, which have been identified as exceeding the ability of the resources to safely and effectively support them in the community. As such, the dually diagnosed and justice clients were reported to remain in inappropriate housing in hostels and shelters. The lack of housing options to support these clients has a significant impact on the agency's ability to stabilize their lives and reduce the likelihood of their re-engagement with the justice system.

Client Vignette: *Ida is a young woman in her early 20s, with a mild developmental disability and personality disorder, the latter attributed to childhood sexual abuse. Child welfare services placed her in foster care, which ended at age 21. She experiences episodes of explosive rage, when she lashes out at anyone nearby, in retaliation for perceived slights or injustices. She has poor insight and little comprehension for the consequences of her actions or the impact on others. She alternately craves independence and rigidly structured controlled environments. A similar pattern emerges in relationships, as Ida is vulnerable to abuse by partners, who are by turns controlling and dismissive. Ida is capable of consenting to her own treatment, although her finances are managed through a trustee.*

COTA Health and the Dual Diagnosis & Justice program became involved with Ida through a mental health court diversion worker, who was alarmed at Ida's volatility and vulnerability. Developmental sector services had been attempting to support Ida but were feeling overwhelmed and out of their depth. Ida has been moving from shelter to shelter, as her behaviour makes it impossible for her to remain for any period of time. Developmental service housing is not an option for Ida, as she puts other residents at risk – she was supported in a mental health boarding home for a brief period, without success. She was vulnerable to financial abuse and responded by aggressive behaviour toward an individual in the community, who called the police.

Ida is again in custody; she has no formal supports beyond the DD&J program, as other providers have withdrawn. If released, Ida, will be in the shelter system again, as an application for MH&J housing was unsuccessful. Ida needs far more support than the present structures are able to provide, as well as supports with expertise in Dual Diagnosis. The cycle of release to a shelter, re-offending and returning to custody can be expected to continue until specialized housing and a network of sustainable supports is available to Ida.

In general it was stated that transitional housing for this client population would likely require services for six months, rather than the current limit of 30 days funded for crisis beds. This longer period would enable clients to successfully move on to more independent living. In addition, supportive housing would require additional resources in terms of frequency of visits and behavioural therapists that are able to work with the dual diagnosis clients on an ongoing basis.

Recommendation 1: *We recommend that the funding requested by the Toronto Mental Health and Justice Coordinating Committee for the dually diagnosed that are involved in the justice system to provide transitional /crisis beds and additional supportive housing units be approved should additional funding become available. This may be most economically provided by identifying specialized housing in the form of a small apartment block with specific dedicated resources such as behavioural therapists, additional support workers skilled in providing services to dual diagnosed clients and clinical back-up to the support workers. Consideration should also be given to seeking sufficient funding for support to enable dual diagnosis clients that are fire setters and minor sex offenders who are currently unable to find appropriate housing in the community, to be fully supported.*

In the interim, we recommend that the Toronto Mental Health and Justice Coordinating Committee work to improve the coordination of support services between the MOHLTC and the MCSS. Planning is required to identify how the dually diagnosed can obtain access to the existing housing units provided through the Service Enhancement Initiative; recognizing that these clients require more support services than are currently being funded by MOHLTC to live safely and independently in the community.

10.1.2 Concurrent Disorders (Mental Illness and Substance Abuse)

Many mental health and justice clients have multiple needs that require access to services from a number of different agencies and ministries. Some of the most challenging clients for whom to provide services for are those with a concurrent disorder. Service providers noted that while it is often difficult to meet the needs of a client with mental illness, for those with a concurrent disorder it is particularly difficult to access addiction services. One service provider referred to addictions as "*the orphan service"*.

As with mental health services there has been a significant shift to the community in the treatment of addiction. However, the mental health and addiction services generally operate as two different systems with different philosophies and different approaches to service.

This can make it extremely difficult for the client with a concurrent disorder to receive coordinated care for both their mental health and substance abuse problems.

Recommendation 2: *That the Toronto Mental Health and Justice Coordinating Committee seek to build upon the current network that includes mental health and substance abuse services and that the MOHLTC provide more funding and services suitable for integrated treatment for those with concurrent disorders.*

10.1.3 Ethnocultural Services and Programs

Service providers stated that providing services to the very diverse ethnocultural community in Toronto is often very difficult. They indicated that many of these clients do not speak English well enough to understand the justice system and the language barriers frequently increased the difficulty in providing adequate support services, diagnosis and treatment for them. In addition, they indicated that for those individuals who come to Canada as refugees, the extreme trauma they faced in their home countries has frequently left them suffering from post-traumatic stress disorders. We noted that a number of service providers are in the process of providing, or have provided training to their staff on cultural awareness and on post-traumatic stress disorders.

In the interviews with service users six of the 19 were identified as immigrants representing visible minorities. All but one of these individuals spoke English fluently, but all expressed the need to have increased ethnocultural awareness and programs for clients that are sensitive to the cultural differences that exist among the immigrant populations, refugees and multicultural minority groups in Toronto.

We examined a study by Kirmayer et al. (2003) that evaluated a cultural consultation service for mental health practioners and primary care clinicians in Montreal designed to improve the mental health services in mainstream settings for culturally diverse urban populations including immigrants, refugees and ethnocultural minority groups. The evaluation found that this service effectively supplemented the existing services to improve diagnostic assessments and treatment for a culturally diverse urban population.

The Mount Sinai Hospital ACT Team is funded to provide ethnocultural services to the court at Old City Hall. The funding for this service is extremely limited with a part-time manger and two part-time staff. Given the limited capacity of this excellent specialized service, we consider that the model that has been developed at the Jewish General Hospital in Montreal, which employs ethno specific consultants to provide cultural liaison and consultation for various mainstream agencies should be adopted in Toronto, rather than have each of the agencies attempt to specialize.

Recommendation 3: *While the majority of ethnocultural clients will continue to receive services in the mainstream system, access to the expertise of specialized ethnocultural services and development of additional ethno-specific agency services should be encouraged by the members of the Toronto Mental Health and Justice Coordinating Committee. Also, the Montreal Jewish General Hospital model of ethno-specific clinical consultation should be studied as it appears likely to be a more economic and expeditious solution for many agencies.(See reference re Kirmayer study).*

10.2 Gaps in Service Types

10.2.1 Forensic Beds for Assessment and Treatment

The boundaries in mental health services are based on waiting lists. While individuals may be assessed, they then wait until the appropriate mental health service is available for them. Some courts on the other hand consider that it is unconstitutional to make a person wait for mental health services, particularly if this waiting period occurs in a jail. This lack of rapid assessment capacity and the ability to immediately direct a client to a forensic bed who has been ordered by the court to receive treatment has created a crisis in the both the mental health and justice system and resulted in at least one individual being transported from Toronto to Thunder Bay and one from Ottawa to Thunder Bay to access a forensic bed for an assessment.

In response to this crisis and the high public profile given to a number of these cases, an inter-ministerial committee (Hussein/Dwornik Action Team - HuDAT) was established in January 2005. The HuDAT Committee, which consists of members from the Ministries of the Attorney General, Community Safety and Correctional Services and Health and Long-Term Care, works to resolve situations where persons have been ordered by a court to have a psychiatric assessment or court ordered treatment from being held in a correctional institution waiting for access to a forensic bed, as well as other inter-ministerial coordination issues relating to forensic clients.

The Law and Mental Health Program (LAMPH) at the Centre for Addiction and Mental Health (CAMH) has signed a MOU with the Mental Health Court at Old City Hall regarding “forth with” court orders. However, at the time of this study we were advised that this MOU which had been developed on the basis of historical numbers requiring services in Toronto was effectively unworkable as the numbers had doubled in the downtown area of the city, as a result the MOU would need to be re-negotiated to provide a reasonable time in which to conduct the assessments required.

MOHLTC has recently announced the funding of 75 new forensic beds in Ontario, which includes 25 for Toronto. However, LAMPH has an agreement with the local community in Parkdale not to increase the number of forensic beds without further consultation. The Ontario Correctional Services on the other hand has experienced considerable improvement and support in dealing with sentenced mentally ill inmates through its partnership with the Royal Ottawa Heath Care Group in operating the St. Lawrence Valley Correctional Complex. A similar arrangement and partnership could be considered between the LAMPH and Correctional Services for remanded inmates in Toronto that would relieve the pressure on forensic beds for assessment and treatments orders by the courts.

Recommendation 4: *That the Toronto Mental Health and Justice Coordinating Committee support and further encourage the development of additional resources to provide Fitness Assessments and Treatment Orders in correctional facilities. This should build on the functional plan previously developed by the Law and Mental Health Program and be subject to the findings of the current review of the St. Lawrence Correctional and Treatment Project.*

10.2.2. Short-Term Residential Crisis Support Beds

In June 1996 the MOHLTC developed a policy guideline, *The Provision of Community Mental Health Services to People who are Homeless or Socially Isolated,* to address the systemic barriers to the housing needs of the homeless/socially isolated population. However, it was subsequently recognized that this policy "offered little substantive solution to housing" the common client population (Ontario MOHLTC, 1999). In 1998 MOHLTC announced funding for a domiciliary hostel program with funding split 80/20 per cent with municipalities. It was estimated at that time that approximately two-thirds of the clients residing in these hostels were "psychiatrically disabled" (Ontario MOHLTC, 1999).

A recent study of the homeless by the John Howard Society of Toronto and the Centre for Urban and Community Studies, University of Toronto (April 2006), while not specifically focusing on the common client, noted the connection between homelessness and involvement in the justice system.

> Many people who get involved with the criminal justice system come from marginalized, isolated and poor pockets of our communities. Some struggle with addiction issues, mental health problems and experience bouts of unemployment. Some individuals lose their housing while they are in custody for relatively short periods of time, while others were homeless when they were arrested and are unable to obtain housing prior to their release. This can be the start of a pattern of cycling in and out of the criminal justice system and repeated homelessness. (John Howard Society of Toronto, 2006)

The Service Enhancement Initiative is the first funding by the province specifically directed to the common client that provides both crisis support beds and supportive housing.

There is general agreement that the need in the system is greater than the current 16 crisis beds, and is particularly acute for those clients with concurrent disorders and for the dually diagnosed. This lack of crisis beds also means that many individuals continue to have what one service provider described as "a *patchwork of services in the community that are inadequate to meet their needs, and frequently includes using shelters and boarding houses with no support".*

Some of the mental health and justice clients that were interviewed for this study indicated that they accessed the crisis beds through the shelters and that there was a need to see this process somewhat more streamlined.

Service providers noted that there is also a substantial gap between the crisis beds and the supportive housing provided under the Service Enhancement Initiative. A number of agencies indicated that for some clients 30 days is insufficient time to provide the support and transition required to enable them to bridge to more independent housing. In addition, they stated that some clients have used the crisis beds two or three times before they are actually able to be stabilized, including a number of clients that are deemed Fit to Stand Trial by a judge, but experience great difficulty in managing independently in the community.

Recommendation 5: *That the Toronto Mental Health and Justice Coordinating Committee work with the MOHLTC and/or the LHINs to encourage the continued application of flexible*

criteria and more flexibility in length of stay for use of crisis beds before these persons move on to more permanent and independent housing.

10.2.3 Housing and Support Services

Housing is generally recognized as one of the most crucial services in providing assistance and stability for clients that are frequently homeless or facing imminent loss of their existing housing. Service providers in both the justice system and community mental health services noted that supportive housing was able to address the need of clients who had many years experience in both the mental health and justice system and were homeless. They also noted that it provided a very important support to those who had a history of struggling to mange their mental illness over several years, but were experiencing their first major crisis in mental health as well as their first involvement in the justice system. The availability of safe, affordable and secure housing and support services has enabled these latter clients to break the cycle early from increasing involvement in the justice system that has previously confronted many common clients as they move through the "revolving door" of homelessness, accompanied by periods of hospitalization and incarceration.

The funding that is provided by the Service Enhancement Initiative for supportive housing has a staff to client ratio of one to eight clients. This staffing ratio was considered by many service providers to be consistent with and somewhat exceed the Level 2 support as defined by the Toronto-Peel Hospital and Community Comprehensive Assessment Project (2002) study. This level of support requires: "individualized support approximately once a week for assistance in identifying needs and accessing a range of core community supports and services. Their psychiatric care could be provided through regular contact with a psychiatrist or mental health nurse in an outpatient clinic, through a community based mental health service or community psychiatrist's office." The one to eight staff ratio enables clients to receive approximately 2.5 staff contacts each week.

In our discussions with the housing service providers they indicated that while the majority of clients fit well within the parameters of Level 2, services have also been provided to clients that more appropriately fit into Level 3. Level 3 requires that there is sufficient additional support such as forensic ACT teams to meet clients needs and safely management them.

At the time of this study, approximately 16% of all applicants were being rejected on the basis that they required more support than is currently available through the program; or due to issues related to safety and/or risk, including a history of assaultive behaviour towards staff, past non-compliance, and offences that include sexual offending or fire setting.

As noted earlier, dually diagnosed clients have been unable to access housing because their support needs are higher than those provided by this program. Similarly service providers also noted that a number of clients require housing that provides a step-down from the hospital and that is accompanied by intensive case management in the community. Lack of housing for clients that are unable to manage in an apartment without ongoing supervision often results in them being released from the justice system and accessing shelters and boarding houses where case management services are frequently non-existent or have them remain in residential treatment programs for periods that exceed their treatment needs.

Although these housings services are relatively new and the majority of clients require the maximum support that is available to them through this program in order to achieve independent living in the community, we envision that as the program matures and clients are stabilized, not all require this continued level of intensive support. We think this will introduce some flexibility in the deployment of support services that will enable more complex clients with higher initial needs to be supported in this housing program.

Recommendation 6: *That the Toronto Mental Health and Justice Coordinating Committee work with the MOHLTC and/or the LHINs to develop more flexibility in the deployment of support services in the supportive housing program, to provide a graduated intensity of designated support staff/client ratios dependent on the individualized needs of the client. This would permit housing units to accommodate a greater range of clients with higher initial needs who can over time be safely supported what, over the course of their care, will be a an average staff to client ratio of 1:8.*

10.2.4 Release Planning and Community Transition from Correctional Institutions

Release planning for inmates with mental illness was considered by the superintendents of the Toronto correctional institutions as key to being able to link inmates with treatment and services in the community. Although funding was made available for two positions in Toronto under the 2005-06 Service Enhancement Initiative, the majority of persons with mental illness continue to be released without any linkages established to local mental health services in the community.

In the recently announced funding for the 2006-07 Service Enhancement Initiative a total of 36.5 FTEs (full time equivalent) were allocated across the province for release planning and transition of inmates to the community. Toronto received 4.5 of these FTEs and they have been allocated to the Toronto Jail, Toronto West Detention Centre and Toronto East Detention Centre, with one FTE provided for probation services.

Superintendents stated that many of the inmates that are serving very short sentences would likely not be in jail if there was better coordination and release planning to assist them on release and to help offenders to become stabilized in the community. These new positions have been designated specifically to provide short term case management (up to six months) in the community to stabilize clients. As with the court support workers, these positions are also being strategically located in the system to become effective boundary spanners for the mental health and justice clients.

Recommendation 7: *That the Toronto Mental Health and Justice Coordinating Committee work with Ontario Correctional Services and funded agencies to develop a consistent job description for the newly funded release planning and community transition positions. These job descriptions should focus on maximizing the impact of providing services and linkages to other systems that these agencies will be able to provide for mental health and justice clients.*

Recommendation 8**:** *That the Toronto Mental Health and Justice Coordinating Committee develop a program that would provide training for front line personnel across the different mental health and justice service sectors involved with the Service Enhancement Initiative.*

This will ensure that expertise is enhanced and standardized across Toronto.

10.3 Gaps in Human Resources

A lack of mental health services and supports to facilitate community reintegration impedes the time it takes for those who are involved in the justice system to return to or to remain in the community.

10.3.1 Access to and Availability of Psychiatrists

The primary concern that was identified by all of the service providers, mental health and justice clients, in the focus group discussion sessions and in the consultations was the lack of access to and the availability of psychiatrists. They all pointed to a lack of psychiatrists in the community that are willing to treat these individuals or enter into a shared care model with agencies who support these clients. As one agency service provider noted, this is not just a problem that impacts on remote northern communities, but is a problem in the largest city in Ontario that is generally considered to be resource rich.

Service providers working in crisis prevention services indicated that the single most requested service by clients is a referral to a psychiatrist; for many clients this referral is not just to obtain medication but also to receive ongoing treatment. With no funding to purchase psychiatric services the agencies must simply seek out individual psychiatrists who are willing and able to see clients.

The mental health court workers indicated that access to psychiatric services was sometimes problematic. The Human Services and Justice Coordination Project (1997) identified two aspects to the assessment needs of the court. The first is the need for a psycho-legal assessment primarily for the purpose of Fitness to Stand trial and the other assessment for the purpose of suitability for diversion, bail and pre-sentence reporting back to court. As well, assessments using the tools under the Mental Health Act for the appropriate disposition of persons with mental illness are seen as necessary and appropriate. The reality is that there are insufficient resources to provide both on a separate basis and court support workers expressed concern about a focus that is entirely on the psycho-legal disposition. They have suggested the following:

- Have the psychiatrists who presently attend at the court provide for all the assessment needs of the clients
- Create a pool of psychiatrists to whom ‘non fitness’ cases could be referred for an appropriate disposition
- Create more hospital day programs linked to the courts in a geographic area as well as access to hospital beds for appropriate clients requiring short term

Similarly, the crisis bed service providers stated that while lack of access to services in the community sometimes creates difficulties in trying to stabilize clients within the 30 day period, the most problematic of these is a referral to a psychiatrist. Service providers stated that the time it takes to obtain an appointment for a client averages six weeks.

Mental health and justice clients interviewed for this study echoed these sentiments. While

the majority were connected to psychiatrists and treatment, they indicated that the great difficulty they had experienced in accessing these services.

For those clients that are dual diagnosed there are only three psychiatrists in all of Ontario who were identified as specialized to provide services to this group.

The lack of access to and availability of psychiatrists was the most common gap identified by all of the respondents to the questionnaires. They identified two challenges, the first being that many clients who could benefit from clinical intervention are reluctant to participate. The second relates to the stigma associated with being a person with mental illness that is involved with the law, and the additional barriers this creates in obtaining effective treatment, particularly in the area of diagnostic assessments, appropriate prescribing and monitoring of medication and admission to hospital when the need exists. In this context, the role of Schedule1 units in general hospitals must be examined in terms of the potential linkages with community service providers to ensure that the necessary supports are available to mental health and justice clients when needed.

It is recognized that some persons with mental illness who are also involved with the law may not be suitable for admission to a general service psychiatric unit. Given the shift in the responsibility for the management of this population over the past ten years from the hospitals to community mental health agencies, a rapid bridge for access to clinical medical services for treatment for these clients is essential. Formal agreements between community service mental health agencies to meet this need and hospital based psychiatrists and physicians could allow for consultation between community case workers and designated medical staff, and would create the potential for accelerated assessments of clients.

A number of options have been explored in the past, from formally linking community agencies to hospitals and independent medical service providers, to funding the purchase of units of medical services by community mental health clients. Meanwhile, the funding of psychiatric services at general hospitals and of community services to persons with mental illness in the community who are supervised by mental health community agencies, continue along separate paths.

One model worthy of note is the recently concluded agreement between the Mental Health Funding Working Group, the OMA and the MOHLTC, in an effort to reach “hard to service” patient populations. The funding that is provided is intended to enable Schedule 1 hospitals to recruit and retain psychiatrists to provide specialized out-patient services in four designated high priority areas. Each hospital is entitled to receive $20,000.00 per year to be used for the sole purpose of supporting a psychiatrist or several part-time psychiatrists who provide services in any of the following four areas:

1. Outpatient psychiatric service for geriatric patients. The psychiatrist(s) should be available at least one half day per week (three and one-half hours) to:

    - Assess, consult and treat patients over the age of 55 years who have mental health problems;
    - Provide support to inpatient services and community agencies for this population including nursing homes, family physicians, geriatricians, etc.

2. Outpatient justice and mental health service. The psychiatrist(s) should be available at least one half day per week (three and one-half hours) for persons who currently have or are a high risk of having problems in the justice system to:

    - Assess, consult and treat patients for Axis 1 disorders;
    - Provide support to inpatient services and community agencies for this population including court support workers, case managers for clients living in residences.

3. Outpatient psychiatric service for adolescents and/or adults with developmental delay and concurrent mental health diagnoses. The psychiatrist(s) should be available at least one-half day per week (three and one-half hours) to:

    - Assess, consult and treat patients who have developmental disability and concurrent mental health problem;
    - Provide support to community agencies for this population including agencies and group homes that have such clients, family doctors, etc.

4. Outpatient service for children and adolescent patients with mental health problems. The psychiatrist(s) should be available at least one-half day per week (three and one-half hours) to:

    - Assess, consult and treat children and adolescents with mental health problems;
    - Provide support to inpatient services and community agencies including child, adolescent and family community services, family physicians, pediatricians, Children's Aid Societies, etc.

This could mean that a total of $80,000.00 per year is available for each Schedule 1 hospital in the province if all four services are maintained for the fiscal year. The funding is also available on an ongoing basis if the services are continued. It is not necessary that the psychiatrist(s) be on call or even on active staff at the hospital; they may instead be granted staff privileges as consultant staff. This may be particularly beneficial if there are a number of qualified psychiatrists with the necessary expertise or if a psychiatrist chooses to cover several hospitals. In addition, the psychiatrist(s) can bill OHIP for all applicable services.

It is expected that some programs will be up and running by July 1, 2006 and hospitals have until September of 2006 to indicate the programs that they are interested in operating in order to receive funding for the following fiscal year.

This program would permit community agencies to negotiate agreements to have their clients seen and clinically assessed when needed. As well, it provides a model for future unique funding of clinical services for mental health and justice clients and, in particular, those with dual diagnosis or concurrent disorders.

Recommendation 9: *That the Toronto Mental Health and Justice Coordinating Committee work with the Toronto Schedule 1 hospitals to link the service needs of community mental health agency clients with hospital psychiatrists. This could provide much needed specialized out-patient services using the funding that has been identified for four high priority areas in the agreement between the Mental Health Funding Working Group, the Ontario Medical Association (OMA) and the MOHLTC***.**

Recommendation 10**:** *That the Toronto Mental Health and Justice Coordinating Committee develop strategies for funding of non OHIP billable services that will encourage Schedule 1 hospitals to work in partnership with community mental health agencies to better serve the mental health and justice clients. In the event that the priority funding is insufficient to meet current demands for services, alternative strategies will need to be developed including pooling and reallocation of program funds.*

It is recognized that the supply of psychiatrists may not be sufficient in the foreseeable future to service the system using the current specialist service model. While psychiatrists are needed for court assessments, some services for this client group could be delegated to other mental health professionals such as nurses with psychiatric training, clinical psychologists and psychiatric social workers.

10.3.2 Access to and Availability of General Practioners

Many individuals who have serious mental health issues also have accompanying serious physical health issues, some of which can be life threatening. Service providers indicated that there is a lack of family physicians and dentists in their communities the community who are willing to treat these clients. In addition, there is a general shortage of family physicians in Ontario, so many can choose who they are willing to take on as patients. Those with complex needs that involve mental illness seem, all too often, not to be considered desirable patients.

While many clients prefer to be a patient of a specific family physician that they can see on a regular basis, the new Family Health Teams are often willing to accept these clients as patients.

Recommendation 11: *That the Toronto Mental Health and Justice Coordinating Committee work with Family Health Teams, family practice groups in general hospitals and community health centres in various local areas to develop a "shared care" relationship for mental health and justice clients utilizing family practitioners, as well as to recommend a variety of strategies be developed including options for provision of non billable service.*

10.4 Gaps in Service Coordination

10.4.1 Cross Sectoral Delivery and Involvement of the Justice System

The service system for persons with mental illness who are involved in the justice system is fragmented, although the Service Enhancement Initiative funding has resulted in the development of networks of services to facilitate service integration across the four service quadrants in Toronto.

