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Ministry of the Attorney General
Ministère du Procurer général

Ministry of Community and Social Services
Ministère des Services sociaux et communautaires

Ministry of Health
Ministère de la Santé

Ministry of the Solicitor General and Correctional Services
Ministère du Solliciteur et des Services correctionnels

We are pleased to provide you with a copy of **A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario.** This document is the result of the cooperative work of the Ministries of the Attorney General, Health, Community and Social Services and Solicitor General and Correctional Services, as well as extensive consultation with stakeholders throughout Ontario.

The Provincial Strategy is the policy blueprint for all operational and policy initiatives for people with a mental disorder and/or developmental disability who come into conflict with the law.

Although the number of these clients is comparatively small, they consume a disproportionate amount of services through the health care, social service and criminal justice system and many frequently fall through the cracks in service delivery.

Achieving the shared goals of safe and healthy communities is a joint responsibility of all ministries engaged in the delivery of services to these clients. Within our ministries the Provincial Strategy will lead the change process for reshaping programs and improving the quality of service that we provide, consistent with the government priorities to rationalize programs, to reintegrate clients into the community, to enhance public safety and to focus on serious crime.

The Provincial Strategy will result in new planning and delivery partnerships and reduce duplication across ministries. While there are no quick and easy solutions to providing services to this challenging client group, we are encouraged by the work of the communities that have already implemented demonstration and pilot projects.

Changing systems is a long term process and requires the continued commitment and efforts of all ministries and service agencies involved. We thank you for your continuing support for this very important change initiative.

Deputy Attorney General	Deputy Minister Ministry of Community and Social Services	Deputy Minister Ministry of Health	Deputy Solicitor General and Deputy Minister of Correctional Services

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Executive Summary

Introduction

The **Human Services and Justice Coordination Project** is a cooperative effort among the Ontario Ministries of the Attorney General, Community and Social Services, Health, and Solicitor General and Correctional Services. It was set up in response to a recognized need to better coordinate, resource and plan services for people with clinical needs who come into conflict with the law. Such individuals are identified as common forensic clients in keeping with ministries' shared goals of achieving healthy and safe communities and recognition that solutions are a joint responsibility.

Human services include both health and social services. This provincial strategy document is considered the policy blueprint for interministerial and ministry-specific operational or policy initiatives which affect common forensic clients. Implementation will be phased in, with appropriate and achievable benchmarks to be established. Expected outcomes include improved quality of service and quality of life for clients; enhanced public safety; and increased service/systems efficiencies within current global spending.

Who are We Talking About?

The strategy targets adults with a mental disorder or developmental disability who are involved in the criminal justice system. The priority for ministry service provision will be common clients who have a current legal involvement or who are considered a high risk for repeat offences. Within mental health, a priority for service provision will be people who have a serious mental disorder.

Although the number of forensic clients is comparatively small, they consume a disproportionate amount of services throughout the health care, social service and criminal justice systems. Different levels of government have funding and program responsibility for the various system components. The major system components are policing services, court services, correctional services, mental health services, developmental services and other social services.

Key Junctures

Twenty key junctures in relation to the progress of a disabled person through the criminal justice system are identified. Key junctures start with prevention and incident response through increasingly more serious interventions by the police, courts and the correctional system (i.e. pre-trial processes; fitness and criminal responsibility; trial; and sentence) and complete with the release of the individual back into the community. The overlap between justice and human service processes are highlighted as well as opportunities for more effective coordination and treatment of common clients.

Coordination protocols are consistent with key ministry business directions. A focus on serious crime and rehabilitative justice means that minor offenders will be diverted into community-based services to address their mental health and/or development needs. A focus on public safety means that high risk, serious offenders will be detained or receive intensive supervision through the correctional or Ontario Review Board systems. Each sector will play a role in achieving these outcomes. The following strategies are identified:

- human services will offer community support and prevention programs (e.g. case management, assertive community treatment) as well as develop crisis response networks that minimize police involvement in minor incidents;
- police will receive appropriate training and have access to human services assistance in responding to incidents. Linkages to human service agencies will facilitate pre-arrest diversion. Only individuals who have committed serious, violent, or repetitive crimes should be arrested;
- crown attorneys will divert minor offenders. Court outreach workers and linkages to human service agencies will facilitate court diversion;
- court linkages to human service agencies and community assessment and treatment planning capacity will facilitate an offender's community release through diversion, or bail, probation or Ontario Review Board supervision;
- local court-based clinical assessments and linkages to regional forensic services will facilitate the timely transfer of unfit or not criminally responsible (NCR) clients from court to appropriate community or institutional forensic services;
- high risk incarcerated offenders with clinical needs will receive appropriate treatment within correctional institutions.

Roles and Responsibilities

Despite mandates which are generally defined in legislation, there is ambiguity about who is responsible for some of the services forensic clients receive. Unique ministry responsibilities and of the various key organizations have been articulated as an important first step in ensuring an appropriate mix of services and supports, addressing gaps in services and reducing duplication of efforts.

Coordinating Committees

A provincial coordinating structure will monitor, observe, and measure the impact of changes within the mental health, developmental services and criminal justice systems in relation to forensic clients; oversee and resolve conflicts regarding the implementation of these coordination protocols; deal with forensic issues within the ambit of provincial responsibility; and coordinate ministry responses to coroner's jury inquest recommendations involving forensic clients. At a minimum, membership will consist of Assistant Deputy Ministers and staff from the involved ministries who will develop provincial interministerial policy as well as lead ministry-specific forensic coordination activities. The provincial committee will report annually to the ministers involved with the project on the reform of forensic services within Ontario.

District and Regional *Human Service and Justice Coordinating Committees* will be established to coordinate communication, joint problem-solving and planning efforts between health, criminal justice and developmental services organizations within specific communities/regions. A major goal of *Coordinating Committees* is to find local solutions to local problems through more effective service coordination. Each *Coordinating Committee* will articulate a strategy for forensic clients that includes the following components: prevention strategy; system design recommendations; crisis plan; community intervention plan; court assessment plan; and case management plan. The strategy must also ensure that appropriate forensic liaison staff are designated.

At the client/agency level there should be:

- adequate mechanisms for developing community service agreements including diversion agreements and community release plans under bail supervision, probation, or conditional discharge;
- criteria for priority admissions;
- an agreement as to institutional treatment services;
- a risk assessment process; and
- interagency working agreements, information-sharing protocols and joint educational initiatives.

Coordinating Committees will establish a process to set clear goals and targets to be achieved (performance indicators) so that it is possible to measure changes in outcomes relating to enhanced coordination and planning. The Committee will prepare an annual report to the provincial committee outlining compliance with protocols; waiting list and resource utilization issues; efforts to reorganize local programs and services; and resource/program or reallocation requirements.

JUNCTURES

OUTCOMES

PREVENTION (Juncture 1)

APPROPRIATE ACTION
1. Involvement with effective community and/or institutional supports
2. Maintain extremely high risk 'untreatable individuals in institutions

REQUIREMENTS
1. Accessible, effective institutional and community supports
2. Coordinated, comprehensive system of supports*
3. Intensive community supports*
4. Shared facility*

OUTCOMES
1. Less victimization
2. Improved Quality of Life
3. Institutional cost avoidance

PROBLEM (Juncture 2)

APPROPRIATE ACTION
1. Referral to effective institutional and/or community support, including intensive community supports
2. Flagging of risk potential by support systems
3. Identified as potential common client
4. Notify potential victims

REQUIREMENTS
1. Accessible, effective, coordinated supports*
2. Ability within support sector to identify potential for offending
3. Awareness of potential victims
4. Ability to share information re. potential*

OUTCOMES
1. Less victimization
2. Improved Quality of Life
3. Cost avoidance
4. Identification, support and monitoring of high risk offenders

INCIDENT (Juncture 3)

APPROPRIATE ACTION
1. Assessment of continued risk
2. Referral to effective supports
3. Referral of high risk/high victimization to police for investigation
4. Identify as common client

REQUIREMENTS
1. Understanding of risk assessment or access to professionals
2. Ability to share information with police*
3. Agreed upon definition of common client*

OUTCOMES
1. Use of police intervention reduced
2. Cost avoidance
3. Early police intervention in high risk cases
4. Early diversion from criminal justice system of low risk

INVESTIGATION (Juncture 4)

APPROPRIATE ACTION
1. Relevant information shared with police
2. Communications needs of individual and police met

REQUIREMENTS
1. Supportive information sharing legislation*
2. Information sharing protocols*
3. Communication support protocols and resources

OUTCOMES
7. Diversion of low risk
8. Flagging of high risk

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*

OUTCOMES
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

JUNCTURES

OUTCOMES

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

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*

OUTCOMES
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

OUTCOMES
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

OUTCOMES
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)

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

OUTCOMES
1. Fewer suicides and victimization in custody
2. Improved Quality of Life
3. Less victimization in the community
4. Cost avoidance

JUNCTURES

OUTCOMES

PART XX.1 CCC (Juncture 10)

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

OUTCOMES

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

TRIAL (Juncture 11)

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

OUTCOMES

1. Cost avoidance
2. Reduced use of detention facility beds

PRE-SENTENCE REPORT (Juncture 12)

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

OUTCOMES

1. Sentence reflects risk and manageable service or supervision plan

SENTENCE (Juncture 13)

APPROPRIATE ACTION

1. Critical information forwarded to correctional facility or other service sector

REQUIREMENTS

1. Enabling legislation and information sharing protocols

OUTCOMES

1. Less victimization in community and institution
2. Fewer suicides in corrections facility

JUNCTURES

OUTCOMES

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

JUNCTURES | OUTCOMES

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*

OUTCOMES
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'*

OUTCOMES
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*

OUTCOMES
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*

OUTCOMES
1. Less victimization in community

Individuals cycle back to prevention stage

A PROVINCIAL STRATEGY TO COORDINATE HUMAN SERVICES AND CRIMINAL JUSTICE SYSTEMS IN ONTARIO

PART 1: Roles & Responsibilities

INTRODUCTION

"Forensic" is commonly defined as the overlap between law and medicine. For the purpose of this project, "common forensic clients" are people with a mental disorder or developmental disability who are involved in the criminal justice system and who require clinical interventions to address the victimization that results from incidents of violence, or to reduce their continual return between systems. Although the number of forensic clients is comparatively small, they consume a disproportionate amount of services through the health care, social service and criminal justice systems. Different levels of government have funding and program responsibility for the various system components. The major system components are policing services, court services, correctional services, mental health services, and developmental services. Other partners and indirect service providers may also be involved in some cases.

Federal, Provincial and Municipal Responsibilities

For the most part, municipalities are responsible for policing. Some provinces, including Ontario, have established provincial police forces. The federal government is responsible for enforcing federal legislation through the Royal Canadian Mounted Police and contracts to provide policing services in those provinces without provincial police. Federal legislation is also enforced by municipal and provincial police.

The federal government is responsible for establishing criminal law. Responsibility for the administration of justice is shared between the provincial/territorial and federal governments. In general, the provinces are responsible for processing all criminal cases. Provincial court judges appointed by the province have jurisdiction over the majority of criminal matters. However, more serious offences such as murders are tried in the superior court where judges are federally appointed. Federal courts hear appeals and cases within federal jurisdiction. The Supreme Court of Canada is the court of final jurisdiction for appeals on questions of law and constitutional issues.

Correctional services are provided by provincial, territorial and federal governments. Generally, the provinces and territories are responsible for offenders with custodial sentences of less than two years, and other types of sentences such as probation, other community sanctions, fines, etc. while the federal government is responsible for all offenders serving custodial sentences of two years or more. Young

offenders are a provincial responsibility, as are offenders held pending trial (remand). For young offenders in Ontario, jurisdiction is split according to the age of the offender between corrections (16 and 17 year olds) and community and developmental services and other social services (14 and 15 year olds). Young offenders must be kept separately from adult offenders.

Ontario is one of three provinces that has established a parole board that is responsible for conditional release decisions for inmates held under provincial jurisdiction. The National Parole Board grants day parole and full parole to incarcerated offenders in federal institutions (as well as provincial inmates in jurisdictions where no provincial board exists).

Responsibility for the provision of mental health programs primarily rests with the provinces, although health services for federal inmates in custody are the responsibility of federal corrections. Provision of mental health services to federal and provincial offenders on conditional release rests with the provinces, as well as forensic clients found unfit or not criminally responsible under the *Criminal Code*. At the federal level, Health Canada plays a leadership role in health issues.