These networks are generally in the early stages of developing common protocols and procedures and do not have formalized agreements to ensure that the current level of collaboration is maintained between the service providers and/or extended to the justice system. However, the capacity to participate collaboratively is not funded and is primarily

dependent on good will and a willingness by agencies to work towards a more fully integrated service system. We saw excellent collaboration between community mental health agencies funded by the Service Enhancement Initiative, but far less so with the justice system which is not at all well integrated with the mental health service system.

Probation officers indicated that connections to mental health services are sporadic across Toronto and are primarily dependent on either a contract with a local psychiatrist in some probation offices or access to one of the programs that provided release planning from correctional institutions to the community. This piecemeal approach to providing mental health services results in many probation clients receiving no services, or experiencing very lengthy waits to access existing services in the community.

Superintendents and senior officials in the Toronto area correctional institutions indicated that they are particularly isolated from the mental health services system. They described connections to the mental health system as "*virtually non-existent with the majority of offenders leaving the institutions without any access to mental health services in the community*". While they acknowledged the excellent services provided by release planning through the Scarborough General Hospital and Homeward programs, they indicated that the majority of offenders with a serious mental illness continue to be released from the detention centres and correctional institutions with no connection to community mental health programs or services.

Communication within the justice system was often not well developed. In particular it was noted that information flow between the courts and the detention centres is lacking, and that often an inmate will receive a "forth with" order from a judge and then be sent directly to the hospital from the court with no information being provided to the detention centre about the individuals whereabouts.

Many of the service providers commented on the need to improve the relationship with justice partners and, in particular, the correctional facilities. Despite diversion strategies, persons with mental illness will continue to be held in detention centres during remand and or sentenced to periods of incarceration. A number of service providers described a major disconnect in the continuity of care and support that occurs when persons are admitted to the correctional system.

Recommendation 12: *That the Toronto Mental Health and Justice Coordinating Committee advocate for the development of a District Mental Health Services and Justice Coordinating Committee in each of the four local areas of Toronto. These committees would be comprised of local mental health service providers and representatives from the local detention centres, probation and parole services, the police services, the crown attorney services and the local hospital so that care can be better coordinated, barriers identified, solutions discussed and implemented.*

The structure, functions, roles and responsibilities of the District Human Service and Justice Coordinating Committee as well as other coordinating bodies we propose be created are outlined in Section 11 of this report and would address current issues that include:

- *More formal liaison with the local correctional facility to allow for comprehensive plans to be developed that will assist with preventing clients from re-offending. This*

would include developing protocols that will allow for designated mental health staff from community service provider agencies to have access to clients in custody, based on a similar arrangement to that which is allowed for legal counsel.

- *Closer working relationships between housing case managers and release planners in the correctional and detention centres, to allow for easier access to housing when the client leaves the institution.*

- *The development of a "best practice" framework specifically targeted at this client group using a consistent approach to identify persons with mental illness. Clients who are incarcerated and collaborating with detention centre staff would be tracked with potential mental health providers, so that when a client moves from one correctional institution to another, the case manager responsible for the client is informed about their status.*

10.4.2 Service Agreements

The funding for the Service Enhancement Initiatives has enabled what service providers described as "*a footprint of service to be made available across Toronto*". The first phase of making this work has been "*talking to each other and setting common goals and work plans*". While the agencies recognize that they frequently represent different philosophies of recovery, they also realize that this coordination enables them to meet the different needs of the client population. The Service Enhancement Initiative has been considered to be both "*a tremendous leap forward and a challenge".*

The current system of mandated collaboration that has developed based on the allocation of funding of agencies within the city and the designated lead agencies has enabled a network to develop. This network of service agencies provides the initial foundation of the development of system integration. The key to making it work has been "*that everyone is now at the table, making a very deliberate effort to make it work*." Agencies have a high degree of accountability to each other, and when something "*doesn't work we fix it and maintain the integrity of the program"*.

Agencies funded by the Service Enhancement Strategy expressed a great deal of frustration with the old system and also their anxiety that a structure that is now working well for them not be dismantled. They stated that for the first time there is a sub-system that is built around the many juncture points of pre-charge and diversion that connect the justice and mental health systems. They also pointed out that there are increasingly more collaborative relationships around common goals and efforts to fill services.

However, the time to develop and maintain these relationships was said to be greatly under estimated. While frontline services are being funded, there is little additional funding for strategic development and support for the collaborative work that needs to be continued to make this network function over the long term. The relationships that have been developed are currently maintained based on trust and good will and considerable effort on the part of the agencies.

As the service provisions under this Initiative mature and the 2006-07 funding rolls out, we recommend that service level agreements be developed that capture the working relationships and responsibilities that these services require to be sustained for the long term. This would ensure a retention of corporate memory and retention of these arrangements well beyond the departure of staff and volunteers who are currently involved.

Recommendation 13: *That the Toronto Mental Health and Justice Coordinating Committee work with the justice system and the member agencies of the mental health and justice network to develop service level agreements. Priority should be given to developing these agreements for the provision of crisis beds and supportive housing so that they clearly delineate the roles and responsibilities of both parties to provide services and support to the common client; identify the accountability relationship in regard to the services to be provided to the client; and set out protocols for communication and information exchange and the working relationships.*

10.4.3 A Common Data Base

We accessed a number of data bases in an attempt to provide a complete picture of the clients, however, each of these data bases focus on only a portion of the total client population. As such, we found that none of the current data bases are sufficiently comprehensive to provide an accurate picture of either service provisions or client profiles.

Over the last ten years there have been several attempts to estimate the size and complexity of the client group, but this has always been hampered by the lack of a common data base. The CDS and MIS data bases that are currently being developed and maintained by the CMHA Toronto for the mental health court support programs in Scarborough and Etobicoke hold considerable promise of being able to provide both service and system level analysis on the common client group. In addition, the court support program is ideally situated as a “boundary spanner” between both the justice and mental health systems to collect information that will be informative on the client population.

We understand that the development of the CDS and MIS data base will be sufficiently advanced by the early fall that it will be able to be shared with other agencies. In addition, we also understand that the data that is currently being collected on both the supportive housing and crisis beds through the registries could also be included in this data base.

This data base would enable the agencies that are funded through the Service Enhancements Initiative to provide an evidence-based picture of their services. It will also allow the Toronto Mental Health and Justice Coordinating Committee to make evidence-based decisions at the systems level.

Recommendation 14: *That the Toronto Mental Health and Justice Coordinating Committee encourage the use of the data elements in the developing court support database to link charge and disposition information to other mental health program information by all agencies that receive the Service Enhancement Initiative funding.*

Recommendation 15: *That the Toronto Mental Health and Justice Network work with its member agencies to prepare an annual report on the activities and clients served through*

the Service Enhancement Initiative. In addition, a review similar to this one of the progress made in this sector should be informed by the results of the provincial service enhancement study and be conducted by the end of 2007/2008.

10.4.4 Information Sharing Across the Systems

While some offenders are well known to the health care staff, others may have no history and very limited information on their health care needs. Both the police and hospitals are often very reluctant to provide any information to corrections staff and community agencies. Sharing of medical information regarding inmates who are hospitalized is actually worse than it was five years ago. For example, one inmate was dying in hospital, but the only way the corrections staff could find out what was happening was to visit the inmate at the hospital.

The Toronto Mental Health and Justice Coordinating Committee should recommend a regulatory change to allow this information to flow between official caregivers in the mental health and justice systems.

Recommendation 16: *That the Toronto Mental Health and Justice Network work with member agencies and legal counsel to reach agreement on the sharing of information essential to the continuity of care from one system to another. It will likely be necessary to seek a regulatory change under PHIPPA (Personal Health information and Protection of Privacy Act) to allow for the flow of information between these providers.*

10.4.5 Assessing Risk and Determining Service Needs

While there are several different instruments that are used in both the mental health and justice systems to assess risk, they vary considerably in the time required to complete them and the level of training required to administer them.

A number of agencies have initiated training on the Level of Service Inventory-Ontario Revision (LSI-OR) tool, a risk assessment tool that is used extensively in Correctional Services and has been validated for use with both inmates and probationers. While this tool provides no information on mental health it is used by probation officers and by social workers in the institutions to make key decisions regarding both level of risk and to identify the criminogenic characteristics of the offenders. The level of training required to administer this tool is also relatively short.

Agencies have pointed out that there is a lack of a common language regarding risk across the mental health and justice systems, both to adequately identify risk and to communicate about risk related factors. The LSI-OR instrument could be used to identify risk while occupying limited time in training and administration, it would also enable service providers to utilize a common language.

Recommendation 17: *That the Toronto Mental Health and Justice Coordinating Committee work with Ontario Correctional Services to coordinate training for community mental health*

agency staff on the use of the LSI-OR (Level of Service Inventory - Ontario Revision) and other standardized assessment tools.

10.5 Gaps in Corporate Systems

10.5.1 Performance Measures and Data Sets for Evaluation

The Toronto Mental Health and Justice Coordinating Committee is to be commended for the high level of coordination and collaboration achieved between service providers as well as with their justice partners. The Police MCIT have effectively brought the police in as partners, and the work that is underway to reach out to the police through the crisis prevention programs is commendable. Similarly, the mental health court workers have impressed the courts with the importance of their contribution and the effectiveness of the diversion programs. We view their positions as both service brokers and boundary spanners for the mental health and justice systems. The crisis bed and the supportive housing programs have met the needs of clients who have previously been unable to access permanent housing and have been homeless and living on the streets and in shelters. Housing is often seen as key to maintaining an individual in the community and to their ability to access community services. The release planning programs and the North York Hospital program have assisted many offenders to access services in the community that, over the long term, will sustain them in the community.

We also want to commend the Mental Health Consultant with MOHLTC for the leadership and support that the Toronto Regional office has provided in assisting in the development of this network of agencies, her work has been exemplary. The strategic funding of the city based on four quadrants and the requirement for mandated collaboration between the agencies has enabled many best practices to begin to emerge.

However, at this time much of the work of the network of committees is not documented and it is, therefore impossible to clearly identify these programs as best practices. As we have indicated earlier in relation to the need to develop formal service agreements that define the relationships with the justice system, we also consider that it is equally important to be able to measure the success of these programs against performance standards and measures. This will require dedicated staff time to maintain records and to translate the data.

Recommendation 18: *That the Toronto Mental Health and Justice Coordinating Committee, informed by the Service Enhancement Initiative, work with MOHLTC to develop performance standards and measures that will enable the agencies to identify their successes and to document their best practices. Extra resources from MOHLTC and later from the LHINs will be critical to provide the data/information and general records upon which performance may be measured and services informed by the results of the Service Enhancement Initiative.*

10.5.2 Education and Training for the Mental Health and Justice Systems

Each of the community mental health agencies indicated that they considered the training they received as appropriate and helpful in doing their work. However it was evident in our

discussions that for many of these staff had very limited knowledge about how the justice system operates.

Similarly, many justice system representatives did not understand the mental health system and many also stated they did not have a good understanding of mental illness. This was particularly evident for correctional institutions and correctional officers. Senior corrections officials stated that in a jail or detention centre, staff often has difficulty in determining whether the inmate is presenting with a mental health problem or is simply a behavioural problem. Once an inmate with a mental illness has received treatment and has become compliant with medication, correctional staff are frequently perplexed about how to continue to assist in maintaining their health. Both service providers and mental health and justice clients commented on the lack of respect and dignity some correctional officers displayed in their dealings with mentally ill inmates.

Both service providers and consumers indicated that police officers who have received training on how to mange their interactions with persons with mental illness and persons in crisis are often particularly understanding of the needs of these individuals. However, we also heard stories where this was not the case, and about officers who showed considerable insensitivity.

The service providers that work with individuals that are dually diagnosed reported that the challenges of working with these clients was generally not well understood by the majority of mental health service providers or those in the justice system.

A number of mental health and justice clients noted that they themselves represent a unique group of teachers who should be encouraged to participate and share insights into their illnesses. They believe that this involvement would bring about greater personal awareness on the part of both mental health and justice officials and service providers. There have been well developed examples of such training programs in Toronto.

Recommendation 19: *That the Toronto Mental Health and Justice Coordinating Committee initiate training that includes using the expertise from all member groups to ensure that both mental health service providers and the justice system are informed about the operations of their respective systems. The Toronto Mental Health and Justice Coordinating Committee should also consider ways and means for clients to contribute to this training.*

10.5.3 Public Education

One of the primary concerns voiced by the clients during the interviews was the issue of stigma that is still attached to being mentally ill. They also identified the need for continuing education of the public to ensure that there is greater awareness of the range of services that are available in the community for the persons with mental illness. Based on their own earlier experiences, a number claimed that many suffer needlessly and will continue to do so unless they are aware of the services and how to access them.

A small number of mental health and justice clients who worked on a part time basis commented on how important their employment is to their sense of well being. However, they also stated that there is frequently a lack of workplace accommodation by employers to

enable persons with mental illness to manage their illness. They perceived that this was also due to a lack of public awareness about mental illness.

Public education campaigns provided by many agencies have brought mental illness and the issues of stigma to the forefront of the public's attention during the last 10 years. These campaigns have offered an excellent way to inform the public about issues relating to general mental illness.

We found during the course of this study that knowledge and information about the Service Enhancement Initiatives under this program are not well understood and that many of the service providers, particularly in the justice system, did not know how to make contact with the service.

The Toronto Mental Health and Justice Committee should consider how they can better inform other service providers about these services. We were particularly impressed by the recent open house hosted by the Scarborough Human Services and Justice Coordinating Committee that enabled the service providers to inform and familiarize local agencies about these services and to make lasting contacts with them.

Recommendation 20: *That the Toronto Mental Health and Justice Coordinating Committee conduct open houses/ information sessions in the West, North and Central quadrants, as has been done in the East quadrant, to inform local service providers about the Service Enhancement Initiatives in their communities. This would be particularly timely as the second round of funding announcements will be awarded shortly.*

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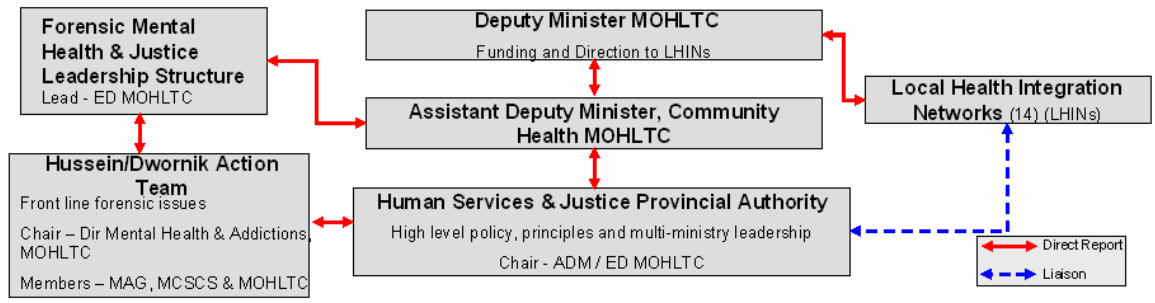
11. SYSTEM DESIGN FOR HUMAN SERVICES AND JUSTICE

11.1.0 Provincial, Regional and Local Leadership Structures

Many persons interviewed favour a provincial body to provide leadership for the complete mental health system in Ontario. Whether or not such a broadly mandated structure is created, it is generally felt that strengthened provincial leadership is needed in the forensic and the broader human services and justice field. The view expressed is that strong leadership is needed to enhance horizontal planning and delivery of programs in this complex forensic services area, to create a system where it does not now exist.

Reader's note: Each subsection of the proposed organizational structure is represented by its own chart. The reader may wish to refer first to section 11.1.7 to view the complete structure in graphic form.

11.1.1 Provincial Authority



Human Services and Justice Provincial Authority

We were told that a provincial level structure should be established to provide cross systems leadership in all aspects of the planning, development and delivery in the human services and justice field in Ontario.

At the same time, it is strongly felt that every effort should be made to resist the expansion of this structure from its central purposes. Those responsible must ensure its integration at a policy and planning level with the many structures in government and in the non-government sectors that plan for and service the large population of mentally ill persons who have not become involved with the justice system.

For purposes of this document the provincial structure for the human services and justice area will be called the Provincial Authority.

It is difficult to set out appropriate roles and responsibilities for Regional/District and Ad Hoc Working Group structures for Toronto without contemplating what the roles should be for a Provincial Authority to which they would relate.

If a provincial body is not established, a strengthened central structure is nevertheless a necessity. The responsibilities set out in section 11.2 will still need to be performed. It is

suggested that an Assistant Deputy Minister or Executive Director in the MOHLTC should be assigned leadership responsibility. This individual should establish a committee of senior level staff from each of the six involved ministries to assure provincial level direction for the Regional Human Services and Justice Coordinating Committees, the ministries and the relevant LHINs.

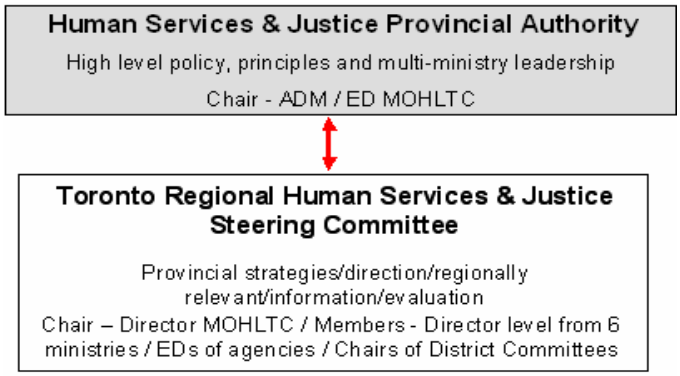
This multi ministry structure would relate to the Provincial Human Services and Justice Coordinating Committee currently in existence. It is chaired by the Director, Mental Health and Addiction Branch and the membership includes the chairs of each of the Regional Human Service and Justice Coordinating Committees.

Each of the provincial roles and responsibilities (set out in Section 11.2) should be assigned by the Assistant Deputy Minister's Committee to one or more of the responsible provincial ministries involved through their representatives. In addition, some psychiatric hospitals and non government organizations (NGO) could take on or expand current information collection and dissemination duties. Similarly, the Ontario Mental Health Foundation could take on certain of the research responsibilities contemplated for the Provincial Authority.

Recommendation 21: *That the Toronto Mental Health and Justice Coordinating Committee recommend to the MOHLTC that a strengthened Provincial Authority be created for the human service and justice field. This structure should provide assertive leadership both for the forensic field and for the broad human service and justice field. Such a Provincial Authority could be separated into two closely related components, one with the responsibility for the small but very complex and demanding forensic field, and the other for the human service and justice population.*

This authority would provide much needed inter-ministry leadership and would provide much needed human services and justice information to the LHINS responsible for the Toronto area.

11.1.2 Regional Human Services and Justice Steering Committee



Toronto Regional Human Services and Justice Steering Committee

It is widely felt that the structures proposed in *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems* (1997), the *Making It Happen, Implementation Plan*

for Mental Health Reform (1999) and the *Forensic Services Expert Advisory Panel* (2002) reports continue to have a great relevance to today's needs. However, it is clear that there is a need for more than coordinating efforts to cause this complex set of systems and well intentioned staff to deliver effective and timely programs. More clout is needed at both the provincial and regional levels.

As stated in Section 11.1.1, a structure is needed at the provincial level which has a considerable authority assigned to it by Cabinet, whether it is an independent or an intra government body. In order for the direction of the provincial body to be carried out and for it to receive authoritative and representative advice from across the province, Regional Human Service and Justice Coordinating Committees should be given newly developed and explicit responsibilities.

A change of name to Regional Human Services and Justice Steering Committee is proposed in order to make evident that shift to a body with more direct influence.

- Senior level membership would need to be specified by the Provincial Authority. Director or equivalent level membership from government ministries and Agency Executive Director or Deputy Executive Director rank persons from non government agencies would be required if the regional body is to lead at the level contemplated. The Chairs of the District Committees (described later) and the Chairs of Sector Committees, such as the later described Mental Health and Justice Services Network would be approved/appointed by the RHSJSC. It is essential to assure that persons with operating experience are members of this group as well as consumer and family/key support representation.

- Participation would need to be set out in the Business Plan commitments to this program by each ministry and agency.

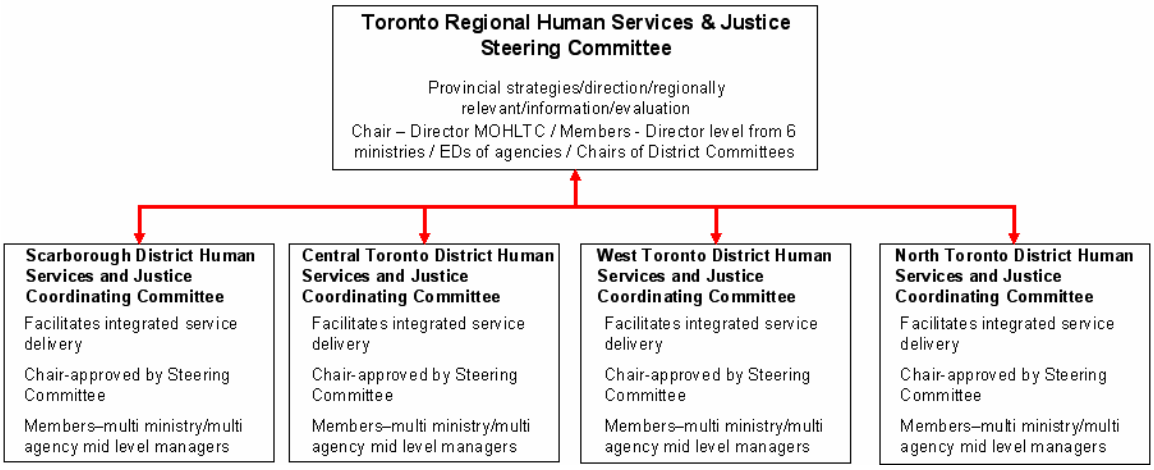
- The Steering Committee would be chaired by a leader from the sector, chosen by the Provincial Authority or Assistant Deputy Minister, Community Health, having sought recommendations from the agencies and ministries directly involved. A Deputy Chair would be similarly chosen and this person would take over the chair post after two years.

- Other executive roles would be filled by a vote of the membership of the Steering Committee. Staff would report to the Chair.

Recommendation 22: *That the Toronto Mental Health and Justice Coordinating Committee recommend to the MOHLTC that the regional human services and justice structure be given a more authorative role for the Toronto human services and justice field. That the name Toronto Regional Human Services and Justice Steering Committee be adopted to make evident the shift to a body with more direct influence.*

This structure and the Toronto Mental Health and Justice Network will be vital data collection and analysis locations that will provide much useful information to the LHINs. As a first step the Regional Health and Justice Coordinating Committee could begin to take on these broader responsibilities until the Regional Steering Committee is authorized, if that occurs.

11.1.3 District Human Services and Justice Services Coordinating Committees



District Human Services and Justice Coordinating Committees

It is proposed to establish a coordination function for each of the current four Toronto quadrants/local areas by creating District Committees. Their work would be guided by the Toronto Regional Steering Committee. They might be called District Human Services and Justice Coordinating Committees (DHSJCC) and would be operations committees in function.

- They would take their general direction from the Regional Steering Committee and then tailor their planning and programs to the particular service needs of their area.

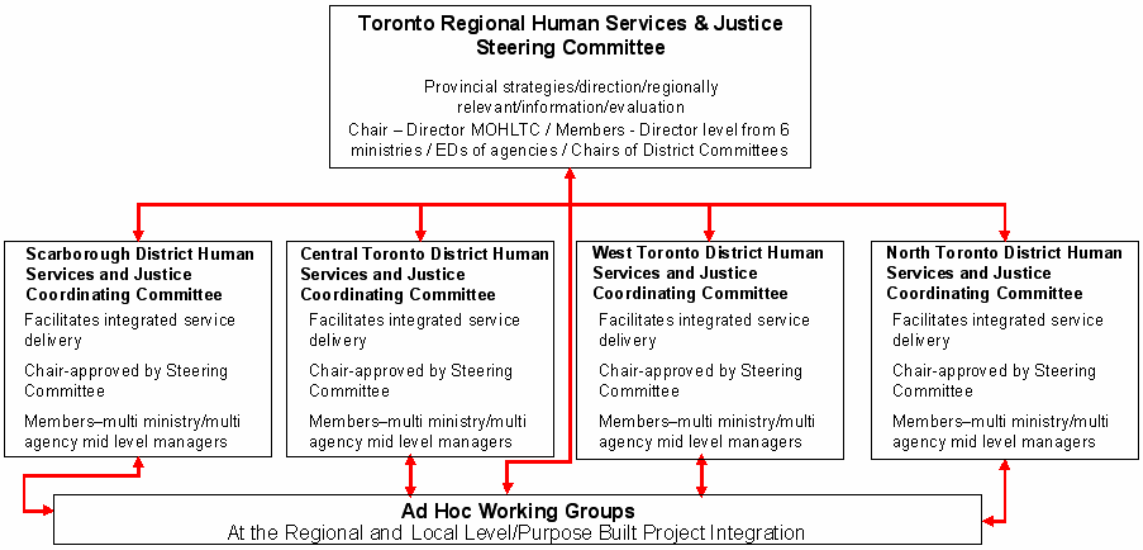
- The membership of the four District Committees would be approved by the regional body upon recommendation of the mental health and justice government and non government agencies in that area.

- The Chair of each District Committee would be appointed by the Regional Human Services and Justice Steering Committee after receiving a list of proposed appointees from the District membership. The Chair would become a member of the Regional Steering Committee.

- Each District Committee would be associated with a particular court or courts, as it is the crown attorneys and the courts that are the source of referrals to the mental health agencies for diversion of mentally ill persons from the justice system.

Recommendation 23: *That the new Regional Human Services and Justice Steering Committee establish a District Human Services and Justice Coordinating Committee for each of the four local areas of Toronto into which it is currently divided for the Service Enhancement Initiative. These Committees would provide front-line coordination among human service and justice providers in their respective areas.*

11.1.4 Working Groups

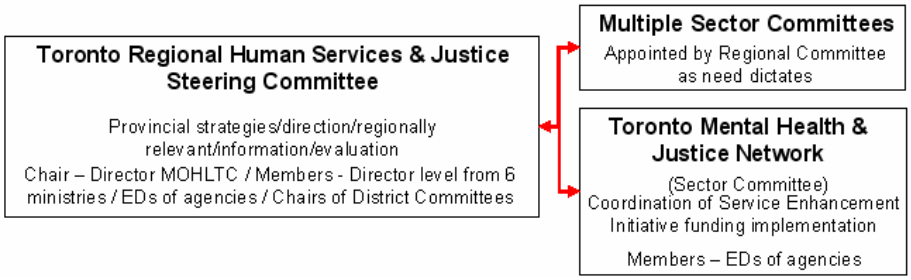


Working Groups

Working Groups could be established or approved by either the Regional Human Services and Justice Steering Committee or the District Human Services and Justice Coordinating Committees to coordinate the mutual efforts of agencies, as required. Their scope would be either at a city-wide level or focused on a particular quadrant depending upon the task.

Recommendation 24: *That inter-agency coordination of services between two or more agencies be led by "purpose built" Ad Hoc Working Groups approved by either the Regional Human Services and Justice Steering Committee or the District Human Services and Justice Coordinating Committees.*

11.1.5 Toronto Mental Health and Justice Network – A Sector Committee

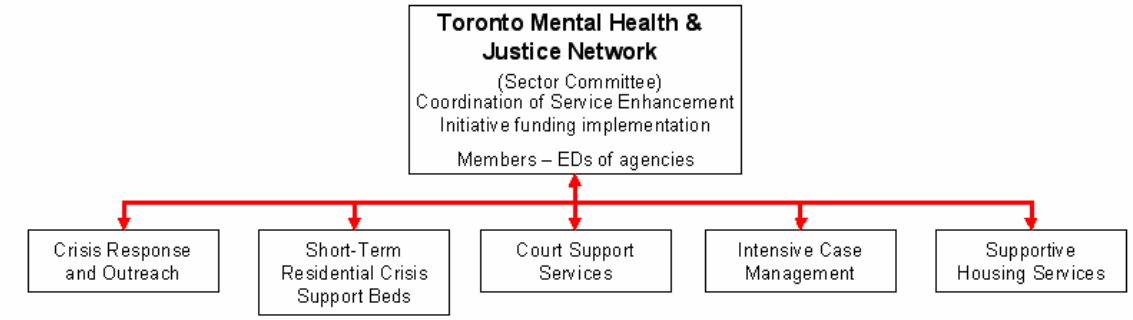


Toronto Mental Health and Justice Network

The Toronto Regional Human Service and Justice Steering Committee should establish or use currently operating sector committees for special purposes. Sector Committees could be established to give special attention to the following populations; addictions, developmental disability, fetal alcohol spectrum disorder, acquired brain injury, high risk fire setters, etc. This arrangement would allow for a functional operational focus in particular

areas and would complement the geographic design of the proposed Provincial, Regional, and District committees.

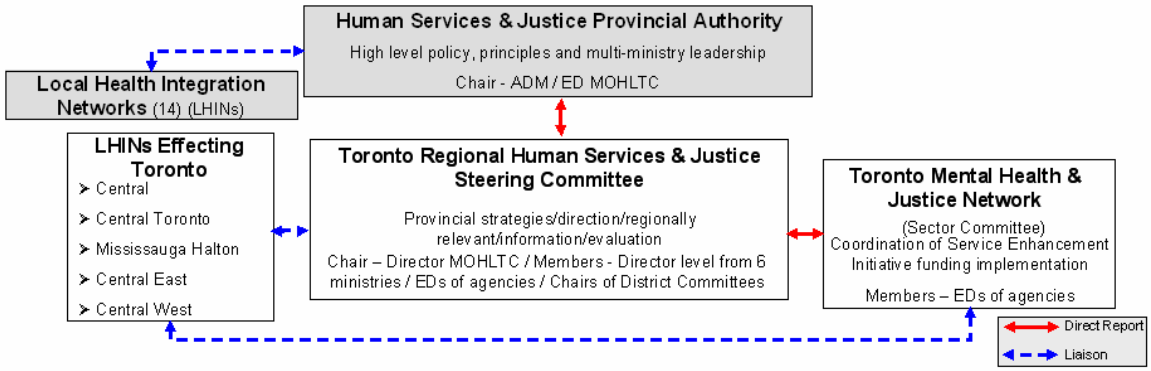
The current Toronto Mental Health and Justice Network should serve as one of these functional sector committees as it is well placed to continue to facilitate the integration and coordination needed as the Service Enhancement Funding is absorbed. This committee would continue to be known as the Toronto Mental Health and Justice Network.



Service Enhancement Initiative: Committee Structure

Recommendation 25: *That the Regional Human Services and Justice Steering Committee authorize the creation of Sector Committees to lead service coordination across Toronto for particular client groups, such as addictions, developmental disabilities, fetal alcohol spectrum disorder, acquired brain injury, etc. The current Toronto Mental Health and Justice Network would become the Sector Committee for mental health and justice services across Toronto.*

11.1.6 LHINs: Boundary Alignment with Mental Health and Justice Service Areas



Boundary Alignment with Mental Health and Justice Service Areas

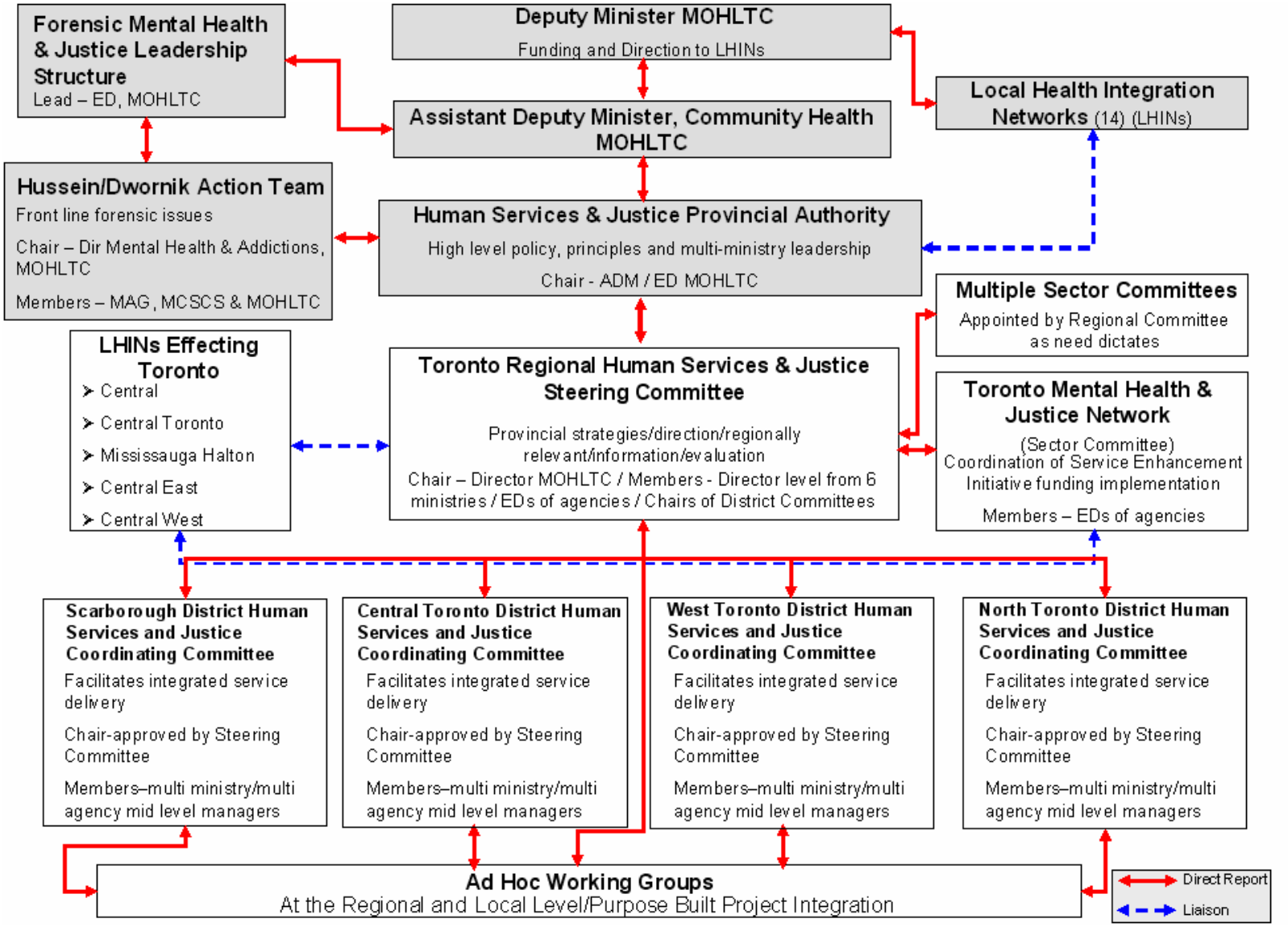
It does not seem practical to attempt to align the geographic boundaries of the mental health and justice related services to the boundaries of the five Toronto LHINs, even though in the future each of the five Toronto related LHINs will fund such programs in their geographic area.

The LHIN boundaries were designed to follow the flow patterns of patients requiring physical care in the health system and the mentally ill and other groups who encounter the justice system flow quite differently and in a way which relates to the boundaries for police services and the courts. For a time, the justice system becomes the predominant service system for the individual.

It will be essential for the five Toronto area LHINs to plan their full spectrum of community mental health programs and funding in a fully coordinated manner, even though the flow of funds will occur from each separate LHIN budget to the service delivery organizations in its area.

Recommendation 26: *That the Toronto Mental Health and Justice Coordinating Committee recommend to the MOHLTC that boundaries for the human services and justice field use the courts in Toronto as the primary focus for their service system design. That linkage to the five Toronto LHINs by the proposed Toronto Regional Human Services and Justice Steering Committee, the four District Human Services and Justice Coordinating Committees and Sector Committees should be given very high priority by all areas. These committees should serve as the key planning and integration structures for this field and advise the five Toronto LHINs.*

11.1.7 Organizational Structure for Provincial, Regional, District and Working Group



In summary, these proposals visualize provincial and regional structures in human services and justice with much more authority and influence, as well as greater accountability, for their work. Coordination would give way to a more authoritative approach at these two levels. By contrast, coordination would be the key activity at the District and the Working Group levels.

11.2.0 Roles, Responsibilities and Functions at each Level of Responsibility

11.2.1 Roles, Responsibilities and Functions of the Provincial Authority

These roles and responsibilities are presented in two groups, those that would be essential for the forensic field, narrowly defined and those that would apply to the broad human services and justice field.

Forensic Field – Narrowly Defined

The Provincial Authority should take on the following responsibilities for the narrowly defined and specialized forensic human services and justice field.

- To develop and recommend policies and practices to all relevant ministries and sectors that will ensure coordination of forensic mental health services across Ontario.
- To develop strategies that will improve inter-ministry, hospital, court, police and non- government system coordination in the delivery of forensic services.
- To identify issues that may impede effective management of the forensic mental health system.
- To develop and recommend service guidelines, programs, projects and initiatives.
- To establish performance measures concerning the forensic services system coordination and management.
- To monitor and evaluate the effectiveness of the forensic mental health system.
- To be a key point of liaison between the provincial government and the Ontario Review Board.
- To draft principles which are formally agreed to by the six ministries and which would be embedded in all Ministry contracts with service agencies and in the MOHLTC instructions to all LHINs.
- To promulgate as a key principle that mental health care can and must be provided within and side by side with any component of the forensic system; that it is not simply a MOHLTC responsibility.

- To recognize that a well functioning mental health system, including appropriate housing, is key to the provision of appropriate services for the forensic population.

- To perform an advisory role with each ministry and with the Management Board of Cabinet in the annual preparation of ministry business plans, to assure that the needs of this population are adequately represented in program and funding proposals for subsequent years.

- To assist the ministries to "get the incentives right" for development of the forensic services.

- To perform an appraisal and evaluation role with regard to the annual disposition of forensic funding and its impact in each of the ministries and each LHIN for each of the six Deputy Ministers and Management Board of Cabinet.

- To develop a methodology for data collection from all elements of the mental health and justice field.

- To develop a scheme for adequate data/information flow from agency to agency, including patient/client medical information.

- To provide a report to the six ministries involved, every six months, with data collected about this population, by region and by LHIN, including information concerning system successes and problems.

- To assure that the organizational design developed for forensic services is of a dynamic nature to allow for the ever changing nature of government, non-government and government agency structures and mandates, including the LHINs.

- To study and propose innovative methodologies to securely manage and provide treatment for this population wherever they may be in the heath care, housing, social services or justice systems, if the individuals are receptive to treatment.

Human Services and Justice Field – Broadly Defined

The Provincial Authority should also take on the following roles and responsibilities for the remainder of the common client group composed of the complete, non forensic human service and justice population.

- With the Regional Human Services and Justice Coordinating Committees (HSJCC), to develop a consistent set of operating guidelines for them.

- To assure that Regional HSJCCs are operating effectively in all regions.

- To assure that the Regional HSJCCs have a consistent set of data collection practices.

- To meet with these regional bodies individually on a regular basis to ensure the flow of information, guidance, etc.

- With the Regional HSJCCs, to facilitate development of district and or local coordinating bodies as appropriate to the services in the area.

- To be a central point for information, advice and guidance for the various Regional HSJCCs.

- With the Regional HSJCCs, to develop a consistent set of operating principles for the district and local coordinating bodies.

- To liaise with other provincial structures in the general human services area, including the mental health field, to ensure improved integration at the legislative, policy and operating levels.

- To collect and disseminate information about best practices.

- To propose research and evaluation programs in all sectors of this field.

- To develop and promulgate sample agreement documents.

- To examine and propose means to use telemedicine and alternative staffing arrangements to increase service levels.

- To serve as an important source of information and advice to the National Mental Health Commission (as proposed in the Kirby Report), should it be established.

- To develop methods of increasing the cost effectiveness of the funds spent on clients/offenders in the broader human services and justice field.

- To facilitate development of appropriate specialized ethno-cultural services across Ontario, recognizing that most services that these individuals will receive will be within the mainstream system.

- To study models used in other jurisdictions to intercept individuals in need of mental health care at the "juncture points" in the service systems. Juncture points are the significant decision and program change points for the individual as they pass through the justice system (*Appendix B: Provincial Strategy to Coordinate Human Services and Justice Systems: Coordinating Protocols at Key Junctures Points).*

- To lead an initiative to overcome the reported frequent interruption of the provision of medication at various points in the mental health and justice process.

11.2.2 Roles, Responsibilities and Functions of the Regional Human Services and Justice Steering Committee

The proposed functions of the Regional Human Services and Justice Steering Committee are outlined below:

- Translate the strategy for Human Services and Justice, as set out by the Provincial Authority, into regionally relevant policy and program plans.

- Utilize the "juncture point" documentation from past reports to create foci for the development of future mental health and justice programs.

- Assure that the concurrent disorder, dual diagnosis, fetal alcohol spectrum disorder, acquired brain injury, and fire setter populations are included in the planning and program development processes.

- Facilitate the further development of the District/Quadrant bodies in accord with the directions of the Provincial Authority.

- Appoint the membership of the District bodies and approve the Chair of each District body using recommendations from each District group and an open and transparent process.

- Approve the creation of Sector Committees and ratify the membership of each

- Play a direct role with the District bodies to assist them to develop work plans for the subsequent year flowing from the Provincial Authority business plan and local needs.

- Appraise the work of the District bodies on a semi annual basis.

- Liaise with the five Toronto LHINs collectively to assure the human services and justice program planning and funding allocations are given high priority in the annual Business Plans of the LHINs.

- Liaise with each of the several ministries delivering services to the human services and justice population to assure that they are provided with program plans and proposed individual budget allocations to assure that their services to this population is maximized. The focus would be to assure that these particular initiatives are included in the individual annual ministry Business Plans.

- Develop a strategy for the further development of human services and justice programs for Toronto's large and diverse ethno cultural population.

- Assist with the development and standardization of service agreements with delivery agencies and MOHLTC and eventually the LHINs as funder.

- Implement the data collection protocols set out by the Provincial Authority in order to provide information relevant to planning and evaluation both for the Provincial Authority, the LHINs and the delivery agencies.

- To lead in the program evaluation processes in the Toronto region for these programs.

- To propose educational and training initiatives to the Provincial Authority and with those funds facilitate leading edge training and development in the mental health and justice field.

- Make proposals for research initiatives to the MOHLTC and to the Ontario Mental Health Foundation, universities and other research bodies.

- With the Provincial Authority, to collect and disseminate information about best practices.

- To provide regular reports to the Provincial Authority with general program data and information and identifying system successes and problems.

- As with each of the Regional Human Services and Justice Steering Committees across the province, to take responsibility for the development of specialized programs for groups widely represented in their area. In Toronto this would certainly include the large refugee population.

- To facilitate negotiation with LHINs when agencies deliver services in more than one LHIN area and wish to operate with a single contract. In the case of Sector Committees, such as the Toronto Mental Health and Justice Network, this role should be delegated to these Network structures as they will be deeply involved with service delivery in their particular specialty.

11.2.3 Roles, Responsibilities and Functions of the District Human Services and Justice Coordinating Committees

- To be guided in their work by the Regional Human Services and Justice Steering Committee.

- Through their individual chairs, to bring proposals for service development and identification of impediments to the provision of service to the regional body.

- To organize their individual activities around the court in their quadrant as the main source of client referrals.

- To be the key body in facilitating and coordinating the operationalization by individual agencies and agency partnerships of the programs funded by any one of the various ministries who deliver service to this population. This would include not only the MOHLTC, MAG and MCSCS but, also MA &

Housing, MCSS and MCYS.

- To link to the individual LHINs in their district concerning program planning, budgeting and operational issues.

- To utilize the data and information provided by the provincial and regional bodies to assist agencies to develop new programs and to change those in place as indicated by evaluations and other indicators.

- To approve the creation of Working Groups described in the next section.

11. 2.4 Roles, Responsibilities and Functions of the Working Groups

- Working Groups will be approved by the Regional Human Services and Justice Steering Committee or the District Human Services and Justice Coordinating Committee dependant upon the geographic scope of the Working Group's mandate. This will allow the full connection of their local integration efforts to similar efforts in that district as well as across Toronto.

- Agencies will no doubt continue to find it beneficial to set up local groups and clusters of partners where coordination can facilitate the delivery of higher quality and better linked and integrated services.

- These Working Groups will not have a special set of functions in the long range planning sphere as they will be "purpose built" and not funded for their operation.

11.3.0 Currently Operating Sector Committee - Toronto Mental Health and Justice Network

The Toronto Mental Health and Justice Network is well positioned to assist in maintaining the considerable momentum created by the significant new base budget funding provided over the past two years within the envelope described as the Service Enhancement Initiative.

It is suggested that the Committee continue as the Toronto Mental Health and Justice Service Network. It would report to the Toronto Regional Human Services and Justice Steering Committee.

- Membership would include executive/ management level staff of Service Enhancement Initiative funded programs including: safe beds, crisis prevention, police crisis teams, courts, release planning/case management and supportive housing.

- The Network would report on program deliverables, quality and outcomes to the Toronto Regional Human Service and Justice Steering Committee and through that structure to the ministries and the relevant LHINs.

- In conjunction with the regional body it would coordinate training and education across sectors i.e. police, courts.

- Currently operating Mental Health and Justice Network Committees: crisis, safe beds, supportive housing, courts could be maintained and could be reconfigured as necessary i.e. crisis/ safe beds and others

- Each Network Committee would meet at least annually to review data submitted to CDS and MIS, review relevant research and make recommendations to the Toronto Mental Health and Justice Network about changes and enhancements to funded services.

- Rationale: Sector- based Networks would give the Regional Steering Committee, the ministries and the LHINs a self managed and accountable network of services. Reports could be provided in terms of where the clients are coming from and where services are provided, as well as outcomes reflected in the CDS/ MIS data.

- To function effectively, the Toronto Mental Health and Justice Network requires a coordinator and data manager. If no funding is made available, the Network would have to commit to convening itself as would its work groups and would use existing data sources for quality management purposes.

- The Network would focus on the operational coordination of the funded mental health programs. Referral sources (courts, detention and correctional centres and probation services) from all ministries would be able to access this group on program related issues.

- Ministries would exert influence on the Network through the Regional Steering Committee upon which they would be represented.

- The Network would elect its own chair from its members and set up subcommittees and work groups, as required.

This Network could serve as a very useful pilot for similar structures needed for other sectors such as fetal alcohol, acquired brain injury, developmentally handicapped and learning disabled.

11.4.0 Relationships of the Proposed Structures to the LHINs, MOHLTC and Other Partner Ministries

The Ministry of Health and Long-Term Care has its relationship to the LHINs well defined in legislation. The Ministry will soon be setting out clear program expectations for each LHIN to accompany their funding allocations.

The other five ministries involved with the human services and justice programs would benefit greatly in furthering their provincial, regional and local linkages to the LHINs through creation of a set of structures such as those contemplated in this

report. These structures would assist them as a group to influence the provincial expectations set out for each LHIN with regard to these complex population groups.

These structures could also be of great assistance in facilitating the arrangements which will be needed between the LHINs and the delivery structures of the other ministries at the regional and district levels.

Ministries and in the case of MOHLTC funded programs, the LHINs will contract with individual agencies for the provision of services that, hopefully, will be based on the proposals coming from a Provincial Authority, as well as the Regional Steering Committees and District Coordinating Committees in each geographic area.

Recommendation 28: *That the Toronto Mental Health and Justice Coordinating Committee meet with the leadership of the five Toronto LHINs and their committees dealing with cross jurisdictional issues, as soon as possible, to explore the development of a plan that will ensure continuity and development of services to mental health and justice clients.*

11.5.0 Funding Requirements

It will be essential for the Regional Steering Committee and the District Committees to be appropriately funded to carry out the activities set out herein. An office with a small number of staff is required for the Steering Committee.