Responsibility for a range of other relevant services such as welfare, housing, and developmental services and other social services provided to the mentally disordered and to offenders are split to a larger or lesser degree between provinces and municipalities.[1]

Decision-Makers

There are many decision-makers within the criminal justice system. Police, justices of the peace, judges, juries, defence counsel, the crown, parole boards, and the Ontario Review Board are a few. In turn, these people are often advised by others such as the public, victims, witnesses, offenders, victim advocacy groups, clinicians, social workers, and correctional officials based in institutions and parole/probation offices. Legal decision-makers will decide the outcome of criminal charges (not guilty, guilty, or not criminally responsible), length of sentence and level of control of an offender while in custody or under sentence.

The mental health system is equally complex. Decisions will depend on what kind of services the individual is considered to need and chooses to receive. The formal mental health system is composed of several key organizations, including District Health Councils, psychiatric facilities, community mental health programs, and mental health professionals (including physicians, psychologists, nurses, social workers, occupational therapists, etc.). Consumer/survivors and families are recognised as equal partners in both planning and delivering mental health supports, either jointly with other service-providers or as alternatives to the formal mental health system. Mental health decision-makers will decide what treatment or programs will be offered to individual clients, based on need, choice, and service availability. For accused under Part XX.1 of the *Criminal Code* however, the admission of clients to particular facilities or services is decided through the legal decision-making process and does not require a physician's order.

The developmental services system is composed of ministry-operated Schedule I facilities and (usually non-profit) transfer payment agencies working in the community, who employ professional and non-professional staff to provide services and supports. Long term ministry policy reflects a direction of downsizing the number of individuals living in facilities and facilitating their integration back into community life as full participants of society. In planning services and supports, individual and family choice is emphasized and plans are tailored on an individual basis. Service providers in conjunction

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1. Joint Action Committee on Corrections and Mental Health *Draft Final Report* (April 1995)

with the individual and family collectively affect decisions around the type and quantity of services available to each client including the environments in which clients reside. These decisions contribute to the extent and success of community integration for the client.

Role and Mandate

Despite mandates which are generally defined in legislation, there is ambiguity about who is responsible for some of the services forensic clients receive. Clear articulation of unique ministry responsibilities and of the various key organizations is considered an important first step in providing an appropriate mix of services and supports, addressing gaps in services and reducing duplication of efforts.

Appendix A describes the role, mandate, and service responsibilities of provincial ministries and key organizations which are directly responsible for the care and management of forensic clients. Provincial ministries are those that participated on the **Human Services and Justice Coordination Project** (formerly known as the Mental Disorder and Justice Review Project), namely, the ministries of the Attorney General, Community and Social Services, Health, and the Solicitor General and Correctional Services. Key organizations include District Health Councils/Mental Health Authorities; psychiatric facilities; community mental health programs; police; the judiciary; crown attorneys; correctional facilities; probation and parole offices; community corrections programs; developmental services facilities; developmental services transfer payment agencies; and developmental services local planning groups or advisory committees and hard to serve committees.

Although ministries have been assigned a lead role in terms of unique areas of service provision, it is expected that stakeholders will work cooperatively to ensure that services meet broad client needs and public safety objectives which may include operating programs collaboratively or participating in joint ventures. Similarly, new areas of service may be recommended which should operate interministerially, and not under the lead of any one ministry (e.g. assertive case management programs for released offenders with a history of criminal offences and human service contacts or specialized shared settings for common clients).

PART 2: Coordination Protocols at Key Junctures

GENERAL

This section describes the 20 key junctures in relation to the progress of a disabled person through the criminal justice system as well as the coordination protocols that apply at each of these points. The emphasis is on making more effective use of existing legislation and achieving coordination through the development of policy and guidelines. Protocols will establish more sensitive and flexible referral processes between organizations in the health, developmental services and criminal justice sectors, and improve effective collaboration between professional staff and agencies. The organizational framework, or mechanism through which specific coordination protocols may best be put into effect has been identified. As well, a general organizational structure to oversee implementation and further develop planning and service delivery mechanisms between organizations has been proposed.

It is acknowledged that in some areas, legislative amendments may greatly facilitate the achievement of specific government objectives (e.g. exchange of information; community treatment and supervision; and Part XX.1 of the *Criminal Code*). Where appropriate, these may be pursued by ministries through a separate process.

Target Group

For the purposes of this project, the priority for ministry service provision will be common clients of mental health and/or developmental services and criminal justice sectors who have a current legal involvement or who are considered a high risk for repeat offences. However, particularly at the preliminary stages of prevention, investigation, and early intervention, we cannot accurately predict the existence or extent of disability or criminal behaviour, and coordination and planning activities must therefore influence a wider range of people. Thus, the target group at each juncture point has been identified separately, as this will change throughout the process. It is acknowledged that system problems arise not so much because of the client but as a result of difficulties in getting several systems to respond in a coordinated manner to meet clients' needs effectively. The term "disability" in this article means mental or cognitive impairment, not physical incapacity.

Common forensic clients are defined 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. Current forensic clients are presently involved with some criminal justice process. Individuals who are considered at high risk for repeat offences are distinguishable from other common clients primarily by the extent and the seriousness of their criminal and clinical problems. The person will have a more extensive history of contacts with both law enforcement and human service agencies, or prolonged periods of institutionalization in a treatment facility because of severe maladaptive or violent behavioural patterns. Often, common forensic clients will also exhibit 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 for homelessness, living in poverty, and have physical health problems;
- identified as a difficult, chronic, multi-problem or "hard-to-serve" consumer, lacking skills, motivation, and supports.

Within the health sector under mental health reform, the priority for service provision is people who have a serious mental disorder - this will also apply to people with mental illness who come into conflict with the law. There are three dimensions used to identify individuals with serious mental disorder — disability, anticipated duration and/or current duration, and diagnosable disorders. The critical dimension is the extent of the disability and the risk of serious harm related to a diagnosable disorder.

Disability refers to difficulties that interfere with an individual's capacity to function normally in one or more major life activities, including eating, bathing or dressing, maintaining a household, managing money, getting around the community, and appropriate use of medication and functioning in social, family and vocational-educational contexts. Duration refers to the acute and on-going nature of the problems identified either through empirical evidence or subjective experience. This does not necessarily mean continuous, observable evidence of disorder but may include acute or intermittent episodes between which there are periods of full recovery. Diagnosable disorders of predominant concern are schizophrenia, mood disorders, organic brain disorders, and paranoid or other psychoses.[2]

It should be noted that the definition of "mental disorder" is sometimes considered to also include people with sexual disorders, organic disorders, personality disorders or addictions. Both adults and children may be affected. Depending on the identified problem, different ministries or program areas must become involved. Coordination and service-delivery strategies should be developed to best respond to each of these unique problem areas; these will be addressed in later stages of the development of a provincial strategy and have not been specifically included at this point.

OVERALL ORGANIZATION

2. Ontario Ministry of Health, *Definition of the Priority Population for Mental Health Reform* (Dec. 1994)

Provincial Coordination

Cross sector collaboration at the individual consumer, program, system, and policy levels has to occur simultaneously to facilitate and support cross sector linkages and access. The ministries of the Attorney General, Community and Social Services, Health, and Solicitor General and Correctional Services will design and put into place a provincial forensic coordinating structure to: monitor, observe, and measure the impact of changes within the mental health, developmental services and criminal justice systems in relation to forensic clients; oversee and resolve conflicts regarding the implementation of these coordination protocols; deal with forensic issues within the ambit of provincial responsibility; and coordinate ministry responses to coroner's jury inquest recommendations involving forensic clients.

At a minimum, membership will consist of Assistant Deputy Ministers and staff from the involved ministries who will develop provincial interministerial policy as well as lead ministry-specific forensic coordination activities. Linkages may be established with other relevant provincial organizations such as the Ministry of Municipal Affairs and Housing, and Training and Education.

Provincial standards on service delivery, education, and evaluation or outcome measures will be developed by the provincial committee through consultation with stakeholder groups. Standards should strive to represent small, medium, and large communities with special attention to varying demographics, the specific socio-economic needs of different communities including its urban, rural, or northern location, as well as needs that are specific to race, ethnicity, gender, age etc. The implementation of standards and/or evaluation measures will in most cases be a shared responsibility between the province and local communities through the *Human Service and Justice Coordinating Committee.*

The provincial committee will report annually to the ministers involved with the project on the reform of forensic services within Ontario, including compliance with coordination protocols in specific districts/regions, the impact of changes undertaken, the development of new and innovative programs and services, and barriers to implementation.

District and Regional Coordination

District and Regional *Human Services and Justice Coordinating Committees* will be established to coordinate communication, joint problem-solving and planning efforts between health, criminal justice and developmental services organizations within specific communities/regions. A major goal of *Human Services and Justice Coordinating Committees* is to find local solutions to local problems through more effective service coordination. Particularly in regions where several district committees have been established and are functioning effectively in responding to local issues, regional committees should be considered to deal with issues concerning access to regional facilities.

Membership of coordinating committees should include at a minimum representatives of the judiciary, legal system, police, community and institutional corrections, community and institutional mental health, community and institutional developmental services, consumers and families. Community representatives should also be included to ensure that the needs of the community are expressed and considered through planning and service-delivery mechanisms. District Health Councils will play a leadership role in facilitating the establishment of district committees; once the committee is established however, their ongoing involvement will be primarily in relation to health planning matters.

Each *Human Services and Justice Coordinating Committee* will articulate a strategy for forensic clients within specific districts/regions that includes the following components: prevention strategy (**Juncture 1**); system design recommendations from review of mental health and developmental services plans

(**Juncture 2**); crisis plan (**Juncture 3**); community intervention plan (**Juncture 5**); court assessment plan (**Junctures 9 and 10**); and case management plan (**Juncture 16**). District strategies for forensic clients should be reviewed and coordinated at the regional level, having regard to the availability of different levels of secure psychiatric facilities and specialized community services.

The district strategy for forensic clients must also ensure that at the client/agency level, there are adequate mechanisms for developing community service agreements including diversion agreements (**Junctures 7, 8, 9**) and community release plans under bail supervision (**Juncture 7**), probation (**Junctures 12 and 15**), or conditional discharge (**Juncture 18 and 19**); criteria for priority admissions (**Juncture 10**); an agreement as to institutional treatment services (**Junctures 8 and 14**); a risk assessment process (**Juncture 17**); as well as interagency working agreements, information-sharing protocols and joint educational initiatives. Lead agencies (police, crown, hospital, detention centres, probation etc.) should have specially designated forensic liaison staff (**Juncture 6**).

Human Services and Justice Coordinating Committees will establish a process to set clear goals and targets to be achieved (performance indicators) so that it is possible to measure changes in outcomes relating to enhanced coordination and planning. The Committee will prepare an annual report to the provincial committee outlining compliance with protocols; waiting list and resource utilization issues; efforts to reorganize local programs and services; and resource/program or reallocation requirements.

There is a need for increased cultural sensitivity, better communication and links with minority communities within justice and health systems. *Human Services and Justice Coordinating Committees* should review the Ministry of Health's Anti-Racism Strategy in dealing with service and training issues involving forensic clients, particularly where stigma or racial stereotyping may affect perceptions of dangerousness or criminality of certain groups of offenders. Committees may wish to also review recommendations from the Commission of Inquiry into Systemic Racism within the Criminal Justice System. Particularly in northern Ontario, there is a critical need to pay attention to issues concerning first nation communities as these affect health and criminal justice systems.

Ministries should designate their resources in terms of provincial, regional and district planning and coordinating activities, as well as service catchment areas for the purposes of forensic coordination.

1. PREVENTION

Description

At this juncture, the potential offender typically resides in the community prior to coming into conflict with the law. Although not always recognized as such, a wide array of supports and services in communities do exist that may have a direct or indirect effect in preventing crime. These are available to all people in Ontario to one degree or another. At the very basic level, supports include the family and community institutions: work, school, police, and possibly the church. Beyond that, the community also contains numerous agencies and institutions which provide services to those who require them including legal assistance, medical and psychiatric care, housing, social assistance, child welfare, emergency services, etc.

Coordination Protocols

Organizational Framework

1.0

Human Services and Justice Coordinating Committees should develop strategies and/or advocate for programs within specific districts/regions aimed at preventing and/or mitigating the effects of mental illness or developmental disability and crime, including educating the community about such issues. Consumers, families and victims should be involved in developing a crime prevention strategy, taking into account the effects of mental disorder or developmental disability on behaviour.

Target Group

The target group for education initiatives is all citizens. The target group for treatment efforts is people with a mental illness or developmental disability.

Service Delivery

1.1

All partners — consumers, families, service providers, victims, interested citizens, volunteers, diverse communities, planners and government — will need to work together to make the vision of mental health reform and crime prevention a reality. Any efforts at reducing victimization will be strongly dependent on the ability of individual communities to establish and coordinate services and programs for individuals who are a risk to the community.

1.2

Government policy, funding and reform or restructuring initiatives should be well communicated and coordinated with affected stakeholders to determine the impact these may have on achieving healthy and safe communities.

1.3

Prevention efforts should begin as early as possible. By the time an individual needs treatment or has been arrested, interventions are more difficult, costly, and less successful. Public policies and support networks should be developed to enable families and children to break the cycle of aggression. Research has shown that children who are at risk for developing behaviour control problems can be identified at a very early age, and that exposure to prosocial role models as well as learning communication and problem-solving skills may reduce the level of victimization. Further pilot programs and outcome studies should be considered. Physicians and care providers dealing with women during pregnancy or with young children as well as educators should take special care to provide high risk families with good information about dealing with aggression.

1.4

More accessible information about mental illness or developmental disability and crime prevention targeted to consumers, service providers, potential victims, and the general public is required. In particular:

- a broad educational effort regarding public perceptions about mental illness or developmental disability and stigma should be undertaken;

- similarly, the public and service providers should be better educated about forensic clients. Public and professional educators must challenge the stigma and myths of being disabled and in conflict with the law as an important first step in developing sensible prevention initiatives;
- the public as well as service planners should be aware of cohort studies concerning forensic clients, and in particular the distinction in terms of numbers and service needs of the public nuisance offender and offenders who commit serious crimes against the person;
- public education targeted specifically to school-age children about mental illness or developmental disability and crime prevention (particularly sexual offences) should begin at the earliest opportunity.

1.5

Like the prevention of mental illness, crime prevention should be an important focus of communities. Where a Crime Prevention or Community Services Officer has been established in local police divisions, these officers should be trained with community organizations to set up programs aimed at improving prevention.

1.6

If early prevention is not possible, effective treatment is critical. Effective treatment interventions should be offered at this stage, and any subsequent stage of the criminal justice process where clinical needs have been identified. Clinical needs are not captured by diagnosis, but by current symptoms, skill deficits, and other psychosocial needs. There is sufficient evidence to make the strong statement that treatment that is well-designed and responsive to specific needs can reduce an offender's criminal recidivism as well as have other positive effects (symptom reduction, community and social adjustment, and happiness).

1.7

The strongest predictor of violence and criminality is past history of violence and criminality, regardless of diagnostic group. Substance abuse appears to be a significant risk factor for violence and criminality among the mentally ill both in the community and in hospitals as well as offender populations. Within each community, at least some prevention and treatment programs should be specifically targeted to offenders with violent/criminal histories and substance abuse problems. Programs that are highly structured and behavioural or cognitive-behavioural, that are run in the community rather than in an institution, that are run with integrity and enthusiasm, that target higher rather than lower risk offenders, and that are intensive in terms of number of hours and overall length of program can be expected to be considerably more effective than others. Programs that are based on fear or punishment, as well as traditional psychotherapy or casework, can be expected to be considerably less effective with offenders than other programs, and some of these programs may even be harmful for certain offenders.

1.8

Many clients who would benefit from treatment are reluctant to participate. Consistent with the principles of mental health reform, the Ministry of Health should develop strategies in cooperation with consumer/survivors to enhance the provision of treatment in the community, particularly in situations where treatment will directly lead to a reduction in that individual's risk of violence or criminal recidivism. Strategies must consider both voluntary treatment and treatment through substitute consent, as well as the effect of coercion on continuing compliance and/or the development of therapeutic alliances between consumers and health providers.

1.9

It is acknowledged that not all the effects of mental disorder or developmental disability can be mitigated. For a small number of individuals who present an extraordinarily high risk of violence, indeterminate detention may be the only possible mechanism to prevent future violence. Criminal and human service legislation must provide for preventative detention where there is a demonstrable and serious risk of violence.

1.10

Further studies about the relationship between aggression and mental disorder or developmental disability would be helpful; results should aid education and evaluation efforts. There appears to be a well established but somewhat weak relationship between violence and mental disorder which means that while the mentally ill may be considered somewhat more violent than the general population, only a minority are likely to be violent. Certain diagnostic categories such as affective disorder or schizophrenia (as compared to substance abuse disorders) to date show no or only slightly elevated risk of violence. Although a causal link between violence and mental disorder has not been established, current research is beginning to identify individuals who show propensities for violence from an early age. More research should be done to discover what preventative techniques will render identified high risk groups less likely to commit violence, and this should be done for groups with and without a major mental illness or developmental disability separately. This may be tied into **Juncture 17** as a function of the centre of excellence for risk assessment.

1.11

With respect to developmental disability, experts cite widespread acceptance of opposite myths associated with individuals' behaviours: that individuals are incapable of being guilty of wrongdoing or, at the other extreme, that individuals are permanently disturbed in some manner. Research into public attitudes and the best means of addressing such myths can be of great assistance in identifying the root cause of problem behaviours early on, so that individuals may benefit from appropriate treatment in the earliest instance.

Evaluation

Quantitative evaluation is difficult, as there are no current statistics relating disability to crime, and thus no way of measuring the success of prevention activities in reducing crime. Each ministry or program which includes crime prevention or health promotion as part of its mandate should develop an evaluation strategy to measure the effectiveness of the activities undertaken in this regard (i.e. safe community or community policing models, justice councils, mental health reform health promotion guidelines). In particular, evaluation techniques should be developed to measure the impact of prevention activities on crime itself; citizen fear of crime; changes in community perceptions about mental illness or developmental disability following broad educational initiatives; citizen satisfaction with police, mental health and developmental services and other social services; and/or quality of life indicators.

In order to connect planning and operations, more effective program evaluation systems which provide timely feedback on the true value of prevention, treatment and community support programs are necessary. Programs should be evaluated in terms of measurable outcomes. The quality of life for clients in programs as well as recidivism rates should be considered.

Many prevention programs are community-based allowing for natural comparisons among communities employing different prevention approaches. Data should be collected as to what programs were implemented, where, for how long, with what degree of integrity, and the effects on criminal activity.

Outcome studies should be used to determine the extent to which these or similar programs should be developed and funded.

2. PROBLEM

Description

At this juncture, symptoms of mental disorder become apparent and the person's behaviour is affected. For developmentally disabled clients, behaviours become increasingly disruptive to others. A person may obtain assistance in dealing with problems through a variety of mental health or generic programs, or informal supports. However, services must not only be available and accessible, but the consumer must consider the assistance offered to be relevant in responding to his or her perceived difficulties.

Coordination Protocols

Organizational Framework

2.0

Services for forensic clients should be integrated within a total system of care that includes health and addictions programs, developmental services and other social services, policing, justice, and correctional programs. *Human Services and Justice Coordinating Committees* will review existing services and will develop recommendations to better integrate service sectors as well as enhance the provision of services and/or public safety.

Target Group

The target group is people with a mental illness or developmental disability with a special focus on the seriously mentally ill and individuals who are aggressive.

Service Delivery

2.1

Information about what services are available to respond to particular problems is crucial to informed problem-solving. Consumers and family members should be able to obtain support and information on resources through the traditional support networks of family doctor and community programs at the first sign that problems are developing. A mechanism needs to exist that will provide these sources with "one stop" information, including information about resources in other service sectors where necessary (e.g. addictions or dual diagnosis). The use of innovative technologies should be explored in this regard.

2.2

Community agency clients should be encouraged to sign a service agreement outlining the nature and extent of services to be provided; information that may be exchanged with other service-providers, the police or other officials; and situations in which services may be terminated. Clients should be thought of and encouraged to be service participants rather than service receivers so that they may accept some responsibility for the services to which they have agreed.

2.3

If the person is involved with an assertive case management and outreach program as a result of past conflicts with the law (see **Juncture 5 and 20**), a community case conference should be held in response to any possibly significant change in the person's behaviour. The case manager will keep in touch with those people who are likely to notice a change in the person's behaviour (family, friends, school, landlords or work supervisors etc.). The case conference should involve the consumer and his or her primary case worker, family, and other direct service providers - both health, social services and corrections. In the alternative, the case manager may arrange for a general consultation session involving police, probation and parole, health care providers, and community representatives — members of *Human Services and Justice Coordinating Committees* might assume this general consultation function. The community case conferencing function should be part of mandate of any assertive case management program that deals with forensic clients.

2.4

For people with mental health problems, the Ministry of Health should aim to fund and provide a seamless range of mental health services that are responsive to client needs and community demands, and provided within the least restrictive environment. This includes services provided in institutions, communities, and at various levels of security. The mental health plan should encourage service approaches that will increase the capability of the mental health system to provide treatment within community settings and ensure continuity between inpatient and community care. These approaches often combine clinical and case work skills within a team concept. For chronic disorders like schizophrenia, assertive case management and treatment services should be provided at the problem stage before the person has become entrenched in a repeat cycle of criminality and institutionalization.

2.5

For people with developmental disabilities, the Ministry of Community and Social Services is committed to community living. This includes moving facility clients out of large scale residential settings, and ensuring the provision of individualized supports for all people with a developmental disability. Within this project, some factors will support the ministry's commitment: the availability of appropriate services including effective case management, education for clients and service providers, and service coordination across the health and justice systems. The provision of individualized, evidence-based treatment plans that suit the client's risk level is of particular importance to long term community integration. Communities will be expected to support the diversion of low-risk offenders to help realize the goal of community living. Where treatment involves the management of risk at levels that exceed community readiness, interim measures that provide for more restrictive, but nevertheless humane, intervention will need to be considered by the ministry and its community partners in concert with other ministries. Full community integration means that individuals, and not the ministry nor the community, are accountable for the choices they make regarding both their privileges and obligations as citizens.

2.6

For people with dual diagnosis, the ministries of Health and Community and Social Services have released guidelines to articulate each ministry's role with respect to shared service responsibilities and

to coordinate the provision of appropriate programs. Clients should have access to the services they require in both the mental health and developmental service systems. Experience consistently points to the success of a cross sector interdisciplinary team approach that is integrated within the mental health and developmental sectors' continuum of supports and services in meeting the needs of this population. Education and training initiatives undertaken within both sectors should integrate and promote increased knowledge and skills regarding dual diagnosis.

2.7

Human Services and Justice Coordinating Committees should complete a systems-based needs assessment to develop a shared understanding of system functions and the capacity of systems to fulfil these functions. In particular, the following questions should be addressed:

- What is the scope, capacity and potential of existing services and supports? What resources are being spent now, including estimates of the indirect costs of crime? Are resources matched to client needs? Do offenders have equal access to programs? How effective are these services in relation to the costs of providing service in that fashion?
- Who delivers services (consider services to both offenders and victims)? Is there someone else that should help or could deliver services more effectively? Can volunteers be utilized more effectively? Who is paying? What are they paying for?
- To what extent is realignment or redirection of already existing resources required or possible in order to achieve key functions? How are services reviewed? Is there a process to review current expenditures, reallocate costs according to priority need areas, and develop new resources?
- Who are the partners at each step of the process? Are they aware of each other and of the potential for partnership? Are there any partners missing? What partnerships need to be developed or strengthened? What is the most effective way of ensuring this partnership is effective (i.e. memorandum of understanding, letters of agreement, protocols, or operating guidelines?)
- Are there issues that must be referred to another level or body for solution? If so, who makes the referral?
- Have all solutions short of legislative change been considered? If so, are there still implications for federal or provincial legislation in ensuring that public safety is reasonably protected? How can these be brought to the attention of the legislators?
- How does the community look like today? What are the problems? What should it look like?
- How do we facilitate change — what actions are required and who must take them?
- How can we measure the results?

2.8

Mental health and developmental service plans should be reviewed by the *Human Services and Justice Coordinating Committee* in terms of accessibility and appropriateness of services to forensic clients and those at risk of conflict with the law. Within the mental health sector, district and regional mental health services will be identified in DHC mental health plans. Within the developmental services sector, MCSS Area Office staff will provide relevant planning information to the *Human Services and Justice Coordinating Committee* and will facilitate service coordination activities. Presently, service planning and service coordination is carried out by local planning groups, advisory committees, and hard-to-serve committees. Any restructuring of social services that takes place will need to integrate the links between such bodies and the *Human Services and Justice Coordinating Committees*.