Each District Committee will need staff support and they could be drawn from the Regional Steering Committee staff by secondment. Locating these individuals in the Regional Office would better knit the total regional team together and avoid the necessity and cost of separate offices in each District.

Recommendation 29: *That the Toronto Mental Health and Justice Coordinating Committee recommend to the MOHLTC appropriate funding for each of the proposed leadership bodies to allow them to carry out the roles and responsibilities set in recommendation 11.2.0 and 11.3.0. It is suggested that a formula such as that used in service contracts by the MOHLTC for the administrative overhead allowance in service contracts be utilized. This would mean an allocation of 3 to 5 % of the service enhancement funding allotment to staff support for the Regional Human Services and Justice Coordinating (Steering) Committee and the Mental Health and Justice Network. It is recommended that the human service and justice ministries and the Toronto area LHINS develop a pooled fund for this purpose as a pilot project for three years.*

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APPENDICES

Appendix A: Request for Proposal Service System Assessment: Toronto Mental Health & Justice Coordinating Committee

Proposals are requested for a service system assessment pertaining to services for persons with mental illness residing in Toronto Region and at risk of involvement or currently involved with the criminal justice, correctional and/or forensic mental health systems.

Project deliverables include:

- A comprehensive description of the current services available to people with mental illness who are involved or at risk of involvement with the criminal justice system in Toronto. Services will be mapped at juncture points i.e. police, courts, hospitals, community services and include mental health as well as generic services.
- Services will be identified by area of the city covered and will also be mapped to the LHINS serving the Toronto region.
- Services will also be assessed in relation to their capacity to meet the needs of diverse communities
- An analysis of characteristics of individuals with mental illness being served or coming into contact with services
- Identification of the challenges and gaps in the current delivery structure and its component parts as related to mentally ill persons at risk of arrest or currently involved with the criminal justice, correctional systems and/or forensic systems
- Identification of options that are available to organize and deliver existing mental health and criminal justice service components in a coordinated fashion
- Identification of further service enhancements needed to facilitate a seamless system of service to the target population of mentally ill persons at risk of involvement with the criminal justice system or currently involved in the criminal justice, correctional and/or forensic mental health systems

- ✓ Construction of questionnaires to obtain a comprehensive description of the roles, functions and services provided
- ✓ Compilation of a comprehensive description of agencies and services and services available to people with mental illness involved in the criminal justice system. This in includes description of the roles, functions and services provided in Toronto region and data on mentally ill individuals served or having contact with services, and observations about the match between needs and care pathways.
- ✓ Facilitation of focus groups with providers, consumers and families and committee discussion pertaining to gaps in existing service structure, service enhancement needs and possible options for organizing existing components of the service delivery structure
- ✓ Recommendations on options for a coordinated service delivery system including recommendations for future service enhancement to create a seamless system of services
- ✓ The description of services and client characteristics is to be completed by March 31st. Facilitation of discussion on gaps, needs and options would occur in April and May. Final report with recommendations on options and needs would be submitted by June 30th, 2006.

Appendix B: Biographies of Consultants

Michael S. Phillips, PhD. FCCHSE

Michael is an internationally recognized expert with more than 30 years experience in the field of forensic mental health and the criminal justice system. He has extensive experience in both research and evaluation. He is a recipient of the Amethyst Award for Outstanding Achievement in the Ontario Public Service for his work in developing the court diversion program for mentally ill offenders throughout Ontario.

Michael represented the Ministry of the Attorney General on the Human Services and Justice Coordination Project and he continues as a consultant to provide expertise on both mental health and criminal justice issues to the government, agencies and Human Service and Justice Coordinating Committees throughout the province.

Michael is the Chair of the International Institute on Special Needs Offenders and Public Policy (Canada) that hosted a three day international conference in Ottawa in September 2005.

Most recently Michael completed a feasibility study for the Ministry of the Attorney General on *Developing Fitness Clinics in Ontario Correctional Complexes,* and he also organized a two day training session for court support workers for the Ministry of Health and Long -Term Care.

He presently sits on an inter-ministerial committee created as a result of a recent court decision on the availability of psychiatric assessment services to the court.

He also is currently the criminal justice sector member-at-large on the Executive Advisory Committee of the System Enhancement Evaluation Initiative.

Pauline A. Radley, BSc. MA

Pauline has more than 30 years experience working in the criminal justice system. She has extensive experience in policy development and program evaluation and was the Director of Policy and Planning for the Ministry of Correctional Services.

She was the Director of the Human Services and Justice Coordination Project and responsible for the development of *A Provincial Policy to Coordinate Human Services and Criminal Justice Systems in Ontario.* This project involved extensive consultation with stakeholders in the social service, health and criminal justice sectors across Ontario.

Pauline currently teaches part-time at the University of Western Ontario in the Sociology Department on program and policy evaluation and in criminology. She provides consulting services on mental health and criminal justice issues to the government and not-for-profit criminal justice agencies.

In 2005 she conducted a *Preliminary Study of Youth Suffering with Mental Health Issues and Involved in the Criminal Justice System* for the Ministry of the Attorney General, and

is currently conducting evaluations on a number of the criminal justice programs operated by St. Leonard's Society of London.

Glenn R. Thompson, BA. MSW. RSW

Glenn has an extensive background in a variety of non- profit and governmental organizations in Canada and the UK, dealing with individuals, social problems and public policy. He spent one year with the Ministry of Health in the UK where he was employed as a psychiatric social worker at a therapeutic community psychiatric hospital. From 2000, he spent two years with the Government of Nunavut where he was the Executive Director, Baffin Region, Department of Health and Social Services.

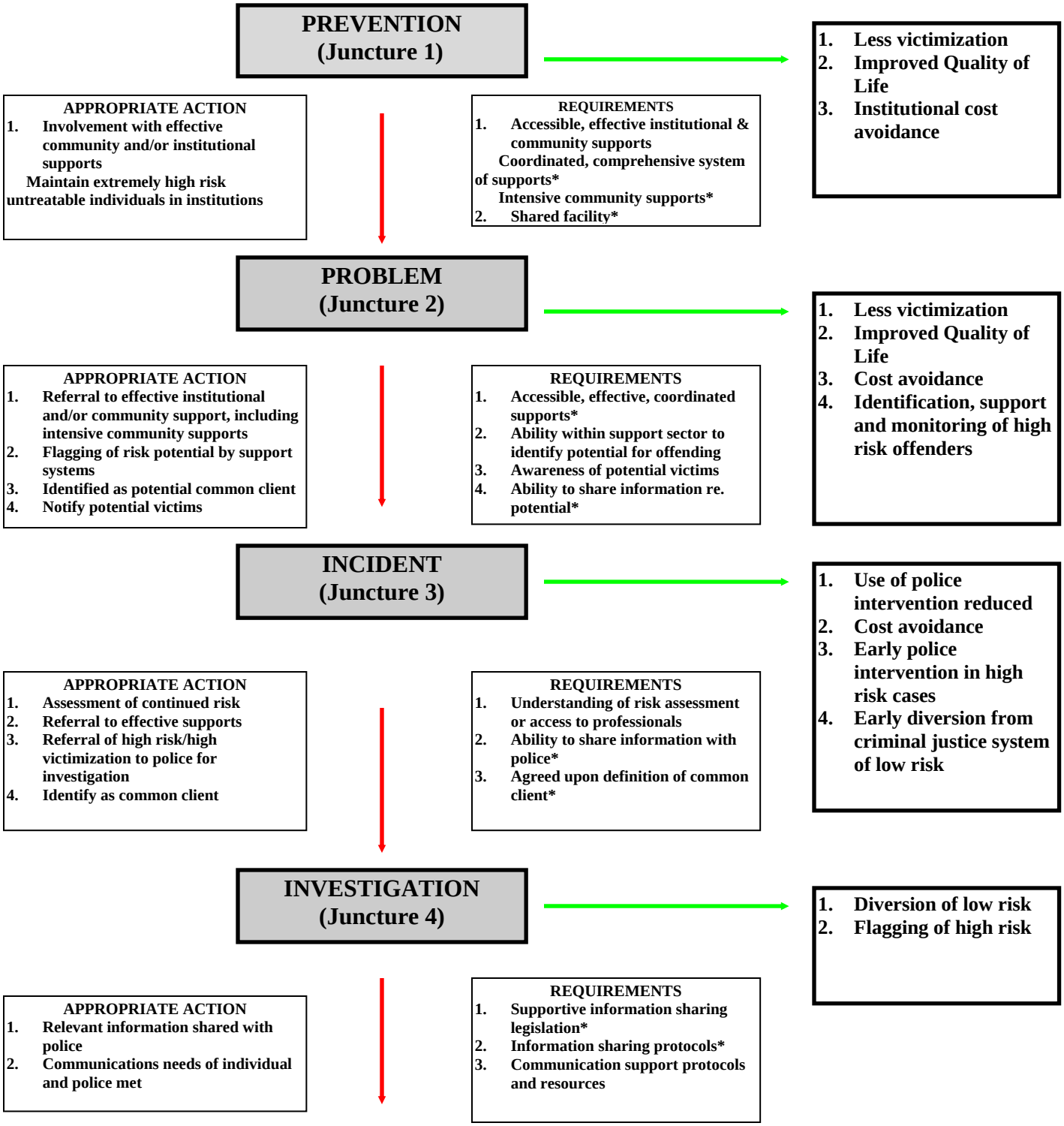
In the 16 years between 1975 and 1991, Glenn served as Deputy Minister in six Ontario government ministries. He served as Deputy Minister of Correctional Services from 1975 to 1981, where he began his social work career in 1960. Subsequently, he was Deputy Minister of Energy, Government Services, Municipal Affairs, Labour and Housing.

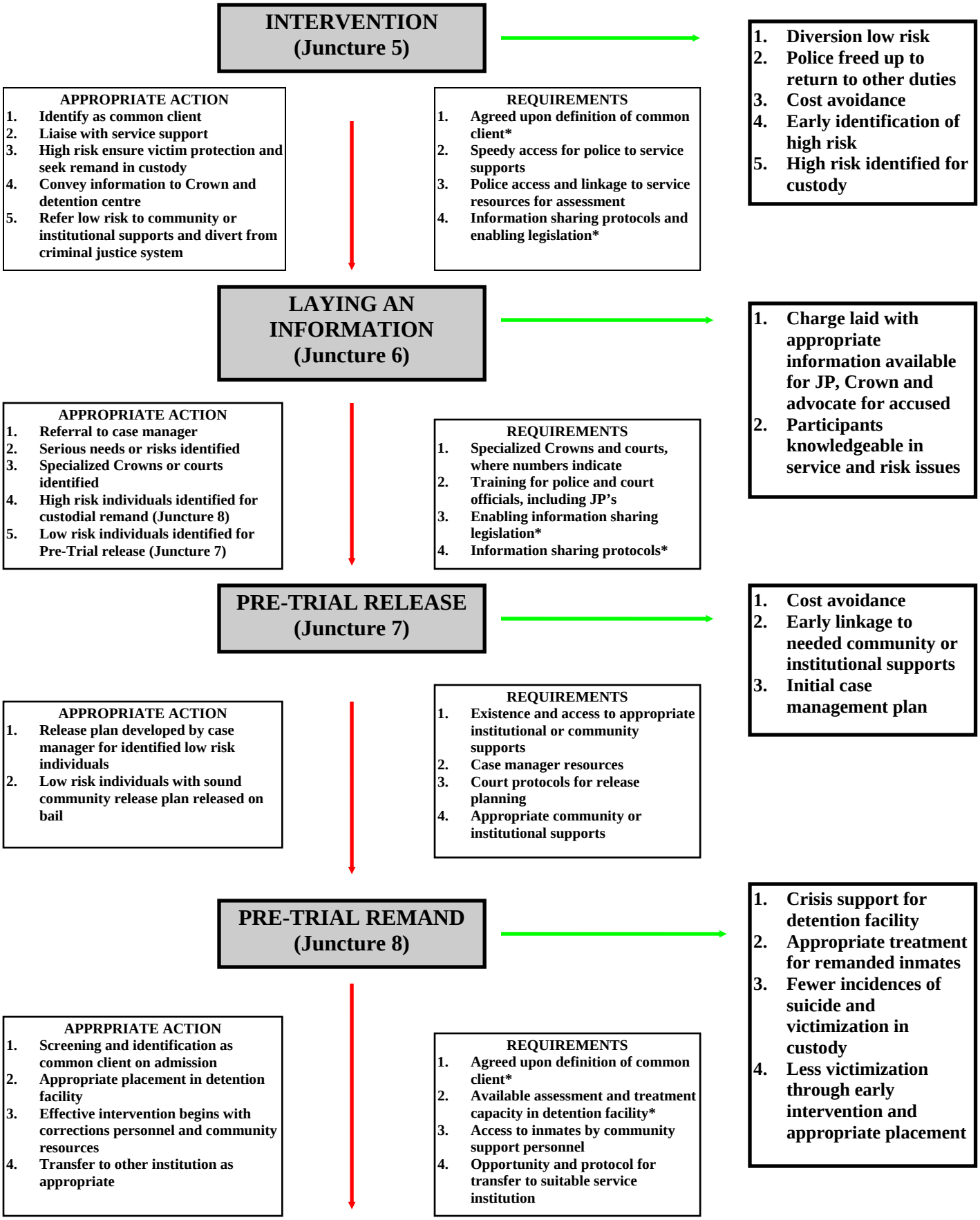
His Deputy Minister appointments spanned Ontario's three major political parties and four Ontario Premiers.

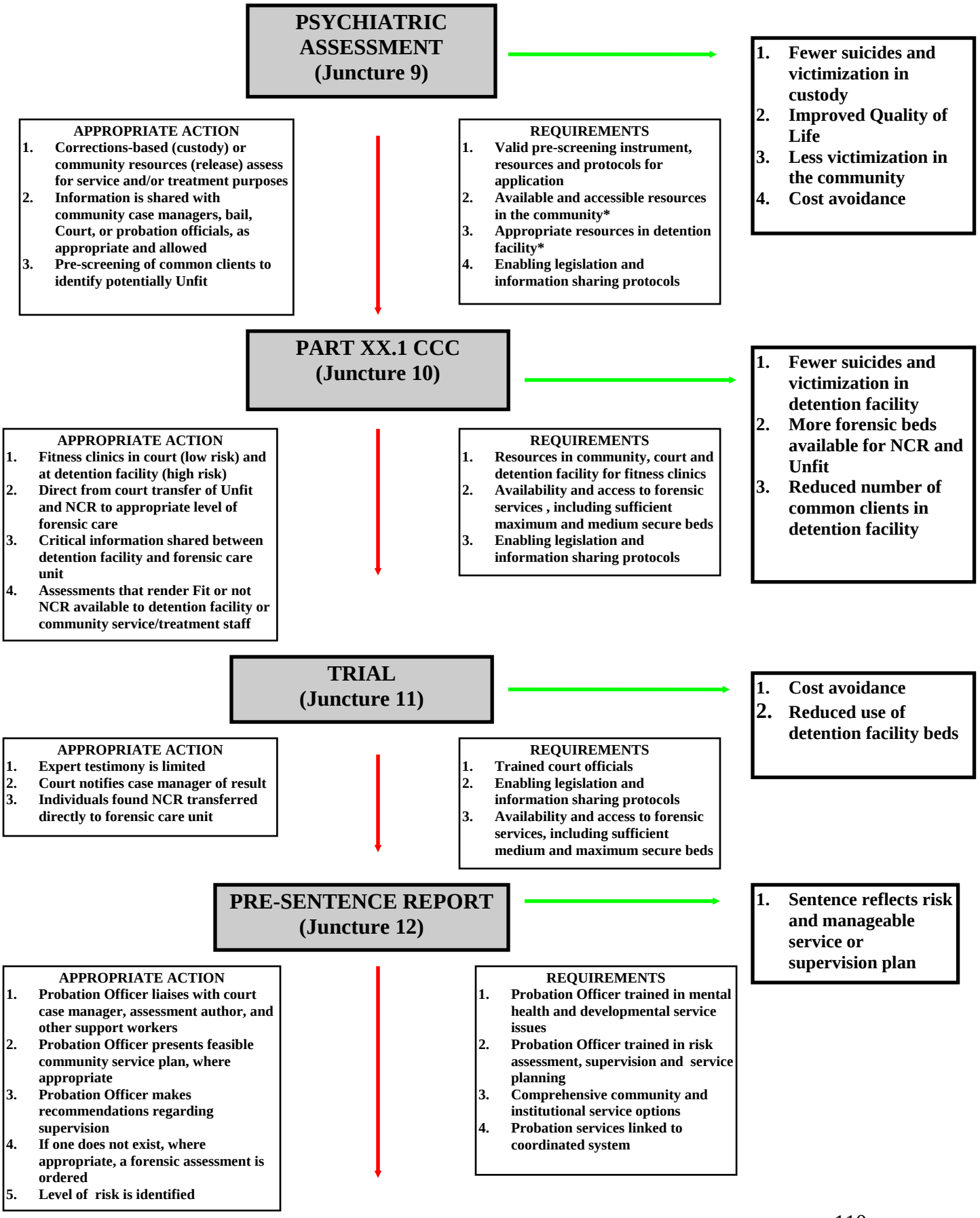
Following his retirement from the Ontario Public Service in 1991, after 31 years, Mr. Thompson joined the Canadian Mental Health Association, Ontario Division, as Executive Director where he served for 9 years. After his two years in Nunavut, he was appointed as half time Executive Director of the Canadian Criminal Justice Association in Ottawa from 2002, for 18 months, to stabilize the organization and to assist in locating a permanent Executive Director. From the fall of 2004 he returned to the CMHA, Ontario as Interim CEO and from early 2005 has been active in a general consulting practice and in volunteer activities.

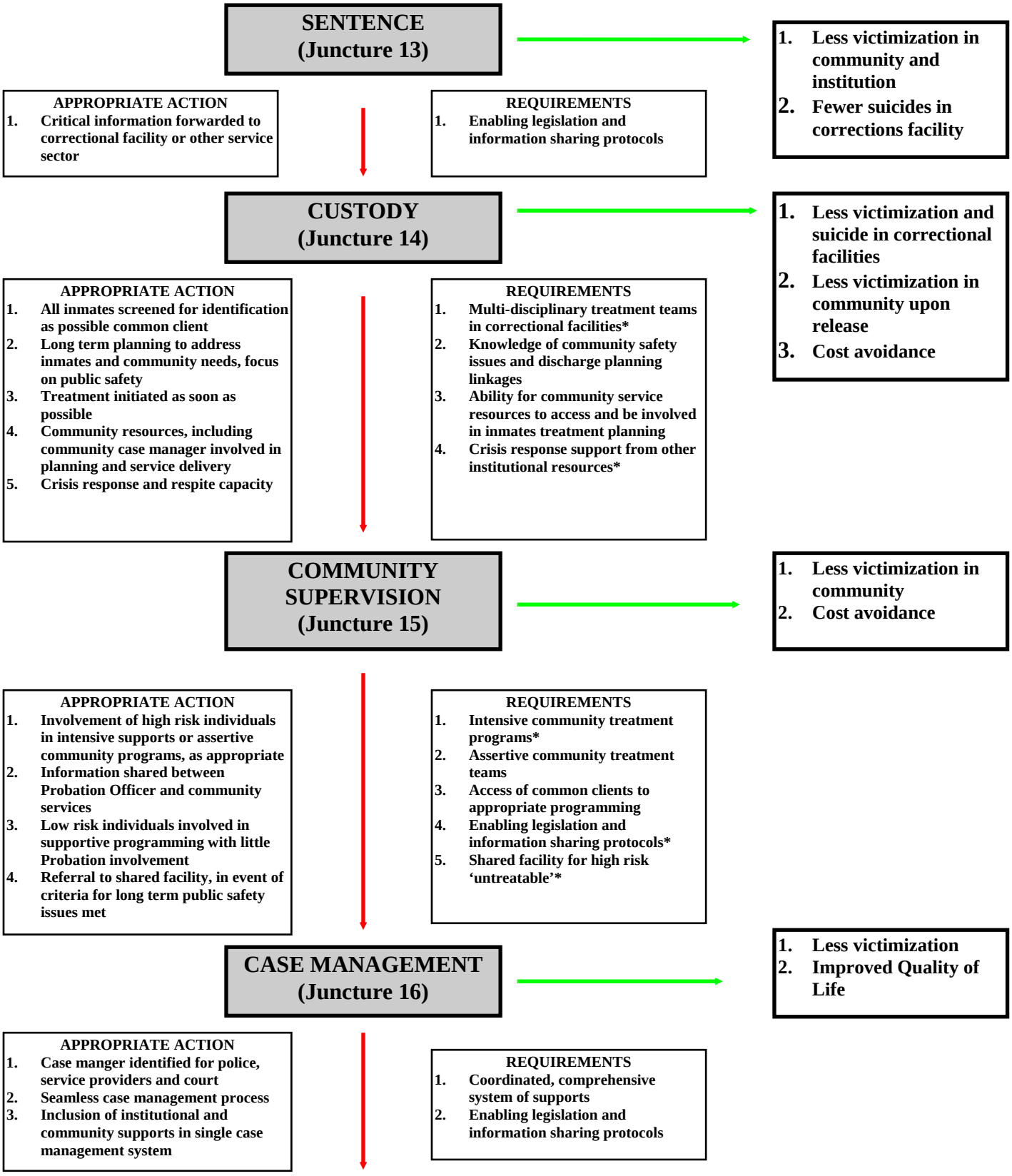
Mr. Thompson was awarded the Governor General's Centennial Medal in 1967 and in 2000 was awarded the Ontario Lieutenant Governor's Medal of Distinction in Public Administration.