2.9

Ministries will work together to develop strategies to avoid exposing other systems to pressure to provide an alternative living environment to discharged clients who are unable or ill-equipped to live in the community. Institutional downsizing may have an impact on forensic systems if proper planning and suitable alternative supports for clients are not in place.

2.10

Forensic clients who are common to several ministries are found in each system. Placement planning and efforts to build community support networks are enormously challenging for any one ministry working in isolation from the others with respect to these clients. Where common clients have been identified, ministries should develop a shared placement planning process.

Evaluation

Human Services and Justice Coordinating Committees will establish their own mechanisms to evaluate outcomes and the effectiveness of their coordinating efforts. Evaluation techniques should include some analysis of data collected at the program level (i.e. number of referrals for coordinated service delivery, number of clients diverted, number of clients jointly managed, cost of service provision etc.). Other mechanisms may include the identification and follow-up of random case studies; client, agency, and community satisfaction evaluations; client outcomes and quality of life indicators; and/or participant observation studies or other action research methods.

It is noted that under mental health reform, the mental health system is expected to be accountable to consumers/survivors, their families and the community. These sectors will each assist in the development of evaluative tools and mechanisms.

Agreed upon outcome measures for the mental health system that will measure the effectiveness of the services and supports provided to the severely mentally ill, including the reduction of inpatient utilization, should be developed. Likewise, specific outcome measures need to be developed for the developmental services system.

Existing services should be evaluated as to whether they are supported by the population base, regularly reviewed, accountable for their work, and are discontinued if they no longer meet needs.

3. INCIDENT

Description

At this juncture, the person apparently has acted in an aggressive or anti-social manner or committed a crime. The incident may have caused the public to complain to police or other agency such as a crisis centre. Or, there may have been a serious occurrence in the home that pushes the family or the individual to seek help from treating professionals or support workers. The number of ways the incident may come to the attention of service systems are varied, but in most cases it is either the result of an escalation in the behaviour, or the offender being caught after committing a crime.

Coordination Protocols

Organizational Framework

3.0

Human Services and Justice Coordinating Committees should develop mechanisms to coordinate the appropriate involvement of local police agencies and mental health or developmental service providers in light of the seriousness of incidents. Every attempt should be made to limit police involvement in nuisance or minor situations involving the disabled (but not serious crimes) through the provision of effective crisis response services within each service system. Police and service providers may need to develop common procedures to respond to crisis or other situations, to share information, and to resolve operational inefficiencies.

Target Group

The target group is people with a mental illness or developmental disability who have acted aggressively or committed a crime.

Service Delivery

3.1

Research suggests that family members, not the general public, are the most likely targets of violence involving the mentally ill. Incidents often involve episodes of damage to property, minor assaults, or threatening behaviour. Families should be provided with support, as well as education about techniques for managing disturbed behaviour, and preventing or diffusing a crisis situation.

3.2

Frequently, police are requested to intervene in a crisis situation involving the mentally ill. Under Mental Health Reform guidelines, District Health Councils will involve the police and other stakeholders as partners in the development of a crisis plan to respond to a crisis involving a person with mental disorder or a dual diagnosis. The final crisis plan must be formally approved by senior managers within police, health and developmental services organizations. To assist in the development of a crisis plan, police and service agencies should develop a typology of situations to identify what kind of situations would benefit from the intervention of a clinician or support worker, and what type of intervention is likely to reduce or prevent harm.

3.3

Where need has been determined and resources permit, police and mental health agencies may operate shared programs where trained police and support workers respond jointly to crisis calls involving the mentally ill. These programs may form part of the district's crisis plan. In remote or rural areas that are underserviced with respect to police and medical personnel, 24 hour crisis telephone services staffed by trained mental health professionals should be established.

3.4

A crisis response capacity is required in the developmental services sector to support individuals, families and service providers dealing with clients experiencing placement failures/crises. Regularly reviewed community crisis planning will be expected in all communities. Local attempts to deal with

problems through local planning groups or advisory committees and hard to serve committees are encouraged. Planning should be coordinated with the mechanisms that may evolve as a result of any social services restructuring. "Last resort" mechanisms include referral to the provincial IMPAC committee or one of the remaining Schedule I Developmental Services facilities, as per the Facility Admissions Protocol. Until crisis planning becomes well established, service providers, individuals and families are encouraged to plan for foreseeable risks through the use of alternate or back-up service plans in the event that the primary service plans for such individuals fall through unexpectedly.

3.5

Where police do respond to an incident involving a mentally ill person, the police officer should have the option of requesting assistance from a mental health worker in cases where certification under the *Mental Health Act* or the provision of other health supports may be the most appropriate immediate response to the situation. Likewise, assistance from a developmental services worker in situations involving a developmentally disabled client should be available. In particular, the investigating officer may receive information regarding symptomatology of disabled people and various possible courses of action, including the availability of community resources, triage and emergency services and/or a case manager for the type of individual in question. Information may be provided to the officer verbally over the phone. Mental health and developmental services contacts should be communicated to patrol officers directly, or through a designated forensic liaison police officer.

3.6

The Ministry of the Solicitor General and Correctional Services should, in consultation with the police community and other stakeholders, continue to research the most effective police response to people with a mental disorder or developmental disability. As a priority, this should include a careful review of police response to serious incidents.

3.7

Crisis situations can occur in correctional institutions as well as the community and the health crisis response system should be linked to these settings. The crisis service may perform a gatekeeping role in determining access to hospital or emergency psychiatric or other respite resources.

3.8

At the local or program level, interagency working agreements or guidelines may be developed to increase efficiency and facilitate cooperation between criminal justice, developmental, and mental health organizations and ensure the client receives necessary assessment and treatment, case management or other appropriate supports. For example, police and emergency psychiatric services should agree on procedures to reduce the amount of time police must spend waiting with a mentally ill person before custody of the person transfers to the hospital. Formal, ongoing consultation about interagency protocols should occur at both the staff and managerial level of all organizations involved in the process.

3.9

Police/service provider linkages, common procedures, and crisis plan should be reviewed by the *Human Services and Justice Coordinating Committee* in terms of the accessibility and appropriateness of strategies for the target group. For mentally ill clients, linkage mechanisms will include but will not be limited to the normal procedures under section 17 of the *Mental Health Act.*

Evaluation

Outcome evaluations regarding the effectiveness of local crisis response services should be undertaken.

If intervention is not effective in preventing problem behaviours from escalating, the impact is likely to be experienced by the police in particular and the criminal justice system generally. Where police have been involved with a mentally ill or developmentally disabled client, police and/or client database systems should record the number of occurrences and behaviour precipitating police involvement, as well as outcomes to establish whether an assertive case management program or other course of action is indicated to prevent or reduce repeated occurrences.

General statistics concerning levels of victimization would be helpful. Victimization statistics are available through three possible sources:

- Victim Witness Offices, Ministry of the Attorney General
- Victims Bureau, Ministry of the Solicitor General and Correctional Services
- Victimization Surveys, Statistics Canada, Canadian Centre for Justice Statistics.

Some reliable definitions or measures are however required to identify mentally ill or developmentally disabled victims or perpetrators separately from other offenders.

Family, consumer, and agency satisfaction surveys should be conducted periodically. In particular, families and consumers should be asked about outcomes and the effectiveness of the systems in meeting their needs and expectations in response to an incident. Police agencies should be asked about their satisfaction with the quality of service they receive from mental health agencies, waiting times, and client outcomes. Mental health and developmental service providers should be asked about their satisfaction with the information they receive from police, and the appropriateness of police requests for assistance. Satisfaction survey techniques might be used at all stages of the criminal justice process.

4. INVESTIGATION

Description

Where police or mental health workers have responded to an incident, an investigation leading to some form of intervention will generally take place. The investigation will assist decision-makers in determining the most appropriate course of action at **Juncture 5**. The decision will depend to a great degree on the nature and seriousness of the incident, background information including prior contacts with the person, and information about the availability of appropriate resources in the community.

Coordination Protocols

Organizational Framework

4.0

Investigations are primarily conducted under the jurisdiction of a single agency. Coordination activities will be related primarily to information sharing, both during and at the conclusion of an investigation.

Target Group

The target group is people with a mental illness or developmental disability who have acted aggressively or committed a crime.

Service Delivery

4.1

Where they are involved, police have responsibility for obtaining as much information about the incident as possible. The disabled person, family members, other persons on the scene, and support workers, health care professionals or other experts may be asked for information about the individual and/or appropriate community services. Wherever possible and permitted under legislation, information should be shared with the police. In turn, police will provide this information to service providers and crown officials if necessary. Wherever possible, innovative technologies may be used to share information more efficiently.

4.2

Guidelines concerning the appropriate exchange of information between agencies should be developed at both the provincial and the local level. Agency staff should be trained in the appropriate application of confidentiality legislation, duty to warn criteria, and information exchange guidelines as these apply to particular programs. This protocol will apply at this and all subsequent juncture points.

4.3

Similarly to **Juncture 3**, the investigating officer may receive assistance from service providers regarding the symptomatology of disabled people and the various possible courses of action, including the availability of community resources for the type of individual in question. If referral to a community agency or case manager is warranted, it will be determined through the intake process whether the community agency is willing and able to serve the person, and whether the person is willing to accept the service suggested. Even if services are not provided, the referral agency should maintain contact with the individual until an appropriate resource is found, or no further follow-up is required.

4.4

In situations where the investigation may be commenced under the jurisdiction of a service agency, police will be contacted immediately if and when, during the investigation, it is suspected that a serious or violent crime has been committed.

4.5

Special care should be taken to keep a disabled person informed about the progress of the investigation. It is important that the person be kept informed of their rights at each stage of the process, in particular, the availability of legal assistance should this need arise. Community programs workers in the developmental services system, volunteer groups, or members of the client's natural support network may be encouraged to act as an advocate for the individual.

4.6

During the course of an investigation, crown counsel are available to give advice to the police if requested with respect to legal issues, including an assessment of what evidence is required to proceed with prosecution.

Evaluation

The evaluation of investigation and information-sharing processes should be addressed through police and service provider satisfaction surveys and outcome measures of the effectiveness of investigations.

5. INTERVENTION

Description

Intervention refers to a course of action that is initiated in response to the incident. After completing a preliminary investigation, a police officer may do one or more of the following: take no action; informally divert the individual to the care of a relative or other appropriate person, or to a hospital, physician, mental health agency, detoxification centre, developmental services or other social service agency; issue a warning or other sanction; or arrest the accused under the *Criminal Code* or other applicable statute and recommend the laying of charges where appropriate. If the person is mentally ill, the police may also apprehend the person under section 17 of the *Mental Health Act* and take them to a psychiatric facility for examination, possibly leading to certification.

Cooperation between police, developmental services and mental health agencies may be required in situations where a person has been arrested but appears to require mental health or other behavioural treatment, or where police are attempting to divert the person to a service provider as an alternative to arrest.

Coordination Protocols

Organizational Framework

5.0

To provide guidance to police, mental health workers and developmental services as to whether a criminal prosecution is appropriate, arrest criteria should be developed as part of a resource package for police dealing with the disabled. Where a mentally disordered or developmentally disabled individual has committed a serious, violent or repetitive crime, police should arrest him or her. For crimes that are not serious, violent, or repetitive, mental health and/or developmental services should be offered to the individual as an alternative to arrest as specified in a "Community Intervention Plan".

Target Group

The target group is people with a mental illness or developmental disability who have acted aggressively or committed a crime.

Service Delivery

5.1

Human Services and Justice Coordinating Committees will work with police, hospital, developmental services and community representatives to develop a "Community Intervention Plan" which clearly specifies which mental health, developmental or other services (e.g. detox, accommodation) will receive individuals from the police in situations where the police do not arrest the person, but it is not appropriate for police to take no action. The framework for the provision of services to individuals diverted by police as an alternative to arrest will be contained in district mental health and local developmental services plans. Service plans will focus on community-based options, and institutionalization should be considered only as a last resort strategy. Admissions to psychiatric facilities will be based on criteria under the *Mental Health Act* which are based on a standard of harm to self or others. Admissions to Schedule I facilities under the *Developmental Services Act* will be guided by the Facility Admissions Protocol which adheres to a no admission philosophy, keeping in mind the long standing policy of facility downsizing. As an alternative to facility admissions, consideration may be given to designating a number of "crisis" or "respite" beds in hospitals or community organizations for police referrals.

5.2

Every mentally ill or developmentally disabled person who faces a current legal involvement, or who has been identified as a common client of human service and criminal justice systems, should be referred to a case manager or assertive community treatment team within the appropriate service sector. Police, family, courts, and other service providers are all potential referral sources. Case managers will provide services to the client (with his or her consent) throughout the forensic, general, and/or correctional service systems depending on the type of intervention appropriate to the circumstances. Where a client is unwilling to accept the assistance of a case manager, he or she will be followed through an assertive outreach approach. The ministries of Health and Community and Social Services will ensure that designated case management programs within each respective sector have a proactive, cooperative admission policy for forensic client referrals. This protocol will apply at any juncture point where a forensic client is first identified.

5.3

Police officers should receive training in and emphasize the pre-arrest diversion of forensic clients whose behaviour falls within the ambit of the general police discretion not to arrest, but it is not appropriate for police to take no action. At the same time, police officers need to receive training around the myth of 'innocence' that may prevail when people with disabilities engage in serious offending behaviour. If a charge is indicated based on the offending behaviour, it should be laid by the officer and then reviewed for possible diversion by the crown (see **Junctures** 7,8,9). Police training should also include crisis response and de-escalation techniques involving the mentally ill and the developmentally disabled and effective means to protect the safety of the public, the client, as well as the officers responding to the incident.

5.4

Community programs should be the primary point of pre-arrest diversion for people with mental disorders or developmental disabilities who commit minor crimes. Police forces and community programs should cooperatively develop pre-arrest diversion procedures (e.g. referral and access to services, case management, exchange of information, etc.). The pre-existing network of diversion linkages between the crown and mental health programs may be used for this purpose. With respect to the mentally ill, psychiatric hospitals and general hospital psychiatric units should be available for consultation with community programs regarding the treatment and risk management of clients in community programs as a result of diversion. With respect to the developmentally disabled, community resources and local expertise should be identified for the purpose of developing pre-arrest diversion procedures.

5.5

To facilitate diversion or suitable alternatives to arrest, community support programs should be developed according to models that have proven to be effective in dealing with the chronically mentally ill (e.g. assertive community treatment teams) or the developmentally disabled. As individuals diverted by the police or the crown would be unlikely to have characteristics of persistent criminality, specialized forensic programs are not required. Every reasonable effort will be made to assist individuals in functioning appropriately in the community and to prevent a pattern of repetitive criminal behaviour from developing. Community-based mental health programs will be developed through mental health reform community investment strategies. It is expected that, based on need, similar programs will be developed in the developmental services system, particularly within the context of social services restructuring.

5.6

For mental health interventions, it is noted that assistance may be voluntary, or involuntary through the civil committal process in accordance with statutory criteria. For involuntary civil committal, clients will undergo assessment, custody, and release phases not dissimilar to the criminal justice route. Coordination protocols contained at **Junctures 16 to 20** will also apply to this group of patients, with some modifications.

5.7

Police will arrest a person whose behaviour is serious, violent or repetitive. Police and mental health staff should be aware of what actions police may take when a person who has been arrested appears to require emergency mental health treatment; and the responsibilities of service agencies after receiving arrested individuals from the police. In situations where psychiatric intervention may be necessary immediately, police will accompany the individual to the nearest emergency psychiatric service before the individual is arraigned. Where a mentally ill person under arrest has been admitted to hospital, he or she will only be discharged into the custody of the police or other appropriate court official. In other cases or in situations involving a person with developmental disabilities, police will process the individual through the normal channels, but at the accused's first appearance will provide information about the person's mental condition to the Justice of the Peace who may make the appropriate order to enable the person to receive assistance.

5.8

Generally, individuals will not be diverted after arrest but prior to an information being laid. Police holding cells are not used simply for the purpose of "getting the person off the streets" or because other more appropriate crisis, detox, or respite services do not exist.

5.9

Each person or agency who intervenes with a mentally ill or developmentally disabled person shall use a client-based decision-making approach. In deciding the most appropriate intervention, the following questions will be considered:

- What is happening? Where is the client? Who has information about the client? What other information exists and who has it? Who needs to know?
- Is public safety assured? Who is making the decision? Based on what information?
- Are the individuals responsible for the process provided with the information and training they require to do the job?
- How is risk assessed? How can risk best be managed? What intervention strategies are in place and what should be in place (i.e. supervision, monitoring, programs, treatment)
- Who takes responsibility for the client at the next stage? How can we ensure that the client is not "lost"? Who is accountable for the client?
- Are the rights of the client being protected?
- What barriers exist to achieving effective solutions and how can they be overcome?
- Are there legal issues which need to be resolved (i.e. consent to treatment, privacy, professional ethics/standards)?
- Is there overlap or duplications that can be avoided? Is there sufficient overlap to ensure that there are no gaps?

5.10

Each system and program or agency that comes into contact with forensic clients has a responsibility to educate their staff, and ensure that they have the training, resources, support and tools necessary to work with clients with disabilities, consistent with the organization's mandate and expertise. This protocol will apply at all juncture points as proper education and training is considered one of the keys to successfully working with forensic clients. Education within college and university programs as well as ongoing staff training are key activities that contribute to systems change. Different learning strategies may be utilized as appropriate and as resources permit.

The provincial committee should sponsor and disseminate generic educational materials and training packages about the key junctures and coordination protocols. Joint, cross sector, interdisciplinary approaches are most effective in this area. Agencies from different ministries should collaborate on the development of cross-agency or multi-discipline training materials for specific programs. Wherever possible, joint training programs or blended "learner groups" should be encouraged where representatives from different constituencies can come together to share concerns and help each other better understand their respective roles.

The development of training videos and other resource material is encouraged to engage staff who are unable to participate in such activities directly. A consumer role in the development and delivery of training should be encouraged. In addition to information about mental disorder or developmental disability, the perspective of employee wellness and work-related mental health issues such as stress and depression should be considered in the development and delivery of training.

5.11

Referral agencies (police, GPs, emergency rooms, crowns, etc.) and/or case managers will keep note of individual cases where locating an appropriate placement for a forensic client has been problematic

or inordinately time consuming because of waiting lists or restrictive admission criteria. *Human Services and Justice Coordinating Committees* will review cases regularly, and will discuss strategies for more effective resource utilization, directed placement, or increased resources to control placement difficulties.

5.12

Similarly, "difficult to serve cases" (i.e. people who do not clearly fit within the mandate of any one agency or system and as such are often denied services because of compounding problems such as sexual aggression, substance abuse, etc.) should be brought to the attention of the *Coordinating Committee*. Multi-agency committees should be involved in developing an appropriate program response for clients.

5.13

Ministries should establish a collaborative process to review privacy legislation and its impact on effective service provision to the target group.

Evaluation

Performance measurement indicators for this juncture will include the development of an integrated justice database system to ensure that all mentally disordered people who have been arrested have been accused of a serious, violent or repetitive crime.

For people who have not been arrested, the Ministry of Health will develop a mechanism to evaluate the effectiveness of assertive case management programs in relation to preventing the seriously mentally ill from engaging in repetitive minor criminal behaviour. The evaluation will include both clients who have been engaged in the program, as well as those who were referred but were unable to participate. In addition, different styles of case management programs should be evaluated. A formal random assignment study should be considered, comparing relatively costly, high intensity case management programs with various alternative models for offenders of varying levels of risk. In theory, high intensity service may increase the crime among low risk cases, but have the opposite effect on high risk cases.

If a Community Intervention Plan or service agreements between agencies are developed, program evaluation criteria should consider the effectiveness of these agreements in achieving the agency's goals.

6. LAYING AN INFORMATION

Description

Every criminal prosecution is commenced by the laying of an information under oath before a justice of the peace. After hearing the allegations of the informant (generally the arresting police officer), the justice will determine whether or not a case is made out for compelling the appearance of the accused to answer to the charge. This is the formal entry point to the judicial system for all people accused of a crime.

Coordination Protocols

Organizational Framework

6.0

Responsibility for the prosecution of an accused within the framework established by the Charter of Rights is a function of the court system. As a result of his or her legal involvement, a disabled accused will also interact with one or more of the developmental, mental health and correctional systems. Coordination will occur for agencies within these systems to receive individuals from the courts in appropriate circumstances or otherwise assist in the just disposition of cases.

Target Group

The target group is people with a mental illness or developmental disability who have committed a crime.

Service Delivery

6.1

Forensic liaison crowns and/or crowns who receive specific training with respect to Ontario Review Board cases should be available throughout the province. In particular, courts in all larger urban centres should have at least one designated crown with specialized knowledge of procedures as these apply to disabled persons. In addition, in areas of the province where need has been determined, special judges, justices of the peace, defence counsel as well as crown attorneys should also be encouraged to specialize in dealing with disabled accused. It is however noted that specialization should not detract from the need for all practitioners to have a broad-based understanding of the disabled in the criminal justice system.

6.2

To ensure continuity and appropriate care for an accused with disabilities, crown attorneys should implement a case management approach based on the same principles as those outlined for family court case management. Case management should begin at the point of arrest or whenever the accused is identified as disabled, and continue through to the conclusion of the court process. At a minimum, it should include coordinated file or information management policies and practices to ensure that key information (police reports, CPIC, medical reports, crown brief, judges reasons, Ontario Review Board reports etc.) are provided in a timely manner to health, developmental or correctional service providers involved in the offender's assessment, care and treatment.

6.3

To facilitate diversion and other service linkages for clients with disabilities, the mental health and developmental services systems should be linked to criminal courts. A mental health court outreach worker should be designated within criminal courts in larger urban centres which deal regularly with disabled accused; other courts should be linked with community service agencies which will assist the court in reviewing the client's suitability for community supports and developing appropriate service plans. Where a court outreach program has been established, the worker will do a preliminary review to assess client needs and suitability for community services, and will act as a service broker to connect

the client with the appropriate service and support providers. The court outreach worker will also act as a mental health resource to criminal justice officials.

6.4

Where volume warrants, the court outreach worker may be trained in both mental health and developmental services systems (in this case, program funding and/or training would be negotiated between the ministries of Health and Community and Social Services) or a separate court outreach position for developmental services may be designated. In communities with a low volume of developmentally disabled clients, the mental health court outreach worker could assist in identifying an accused with developmental handicap. Linkages between the court outreach program and the developmental services sector will be established to perform the actual court outreach/linkage functions.

6.5

Similarly to **Juncture 5**, each forensic client should be referred to a mental health or developmental services case manager who will follow the person through the criminal justice process, linking them to services or supports as appropriate or otherwise attempting to meet their mental health and/or developmental needs, until criminal charges are disposed of (see in particular **Junctures 7, 8, 12, 15, 18, 19, and 20**). The case manager will attempt to work with the person in the community afterwards to prevent a reoccurrence of the criminal behaviour. In some cases, the court outreach worker may act on a temporary basis as the person's case manager, but the outreach worker's primary function is brokerage and linkages to general case management systems to provide continuity and longer-term involvement are necessary.

6.6

Special care must be taken to explain to forensic clients and their families what will happen throughout the criminal justice process, and their rights at each juncture. While this is typically a function of defence counsel, the disabled person may interact with a number of other court officers, service-providers, and correctional staff and may need information repeated through many different sources. The role of volunteer organizations in providing support to disabled accused facing trial should be further explored, particularly where the individual may have special needs (i.e. women, youth, members of ethnoracial or aboriginal communities). Research indicates that defendants with a developmental disability are more likely to confess and plead guilty; make less use of plea bargains; make fewer appeals; and serve longer sentences. A special understanding of such behaviours, and of the potential advocacy role of the clients' various supports is necessary in order for people with a developmental disability to be treated fairly by the justice system.

6.7

Especially where families have been victimized, procedures should be developed to include them in court processes to give them more control over what happens to the accused, and to provide input into the outcome of the case. The police officer at the scene should invite victims to attend the next day's bail hearing, and inform them of the opportunity to ask for a Victim Protection Order.

6.8

At bail court, serious psychiatric or developmental difficulties may be identified by the court outreach worker, or a mental health worker through the triage and assessment process. For prisoners remanded in custody, serious psychiatric or developmental difficulties may be identified by the attending physician or health care team at a correctional facility. In these cases, procedures under the *Health Care Consent*

Act or *Substitute Decisions Act* may be initiated to ensure the person receives necessary treatment. The crown will be kept informed of the current civil status of the accused.

6.9

Ministries should develop strategies to enhance service coordination between services within their jurisdiction. To facilitate intra-sector coordination, each major system that is involved with the prosecution or diversion of mentally ill or developmentally disabled offenders (i.e. the local psychiatric hospital, the regional psychiatric hospital, the crown's office, police, the probation and parole office, local detention centres, MCSS local area offices etc.) should select a staff member to liaise with other systems in regards to cases involving an accused with disabilities. Forensic liaison staff may meet regularly to discuss issues and ensure processes are working. As well, linkages should be established and maintained with the duty counsel program and/or the criminal defence bar.