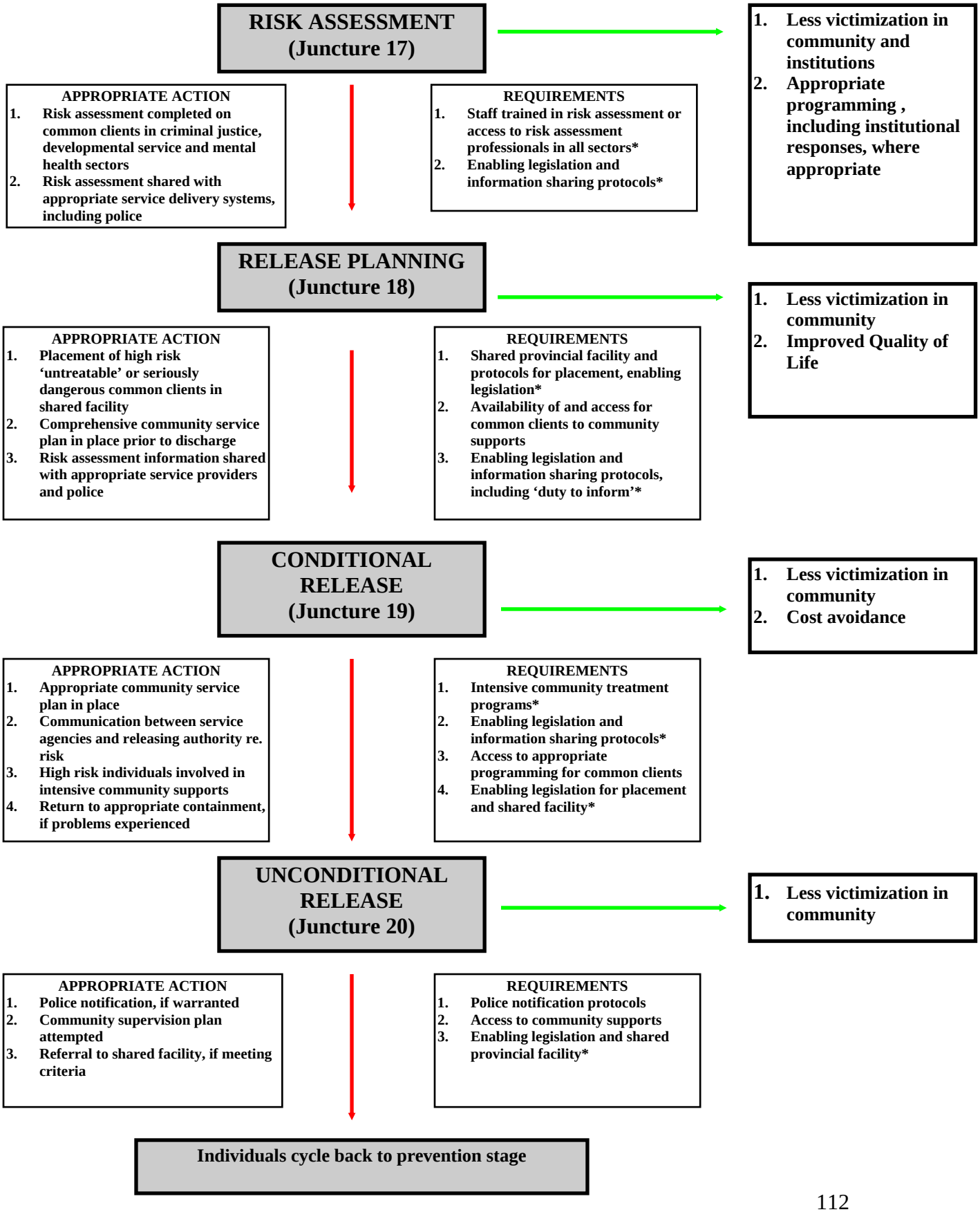
Appendix C: Provincial Strategy to Coordinate Human Services and Criminal Justice Systems: Coordinating Protocols at Key Juncture Points




INTERVENTION (Juncture 5)
APPROPRIATE ACTION
1. Identify as common client
2. Liaise with service support
3. High risk ensure victim protection and seek remand in custody
4. Convey information to Crown and detention centre
5. Refer low risk to community or institutional supports and divert from criminal justice system
REQUIREMENTS
1. Agreed upon definition of common client*
2. Speedy access for police to service supports
3. Police access and linkage to service resources for assessment
4. Information sharing protocols and enabling legislation*
1. Diversion low risk
2. Police freed up to return to other duties
3. Cost avoidance
4. Early identification of high risk
5. High risk identified for custody
LAYING AN INFORMATION (Juncture 6)
APPROPRIATE ACTION
1. Referral to case manager
2. Serious needs or risks identified
3. Specialized Crowns or courts identified
4. High risk individuals identified for custodial remand (Juncture 8)
5. Low risk individuals identified for Pre-Trial release (Juncture 7)
REQUIREMENTS
1. Specialized Crowns and courts, where numbers indicate
2. Training for police and court officials, including JP's
3. Enabling information sharing legislation*
4. Information sharing protocols*
1. Charge laid with appropriate information available for JP, Crown and advocate for accused
2. Participants knowledgeable in service and risk issues
PRE-TRIAL RELEASE (Juncture 7)
APPROPRIATE ACTION
1. Release plan developed by case manager for identified low risk individuals
2. Low risk individuals with sound community release plan released on bail
REQUIREMENTS
1. Existence and access to appropriate institutional or community supports
2. Case manager resources
3. Court protocols for release planning
4. Appropriate community or institutional supports
1. Cost avoidance
2. Early linkage to needed community or institutional supports
3. Initial case management plan
PRE-TRIAL REMAND (Juncture 8)
APPRPRIATE ACTION
1. Screening and identification as common client on admission
2. Appropriate placement in detention facility
3. Effective intervention begins with corrections personnel and community resources
4. Transfer to other institution as appropriate
REQUIREMENTS
1. Agreed upon definition of common client*
2. Available assessment and treatment capacity in detention facility*
3. Access to inmates by community support personnel
4. Opportunity and protocol for transfer to suitable service institution
1. Crisis support for detention facility
2. Appropriate treatment for remanded inmates
3. Fewer incidences of suicide and victimization in custody
4. Less victimization through early intervention and appropriate placement


PSYCHIATRIC ASSESSMENT (Juncture 9)
1. Fewer suicides and victimization in custody
2. Improved Quality of Life
3. Less victimization in the community
4. Cost avoidance
APPROPRIATE ACTION
1. Corrections-based (custody) or community resources (release) assess for service and/or treatment purposes
2. Information is shared with community case managers, bail, Court, or probation officials, as appropriate and allowed
3. Pre-screening of common clients to identify potentially Unfit
REQUIREMENTS
1. Valid pre-screening instrument, resources and protocols for application
2. Available and accessible resources in the community*
3. Appropriate resources in detention facility*
4. Enabling legislation and information sharing protocols
PART XX.1 CCC (Juncture 10)
1. Fewer suicides and victimization in detention facility
2. More forensic beds available for NCR and Unfit
3. Reduced number of common clients in detention facility
APPROPRIATE ACTION
1. Fitness clinics in court (low risk) and at detention facility (high risk)
2. Direct from court transfer of Unfit and NCR to appropriate level of forensic care
3. Critical information shared between detention facility and forensic care unit
4. Assessments that render Fit or not NCR available to detention facility or community service/treatment staff
REQUIREMENTS
1. Resources in community, court and detention facility for fitness clinics
2. Availability and access to forensic services , including sufficient maximum and medium secure beds
3. Enabling legislation and information sharing protocols
TRIAL (Juncture 11)
1. Cost avoidance
2. Reduced use of detention facility beds
APPROPRIATE ACTION
1. Expert testimony is limited
2. Court notifies case manager of result
3. Individuals found NCR transferred directly to forensic care unit
REQUIREMENTS
1. Trained court officials
2. Enabling legislation and information sharing protocols
3. Availability and access to forensic services, including sufficient medium and maximum secure beds
PRE-SENTENCE REPORT (Juncture 12)
1. Sentence reflects risk and manageable service or supervision plan
APPROPRIATE ACTION
1. Probation Officer liaises with court case manager, assessment author, and other support workers
2. Probation Officer presents feasible community service plan, where appropriate
3. Probation Officer makes recommendations regarding supervision
4. If one does not exist, where appropriate, a forensic assessment is ordered
5. Level of risk is identified
REQUIREMENTS
1. Probation Officer trained in mental health and developmental service issues
2. Probation Officer trained in risk assessment, supervision and service planning
3. Comprehensive community and institutional service options
4. Probation services linked to coordinated system


SENTENCE
(Juncture 13)
APPROPRIATE ACTION
1. Critical information forwarded to correctional facility or other service sector
REQUIREMENTS
1. Enabling legislation and information sharing protocols
1. Less victimization in community and institution
2. Fewer suicides in corrections facility
CUSTODY
(Juncture 14)
APPROPRIATE ACTION
1. All inmates screened for identification as possible common client
2. Long term planning to address inmates and community needs, focus on public safety
3. Treatment initiated as soon as possible
4. Community resources, including community case manager involved in planning and service delivery
5. Crisis response and respite capacity
REQUIREMENTS
1. Multi-disciplinary treatment teams in correctional facilities*
2. Knowledge of community safety issues and discharge planning linkages
3. Ability for community service resources to access and be involved in inmates treatment planning
4. Crisis response support from other institutional resources*
1. Less victimization and suicide in correctional facilities
2. Less victimization in community upon release
3. Cost avoidance
COMMUNITY SUPERVISION
(Juncture 15)
APPROPRIATE ACTION
1. Involvement of high risk individuals in intensive supports or assertive community programs, as appropriate
2. Information shared between Probation Officer and community services
3. Low risk individuals involved in supportive programming with little Probation involvement
4. Referral to shared facility, in event of criteria for long term public safety issues met
REQUIREMENTS
1. Intensive community treatment programs*
2. Assertive community treatment teams
3. Access of common clients to appropriate programming
4. Enabling legislation and information sharing protocols*
5. Shared facility for high risk 'untreatable'*
1. Less victimization in community
2. Cost avoidance
CASE MANAGEMENT
(Juncture 16)
APPROPRIATE ACTION
1. Case manger identified for police, service providers and court
2. Seamless case management process
3. Inclusion of institutional and community supports in single case management system
REQUIREMENTS
1. Coordinated, comprehensive system of supports
2. Enabling legislation and information sharing protocols
1. Less victimization
2. Improved Quality of Life


RISK ASSESSMENT
(Juncture 17)
APPROPRIATE ACTION
1. Risk assessment completed on common clients in criminal justice, developmental service and mental health sectors
2. Risk assessment shared with appropriate service delivery systems, including police
REQUIREMENTS
1. Staff trained in risk assessment or access to risk assessment professionals in all sectors*
2. Enabling legislation and information sharing protocols*
1. Less victimization in community and institutions
2. Appropriate programming , including institutional responses, where appropriate
RELEASE PLANNING
(Juncture 18)
APPROPRIATE ACTION
1. Placement of high risk 'untreatable' or seriously dangerous common clients in shared facility
2. Comprehensive community service plan in place prior to discharge
3. Risk assessment information shared with appropriate service providers and police
REQUIREMENTS
1. Shared provincial facility and protocols for placement, enabling legislation*
2. Availability of and access for common clients to community supports
3. Enabling legislation and information sharing protocols, including 'duty to inform'*
1. Less victimization in community
2. Improved Quality of Life
CONDITIONAL RELEASE
(Juncture 19)
APPROPRIATE ACTION
1. Appropriate community service plan in place
2. Communication between service agencies and releasing authority re. risk
3. High risk individuals involved in intensive community supports
4. Return to appropriate containment, if problems experienced
REQUIREMENTS
1. Intensive community treatment programs*
2. Enabling legislation and information sharing protocols*
3. Access to appropriate programming for common clients
4. Enabling legislation for placement and shared facility*
1. Less victimization in community
2. Cost avoidance
UNCONDITIONAL RELEASE
(Juncture 20)
APPROPRIATE ACTION
1. Police notification, if warranted
2. Community supervision plan attempted
3. Referral to shared facility, if meeting criteria
REQUIREMENTS
1. Police notification protocols
2. Access to community supports
3. Enabling legislation and shared provincial facility*
1. Less victimization in community
Individuals cycle back to prevention stage

Appendix D: Questionnaire for Community Agency Service Providers

This survey is concerned with persons with a mental illness who may or have come in contact with the law.

Service Providers' Questions

When answering each question please place an **X** to **all** responses that are relevant to the question.

1	**Question**	**(X) Response**	
Do you provide services to people with a mental illness who are at risk of becoming criminalized or are already a client of the Justice system?		Yes	
		No	
		Do not know	

2	**Question**	**Response (approx)**	**%**
If you answered yes to # 1: What is the nature of the illness and its <u>percentage in</u> the population you serve?		Seriously mentally ill *****	
		Moderately mentally ill **	
		Persons in crisis	
		Personality Disordered	

***** ***<u>Seriously mentally ill</u>*** *includes Axis I diagnostic categories of schizophrenia, schizoaffective disorder, bipolar and affective disorders.*

****** ***<u>Moderately mentally ill</u>*** *focuses on Axis II & III diagnostic categories such as the personality disorders, mental retardation and anxiety disorders*

3	**Question**	(X) R**esponse**	
Are you funded to provide these services targeted to persons at significant risk of being involved or are currently involved with the criminal justice system?		Yes	
		No	
		Do not know	

*Answer 4 if you answered **yes** to 3, otherwise continue to 5*

(√) only 1 response

4	**Question**		**(X)Response**		**(X)Response**
What percentage of your budget is specifically targeted to persons with a mental disorder at significant risk of being involved or are currently involved with the Criminal Justice system?		1-5 %		30-50 %	
		5-10 %		Over 50 %	
		10-30 %		Don't know	

Please check **(X)** <u>all</u> services:

5	**Question**	**(X) Response(s)**	
What type of services do you offer to these clients?		Life Skills	
		Relapse prevention	
		Crisis response/intervention	
		Case Management *****	
		Assessment	
		Treatment/ Counseling	
		Rehabilitation	
		Discharge Planning	
		Other	

****case management**: Coordinates a continuum of services based on clients choice and needs*

6	**Question**	**(X) Response(s)**	
How do these clients access your service?		Diversion	
		Probation	
		Bail	
		Referral by police or other Justice Officials	
		After Sentencing	
		Other (state service)	

7	Question	(X) Response(s)	
What are the admission criteria?		Addiction	
		Mental Illness	
		Developmental Disorder	
		Concurrent Disorder †	
		Other: specify	

† Concurrent Disorder: *mental illness plus addiction*

8	Question	(X) Response	
Are there exclusions from your program?		Yes	
		No	

9	Question	Written Response(s)
If yes to # 8 please specify:		

10	Question	(X) Response	
Do you provide service to ethno-cultural population?		Yes	
		No	

11	Question	(X) Response	
Are your services designed to deal with ethno-cultural challenges?		Yes	
		No	

12	Question	(X) Response	
Are staff trained to provide culturally sensitive and appropriate care?		Yes	
		No	

13	Question	(X) Response	
Is there a waiting list for your service?		Yes	
		No	

14	Question	(X) Response (select one only)			
If you responded yes to # 13 How long?		< 24 hours		7-30 days	
		2-3 days		30-60 days	
		3-7 days		Over 60 days	

15	Question	(X) Responses	
Who refers these clients to you?		Self	
		Family	
		Medical Therapist	
		Mental Health Court Support Program	
		Police	
		Jail/Detention Centre	
		Court Personnel	
		Probation/Parole Staff	
		Specialty Hospital	
		General Hospital	
		Home for the Aged	
		Nursing Home	
		Group Home	
		Other:	
		Unknown	

16	Question	Number
How many of these clients (*persons with a mental disorder at significant risk of being involved or are currently involved with the Criminal Justice system*) do you see over a 1 year period (2005) (please indicate)		

17	Question	(X) Response		
Do you have specific programs for the following:		Concurrent disorders ***†***	Yes	
			No	
		Dual Diagnosis ***††***	Yes	
			No	
		Transitional Aged Youth	Yes	
			No	

† Concurrent Disorder: *mental illness plus addiction*

†† Dual Diagnosis: *mental illness plus developmentally disordered*

18	Question	(X) Response	
Do you have any formal agreement/arrangements between your service, Criminal Justice agency or local hospital to better serve the client group?		Yes	
		No	
		If yes specify the type of agreement:	

19	Question	(X) Response	
Do you provide service for mentally ill released offenders?		Yes	
		No	
		Do not know	

20	**Question**	**(X) Response(s)**		
If yes to question 19; Do you have clients from any of the following?		Federal Penitentiary *	Yes	
			No	
			Do not know	
		Provincial Correctional Facilities **	Yes	
			No	
			Do not know	
		Local Detention / Remand Centres ***	Yes	
			No	
			Do not know	

Definitions: (*** ** ***)** see Question 21

21	**Question**	**(X) Response(s)**		
Are your services involved in discharge planning for mentally ill inmates in any of the following?		Federal Penitentiary *	Yes	
			No	
			Do not know	
		Provincial Correctional Facilities **	Yes	
			No	
			Do not know	
		Local Detention / Remand Centres ***	Yes	
			No	
			Do not know	

**** Federal Penitentiary:*** *houses inmates who are serving a sentence of two of more years*

**** ***Provincial Correctional facilities:*** *have in their custody persons who are serving a sentence of less than two years*

***** ***Local Detention/Remand Centres:*** *house accused individuals pending their trial or resolution of their court matter*

22	Question	(X) Response	
Do you think that you are serving this population adequately?		Yes	
		No	

23	Question	(X) Response(s)	
If you answered <u>no</u> to question # 22 What are the gaps and barriers?		No connection between Mental Health and Justice	
		Insufficient trained staff	
		Absence of a system	
		Absence of direction	
		Lack of coordination	
		Lack of housing	
		Lack of funding	
		Other (specify)	

24	Question
What additional services/resources do you require within your program/service to better serve these clients? (please specify)	

Written Response

25	**Question**
What additional services/resources are required outside of your organization to better serve these clients? (please specify)	
Written Response	

26	**Question**
In what ways would you organize services in your area to better meet the needs of the mentally ill who are in contact with the Justice System? (please specify)	
Written Response	

27	**Question**
How would you change the Justice and Mental Health Systems to better meet the needs of the clients in your area? (please specify)	
Written Response	

28	**Question**	**(X) Response**	
Do you (the respondent to this survey) sit on any planning or organizing committees related to services for this client group?		Yes	
		No	

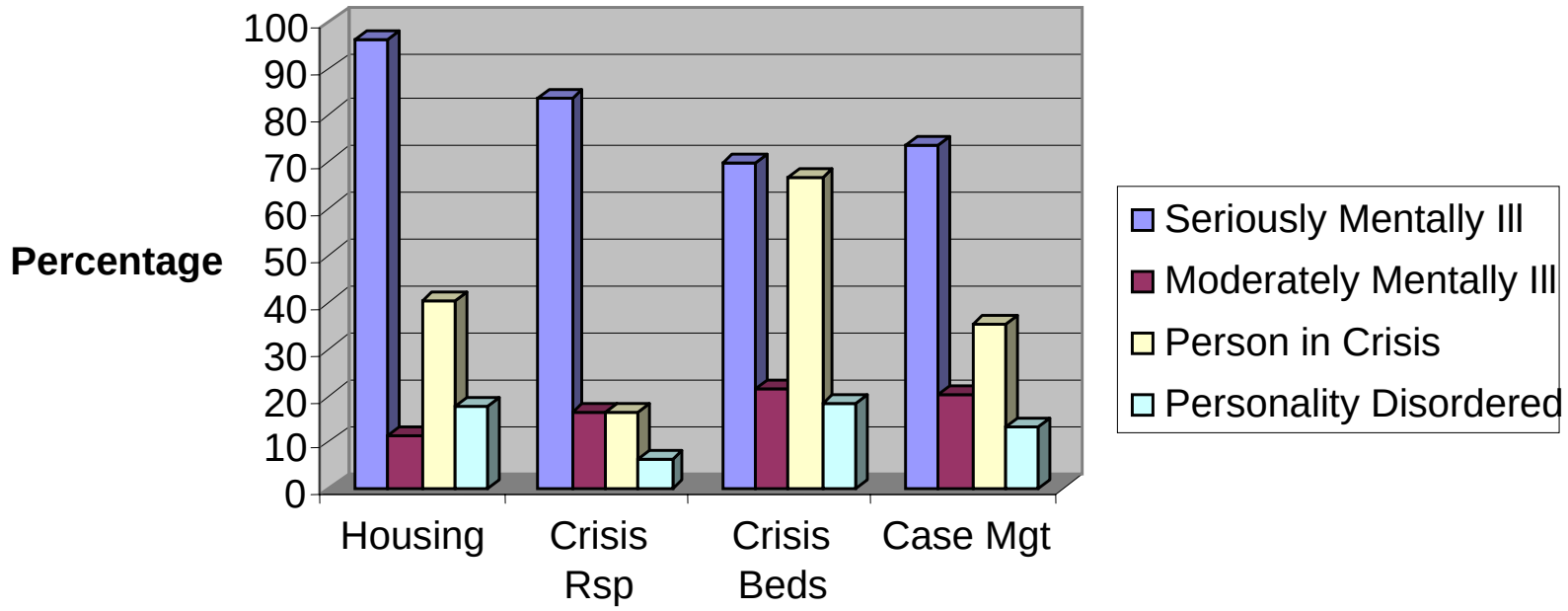
29	If yes to question 28 specify:

30	Additional Comments:

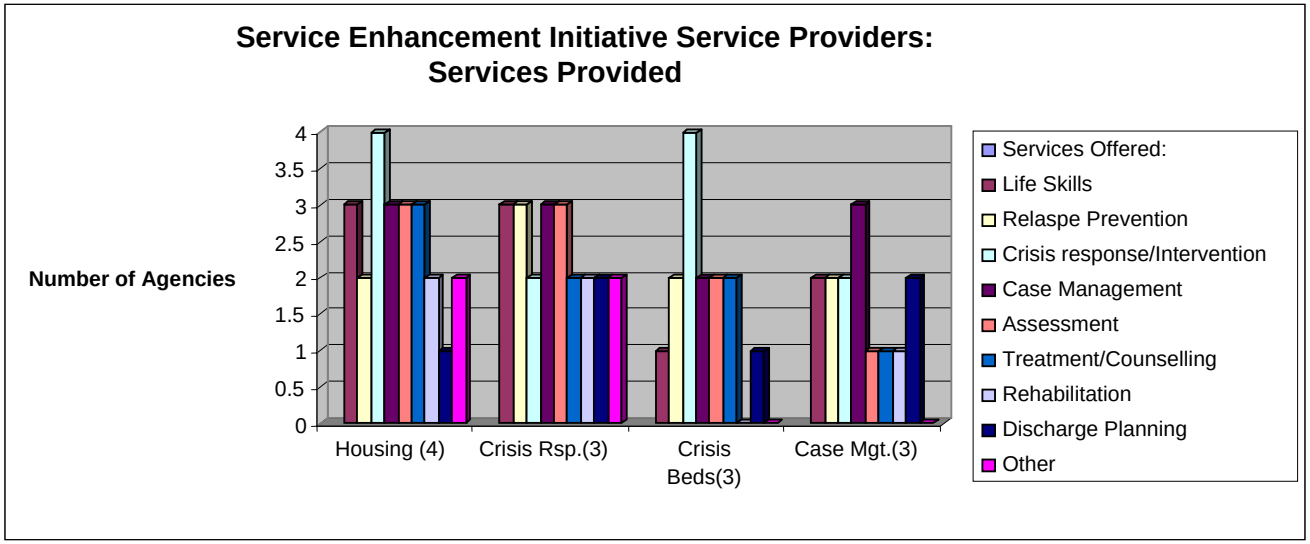
Appendix E: Comparison of Responses by Service Enhancement Initiative Funded Agencies on Selected Variables

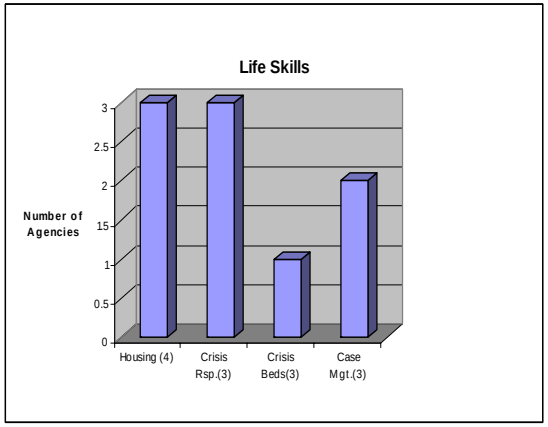
			Housing	Crisis Response	Crisis Beds	Case Management
2	**Question**	**Response (approx) %**	**%**	**%**	**%**	**%**
If you answered yes to # 1: What is the nature of the illness and its <u>percentage in</u> the population you serve?		Seriously mentally ill	**96.25**	**83.3**	**70**	**73.33**
		Moderately mentally ill	**11.25**	**16.7**	**21.66**	**20**
		Persons in crisis	**40**	**16.6**	**66.66**	**35**
		Personality Disordered	**17.5**	**6.6**	**18.33**	**13.33**

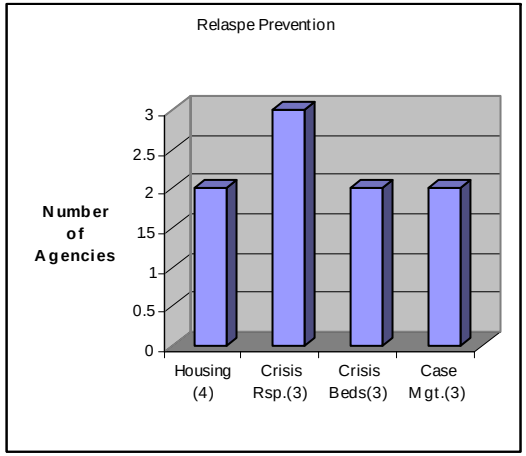
Service Enhancement Initiative Service Providers: Primary Focus