6.10

Human Services and Justice Coordinating Committees will prepare resource materials and are encouraged to make standing arrangements for meeting information requests from courts or other stakeholders (e.g. available psychiatric beds or community treatment programs, residential programs, level of security, etc.). It is important that all parties be familiar with *Criminal Code* and *Mental Health Act* provisions, as well as the requirements of various mental health and developmental service programs. Local efforts to develop service registry systems are encouraged to facilitate access to services that may be available in multiple sites. Knowledge or understanding of mental health, developmental and risk prediction issues is important to all stakeholders in the criminal justice process who may be required to make decisions about or accept the referral of a forensic client. Information or training sessions about these issues may be sponsored by the *Human Services and Justice Coordinating Committee* or hosted jointly between organizations.

Evaluation

Related to **Juncture 5**, the integrated justice system database should capture criteria to ensure that the prosecution of a mentally disordered or developmentally disabled individual continues to be in the public interest (i.e. charges relate to a serious, violent, or repetitive crime).

JUNCTURES 7, 8, & 9 ARE DIVERSION POINTS

Description

Diversion is defined as a pre-trial procedure where crown counsel uses his or her discretion on a case-by-case basis not to prosecute a person with criminal charges pending against them. Crown counsel will closely monitor the case and may terminate proceedings against an accused person if it is determined that there is no longer a substantial likelihood of conviction if the case proceeds to trial, or where an appropriate alternative course of action is arranged. For instance, if someone charged with a

relatively minor matter were to be committed under the terms of the *Mental Health Act* or were to voluntarily agree to accept community treatment or support services, crown counsel might consider it no longer in the public interest to proceed with the prosecution. A stay of proceedings can be entered at any time prior to the completion of the trial.

Coordination Protocols

Organizational Framework

7,8,9.0

Responsibility for making diversion decisions is a function of the crown attorney. Policy and operational guidelines will establish the framework to coordinate diversion referrals. Diversion linkages will be established between courts, community agencies, and psychiatric hospitals.

Target Group

The target group is people with a mental illness or developmental disability who have committed a crime, with a special emphasis on minor crimes.

Service Delivery

7,8,9.1

Diversion policy guidelines should be revised to include developmentally disabled accused. Greater flexibility should be built into diversion arrangements to permit a reasonable level of care and control reflective of the needs of the person. Diversion may occur at several different points of time, depending on the person's willingness to participate in a rehabilitation program, the degree of seriousness or repetitiveness of the behaviour, and the success of previous diversion attempts. A person who is a first time offender and whose behaviour is minor may be immediately diverted (i.e. charges withdrawn) based simply on their intent to seek treatment and supports in the community. Extra caution is however warranted where a person's behaviour is relatively more serious or he or she has failed at previous diversion attempts. Programs that have a degree of coercion but avoid the negative consequences of normal criminal justice processing arguably have a positive effect on recidivism. In these cases, the individual should not be immediately diverted — charges should be stayed for some period of time until the person has demonstrated that he or she is successfully engaged in a therapeutic process.

7,8,9.2

The diversion program for offenders with disabilities depends on good communication and cooperation between the crown, defence counsel, service providers, and the client prior to any decision about diversion being reached.

7,8,9.3

The person's case manager will assist in developing a diversion plan by investigating the person's needs and the availability of appropriate community supports and providing information to the crown and defence counsel. To help motivate clients to follow-through with treatment plans, the individual will be encouraged to sign a service agreement with any service agency with which he or she becomes involved as a result of diversion.

7,8,9.4

Appropriate community services must be available to diverted individuals. Local mental health, developmental and other social services will ensure that such clients have access to appropriate services to meet identified mental health and/or developmental needs. With respect to the mental health service component, district and regional mental health services will be identified in DHC mental health plans. Within the developmental services sector, MCSS Area Office staff will provide relevant planning information to the *Human Services and Justice Coordinating Committee* and will facilitate service coordination activities. Presently, service planning and service coordination is carried out by local planning groups, advisory committees, and hard-to-serve committees. Any restructuring of social services that takes place will need to integrate the links between such bodies and the *Human Services and Justice Coordinating Committees*.

7,8,9.5

In developing diversion agreements and with the victim's consent, opportunities for restitution or reconciliation with victims (if any) should be explored.

7,8,9.6

Community programs may sign agreements with the Ministry of the Attorney General outlining the conditions under which they will provide services to clients who have been diverted from the criminal justice system as well as general expectations regarding exchange of information. Agreements should be available through the *Human Services and Justice Coordinating Committee* or the crown attorney to any person attempting to work out a diversion plan for a forensic client.

7,8,9.7

Service providers are generally expected to provide services in a professional and competent manner in conformance with the standards of their profession and the laws of Ontario. These are the same expectations for agencies who serve clients who have been diverted or are subject to judicial conditional release. Staff and agencies will be liable for negligent actions, not errors in judgement. It is acknowledged that clients may sometimes behave in a harmful manner or make decisions over which agencies have no control.

7,8,9.8

Recurring problems in diverting forensic clients because key supports (including housing and other nonclinical supports) are not available or in insufficient supply within local communities should be brought to the attention of the *Human Services and Justice Coordinating Committee*. Service problems which can't be addressed locally or regionally may be reported to the provincial committee. It is expected that *Human Services and Justice Coordinating Committees* will explore all available options at the local level before forwarding unresolved issues to the province. The Committee should suggest new methods, protocols, etc. that might be established to address the issues.

Evaluation

Performance measurement indicators for diversion will include the development of a database system to record the number of individuals diverted, the agencies involved in providing service, the cost of services, the length of time to develop and implement the diversion plan, and client outcomes, including quality of life and service effectiveness.

Evaluation studies (both natural and formal) should be considered to find out whether a particular type of diversion has had its presumed effect.

The accuracy and reliability of professional opinions about clients may be measured. Formulations about prognosis, future behaviour, and clinical presentation should show reasonable levels of convergence and divergence. That is, experts should generally agree about the same individual but they should achieve that agreement without saying the same things about everyone. This type of research may also be considered at **Junctures 9, 10 and 17**.

Agency, client, and family satisfaction surveys should be conducted periodically.

7. PRE-TRIAL RELEASE

Description

The basic philosophy of the pre-trial release provisions is that prior to conviction, all those persons who do not constitute a danger to the public and who will show up for trial should not be detained in custody. The court or in some cases a peace officer may order the release of the accused if he or she gives a promise to appear or enters into an undertaking or a recognizance with or without sureties. For serious offences, or where the Justice of the Peace does not believe it likely that the accused will appear before the court at the prescribed place and time, the accused will be remanded into the custody of a jail or a detention centre until trial.

Release decisions are made independently of referrals under the mental disorder provisions (see **Juncture 10**) and a referral for assessment under Part XX.1 of the *Criminal Code* may be made without requiring the offender to be held in custody.

Coordination Protocols

Organizational Framework

7.0

Alternatives to incarceration should be considered wherever possible. Court officials will make every effort to develop a suitable community release plan with the cooperation of the accused and service-providers. Families should also be involved in appropriate cases.

Target Group

The target group is people with a mental illness or developmental disability who have committed a crime that is not divertable, with a special focus on nonviolent crimes.

Service Delivery

7.1

Good liaison between bail information or bail support programs, the police, and health and social services are important at this juncture to reinforce the importance of ongoing rehabilitation and community safety.

7.2

A decision-making approach that focuses on public safety should be used at this juncture. In deciding the most appropriate intervention, the following questions will be considered:

- Do stakeholders communicate effectively? In particular, are case management processes integrated across relevant human service systems?
- Do knowledgeable crowns deal with bail cases?
- Is there clear bail criteria and formal policies? According to what information are decisions made?
- Have mental health and risk prediction issues been adequately addressed?
- Is there psychiatric input - if so, are psychiatric resources to the court used effectively?
- Which should take priority - dealing with mental health or criminality issues?
- Are opportunities for diversion or bail supervision in the community fully explored?

7.3

The person's case manager will assist in developing a plan for the release of the individual under bail supervision by providing information and investigating the person's needs and the availability of appropriate community supports. Supports necessary to ensure that the accused appears at court whenever he or she is required to attend may additionally be provided through the health or developmental services case management system. Particular attention should be paid to the development of case management services in underserviced areas of the province where psychiatrists or professionals specializing in forensic work are in short supply, and where an accused would be more likely to be held in custody prior to trial because appropriate community supports are not available.

7.4

Appropriate community services must be available to clients under bail supervision. Local mental health, developmental and other social services will ensure that such clients have access to appropriate services to meet identified mental health and/or developmental needs. With respect to the mental health service component, district and regional mental health services will be identified in DHC mental health plans. Within the developmental services sector, MCSS Area Office staff will provide relevant planning information to the *Human Services and Justice Coordinating Committee* and will facilitate service coordination activities. Presently, service planning and service coordination is carried out by local planning groups, advisory committees, and hard-to-serve committees. Any restructuring of social services that takes place will need to integrate the links between such bodies and the *Human Services and Justice Coordinating Committees*.

7.5

Suitable accommodation for the defendant in the community should be identified. Where supportive housing is required, an accused person will not be denied access to such services because he or she faces criminal charges.

7.6

Every effort should be made to reduce the number of people with mental disorder detained at a correctional detention centre awaiting assessment or treatment at a psychiatric facility. The community release plan may contain provisions to enable a mentally ill offenders to await assessment and treatment out of custody.

7.7

Only with the prior agreement of a treatment facility should a mentally disordered accused be remanded on bail with a condition of residence or attendance at the facility. If such conditions are considered desirable, the court should also make the appropriate order to permit the release of the accused to the community should he or she no longer continue to require institutionalization while under bail supervision. Where an accused is not released on bail, but is seriously mentally ill and in need of hospitalization, transfer of that individual to a psychiatric facility may still be arranged according to the protocols set out at **Juncture 8**.

7.8

Where a forensic client is released pre-trial, the appropriate court official will ensure that the person's case manager or the facility or community service involved in the person's care is informed about the release decision to facilitate appropriate treatment follow-up.

7.9

Recurring problems in releasing a forensic client under bail supervision because key supports (including housing and other nonclinical supports) are not available or in insufficient supply within local communities should be brought to the attention of the *Human Services and Justice Coordinating Committee*. Service problems which can't be addressed locally or regionally may be reported to the provincial committee. It is expected that *Human Services and Justice Coordinating Committees* will explore all available options at the local level before forwarding unresolved issues to the province. The Committee should suggest new methods, protocols, etc. that might be established to address the issues.

Evaluation

Performance measurement indicators for this juncture will include the development of an integrated justice system database system to ensure that all disabled people who have been refused bail have apparently committed a serious or violent crime and not merely because their circumstances and way of life are unstable.

The number of individuals released under bail supervision, the agencies involved in providing service, the cost of services, the length of time to develop and implement the bail release plan, and client outcomes, including quality of life and service effectiveness should be recorded. Agency, client, and family satisfaction surveys should be conducted periodically.

8. PRE-TRIAL REMAND

Description

In most cases, a remanded prisoner will reside in a jail or detention centre until the outcome of their trial is established. As much as possible, this is done at a geographically convenient facility to facilitate court appearances and to maintain contact with the local community including family. Court ordered psychiatric assessments and other pre-trial processes (e.g. examination for discovery) typically occur at this stage.

It is noted that a remand prisoner may be transferred to a hospital for medical reasons, including psychiatric treatment, under the authority of the superintendent of the detention centre. A specific court order for assessment is not required. However, current correctional policy does require remand prisoners to be escorted.

Coordination Protocols

Organizational Framework

8.0

Treatment should begin as soon as possible in whatever location the client is situated. A process of cooperative treatment planning should be initiated to address an offender's immediate and long-term treatment needs.

Target Group

The target group is people with a mental illness (with a priority being the seriously mentally ill) or developmental disability who have committed a crime that is not divertable and who represent a public safety risk.

Service Delivery

8.1

Every forensic client should be offered effective and appropriate treatment for their mental condition or developmental disability while in custody. If a mentally ill offender requires and can benefit from treatment that is not reasonably available within a correctional centre, he or she should be transferred to a psychiatric facility. In some circumstances, correctional staff may be required to provide security for the person while he or she is in hospital. The attending physician and the officer-in-charge of both the treatment and the correctional facility must first agree as to the appropriateness of transfer, as well as

the necessary security arrangements. Transfer and security agreements, and protocols to establish the responsibility for the security of the person during transportation should be outlined in ministry policy guidelines.

8.2

Mental health, developmental services and correctional systems are capable of providing effective services and supports for forensic clients at this juncture; the strengths and capabilities of existing programs should be built upon to maximise effectiveness as well as avoid duplication of services. Generally, specialized treatment requiring hospitalization should be provided in health facilities, while general treatment and personal care should be provided in jails and detention centres. (Specialized psychiatric treatment may also be available in some correctional treatment facilities.) The ministries of Health, Community and Social Services and the Solicitor General and Correctional Services will articulate through an institutional treatment agreement the core clinical services which should be available within all detention centres, as compared to problems which warrant either transfer of an accused to a specialized treatment facility or the provision of additional supports to the client in custody through the human service sectors. Each correctional facility should have a "open door" policy permitting easy access to workers from the different service systems who are continuing to maintain contact and provide supports to clients in custody. With respect to core services within detention centres, staffing levels and/or an appropriate staff mix should be identified in the treatment agreement. Staff from different service sectors may be identified to support the core services team within the detention centre.

8.3

Human Services and Justice Coordinating Committees will review any agreement as to institutional treatment services and transfer guidelines that may be developed between the ministries and will develop additional criteria relevant to the facilities within specific regions and districts based on available treatment programs and security to provide guidance to correctional superintendents and hospital administrators.

8.4

Where there is clearly a gap in services in available types of facilities to deal with particular clients with serious behaviour difficulties (e.g. non-psychotic clients who "act out" in a destructive or self-harming manner), ministries should collaborate in developing a program proposal(s) to better respond to client and institutional needs, which may involve sharing resources and clinical expertise between agencies or facilities.

8.5

Methods of reimbursement (salary, sessional payments, retainers, OHIP billings) of treating professionals within health, corrections, and developmental services should be reviewed to obtain a clearer picture of current expenditures.

8.6

As part of normal admission procedures, every prisoner should be screened for signs of mental disorder or developmental disability. Where problems are identified as a result of the initial screen, a more intensive assessment, examination and triage process should be available. The examiner will consider information provided by the court to the correctional facility (see **Juncture 6** — police report, CPIC, medical reports, if any) in conducting this examination. The results of the initial screening process and the mental status examination will be used to develop an appropriate treatment program and/or set of supports for the individual while under remand.

8.7

A Health Care Coordinator will be designated at each remand centre. If a case manager has been selected to oversee the development of a diversion agreement or community release plan, this person will liaise directly with the MSGCS Health Care Coordinator throughout any period that the accused has been remanded in custody prior to a diversion or release order being made. In addition, the Health Care Coordinator and the person's case manager will coordinate arrangements for the accused to be admitted to or discharged from an appropriate treatment facility if necessary. The Health Care Coordinator will ensure that the treatment facility to which an accused may be transferred is informed of any relevant medical information about the accused and, with the consent of the individual, should share any relevant health care information with the case manager.

8.8

If a mentally ill accused is transferred to a psychiatric facility for examination and is subsequently certified under the *Mental Health Act*, the superintendent of the correctional facility will ensure that the local crown attorney is kept advised of the offender's status. The crown attorney may consider any hospitalization of the accused as a factor in exercising his or her discretion with respect to staying criminal charges. In the alternative, the crown may consider whether it is necessary to bring the accused before the court at an early date to address the issue of the accused's fitness.

Evaluation

Performance measurement indicators for this junction will include the development of an integrated justice system database to ensure that all forensic clients who are remanded in custody pending trial have been charged with a serious or violent crime.

If an agreement about treatment and support services has been developed by the ministries, evaluation mechanisms will consider whether the agreement has clarified referral criteria and reduced the frustration of referral agencies (i.e. health care coordinator satisfaction surveys). The outcomes of referrals should also be measured.

Treatment programs should be evaluated in terms of effectiveness and client outcomes. The Ministries of Health, Community and Social Services and Solicitor General and Correctional Services should establish a compatible approach to program statistics and program evaluation for all programs targeted to forensic clients to facilitate some comparison of health, developmental, and correctional treatment and support programs.

9. PSYCHIATRIC ASSESSMENT

Description

A psychiatric assessment may be initiated at bail court or at some later stage of the criminal justice process. If the person has been remanded in custody, a psychiatric assessment may involve transfer from the detention centre to another centre for evaluation. Upon completion of the assessment, the accused may be transferred back to the jail or detention facility to await court proceedings.

Clinical assessments as to suitability for diversion, suitability for bail release, or pre-sentence reports for the court will be considered under this section. Psychiatric assessments under Part XX.1 of the *Criminal Code* (fitness to stand trial, criminal responsibility, or appropriate mental disorder disposition) will be considered under **Juncture 10** below.

Coordination Protocols

Organizational Framework

9.0

Human Services and Justice Coordinating Committees will review local needs, demands, and the availability of resources to develop a plan for court referred clinical assessment services within specific districts. The plan for clinical assessments should address the full range of assessment services that may be required by the courts or treating agencies; identify personnel or lead agencies as well as referral sources; and where services are provided through different agencies, develop strategies to streamline services and avoid duplication.

Target Group

The target group is people with a mental illness or developmental disability who have committed a crime.

Service Delivery

9.1

The ministries of the Attorney General, Health, and Community and Social Services will develop guidelines for court referred clinical assessments related to diversion, bail release, or sentencing. Guidelines should outline ministry expectations, level of service involvement, lead agencies, and criteria for court initiated referrals. In developing their court assessment plan, *Human Services and Justice Coordinating Committees* should identify the anticipated volume within the community and what services need to be in place. As assessments at this juncture cannot be unilaterally imposed by the courts, ministries and lead agencies will need to explicitly agree to be involved with this assessment process.

9.2

Community-based clinical evaluations are an expectation of mental health and developmental services systems and are part of a program's overall responsibility to integrate clients back into the community. These general assessment services should also be available to forensic clients facing diversion, bail, or sentencing through the criminal justice system and this function should be made available within existing programs. Both the court and program staff will benefit through having access to assessment findings. Information useful to the court at this juncture is similar to general program or intake requirements (i.e. what's the person need, level of risk, expressed wishes, what services are available etc.) Much of this information already exists or is easily obtainable and needs to be linked into the court process to assist in community release planning. The flow of information back into the court should rely to as great extent as possible on existing documentation or documentation that is also relevant to program requirements.

9.3

Where diversion, bail release, or probation is being considered for a client with disabilities, a preliminary evaluation of the client's needs and program suitability should be completed by the court outreach worker or case manager. Referral to a facility or community agency for a more detailed assessment may be made by the case manager, not directly through the court. Within both mental health and developmental services sectors, lead clinical agencies which will accept referrals for more intensive assessments should be identified within the *Human Services and Justice Coordinating Committee* assessment plan.

9.4

Assessment should be seen as an on-going process, not merely an event conducted around the time of a key decision. Information generated through assessments at various stages of the criminal justice process should be used to inform decision-makers at subsequent stages. The intensiveness of the assessment should be connected to the seriousness of the crime and the degree of mental disorder or developmental disability. Every attempt should be made to use clinical services with which the offender is currently involved or where the offender has previously been assessed, as these organizations will be most familiar with the person's current mental status and previous history. The use of independent fee-for-service professionals solely for the purposes of court assessments at this juncture is not recommended as a strong connection between the assessment and subsequent treatment, follow-up, and service planning is critical. Offenders who are considered for diversion, bail or community release under probation will often not be charged with serious offences, and knowledge of local services and/or support networks is essential in both conducting the assessment and making arrangements for proper care, support and treatment of the individual in the community.

9.5

In most cases, clinical assessments to determine suitability for diversion, suitability for bail release, or for the purposes of a pre-sentence report should be completed on an out-patient basis. If the proposed examiner requests that the patient be hospitalized, an assessment may be ordered for not more than 72 hours. If an assessment in a psychiatric facility is required, a judge or Justice of the Peace may be required to complete a Form 6 or Form 8 under the *Mental Health Act.*

9.6

Where the assessor is not the recommended service provider, clinicians affiliated with a treating facility or program should be consulted before any recommendation related to the need for inpatient admission or follow-up care is considered. Prior consultation should streamline the intake and admissions process and ensure that program criteria and resource availability have been taken sufficiently into account during this assessment.

9.7

The agreement of the client for an assessment at this juncture is required, as well as specific consent to release the assessment results back to court. Where the client is unwilling, the alternative for the court is to proceed with the formal mechanisms under Part XX.1 of the *Criminal Code*, or to make remand/sentencing decisions without any mediating information concerning the availability of treatment and supports for the client. The defence lawyer and the person's case manager will explain these alternatives to the client.

9.8

Court officials, case managers and representatives of local assessment services should agree beforehand on a set of standard procedures for notice and timely access to services and the content of

reports to the judiciary. Where a detailed assessment is required, the proposed assessor will suggest in advance the length of time an assessment should be in effect and the effective date of the order. The court will ensure the proper documentation is completed to permit the release of the accused for the purposes of the assessment, if necessary.

9.9

Information packages and resource materials should be prepared for mental health professionals who conduct assessments for the courts to assist them in applying the appropriate legal criteria, in preparing a report, and in providing evidence to court. *Human Services and Justice Coordinating Committees* should host training workshops for mental health professionals, crown attorneys and judges involved with court-ordered psychiatric assessments at this juncture.

Evaluation

Performance measurement indicators for this juncture include the development of an integrated justice system database to track the number of assessments for bail or diversion release, or pre-sentence reports requested by the court, the crown, or the defence, and the number of assessments actually conducted. Waiting periods, the length of time to complete the assessment, and the place of assessment should be noted, as well as the method of presentation to the court.

If guidelines or standards for the completion of court-ordered psychiatric assessments are developed, the satisfaction of both the examiner and the referral agency with such guidelines should be measured.

Research should be conducted periodically to compare the psychiatric assessment report with client outcomes, including recidivism data and any barriers to implementing the recommended treatment plan.

10. PART XX.1 OF THE CRIMINAL CODE (MENTAL DISORDER)

Description

The *Criminal Code* contains a separate process for some mentally ill accused. The mental disorder provisions contained in Part XX.1 of the *Code* will begin to overlay the general criminal justice process at the point where the accused's mental status is brought into issue. The provisions include assessment orders, treatment orders, the determination of fitness to stand trial, findings of not criminally responsible (NCR) or dual status offenders, disposition orders, and the composition and function of the Ontario Review Board. These processes can take effect by court referral through the pre-trial, trial and appeal stages.

As a general legal principle, to stand trial, an accused must be aware of and able to participate in the legal proceedings. To be found criminally responsible for a crime, an offender must have the capacity to

appreciate the nature and quality of the act and of knowing that it was wrong at the time the offence was committed.

Coordination Protocols

Organizational Framework

10.0

The Ministry of Health will ensure the provision of specialized forensic assessment and treatment services as well as general mental health programs within specific districts/regions that respond to the needs and level of risk of forensic patients and meet the requirements of the *Criminal Code*. Forensic Coordinating Committees will review the ministry's forensic services plan in light of local needs, demands, and the availability of resources.

Target Group

The target group is people with a mental illness who have committed a crime that is not divertable, with a special focus on individuals who have committed a serious crime and/or who have a serious mental illness. People with developmental handicap are not specifically part of this target group -where such individuals have been caught under Part XX.1 of the *Criminal Code,* they should have access to services within whatever system is best equipped to respond to their needs.

Service Delivery

10.1

Specialized forensic psychiatric services should deal with the assessment, treatment, and clinical management of mentally ill persons who may be accused of, or committed violent, dangerous, or criminal acts. The health forensic system should primarily serve people who require treatment or assessment in secure custody or special conditions of supervision in the community because of their violent, dangerous or criminal propensities. Other forensic patients should be treated and supervised through general mental health services (community mental health agencies and local Schedule 1 psychiatric facilities) who will have access to support, consultation, and in some cases risk assessment information through specialized forensic services. The framework for the provision of mental health services to forensic clients will be contained in district/regional mental health or Ministry of Health plans.