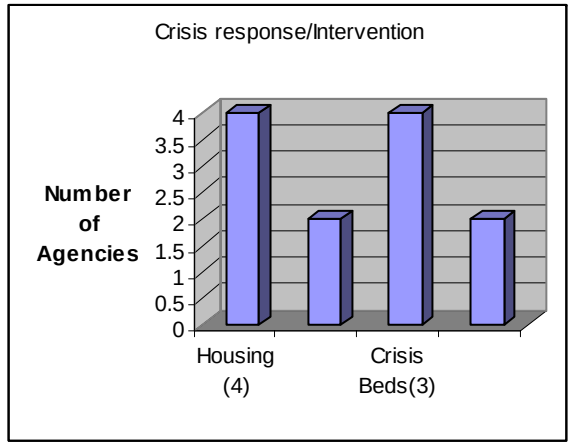


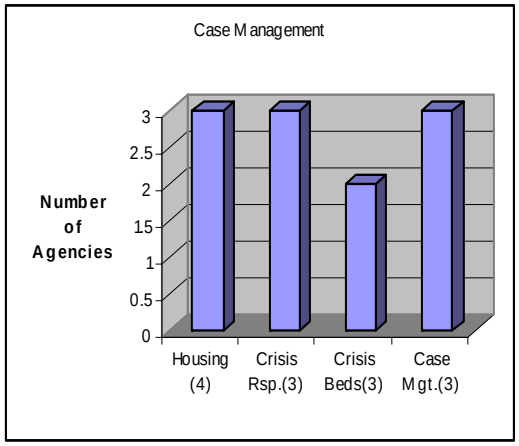
5	Question	Response(s)	Housing 4 Agencies	Crisis Response 3 Agencies	Crisis Beds 3 Agencies	Case Management 3 Agencies
What type of services do you offer to these clients?		Life Skills	3	3	1	2
		Relapse prevention	2	3	2	2
		Crisis response/intervention	4	2	4	2
		Case Management *	3	3	2	3
		Assessment	3	3	2	1
		Treatment/ Counseling	3	2	2	1
		Rehabilitation	2	2	0	1
		Discharge Planning	1	2	1	2
		Other	2	2	0	0

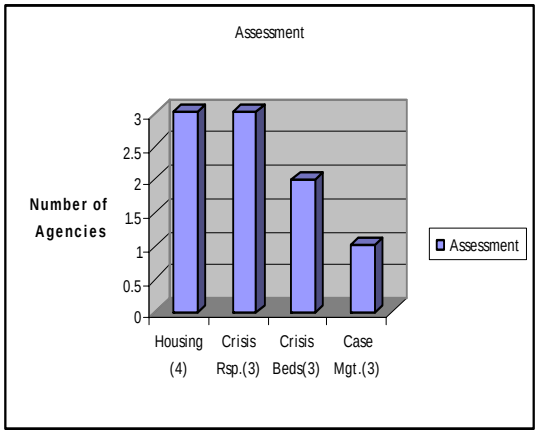

Service Enhancement Initiative Service Providers:
Services Provided
Number of Agencies
4
3.5
3
2.5
2
1.5
1
0.5
0
Housing (4)
Crisis Rsp.(3)
Crisis Beds(3)
Case Mgt.(3)
Services Offered:
Life Skills
Relaspe Prevention
Crisis response/Intervention
Case Management
Assessment
Treatment/Counselling
Rehabilitation
Discharge Planning
Other

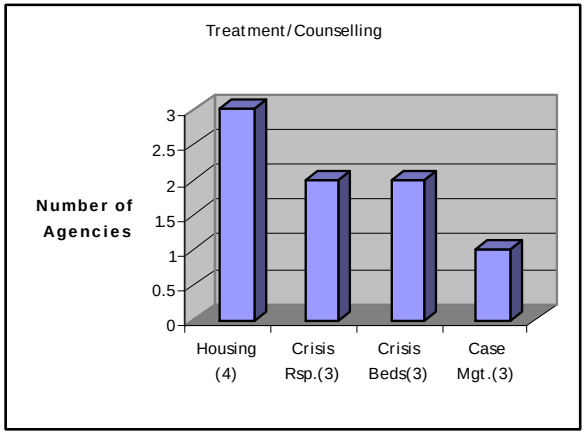

Life Skills
Number of Agencies
3
2.5
2
1.5
1
0.5
0
Housing (4)
Crisis Rsp.(3)
Crisis Beds(3)
Case Mgt.(3)


Relaspe Prevention
Number of Agencies
3
2.5
2
1.5
1
0.5
0
Housing (4)
Crisis Rsp.(3)
Crisis Beds(3)
Case Mgt.(3)


Crisis response/Intervention
Number of Agencies
4
3.5
3
2.5
2
1.5
1
0.5
0
Housing (4)
Crisis Beds(3)

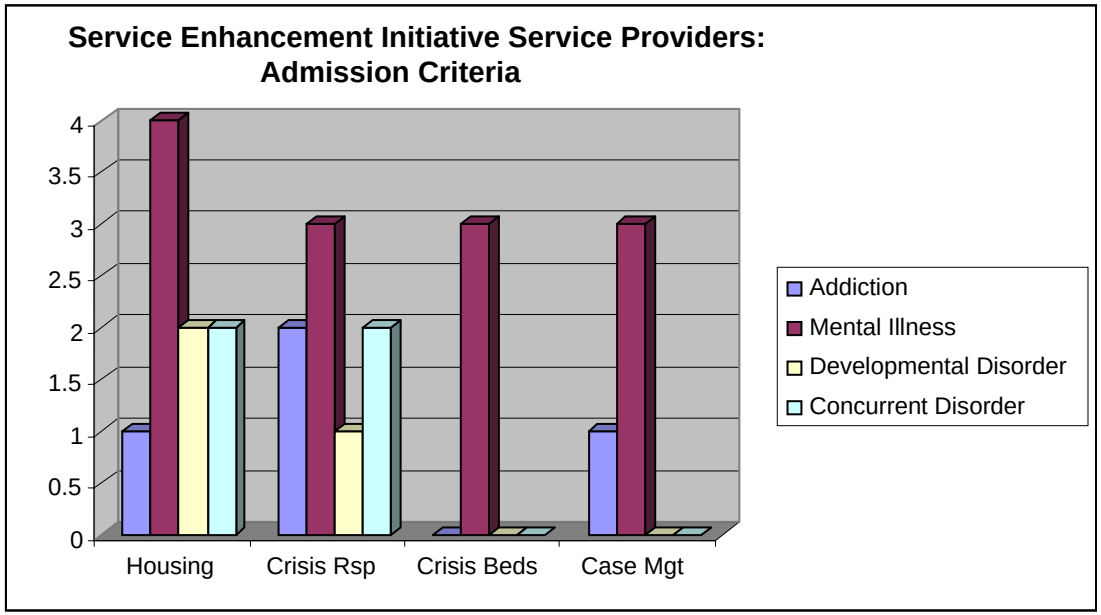

Case Management
Number of Agencies
3
2.5
2
1.5
1
0.5
0
Housing (4)
Crisis Rsp.(3)
Crisis Beds(3)
Case Mgt.(3)


Assessment
Number of Agencies
3
2.5
2
1.5
1
0.5
0
Housing (4)
Crisis Rsp.(3)
Crisis Beds(3)
Case Mgt.(3)
Assessment


Treatment/Counselling
Number of Agencies
3
2.5
2
1.5
1
0.5
0
Housing (4)
Crisis Rsp.(3)
Crisis Beds(3)
Case Mgt.(3)

6	Question	Response(s)	Housing 4 Agencies	Crisis Response 3 Agencies	Crisis Beds 3 Agencies	Case Management 3 Agencies
How do these clients access your service?		Diversion	4	3	2	2
		Probation	4	3	2	2
		Bail	4	3	0	1
		Referral by police or other Justice Officials	4	3	2	1
		After Sentencing	1	3	1	2
		Other: Specify	0	1 hosp	0	0

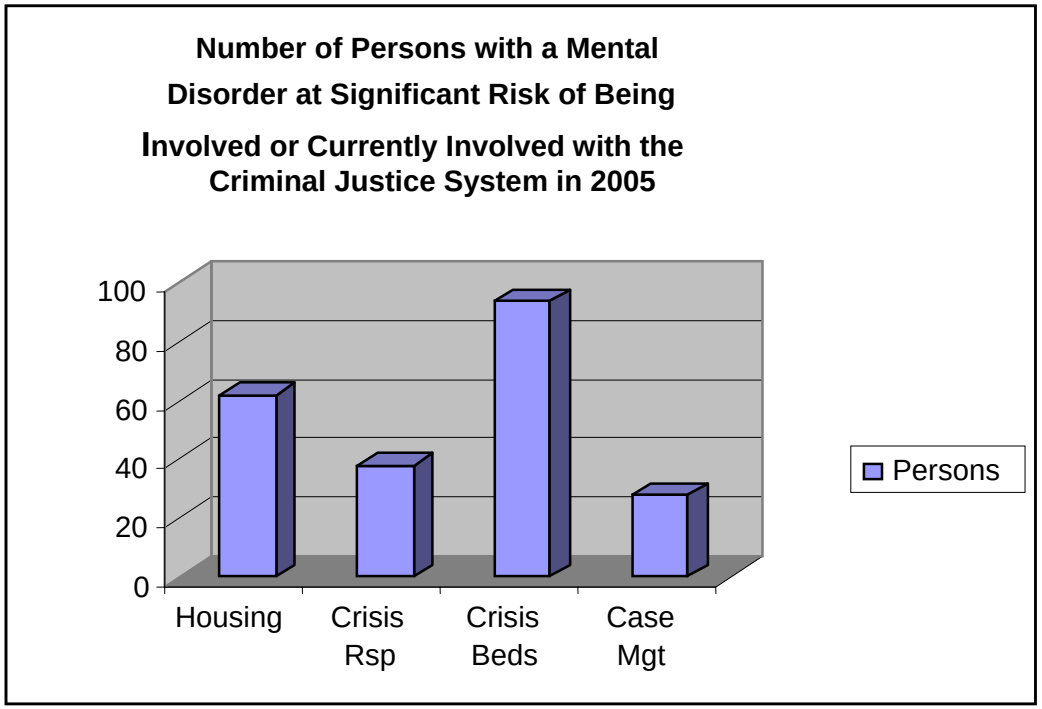
7	Question	Response(s)	Housing 4 Agencies	Crisis Response 3 Agencies	Crisis Beds 3 Agencies	Case Management 3 Agencies
What are the admission criteria?		Addiction	1	1	0	1
		Mental Illness	4	3	3	3
		Developmental Disorder	2	1	0	0
		Concurrent Disorder †	2	2	0	1
		Other: specify	1 current involvement with JS	Dual Dx Cognitive Dx	0	0



10	Question	Response	Housing 4 Agencies	Crisis Response 3 Agencies	Crisis Beds 3 Agencies	Case Management 3 Agencies
Do you provide service to ethno-cultural population?		Yes	4	3	3	3
		No				

15	Question	Responses	Housing 4 Agencies	Crisis Response 3 Agencies	Crisis Beds 4 Agencies	Case Management 3 Agencies
Who refers these clients to you?		Self	1	3	2	2
		Family	1	3	1	1
		Medical Therapist	0	1	1	1
		Mental Health Court Support Program	4	3	4	3
		Police	3	3	4	3
		Jail/Detention Centre	2	2	2	2
		Court Personnel	2	2	2	2
		Probation/Parole Staff	4	3	3	1
		Specialty Hospital	2	1	2	1
		General Hospital	1	3	1	1
		Home for the Aged	0	1	0	0
		Nursing Home	0	1	0	0
		Group Home	0	1	0	0
		Other:	* pre charge *Court Diversion *as per MHJI priority referral sources- MOHLTC	* cultural specific programs * Crisis beds * Mental Health Court Support Prog		
		Unknown				

16	Question	Number	Housing 4 Agencies	Crisis Response 3 Agencies	Crisis Beds 4 Agencies	Case Management 3 Agencies
How many of these clients (*persons with a mental disorder at significant risk of being involved or are currently involved with the Criminal Justice system*) do you see over a 1 year period (2005) (please indicate)			**62 persons**	**38 persons**	**94 persons**	**28 persons**



17	Question	Response		Housing 4 Agencies	Crisis Response 3 Agencies	Crisis Beds 3 Agencies	Case Management 3 Agencies
Do you have specific programs for the following:		Concurrent disorders	Yes	2	0	0	2
			No	2	3	3	1
		Dual Diagnosis	Yes	2	1	2	0
			No	2	2	1	3
		Transitional Aged Youth	Yes	2	1	0	0
			No	2	2	3	3

20	Question	Response(s)		Housing 4 Agencies	Crisis Response 3 Agencies	Crisis Beds 3 Agencies	Case Management 3 Agencies
If yes to question 19; Do you have clients from any of the following?		Federal Penitentiary	Yes	**4**	**0**	**2**	**0**
			No	**0**	**2**	**0**	**1**
			Do not know	**0**	**1**	**1**	**2**
		Provincial Correctional Facilities	Yes	**4**	**3**	**2**	**2**
			No	**0**	**0**	**0**	**0**
			Do not know	**0**	**0**	**1**	**1**
		Local Detention / Remand Centres	Yes	**4**	**3**	**3**	**3**
			No	**0**	**0**	**0**	**0**
			Do not know	**0**	**0**	**0**	**0**

21	Question	Response(s)		Housing 4 Agencies	Crisis Response 3 Agencies	Crisis Beds 3 Agencies	Case Management 3 Agencies
Are your services involved in discharge planning for mentally ill inmates in any of the following?		Federal Penitentiary	Yes	2	0	0	0
			No	2	3	3	2
			Do not know	0	0	0	1
		Provincial Correctional Facilities	Yes	2	1	0	2
			No	2	2	3	1
			Do not know	0	0	0	0
		Local Detention / Remand Centres	Yes	2	1	0	2
			No	2	2	3	1
			Do not know	0	0	0	0

Appendix F: Types of Services for Mental Health Clients in the Justice System Provided by Agencies Not Funded by the Service Enhancement Initiative

Resource: Mental Health Service Information Ontario (MHSIO) - *ConnexOntario* Health Service Information. Agencies listed as providing one or more of the following:

Mental Health/Justice System Services	**Agencies**	
• Awaiting sentencing • Awaiting Trial/Bail • Community Treatment Order • Conditional Discharge • Court Diversion • Criminal Responsibility Assessment • Federal Parole • Fitness Assessment • Incarcerated • Parole • Pre-charge Diversion • Provincial Parole • Provincial Probation	1	A-Way Express Courier Service
	2	Choices for Living
	3	Consume/Survivor Information Resource Centre of Toronto
	4	Corner Drop-IN (St. Stephens House)
	5	Driftwood Community Centre
	6	Eden Community Homes
	7	Habitat Services
	8	Homeward
	9	LAMP Programs
	10	Margaret Frazer House
	11	My Brother's Place Mental Health Services
	12	New Outlook
	13	Progress Place Mental Health Services
	14	Regeneration Housing and Support Services
	15	Schizophrenia Society of Ontario
	16	Sistering –A Women's Place
	18	Street Health Community Nursing
	17	Toronto East Counselling and Support Service
	19	University Heatlh Network
	20	Woodgreen Community Services, Mental Health and Developmental Services

Types of Services for Mental Health Clients in the Justice System Provided by Agencies Not Funded by the Service Enhancement Initiative

Resource: Ministry of Health and Long-Term Care

Mental Health Justice System Services	Agencies	
	1	416 Drop-in
	2	Across Boundaries
	3	Alternatives: East York Mental Health Counseling Services Agency
	4	Central Neighborhood House
	5	Community Living Toronto
	6	Covenant House
	7	Delisle Youth Services
	8	Dual Diagnosis Program , CAMH
	9	East Metro Youth Services
	10	Elizabeth Fry Society
	11	Ethiopian Association in Toronto
	12	Friends and Advocates Centre Etobicoke
	13	George Herman House
	14	Griffin Community Support Network
	15	Hincks-Dellcrest Centre
	16	Hong Fook Mental Health Association
	18	Jewish Family and Child Service of Greater Toronto
	17	Kennedy House Youth Services
	19	Mens Sana Families for Mental Health
	20	Muki Baum Association for the Rehabilitation of Multi-Handicapped
	21	Native Child and Family Services
	22	Operation Springboard
	23	Parkdale Community Health Centre: Street Health Program
	24	Passages (part of Community Mental Health Centre North York)
	25	Reena
	26	Street Haven at the Crossroads
	27	Surrey Place Centre
	28	Toronto East General Hospital Community Outreach Services
	29	Toronto Support Services
	30	Touchstone Youth Centre
	31	Trinity Square Cafe
	32	York Community Services: Community Health Centre

Appendix G: Questionnaire for Mental Health Court Support Programs

This survey is concerned with persons with a mental illness who have come in contact with the law and are seen through the mental health court services program.

Mental Health Court Support Services Questions

*When answering each question please place an **X in <u>all</u** responses that are relevant to the question.*

1	Question	Specify (approx)
Number of mentally ill accused or offenders in the program had contact within calendar year 2005?		

2	Question	Specify (approx)
Number of clients who applied for Diversion in the calendar year 2005?		

3	Question	Response(s) (approx)	%
What services in the community do you refer clients to?		Specialty Hospital (Forensic Programs)	
		Community Mental Health Service	
		Case management Program	
		Community Support Program	
		General Practitioners	
		General Hospital	
		Group Homes	
		Shelter/Crisis Beds	
		Long Term Housing	
		Psychiatrists	
		Other (specify)	

4	Question	(X) Response	
Is there a wait list to access these services?		Yes	
		No	

5	Question	(X) Response			
If you answer yes to question 4, What is the wait time?		1-5 days		30-50 days	
		5-10 days		Over 50 days	
		10-30 days			

6	Question	(X) Response	
Is there a designated contact person in the services for arranging referrals?		Yes	
		No	

7	Question	Response (approx)	%
What is the nature of the illness and the <u>percentage</u> of each in the population you serve?		Seriously mentally ill *	
		Moderately mentally ill **	
		Persons in crisis	
		Personality Disordered	
		Concurrent Disorder †	
		Dual Diagnosis ††	

Definitions:

- * ***<u>Seriously mentally ill</u>*** *includes Axis I diagnostic categories of schizophrenia schizoaffective disorder, bipolar and affective disorders.*
- ** ***<u>Moderately mentally ill</u>*** *focuses on Axis II & III, diagnostic categories such as the personality disorders, mental retardation and anxiety disorders*
- † ***<u>Concurrent Disorder:</u>*** *mental illness plus addiction*
- †† ***<u>Dual Diagnosis</u>:*** *mental illness plus developmentally disordered*

8	Question	Response(s) (approx)	%
What are the services often needed by clients seen?		Prevention from Criminal Involvement	
		Crisis response intervention	
		Relapse Prevention	
		Care Management	
		Released form Custody Service Planning	
		Rehabilitation	
		Treatment	
		Assessment	
		Housing	
		Discharge Planning	
		Other (please specify)	

9	Question
Please identify system barriers or gaps that hinder effective service to your clients.	
Written Response	

10	**Question**
What additional services/resources do you require within your program/service to better serve the clients?	
Written Response	

11	**Question**
What additional services are required outside of your organization to better serve the clients?	
Written Response	

12	**Question**
In what ways would you organize the services in your area differently to better meet the needs of the mentally ill in contact with the Justice System?	
Written Response	

13	**Question**
Do you (the respondent to the survey) sit on any planning or organizing committees related to services for this client group? Yes/No (circle) If <u>yes</u> please specify	
Written Response	

14	**Question**
How would you change the Justice and Mental Health Systems to better meet the needs of the clients in your area? (please specify)	
Written Response	

15	Additional Comments:

Thank you for your time in completing this questionnaire:

Sincerely
PublicPartner Inc. & Glenn Thompson Consulting

Please complete to following:

Name of Agency	
Person Completing Questionnaire	
Phone Number	

If you are completing your survey manually, please mail your completed hard copy to:

Michael Phillips
Public Partner
14 Forest Trail,
Gormley, Ontario
L0H 1G0

If you are completing your survey electronically, please e-mail your completed survey as an attachment to:

michael-phillips@rogers.com

Appendix H: Questionnaire for Hospitals

This survey is concerned with persons with a mental illness who are likely to or have already come in contact with the law.

Survey Questions for Hospitals

*When answering each question please place an **X in <u>all</u** responses that are relevant to the question.*

1	**Question**	**Response(s) (approx)**	%
Please indicate the percentage of clients seen from the Justice source(s) in 2005.		Police apprehension pursuant to the Mental Health Act	
		Charges before the court	
		Mental Health Court Diversion	
		Probation	
		Serving Custodial Sentence	

2	**Question**	**Response(s) (approx)**	%
What were the sources of referrals for these contacts?		Mental Health Court Support Program	
		Court Personnel (Judge, Crown Attorney)	
		Jail/Detention Centre	
		General Practitioner	
		Probation/Parole Officers	
		Police Officers	
		Other: (please specify)	

3	**Question**	**(X) Response(s)**	
Legal Status on referral?		No Current Charge	
		Current Charges	
		On probation/parole	
		In custody	
		Ontario Review Board	
		Unknown	
4	**Question**	**(X) Response(s)**	
Services Required on referral?		Case Management *	
		Crisis Response	
		Assessment	
		Emergency	
		Treatment / Counseling	
		Other –(please specify)	

***case management:** Coordinates a continuum of services based on clients choice and needs*

5	**Question**
Please identify any gaps or barriers to providing a better service for these clients.	
Written Response	

6	**Question**	**(X) Response**	
Do you have any agreements in place between your hospital and the Justice System to better manage this group of clients?		Yes	
		No	

7	**Question**
What additional services/resources do you require within your program/service to better serve these clients?	
Written Response	

8	**Question**
What additional services/resources are required outside of your organization to better serve the clients?	
Written Response	

9	**Question**
In what ways would you organize the services in your area to better meet the needs of the mentally ill in the Justice System?	
Written Response	

10	**Question**
Do you (the respondent to the survey) sit on any planning or organizing committees related to services for this client group? Yes/No (circle) If yes please specify.	
Written Response	

11	**Question**
How would you change the Justice and Mental Health Systems to better meet the needs of the clients in your area (please specify)	
Written Response	

12	Additional Comments:

Appendix I: Interviews with Mental Health and Justice Clients and Consent Form

The purpose of the interview is to highlight the experiences of the mentally ill persons who are likely to or have already been involved with the justice system as well as to identify elements of the
Mental Health and Justice Systems perceived as being helpful or unhelpful

Questions for User's and Significant Persons

Note: These questions will be asked in interview

1. When you need help, do you know where to go?
2. Do you feel the services are available?
3. What barriers do you encounter when seeking care?
4. What happened that led to you becoming involved with the law?
5. Are you currently involved in a mental health program or programs?
6. How long have you been involved with this program?
7. Who referred you to the program?
8. What aspects of the program did you find most helpful?
9. Who provided help to you while you were in the Justice System?
10. What has your experience been of the Justice process?
11. Before you were involved with the Justice System did you have prior experience with the mental health system?
12. In your experience have services for mentally ill persons who are involved with the law improved or stayed the same?
13. What program or programs were you involved with during your period in the Criminal Justice System?
14. What do you like about the program(s)? Why?
15. What do you dislike about the program(s)? Why?
16. What is your satisfaction level with the program(s)? 1-10 scale
17. How would you make the system better?

Questions for User's and Significant Persons

Person:_____ Date: May____2006

Agency:_____

Sex: M/F Age: <18, 18-24, 25-35, 36-45, 46-55, 55 >

	Question	Answer
1	When you need help, do you know where to go? (re: mental illness)	Y/N
2	Do you feel the services are available?	Y/N
3	What barriers do you encounter when seeking care?	
4	What happened that led to you becoming involved with the law?	
5	Are you currently involved in a mental health program or programs? If yes what **program(s)**	Y/N
6	How long have you been involved with this program?	
7	Who referred you to the program?	

	Question	Answer
8	What aspects of the program did you find most helpful?	
9	Who provided help to you while you were in the Justice System?	
10	What has your experience been of the Justice process?	
11	Before you were involved with the Justice System did you have prior experience with the mental health system? If yes elaborate	Y/N
12	In your experience have services for mentally ill persons who are involved with the law improved or stayed the same? If yes explain	Y/N

	Question	Answer	
13	What program or programs were you involved with during your period in the Criminal Justice System?		
14	What do you like about the program(s)? Why?	**What do you like**	**Why**
15	What do you dislike about the program(s)? Why?	**What do you dislike**	**Why**
16	What is your satisfaction level with the program(s)? 1-5 scale	1 2 3 4 5 Very unsat okay very sat	
17	How would you make the system better?		
Comment/Other			

Mapping Study of Available Services in Toronto for Mentally Ill Persons who are at Risk of or involved with the Criminal Justice System.

CONSENT FORM

PublicPartner Inc and Glenn Thompson Consulting are two companies that work in the Mental Health and Justice Area. They have been retained by the Toronto Human Services and Justice Coordinating Committee to map available services to mentally persons at risk of or who have been involved with the Criminal Justice System.

I understand that this interview is aimed at better understanding the experiences of persons with a mental illness who have been involved with the Justice System. I understand that I will be asked a number of questions about my experiences that will include the impact of the experience, the sources of and the degree of support asked for and received and suggestions for improving the system.

I understand notes will be taken during the interview and that I may have someone sit in with me during the interview.

My responses will be treated as confidential and my name and other identifiers will not be included in the final report.

The interview will take 60-90 minutes and participation is voluntary. I understand that I may withdraw at any time and that the information I may have given thus far will not be used without my consent.

I accept that by participating in the interview I will be assisting in providing for an understanding of the unique needs of mentally ill persons as they go through the Criminal Justice System.

I understand that I will be paid $35.00 for my participation.

I understand the information given to me and I agree to participate.

Signature of Participant:_____ Date: _____

Witness: _____ Date: _____

Appendix J: Focus Groups and Consultations

FOCUS GROUPS

Contact	Ministry/Organization	Title	Focus Group Date
Richard Schneider Margaret Creal	Attorney General	Judge, 102 Court Assistant Crown Attorney 102 Court	April 13, 2006
James Stewart	Attorney General	Chair, Mental Disorder Crown Committee	April 21,2006
Mohamed Badsha Robert Abbatangelo	Mental Health and Justice Network	CMHA Toronto : Co-Chair COTA Health: Co-Chair	February 28, 2006
Mary Jane Cripps	Pre-charge Diversion/ Crisis Prevention	Reconnect Mental Health Services: Chair	March 22, 2006
Mohamed Badsha	Safe/Crisis Beds	CMHA Toronto : Chair	March 30, 2006
Heather Bullock	Communication Committee	MOHLTC	April 18, 2006

Contact	Key Informant Representation	Ministry/Organization	Focus Group Date
Mohamed Badsha	Supportive Housing Lead	CMHA Toronto	April 21 , 2006
Jim Nason	Supportive Housing Lead	LOFT	
Paul Bruce	Supportive Housing Lead	COTA Health	
Carol Zoulalian	Supportive Housing Lead	Houselink Community Services :Chair	
Joyce Line Emma Thomas	Housing Support Workers	Houselink	April 18, 2006
Sharon Deally	Intensive Case Management/ Release Planning	Scarborough General Hospital	April 25, 2006
Scot Hodge	Forensic ACTT	Team Lead East Toronto CMHA Toronto	March 23, 2006

Contact	Key Informant Representation	Ministry/Organization	Focus Group Date
Frank Sirotich	Court Support Consortium	Manager, Scarborough	March 22. 2006
Michael Haswell	Out Patient Court Support Program	Nurse Coordinator North York General Hospital	April 11, 2006
Nancy Blades	North York Court	Supervisor, Mental Health & Commutiy Supports COTA	April 27, 2006
Jorge Zelaya Janey Corderio	102 Court, Old City Hall	CRTC, Mental Health Court Workers	April 18, 2006
Doug Olver	Superintendents: Central Region	Correctional Services	March 16, 2006
Peter Lesperance	Area Managers: Probation and Parole	Correctional Services	March 30, 2006
Jeff Wright	Transitional Youth/ Research	Children and Youth Services: Research and Outcome Measurement, MCYS	March 22, 2006

Contact	**Key Informant Representation**	**Ministry/Organization**	**Focus Group Date**
Mike Federico Mike Donnelly Mike Gottschalk	Mobile Crisis Intervention Teams/ Police	Toronto Police Service	April 18, 2006
Vada Kolishi	Dual Diagnosis & Developmental Services	COTA Health	March 17, 2006
Wendy Chow Dr. Jian Yang	Ethnocultural Mental Health Court Support Services	Program Manager	April 27, 2006

SYSTEMS CONSULTATIONS FOR TORONTO STUDY

Contact	Key Informant Representation	Ministry/Organization	Title	Consultation Date
Steve Lurie	Mental Health Service Provider	CMHA Toronto	Executive Director	April 7, 2006
Diane Doherty	Mental Health Service Provider/Correctional Services	CMHA Halton	Executive Director	April 5, 2006
Pam Hines	Mental Health Service Provider/Consumer	CMHA Windsor-Essex	Executive Director	April 5, 2006
Dr Howard Barbaree	CAMH Mental Health Service Provider	Law and Mental Health Program, CAMH	Clinical Director and Head	April 6, 2006
Jim McNamee	Admin Director, LAMH Program	Law and Mental Health Program, CAMH	Administrative Director	March 23 , 2006/ April 6 2006
Susan Morris	Dual Diagnosis	Dual Diagnosis, CAMH	Clinical Director	April 6, 2006

Contact	Key Informant Representation	Ministry/Organization	Title	Consultation Date
Tom Goddard	Attorney General	Attorney General	Assistant Crown Attorney	May 3, 2006
Judge Edward Ormston	Attorney General	102 Court, Old City Hall	Judge	July 18, 2006
Judge Lauren Marshall	Attorney General	North York Court	Judge	May 9, 2006
Larry Stebbins	Federal Corrections: Forensic Mental Health Project:	Correctional Service Canada	Warden	May 29, 2006
Cathy Gainer			Deputy Warden	
John Currie			Parole Supervisor	
Robert Brown			Regional Administrator, Health Services	
Hugh Osler	Criminal Justice Agency	OACC/ Salvation Army – Correctional and Justice Services	Past President/ Director	April 13, 2006
Mike Conry Cathy Morris	Correctional Services Toronto	Correctional Services	Regional Director Deputy	May 2, 2006
Marg Welch	Correctional Services	Correctional Services	Regional Director	May 5, 2006

Contact	Key Informant/ Representation	Ministry/Organization	Title	Consultation Date
Laura Pisco,	LHIN	Toronto Central Local Health Integration Network	Senior Policy Coordinator	July 26, 2006
W. Michael Fenn	LHIN/ Former Deputy Minister	Mississauga Halton Local Health Integration Network	CEO	March 27, 2006
Michael Klejman	MOHLTC	MOHLTC	Regional Director	June 8, 2006
Dr Peter Prendergast	Mental Health Service Provider	Whitby Mental Health Centre	Chief Psychiatrist	March 29, 2006
Dr Sam Law	Mental Health Service Provider /Ethno-cultural psychiatry	St Michael's/Mount Sinai ACT Team	Director Forensic Program Psychiatrist	June 2, 2006
Al O'Marra	Coroner's Inquests	Office of the Chief Coroner	Chief Legal Counsel	May 1, 2006
David Kelly	Mental Health /Substance Abuse	Ontario Federation of Mental Health and Addictions Agencies	Executive Director	May 23, 2006
Michael Feindel	NCR/ Fitness	Ontario Review Board	ORB Crown	April 21, 2006

Contact	Key Informant/ Representation	Ministry/Organization	Title	Consultation Date
Dianne Macfarlane	Health Systems Research and Consulting Unit	Centre for Addiction and Mental Health	Research Associate	March 20,2006

Appendix K: Service System Assessment -Toronto Mental Health and Justice Coordinating Committee

INTERVIEW GUIDE – SYSTEM DESIGN FOCUS

1. What are the major current structural issues in the mental health and justice field from your perspective?

2. Is a forensic services overview/coordinating committee, commission or other management structure needed for the province? If so, should it have regional mental health and justice committees that are linked to the provincial body?

3. What methodology do you believe that the LHINs are planning to apply to clients/services that cross their boundary lines?

4. Is Cancer Care Ontario and its regional structures a model for mental health and justice service organization in Ontario?

5. Are you familiar with mental health and justice organizational/system design elsewhere in Canada and in other countries that you believe could be beneficially applied to or adapted for Ontario?

6. What are the most promising/productive organizational/system strategies already used in Toronto in the mental health/justice field? In other fields which might be replicated?

7. Is the main need in the forensic area to alter the service system design or to fill in the service gaps? Or must both happen simultaneously?

8. How can consumer/family and key support persons groups be better linked to policy planning and service delivery for the mental health and justice client population?

9. New Zealand (Auckland has 4 district health boards) assigns services that cannot be easily coordinated and delivered by each of their LHIN (equivalent) areas to one LHIN to act as a lead for all. Do you feel that such an arrangement could be effective in Toronto?

10. How would you manage the children's and transitional-age youth populations from an organizational/system perspective?

11. How should services for offenders released from federal correctional institutions be linked into the Toronto mental health and justice service system?

12. There is a lack of readily available information about mental health and justice programs, such as pre-discharge diversion. How should the collection and publication of such management planning data and information be handled in Toronto?

13. Can a risk gradient be applied to clients and potential clients of mental health and justice services, in order to assign funds to the clients that have the highest

likely impact upon public safety and personal need? Does a lack of equity of access for clients of different levels of risk concern you?

14. Toronto has one of the world's most ethno-culturally diverse populations. How should mental health and justice services for these culturally and linguistically diverse population groups be organized?

15. Should the service groupings for mental health and justice services in Toronto be sub-regional (i.e. Scarborough, Etobicoke, etc.)?

16. Should Toronto have a mental health and justice coordinating committee in each of the current four quadrants?

17. How can housing services be linked organizationally to the current and proposed mental health and justice services in Toronto to better ensure availability of accommodation?

18. Are there other ideas and proposals you would like to add to this discussion to assist in the formulation of proposals for change?

Appendix L: Service Mapping of Mental Health and Justice Programs: Funded Under the Service Enhancement Initiative by Key Juncture Point

JUNCTURES	RECOMMENDED STRATEGIES	STATUS
JUNCTURE I,2 PREVENTION AND PROBLEM Prevention refers to the wide array of support and services in the community that have a direct effect of preventing a mentally ill person from being involved with the Law. At the problem juncture symptoms of a mental illness is apparent through the clients behaviour. A key focus of this Juncture is the accessibility and availability relevance of the program in responding to needs	Coordinate Community Service/Programs for persons at risk	The MH&J Crisis Prevention programs target individuals at significant risk of criminal justice involvement through coordination among agencies providing these services as well as other MH&J services (e.g. safe beds and housing). There is limited formal coordination between these MH&J services and traditional mental health community services
	Crime prevention elements in program	Within the MH&J Crisis Prevention programs there are crime prevention elements but these elements are implicit. E.g. part of the admission criteria is set up to operationalize "significant risk of involvement with the criminal justice system".
	Clients linked to Case Managers	The MH&J Crisis Prevention programs provide case management which is short-term. It is intended to stabilize the situation, and thereby reduce risk of involvement w/ cjs or to function as an interim support measure until longer-term and/or higher support services can become involved
	There is access to Medical Care	Inadequate access at the moment
	There is Public Information on available Programs	There are brochures on all the MH&J programs including Crisis Prevention. There is also a common brochure that is in development which provides very general information about all the MH&J services that are part of the MH&J Service Network (e.g. CP, MCIT, Court Support, Safe beds, Housing, Release Planning, Case Management) as well as all the contact information for all these program areas within each of the quadrants.
	There is a Public Education Strategy	There is a MH& J Communication and Education committee that is working on the common brochure noted

	RECOMMENDED STRATEGIES	STATUS
JUNCTURE I,2 PREVENTION AND PROBLEM *Continued*		above. It has developed a powerpoint presentation on the MH&J service network and started to present to some key audiences. It is has also identified priority targets for presentations on the services of the network and is looking to provide training to MH&J service providers so they can present on the entire service network as they conduct outreach on their specific program areas.
	Multi-Agency Planning for High Risk Offenders	Service care planning involving coordination among multiple support to attenuate risk is done on an ad hoc basis.
	Targeted programs for clients with Substance Abuse Issues	There are no programs targeted to persons at risk of involvement with criminal Justice system. There are lengthy wait times to access such services.
	Programs that address Housing and Social Service Needs (Employment, O.D.S.P.)	Individuals can access safe beds and MH&J housing; however individuals who are already linked to case management services or to ACT would not be able to access the safe beds and MH&J housing program unless they have current involvement with the criminal justice system.
	Ongoing Evaluation of What Works in Programs	CP programs are currently attempting to develop a common evaluation framework. There is not any such framework for Court Support programs evaluation which would occur on an intra-agency basis.
	Existence of Service Agreements	Mental Health and Justice Programs are coordinated and work collaboratively but there are not singed formal agreements in place.
	Mechanism for Multi-Agency Case Conference and Plans	Not currently in place and may be difficult to establish especially with cj stakeholders given PHIPA.

	RECOMMENDED STRATEGIES	STATUS
JUNCTURE I,2 PREVENTION AND PROBLEM *continued*	Involvement of Consumer and Family	There is limited consumer and family involvement in the planning and coordinating of services. There are representatives from the consumer and family sectors at the Toronto Mental Health & Justice committee. There is no involvement at the operational tables. The CP work group does have consumer representation.
	Access to ACT Teams	There is no priority access to ACT teams. ACT teams still remain difficult to access though some teams are more accessible then others.
	Monitoring of Client's Behaviour by Case Manager	Yes, varies across agencies.
	Have Agreement on Information Sharing	No, apart from MCIT.

JUNCTURES	RECOMMENDED STRATEGIES	STATUS
JUNCTURE 3,4,5,6 ▪ **Incident** ▪ **Police investigation** ▪ **Intervention** ▪ **Laying of information** At these Junctures the client may have acted in an aggressive or antisocial behaviour or committed a crime or may be a serious occurrence in the home causing the police to intervene. The police may elect to divert the individual or lay charges	Have Crisis Response Program with Police in place	Mobile Crisis Intervention Team (MCIT), this only exists in the South quadrant only. It is hoped this will expand to other parts of Toronto.
	Strategy to provide Information to Family	Not currently in place
	Have a Crisis Plan re: Police and Community Agency Service	Scarborough is attempting to establish a common crisis protocol across crisis providers (mobile crisis, hospital crisis, crisis prevention, safe beds) which includes police;
	Agency Response's to Crisis	Agencies providing crisis prevention, safe beds or participating in MCIT should have specific protocols in place
	Link Crisis Response to other Services such as Crisis Beds etc.	MCIT have access to crisis beds as a priority.
	Establish Inter-Agency Service Agreement and Protocols (to include local Hospital Emergency Departments)	Nothing formally in place
	Joint Training between Mental Health Service Providers and Police	Not currently, except perhaps for MCIT
	Have Protocols in place to minimize Police Waiting Time in Emergency Departments	Not across the city, Scarborough Hospital and Centenary Health Centre (in Scarborough) have established procedures to reduce police wait times
	Establish Information Sharing Protocols between Police and Human Services	Occurs with MCIT. FIPPA maybe barrier

JUNCTURES	RECOMMENDED STRATEGIES	STATUS
JUNCTURE 3,4,5,6 ▪ **Incident** ▪ **Police investigation** ▪ **Intervention** ▪ **Laying of information** ***continued***	Have available Resource Staff to Consult with Police	A factor is the limited hours of operation of the Crisis Prevention Staff
	Provide Ongoing Support to Clients	
	Multi-Agency Community Crisis Plan to specify the Agency which will receive the Clients	Not currently in place. In Scarborough efforts are being made to establish a common crisis protocol across crisis providers (mobile crisis, hospital crisis, crisis prevention, safe beds) which includes police; this protocol will specify which agencies would receive the client and under what circumstances.
	Have Agreement with the Police regarding Pre-Charge Diversion	No
	Provide Training for Police to Recognize Clients who can be Diverted	Not currently
	Such Training to Recognize Symptoms Indicative of Mental Illness and Techniques for De-escalating Crisis Situations	Occurs to a very limited extent at the police college
	Provide Staff Training, Resource and Tools necessary to work with Clients in Need of Mental Health Services	Occurs at an agency level
	Agencies Work Closely with Crowns and the Defense Bar in dealing with a Mentally Ill Accused	Currently in place but this role primarily undertaken by court support staff which operate as boundary spanners
	Have Mental Health Court Outreach Workers in Place	Currently in place
	Have an Inventory of Community and Hospital Resources Information to be available if Needed	Exists among all court support programs but at an agency level

	RECOMMENDED STRATEGIES	STATUS
JUNCTURE 3,4,5,6 ▪ **Incident** ▪ **Police investigation** ▪ **Intervention** ▪ **Laying of information** ***continued***	Fully Inform Clients and Families of the Criminal Justice Process	Currently occurring however within the limits of FIPPA
	Provide Culturally Sensitive Service to Ethno- Racial Mentally Ill Clients during this Stage	In terms of dedicated specialized service, only the Mt. Sinai court support program has this capacity; not aware of the scope of their service; other agencies will of course strive to provide culturally sensitive service but I am not aware of programs that have dedicated resources for this. To a limited extent through the Mt. Sinai Support Program

JUNCTURES	RECOMMENDED STRATEGIES	STATUS
JUNCTURES 7,8,9 DIVERSION POINTS	Work with Crown Attorneys to Develop Specific Diversion Plans including an Agreement acceptable to the Client	Yes, currently in place.
	Work with the Defense Bar in Their Efforts to Advocate For and Work on Behalf of Mentally Ill Clients	Yes, court support programs work with defense bar (as well as crown counsel).
	Involve Client's Case Manager in Developing the Diversion Plan	Yes currently occurring
	Provide Comprehensive Assessments and Triaging the will allow for the Referral of Clients to the appropriate Agency or Service Provider	Yes currently occurring
	Maintain Contact with Client or Case Manager During Remand Custody	Yes currently occurring
	Ensure Client Sign the Diversion Agreement with Receiving Service Agency	No. Not in all courts.
	Provide the Opportunity for Information Sharing and Training with Justice Partners	Yes, currently occurring

JUNCTURES	RECOMMENDED STRATEGIES	STATUS
JUNCTURE 18 RELEASE PLANNING	Participate in release planning in the community	Limited discharge planning in place Will be greatly enhanced with the recent funding earmarked for this purpose
	Link and accept community agencies	
	Work with probation on Supervision of released individuals on probation orders	
	Collaborate with Forensic Services regarding supervision of community release ORB cases	

JUNCTURES	RECOMMENDED STRATEGIES	STATUS
JUNCTURE 19	Provide supervision for released offenders from both Federal and Provincial Correctional Facilities	Wide acceptance of discharged clients from Provincial Detention Centres and Probation Offices to all programs. Limited contact with Federal released clients.

JUNCTURES	RECOMMENDED STRATEGIES	STATUS
JUNCTURE 20	Discharge Planning in Place	Yes, at local detention centres however there may be an underutilization of this service by detention centre staff
	Admission/Readmission to Community Mental Health Program	Yes, release planners would refer to community mental health programs
	Referral to ACT Team	This would be provided by another case management services. Referrals are made. Lengthy wait time.
	Ability to Address Housing and Social Welfare Needs	Released individuals no longer have a criminal justice involvement and may not access Mental Health and Justice Housing except through Crisis Prevention Program
	Application of Juncture 1 Strategies	

Appendix M: Service Mapping of Mental Health and Justice Programs: Funded Under the Service Enhancement Initiative by LHIN

Program & Description	Agency	Location of Agency	Agency location by LHIN Area	Location of Service Delivery By LHIN Area
Intensive Case Management To identify and provide the services required to keep people in the Community with adequate supports through direct support, advocacy and counseling, referral to other service providers to meet present needs, improve skills for daily living and coping with mental illness and education and direct assistance through psychosocial and educational groups	Community Resources Consultants (CRCT)	Toronto	Toronto Central #7	Toronto Central #7
	Comprehensive Rehabilitation and Mental Health Services (COTA)	Toronto	Toronto Central #7	Central #8
	Scarborough Hospital CMHA Program	Scarborough	Central #8	Central #8
	Homeward Mental Health Projects of Metropolitan Toronto	Toronto	Toronto Central #7	Toronto Central #7
	Canadian Mental Health Association Metropolitan Toronto Branch	Toronto Toronto- East Toronto- West	Central # 8	Central East #9 Mississauga/ Halton #6
	North York General Hospital Adult Mental Health Service	North York	Central # 8	Central # 8

Program & Description	Agency	Location of Agency	Agency location by LHIN Area	Location of Service Delivery By LHIN Area
Police Mobile Crisis Intervention Teams The Police Mobile Crisis Intervention Team represents a partnership between the Police and the Mental Health Sector in responding to situations involving mentally ill persons in crisis. The joint response allows the Mental Health Worker to effectively triage the individual at the scene allowing for faster access to the medical services and better utilization of Police and mental health resources.	St. Michael's Hospital	Toronto	Toronto Central #7	Toronto Central #7
	St. Joseph's Health Centre	Toronto	Toronto Central #7	Toronto Central #7

Program & Description	Agency	Location of Agency	Agency location by LHIN Area	Location of Service Delivery By LHIN Area
Short Term Crisis Support Beds These are short tem residential support beds often referred to as 'safe beds' that can be used as an alternative to custody or hospital beds	Gerstein Crisis Centre	Toronto	Toronto Central #7	Toronto Central #7
	COTA Comprehensive Rehabilitation and Mental Health Services	Scarborough and Toronto	Toronto Central #7	Central East #9
	Reconnect Mental Health Services	Toronto	Mississauga/ Halton #6	Mississauga/ Halton #6
	Canadian Mental Health Association Metropolitan Toronto Branch	Toronto	Toronto Central #7	Central #8

Program & Description	Agency/Courts	Location of Agency	Agency location by LHIN Area	Location of Service Delivery By LHIN Area
Court Support Services The Court Support Programs have a primary focus on Pre-charge Diversion of persons with a mental illness from the Criminal Justice System to the Mental Health System. Services include assessments, linkage to Mental Health and other Support Services as well as consultation, case management and psychiatric follow up. While the Court serves a majority of clients in the region in which they are located, there is a large traffic of cross boundary service which is based primarily on where they are charged by the Police	Comprehensive Rehabilitation and Mental Health Services (COTA) Court:	Toronto North York	Toronto Central #7	Central # 8
	Community Resource Consultation of Toronto (CRCT) Courts: ▪ 102 Court Old City Hall ▪ College Park Court	Toronto Toronto Toronto	Toronto Central #7	Toronto Central #7 Toronto Central #7 Toronto Central #7
	CMHA Toronto Courts:	Etobicoke Scarborough	Central # 8	Mississauga/ Halton #6 Central East #9

Program & Description	Agency	Location of Agency	Agency location by LHIN Area	Location of Service Delivery By LHIN Area
Supportive Housing Services Provides rapid, coordinated assess to safe, dignified housing and support to prevent future involvement with the Criminal Justice System. The target population are adults with Mental Health Illness who are currently involved with the Criminal Justice System, are homeless or potentially homeless and can be supported in the Community	Houselink Community Homes Inc.	Toronto	Toronto Central #7	Toronto Central #7
	Comprehensive Rehabilitation and Mental Health Services	Toronto	Central #8	Central #8 Central East #9
	LOFT Community Homes	Toronto	Toronto Central #7	Toronto Central #7 Central #8
	CMHA Toronto	Toronto	Toronto Central #7	Toronto Central #7 Central #8 Central East # 9 Mississauga Halton # 6

Appendix N: Agreement: St. Joseph's Health Centre and Centre for Addiction and Mental Health

CITY OF TORONTO

AGREEMENT made as of the day of , 2002,
BETWEEN:

ST. JOSEPH'S HEALTH CENTRE
(hereinafter called the "St. Joseph's Health Centre")

OF THE FIRST PART

- and –

CENTRE FOR ADDICTION AND MENTAL HEALTH
(hereinafter called the "Designated Hospital")

OF THE SECOND PART

I **Introduction**

The purpose of this Agreement ("Agreement") is to facilitate the placement of forensic patients with an Assertive Community Treatment Team from the St. Joseph's Health Centre for the purpose of their safe reintegration into the community. The Agreement will:

1.1. Clarify the roles and responsibilities of the Assertive Community Treatment Team and the Designated Hospital.

1.2 Define the accountability relationship between the Assertive Community Treatment Team ("ACT Team") and the Designated Hospital within the context of delivery of ACT Team services to mentally disordered offenders subject to disposition orders made by the Ontario Review Board ("ORB"); and

1.3 Set out protocols for communication and information exchange and working relationships that supports the accountability relationship.

II **Definition of Terms Used in this Agreement**

2.1 Assertive Community Treatment Team ("ACT Team")

An ACT Team provides community-based services, to persons with a serious, long term mental illness. In the context of this agreement, the ACT Team provides services to mentally disordered offenders (herein "accused persons") who are under the jurisdiction of the ORB. Service is provided by a multi-disciplinary team. Treatment, rehabilitation and support are given in the community and combines skill teaching with clinical care and case management. Outreach, client choice, and individual service are traditional features of ACT Teams. This

Agreement applies to members of the ACT Team who are either employees of or physicians with privileges at the St. Joseph's Health Centre.

2.2. Designated Hospital

The Centre for Addiction and Mental Health is a facility designated by the Ontario Minister of Health under Part XX.I of the *Criminal Code of Canada* to provide for the custody, treatment or assessment of an accused person under the jurisdiction of the ORB. It is a facility in Ontario at which accused persons are detained pursuant to disposition orders of the ORB and which continues to be named in disposition orders where the accused person has been conditionally discharged by the ORB. For the purpose of this Agreement, "Designated Hospital" refers to the Centre for Addiction and Mental Health.

2.3 Ontario Review Board

The ORB is the Board established pursuant to section 672.38(1) of the *Criminal Code* and which makes or reviews dispositions concerning any accused person in respect of whom a verdict of not criminally responsible by reason of mental disorder or unfit to stand trial has been rendered.

2.4 Disposition Order

The disposition order is an order of the ORB or the court which defines custodial and other conditions under which the Designated Hospital is to detain, treat or assess an accused person. The ORB writes a disposition order for each accused person in its jurisdiction within days of the person being found either not criminally responsible on account of mental disorder, or unfit to stand trial. The disposition order is reviewed annually further to a hearing conducted by the ORB, as required by the *Criminal Code*.

It is understood that a disposition order may permit an accused person to reside in the community, notwithstanding it is a custodial disposition written pursuant to section 672.54(c) of the *Criminal Code*. The disposition order specifies the maximum latitude that the person in charge of the Designated Hospital may permit the accused with respect to access; level of supervision; geographic limitations on travel etc.

The disposition order specifies obligations on the "person in charge" of the Designated Hospital (see section 2.5 below) such as reporting to police in the event of an absence without leave or the conducting of random screening for drug and alcohol consumption.

The disposition order further specifies obligations on the accused person. Examples may include a requirement to refrain from use of substances or to provide urine or breath samples for the purpose of substance abuse screening.

It is understood that in order to be subject to the jurisdiction of the ORB, all persons subject to the ORB's ongoing jurisdiction, have been found to meet the threshhold test of posing a significant threat to the safety of the public.

2.5 Person in Charge

Each Designated Hospital has a named "person in charge" for the purposes of Part XX.1 of the *Criminal Code*. The role of "person in charge" may be assigned to one or more of the staff of the Designated Hospital. The person in charge is responsible for admissions, discharges and transfers of all accused persons subject to the jurisdiction of the ORB within the parameters of the authority granted to him or her in the disposition order. The person in charge is responsible for the quality of the clinical care, management and security provided by the Designated Hospital to the accused person under the jurisdiction of the ORB.

2.6 **Hospital Report for Ontario Review Board**

Prior to a hearing before the ORB, a written report must be prepared by the Designated Hospital staff and submitted to the ORB, the local Attorney General's office and to the accused person. the Hospital Report will contain recommendations being made by the person in charge to the Board as to the terms of the coming year's disposition order. The Hospital Report generally includes a description of the index offence(s); longitudinal history of the accused including previous charges, criminal record history (where known); admissions to psychiatric facilities; description of the person's clinical course during the preceding year; a description of the Forensic Risk Management Plan; a description of those factors which increase or decrease the risk of violent re-offence posed by the mentally disordered accused; recommendations for the terms of the disposition order for the coming year. The Hospital Report may include a formal risk assessment, an actuarial assessment of risk for future violence, or a description of the other criminogenic factors related to the accused person's risk to public safety.

2.7 Risk

Risk is defined as the likelihood that an accused person will commit a future crime that threatens the safety of the public. This likelihood may be expressed as a probability based on

similarity to mentally disordered accuseds who have re-offended within a specific period of time. Risk usually will be expressed as one of three levels of likelihood, specifically, high, moderate or low.

Risk is commonly perceived to have two forms, static and dynamic. Static risk is a constant characteristic of the individual, based on historical factors and personality traits. Static risk does not change over time and does not respond to treatment. Static risk is commonly assessed using the Psychopathy Checklist-Revised (PCL-R), or the Violence Risk Appraisal Guide (VRAG).

Dynamic risk is a variable characteristic of an individual accused, based on circumstantial and changeable personal factors, including emotional state, level of stress and current mental status. Dynamic risk may decrease with effective treatment.

Accused persons referred to ACT Teams by the Designated Hospital pursuant to this Agreement, are being continued under the jurisdiction of the ORB and are therefore legally considered to pose a significant threat to the safety of the public. For the purposes of this Agreement, all accused persons being referred to an ACT Team by a Designated Hospital, will have been evaluated as low or moderate risks of violent re-offence by the Designated Hospital.

2.8 Forensic Risk Management Plan

The Forensic Risk Management Plan (FRMP) is a document detailing particulars of treatment and supervision be provided to the accused person and the interventions that are to be implemented for the express purpose of reducing the risk posed by an accused person assigned to an ACT Team. The FRMP will be prepared jointly by the Designated Hospital and the ACT Team with the consent and involvement of the accused person. The FRMP will be described in the Hospital Report.

The FRMP will include a risk assessment of the accused person performed by the Designated Hospital; a list of obligations on the accused person pursuant to the current disposition order; a list of those obligations on the Designated Hospital pursuant to the current disposition order; a list of those obligations of the Designated Hospital proposed to be assigned to the ACT Team under this Agreement; a detailed account of reporting requirements between the Designated Hospital and the ACT Team; protocols for dealing with non-compliance by the

accused person; and protocols for re-admitting accused persons to the Designated Hospital where necessary.

2.9 Non-Compliance

Within the context of the Agreement, an accused person is non-compliant when he/she breaches any of the terms contained within his/her disposition order.

III Governing Principles

3.1 The Designated Hospital retains its status as a facility designated by the Ontario Minister of Health, pursuant to Part XX.1 of the *Criminal Code* of Canada. Should Designated Hospital no longer retain its status as a designated facility pursuant to Part XX.1 of the *Criminal Code* of Canada, this Agreement shall become null and void. The Agreement is deemed to be terminated on the day the status change is effective.

3.2 The ACT Team will function as an agent of the designated hospital for the care and management of specific low to moderate risk accused persons within the parameters specified in this Agreement. The ORB will be aware of this involvement of the ACT Team and will have approved same, by virtue of inclusion of the FRMP in the Hospital Report.

3.3. The person in charge of the Designated Hospital shall ensure that his/her obligations outlined in the disposition order, in the *Criminal Code* and under this Agreement are met. The co-ordinator of the ACT Team and the assigned ACT psychiatrist(s) will ensure that the obligations of the ACT Team outlined in this Agreement are met.

3.4 For each accused person assigned to the ACT team, the individualized FRMP and a separate service plan will be created jointly by the Designated Hospital and the ACT Team with the accused person's consent. The FRMP will be included in the Hospital Report prepared for the annual Board hearing. The ORB will therefore be aware that it is the recommendation of the Designated Hospital that the particular accused be attached to an ACT Team. A copy of this Agreement and the disposition order currently in force will be attached to the FRMP. These documents will be filed in the accused person's clinical record at the Designated Hospital and in the accused person's file maintained by the ACT team.

3.5 An individual accused will be recommended for placement with an ACT Team only where he or she is subject to a custodial disposition order that permits the individual to live in the community or where the accused is conditionally discharged. Individuals will meet the clinical

descriptors set forth in the "Standards for Community Assertive Treatment Teams" published by the Ministry of Health and Long-Term Care ("MOHLTC"), and, as stated above in section 2.7, will be deemed to be low to moderate risks of violent re-offence in the community.

3.6 The placement of an accused person with an ACT Team must be agreed to in advance by the individual accused, the Designated Hospital and the ACT Team.

3.7 The Designated Hospital guarantees immediate re-admission to an inpatient bed for an accused person placed with an ACT Team when admission is necessary due to failure to comply with a term of the disposition order or at the request of the ACT Team. (a) Where an accused person is subject to a custodial disposition pursuant to section 672.54 (c) of the Criminal Code, the admission will be accomplished with reference to the disposition order and requires no consent. (b) Where an accused person is subject to a conditional discharge disposition pursuant to section 672.54(b) of the *Criminal Code*, admission will be done either voluntarily or pursuant to apprehension criteria under the *Mental Health Act* where these are met in the opinion of the ACT psychiatrist(s). If these two means are unsuccessful, re-admission will be assisted by the police once notified by the ACT Team of a breach of the disposition order in accordance with section 672.91 of the Criminal Code.

IV Roles and Responsibilities

The ACT Team is responsible for:

4.1 Ensuring that the ACT Team have a clear understanding between them of their respective roles in relation to both the Agreement and the individualized FRMP.

4.2 Ensuring that forensic patients meet the clinical descriptors in the admission criteria of MOHLTC ACT standards and that the ACT Team provides the range of services outlined in the ACT Team's standards, unless otherwise agreed to and specified in an addendum to this Agreement pertaining to specific individual accused. In any event, the ACT Team is responsible for ensuring that the ACT Team can provide those services to the individual patients that are specified in the FRMP and the service plan, and that the accused or his or her substitute decision-maker consents to full disclosure of information to the Designated Hospital, in accordance with the provisions of the *Mental Health Act*, as may be amended from time to time.

4.3 Ensuring that the ACT Team maintains the minimum frequency of contact with the accused person as specified in the disposition order and directed to the person in charge.

4.4. Reporting all incidents of an accused person's breach of the conditions stipulated in the accused's ORB disposition to the Designated Hospital as soon as possible after such non-compliance is identified by an ACT Team member.

4.5 Except in circumstances where clause 4.6 applies, when non-compliance with a disposition order term has been identified and reported to the Designated Hospital, the Designated Hospital and the ACT Team will recommend to the person in charge an appropriate course of action or intervention. The person in charge retains sole discretion to decide what measures will be taken in response to a report of non-compliance.

4.6 In any event, when in the opinion of the ACT Team in a high risk situation exists, or when the ACT Team becomes aware the accused person has gone AWOL, to report such situations promptly to the police and to the Designated Hospital.

4.7 Providing a report written in accordance with a template provided by the Designated Hospital for inclusion in the Hospital Report prepared for distribution to the ORB and the parties in advance of every ORB hearing.

4.8 Sending a representative from the ACT Team to all ORB hearings with respect to accused persons assigned to ACT Teams for the purpose of providing evidence to the ORB as to the current status and progress of the accused.

The Person in Charge of the Designated Hospital is responsible for:

4.9 Ensuring that the accused persons being referred for consideration by an ACT Team are either subject to custodial disposition orders permitting them to live in the community or conditionally discharged.

4.10 Ensuring that a risk assessment has been completed and is current at the date of referral and that the accused person being referred to an ACT Team is considered to be either a low or moderate risk for violent re-offence.

4.11 Ensuring that subject to the ACT Team's confirmation, the referred accused person meets the clinical descriptors in the admission criteria of the MOHLTC ACT standards. The person in charge is responsible for ensuring that the accused person will consent to discussion of his consideration for referral with the ACT Team members and to full disclosure of his or her clinical record to the ACT Team and the ACT Co-ordinator. To this end, the person in charge will obtain from the accused person, or from his or her substitute decision-maker, consent to the

release of information in accordance with the provisions of the *Mental Health Act* as may be amended from time to time.

4.12 Ensuring that the person in charge or his/her delegate will meet with the proposed ACT Team to discuss all potential referrals. A thorough review of the accused person's history, risk assessment and future goals will be presented to the ACT Team. Risk appraisal documentation and other relevant documentation requested by the ACT Team will be provided to it on a timely basis. Upon acceptance of an individual accused person by the ACT Team, the ACT Team will be provided with the individual's health card number.

4.13 Ensuring that an FRMP with respect to a referred accused person is jointly developed with the ACT Team.

4.14 Ensuring that where an in-patient admission to the Designated Hospital is necessary, that such admission is guaranteed on an immediate basis for those accused subject to custodial disposition pursuant to section 672.54(c) of the Criminal Code. With respect to an accused person who is on a conditional discharge disposition order, it is understood that the mechanisms for return to hospital may be those pursuant to the *Mental Health Act* and will require involvement by the ACT Team psychiatrist. In the event of a difference of opinion with respect to the need for admission to the hospital between the ACT Team and the Designated Hospital, the Designated Hospital agrees to accept the individual for readmission.

4.15 Ensuring that the Designated Hospital will accept immediate reassignment of the accused person from the ACT Team to the designated Hospital in the event that the person is found to be inappropriate for ACT Team placement by the ACT Team. The procedures for the ACT Team to follow in terms of reassigning persons to a Designated Hospital will be detailed in the FRMP.

4.16 Ensuring that the ACT Team is advised in a timely fashion of upcoming ORB hearings in order that the ACT Team's input to the FRMP and Hospital Report can be obtained. The person in charge will ensure that the ACT Team is advised as to when the ORB will be conducting a hearing in order that the ACT Team members can participate as set out above in clauses 4.7 and 4.8.

4.17 Ensuring that breaches of a disposition order and re-admissions to hospital are reported to the ORB promptly.

4.18 Ensuring that the ACT team is provided with training, education and consultation on forensic issues and other issues as required.

V Communications and Consultations

5.1 The Designated Hospital will ensure that the ACT Team is advised of any initiatives, events or media coverage, likely to have a significant impact on the ACT Team or its sponsoring agency, prior to them becoming public.

5.2 The ACT Team will ensure that the Designated Hospital is advised prior to them being made or becoming public, or as soon as possible thereafter, of any initiatives, events or media coverage which may be expected to have a significant impact on (a) the ACT Team and/or its operations; (b) the ACT Team and/or (c) the Designated Hospital's stakeholders or clients.

VI Reporting

6.1 The Act Team will report regularly to the Designated Hospital on the accused person's clinical status and progress on an agreed to schedule. Changes in the accused person's circumstances or unusual occurrences that are neither breach of conditions stipulated in a disposition order nor emergencies or high risk situations prompting police notification, (described earlier in 4.4 to 4.6) will be reported to the Designated Hospital within 48 hours.

6.2 In addition to the regular reporting schedule, the ACT Team will provide a written annual progress report that will be submitted to the Designated Hospital no less than 45 days prior to the accused person's annual hearing before the ORB. This information will be included in the Hospital Report. Updates to the information will be provided by ACT Team members in oral testimony to the ORB.

VII Accountability

7.1 The Designated Hospital is accountable to the ORB, through the person in charge, for the custody, treatment, management and supervision of the accused person, subject to the need to protect the public from dangerous persons in accordance with the terms of ORB disposition orders and Criminal Code requirements.

7.2 The ACT team is accountable to the Designated Hospital for the day-to-day care, management and supervision of accused persons, who have been referred to and have agreed to work with the ACT Team. The care, management and supervision will be in accordance with the

terms of the FRMP and the service plan. The ACT Team is not accountable for persons who have been re-admitted to the Designated Hospital from the care of the ACT Team.

7.3 The Designated Hospital and the ACT Team are jointly accountable to the ORB for providing an FRMP to be included in the Hospital Report and for providing relevant clinical information for inclusion in the Hospital Report. The Designated Hospital and the Act Team are jointly accountable to the ORB for providing oral testimony at the accused person's annual hearing as to current clinical and risk status.

7.4 The ACT Team and the Designated Hospital are accountable to each other for designating staff in their respective organizations for the purpose of communication and reporting requirements.

VIII INDEMNITY

8.1 The Designated Hospital agrees to indemnify and hold the ACT Team and the St. Joseph's Health Centre and its directors, officers and employees harmless from any and all losses, damages, costs or expenses (including reasonable legal fees and disbursements) suffered or incurred by the St. Joseph's Health Centre directly or indirectly attributable to any failure of the Designated Hospital to perform services in accordance with the provisions of this Agreement or from any negligent act or omission made by the Designated Hospital or its employees in connection with the performance or attempted performance of the terms of this Agreement.

8.2 St. Joseph's Health Centre agrees to indemnify and hold harmless the Designated Hospital and its directors, officers and employees from any and all losses, damages, costs or expenses (including reasonable legal fees and disbursements) suffered or incurred by the Designated Hospital directly or indirectly attributable to any failure of the St. Joseph's Health Centre to perform its obligations in accordance with the provisions of the Agreement or from any negligent act or omission made by the St. Joseph's Health Centre or its employees in connection with the performance of its obligations under this Agreement.

IX INSURANCE

9.1 The Designated Hospital agrees that during the term of this Agreement it shall maintain a comprehensive liability insurance policy in the form and with an insurer satisfactory to the St. Joseph's Health Centre with a policy limit of at least $5 million per occurrence which policy shall, without limitation, include coverage for any negligent acts, errors or omissions made by its

employees or agents in connection with the performance of its obligations under this Agreement. The Designated Hospital agrees to provide to the St. Joseph's Health Centre such proof of insurance as may be requested from time to time.

9.2 The St. Joseph's Health Centre agrees that during the term of this Agreement it shall maintain a comprehensive liability insurance policy in the form and with an insurer satisfactory to the Designated Hospital with a policy limit of at least $5 million per occurrence which policy shall, without limitation, include coverage for any negligent acts, errors or omissions made by its employees or agents in connection with the performance of its obligations under this Agreement. The St. Joseph's Health Centre agrees to provide to the Designated Hospital such proof of insurance as may be requested from time to time.

X PROGRAM EVALUATION

10.1 The Designated Hospital and the St. Joseph's Health Centre shall meet at least annually for the purpose of evaluating the terms of the Agreement.

XI TERM

11.1 Unless earlier terminated in accordance with the provisions of Sections 11.2 and 11.3, this Agreement shall continue from the date this Agreement has been executed by both parties hereto until . Thereafter, this Agreement may be renewed on mutually acceptable terms.

11.2 Notwithstanding the provisions of Section 11.1 hereof, this Agreement may be terminated by the St. Joseph's Health Centre in the following manner and circumstances.

(a) at any time upon giving at least sixty (60) days' prior written notice to the Designated Hospital; or

(b) immediately on the giving of written notice in the event that the Designated Hospital is in default of its obligations under this Agreement; or

(c) immediately on the giving of written notice in the event that:

(i) the Designated Hospital becomes bankrupt or insolvent;

(ii) a receiving order is made against the Designated Hospital;

(iii) a resolution winding up the Designated Hospital is passed; or

(iv) the Designated Hospital derives benefit from any statute relating to bankruptcy or insolvent debtors or the orderly payment of debts.

11.3 Notwithstanding the provisions of section 11.1 hereof, this Agreement may be terminated by the Designated Hospital in the following manner and circumstances:

(a) at any time upon giving at least sixty (60) days' prior written notice to the St. Joseph's Health Centre; or

(b) immediately upon the giving of written notice in the event that the St. Joseph's Health Centre is in default of its obligations under this Agreement; or

(c) immediately on the giving of written notice in the event that:

(i) the St. Joseph's Health Centre becomes bankrupt or insolvent;

(ii) a receiving order is made against the St. Joseph's Health Centre;

(iii) a resolution winding up the St. Joseph's Health Centre is passed; or

(iv) the St. Joseph's Health Centre derives benefit from any statute relating to bankruptcy or insolvent debtors or the orderly payment of debts.

11.4 The termination of this Agreement shall not affect the indemnities herein provided for the benefit of the St. Joseph's Health Centre and the Designated Hospital.

XII **MISCELLANEOUS**

12.1 Interpretation

All words and personal pronouns relating thereto shall be read and construed as to the number, gender and tense as the context in each case requires.

12.2 Relationship Between the Parties

The relationship between St. Joseph's Health Centre and the Designated Hospital is that of independent contractor. Nothing in this Agreement shall be interpreted to create a partnership or joint venture relationship between the parties and nothing in this Agreement shall be interpreted so as to create any employment relationship between the Designated Hospital and the ACT Team.

12.3 Headings

Divisions of this Agreement into Articles and Sections and the use of headings is for convenience of reference only and shall not modify or affect the interpretation or construction of this Agreement or any provisions hereof.

12.4 Severability

If any Article, Section or portion of any Article of Section of this Agreement is determined to be unenforceable or invalid by any court of competent jurisdiction and that decision is not appealed or appealable, for any reason whatsoever, that unenforceability or invalidity shall not affect the enforceability or validity of the remaining portions of this Agreement and such unenforceable or invalid Article, Section or portion thereof shall be severed from the remainder of this Agreement.

12.5 Entire Agreement

This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter hereof and its execution has not been induced by, nor do any of the parties hereto rely upon or regard as material, any representation or writing not incorporated herein and made a part hereof. It is understood and agreed that the care provided by the ACT Team to an accused person will be in accordance with this Agreement, the individual's FRMP, service plan and disposition order.

12.6 Governing Law

This Agreement shall be governed and construed in accordance with the laws of the Province of Ontario and the parties hereto irrevocably attorn to the courts of that province.

12.7 Amendment

This Agreement shall not be amended, altered or qualified except by an instrument in writing executed by duly qualified officers of the parties hereto.

12.8 No Waiver

No failure by any party hereto to insist upon strict performance of any covenant, agreement, term or condition of this Agreement, or to exercise any right or remedy consequent upon a breach thereof, shall constitute a waiver of any such breach or of such covenant, agreement term or condition. No waiver of any breach shall affect or alter this Agreement, but each and every covenant, agreement, term and condition of this Agreement shall continue in full force and effect with respect to any other then existing or subsequent breach thereof.

12.9 Notices

All notices, requests, demands or other communications by the terms hereof required or permitted to be given by one party to another shall be given in writing by personal delivery or by mailing the same by registered mail, postage prepaid, to the person who has executed the Agreement or delegate. Any notice, request, demand or other communication delivered by registered mail shall be deemed to be delivered four days following the mailing. Any notice, request, demand or other communication delivered personally shall be deemed to be delivered immediately.

12.10 Assignment

This Agreement may not be assigned or subcontracted by either party hereto.

12.11 Enurement

This Agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors.

12.12 Application of Agreement

This Agreement applies only to accused persons who are referred to the ACT Team by the Designated Hospital, who agree to work with the ACT team, and from whom executed consents to disclosure of information have been obtained by the Designated Hospital and by the St. Joseph's Health Centre in accordance with clauses 4.2 and 4.11 above.

XIII Approval and Amendments

13.1 This Agreement is effective upon the signature by the person in charge at the Designated Hospital and the Chief Executive Officer (or delegate) of the St. Joseph's Health Centre.

IN WITNESS WHEREOF this Agreement has been executed as of the date first above written.

Date: _____

Centre for Addiction and Mental Health
(Designated Hospital)

Per:

_____

Date: _____

St. Joseph's Health Centre

Per:

_____