10.2

Routine fitness assessments should be conducted through a court-based assessment service, or a local "Fitness Clinic". Depending on the volume of cases involving forensic clients and the availability of forensic medical personnel, the assessment service may be led by a forensic psychiatrist offering a complete range of forensic assessment, triage and diagnostic services, or in underserviced areas, may be run by a non-physician mental health professional who will triage cases, screen for unfitness, and if necessary refer the accused for a more detailed assessment if he or she appears unfit upon the initial screen. To assist service delivery, the use of innovative technologies and computer-based screening tools are encouraged. The Fitness Clinic may exist as a separate program, or may be tied to a broader forensic service that includes triage, preliminary psychiatric assessments as to diversion, bail suitability, and community release, and specialized case management. Longer term assessments should continue

to be conducted primarily in psychiatric facilities — all accused however should first be triaged before being referred to these facilities.

10.3

The administration of fitness and criminal responsibility assessments should involve tools and methods that identify and account for developmental disability as a contributing factor. In appropriate cases, designated developmental service agencies will work with health forensic services to appropriately conduct assessments where such interventions can more effectively address the developmental needs of the individual. Health forensic services will provide advice, and assist developmental services in applying the appropriate legal criteria.

10.4

The provision of court-ordered psychiatric assessments under Part XX.1 is a major concern of both the Ministries of Health and the Attorney General. Procedural and policy guidelines should be developed to expedite referrals and ensure the efficiency of the process. Procedures should address notice of an assessment order, the timing of the assessment in relation to the trial process, information collection issues, and the expedient return of the patient to court or to custody at the conclusion of an assessment. As part of the order, the court will specify the purpose for the assessment. Any clinical report to the court will clearly indicate the opinion of the examiner with respect to the specific legal criteria considered in the assessment, and will outline the relevant clinical information on which the opinion is based. Where inpatient services are required, the system of regional forensic co-ordinators located in psychiatric hospitals designated under the *Criminal Code* should be utilized to coordinate access to hospital beds. Until health information technology improves, a central patient bed registry is not recommended.

10.5

Ideally, clients who have been found unfit or NCR should enter hospital or community care directly from court. Timely access to psychiatric hospital beds has been a major coordinating difficulty. *Human Services and Justice Coordinating Committees* will establish criteria for priority admissions to psychiatric hospital beds, community mental health programs, and other programs. Criteria should take into account the different catchment areas of different services and the ability of various services to accept clients. Candidates who do not meet the criteria for priority admissions may be placed on a waiting list for services while continuing on remand or judicial interim release status. *Coordinating Committees* will review waiting lists quarterly, and will submit a report to the concerned ministries outlining strategies for more effective resource utilization or increased resources to control waiting periods. It is noted that admission criteria is not intended to be binding on the court - crown attorneys should however bring the criteria and the waiting list situation to the attention of any judge who contemplates making a Form 48 or 49 order that contains a specific timeframe for admission.

10.6

For individuals who remain on the waiting list for psychiatric services/admission, the jurisdiction responsible for his or her custody or care will offer reasonably available treatment and support services. At least some staff within each remand facility will be trained to deal with mentally disordered clients, or mental health services will be contracted out to local agencies. The mental health service to which the individual has been referred should be consulted on the development of an appropriate treatment plan, and may offer additional supports to the person if necessary. A similar process through the developmental sector should apply to an accused with developmental disabilities.

10.7

Human Services and Justice Coordinating Committees should develop strategies that will limit the exposure of people with developmental difficulties to the forensic system. In particular, in view of the nature and consequences of a finding of unfitness, the court should ensure that there has been sufficient opportunity to test the prosecution case prior to invoking these provisions to reduce the likelihood of an innocent person being detained (see section 672.25). This may be particularly important in the case of persons who appear to have severe mental impairment whose condition is unlikely to change and consequently may never be able to benefit from a trial.

10.8

For Unfit or NCR clients with developmental disabilities or dual diagnosis who are already in the system, the ministries of Community and Social Services and Health will jointly develop strategies to ensure that this group receives appropriate treatment and care, building on the respective strengths and expertise of each system. Options include designating developmental programs/settings under regulations to the *Criminal Code*; informing the Ontario Review Board about the availability of specific services for forensic clients with developmental handicap who have been conditionally discharged; and/or for ministries to develop shared programs for this group.

10.9

Where continuing treatment of a forensic client is considered warranted, every attempt should be made during the assessment period to ensure that suitable arrangements for follow-up care have been identified before the person returns to court. Similarly, where a client is found unfit or NCR but is considered appropriate for community access, every attempt should be made to obtain approval for community access at the court stage prior to the person's initial disposition hearing. The goal of these arrangements is to minimize the time clients with disabilities are detained or incarcerated, unless there is a compelling clinical or public safety reason. This will depend on good cooperation and communication between the assessment service, treatment facilities or community programs, the family, the crown, and defence counsel prior to the offender's scheduled court appearance.

10.10

For serious or multi-problem offenders, specialized diagnostic assessments and treatment services are the prerequisites for successful outcomes. For these approaches to be truly effective however, they must be implemented across a carefully constructed service delivery system with a continuum of care that guarantees both a range of residential and inpatient alternatives and a consistency of approach across the treatment continuum. Security placements should be linked to risk prediction. A positive agenda of clinical objectives should first be determined, then questions about settings can be considered.

10.11

To enable forensic clients to receive the least intrusive services closest to their home communities, mental health planners and service providers will ensure that programs (both specialized and general) meet the needs of clients, and that forensic clients are not excluded from programs based on their legal status. *Human Services and Justice Coordinating Committees* will develop a suitable linkage or interface mechanism to ensure an offender has access to both general mental health and other support services within districts or specialized forensic services delivered at the regional level depending on his or her needs.

10.12

Procedural guidelines to streamline and expedite disposition hearings should be developed by a Rules Committee with representatives from the Ontario Review Board, Health, and the Attorney General.

10.13

The ministries of the Attorney General, Health, Community and Social Services, and the Solicitor General and Correctional Services should review the number of clinical assessments ordered by or for the court and should develop an agreement to fund and ensure the provision of court assessment services which includes strategies to rationalize costs, streamline expenditures, identify savings, and reallocate resources, if necessary. A costing formula to track the costs of court assessments should be developed. The current fee structure and retainer arrangements for clinical assessments within health, social services and the justice ministries should be reviewed with a view to rationalizing the payment of similar services. Relevant professional organizations (CPA, CAPL, OPA, OMA) should be consulted about any fee restructuring arrangements.

10.14

Police and hospital administrators should be aware of Policing Services Bulletins and Ministry of Health PPH Operating Guidelines outlining the requirements of notice to police about NCR or Unfit patients within their jurisdiction who have access to the community, as well as the relevant portions of CPIC where this information is contained.

10.15

Ministries should collaborate in recommending to the federal government changes to the *Criminal Code* to enhance service effectiveness and efficiency.

Evaluation

Performance measurement indicators for this juncture include the development of a flagging system to check that psychiatric assessments are ordered and conducted in an effective and efficient manner, according to guidelines and procedures that may be developed. In addition, the hospitals' forensic database will record referral and admission information to evaluate the timeliness of access to forensic beds.

If guidelines or standards for the completion of court-ordered psychiatric assessments are developed, the satisfaction of both the examiner and the referral agency with such guidelines should be measured.

Research should be conducted periodically to compare the psychiatric assessment report with client outcomes, including recidivism data and any barriers to implementing the recommended treatment plan.

Waiting list data will be analyzed to measure the impact over time of enhanced coordination in reducing waiting periods.

Follow-up research on the clinical and security needs of forensic patients in the mental health and developmental system should be conducted periodically, with specific reference to where the client is being served compared to level of risk.

Program evaluation measurements for forensic programs should be developed. Evaluation criteria should include consideration of the type of program, program and client outcomes including recidivism rates and quality of life indicators, and client characteristics including level of risk. Forensic programs offered in different parts of the province should be compared for consistency and effectiveness.

A methodology to measure the intensity and level of care an offender requires should be developed to ensure the most efficient use of resources at the recommended level of service.

11. TRIAL

Description

At this juncture, the accused is presumably fit to stand trial, and a trial on the merits of the case is held. The crown will present the indictment and call evidence establishing the facts of the case and the nature of the charge. The defence will either challenge the facts or present evidence of a defence to the charges. The court (either a judge or a judge and jury in accordance with the provisions of the *Criminal Code*) will ultimately determine the issue of responsibility by making a finding of not guilty, guilty, or not criminally responsible on account of mental disorder.

Coordination Protocols

Organizational Framework

11.0

Responsibility for the trial stage is a function of the judiciary. Primary coordination issues at trial include the provision of psychiatric evidence to the court, and arrangements to provide continuity of care following the court's decision. This process will be enhanced through the development of a court-based case management process.

Target Group

The target group is people with a mental illness or developmental disability who have committed a crime that is not divertable, with a special focus on serious crime.

Service Delivery

11.1

Unless absolutely necessary, the court should avoid having physicians, health professionals or other support workers testify in person to protect limited clinical resources. Evidence will be submitted in advance through an expert's report. Where a mental health professional is required to testify, court officials should notify the individual well in advance of the trial date, and special scheduling arrangements should be considered wherever possible to ensure the least disruption of clinical caseloads.

11.2

Training materials and information workshops should be provided to staff working with mentally disordered and/or developmentally disabled clients. Topics should include the disclosure of client information at trial as well as common evidentiary and procedural rules. Materials should consider mental health professionals who fall under the purview of the *Regulated Health Professions Act* and/or the *Mental Health Act,* as well as other clinicians, case managers and support workers in the community.

11.3

Where an individual is released at trial because charges are withdrawn or the person is found not guilty, the appropriate court official will ensure that the person's case manager or hospital, mental health or developmental service involved in the person's care is informed about the court's decision to facilitate appropriate treatment follow-up.

Evaluation

Performance measurement indicators for this juncture include the development of an integrated justice system database to record the number of occurrences where psychiatric evidence is introduced to the court through the crown, defence, or at the motion of the court, the issue for which psychiatric evidence was required, and the trial outcome.

12. PRE-SENTENCE REPORT

Description

Where an offender is convicted of an offence, a pre-sentence report may be prepared to assist the court in considering whether a non-penal disposal may be appropriately imposed. The pre-sentence report should set out the full range of suitable sentencing options, and give details of the type of supervision which could be provided in the community.

If the offender has been found not criminally responsible, the process under Part XX.1 of the *Criminal Code* will be followed. The court may request a psychiatric assessment to determine the most appropriate disposition which will serve the same function as a pre-sentence report (see **Juncture 10**).

Coordination Protocols

Organizational Framework

12.0

Overall development of a pre-sentence report is the responsibility of an assigned probation officer. For forensic clients, a community service plan should be developed prior to any recommendations about community release going forward to the court. To ensure continuity of care and assessment, the individual's case manager will assess the person's needs, investigate the availability of community supports, and assist the probation officer in coordinating the preparation of the pre-sentence report.

Target Group

The target group is people with a mental illness or developmental disability who have committed a crime that is not divertable.

Service Delivery

12.1

There must be good liaison between the offender, the probation officer, the author of the assessment report, the offender's lawyer, case manager and support workers about an appropriate recommendation to the court. Reports should reflect a collaborative approach.

12.2

If a probation order is being considered for an offender who is mentally ill or developmentally disabled, an assessment can be requested to assist the court in determining the person's suitability for community release and any appropriate conditions of supervision with respect to the person's mental condition (see **Juncture 9**). In cases where the index offence is less serious and community release is a realistic prospect, local mental health and/or developmental services, not specialized forensic assessment services, should be utilized to complete the assessment and provide recommendations as to a community service plan. In cases where the offender's index offence or criminal history is more serious, a forensic assessment may be requested. The probation officer will provide the assessor with complete background information about the person as well as the circumstances of the index offence.

12.3

The probation officer preparing the pre-sentence report must be satisfied that the community service plan is feasible and realistic based on the offender's history, and that recommendations have been developed in cooperation with service providers who may be responsible for the offender's treatment and supervision or involved with providing him or her with supports in the community.

12.4

In addition to treatment, recommendations about supervision as well as opportunities to reconcile with or reimburse victims (with the victim's consent) should be explored.

12.5

To avoid duplication of efforts, previous pre-sentence reports should be reviewed and updated wherever applicable.

12.6

Where an offender has a prior criminal record, a copy of any previous pre-sentence report should be forwarded to a receiving institution or service provider after sentencing, even if the report has not been updated to include the new charges.

Evaluation

Agency, client and family satisfaction surveys should be conducted periodically. For example, courts should be asked whether they are satisfied with the quality and usefulness of the report, community programs should be asked whether they were involved with the process and are satisfied with the information received, and probation officers should be asked whether they had access to sufficient information to complete their responsibilities.

Outcome measures should be developed as well as mechanisms to track and monitor the client after release.

13. SENTENCE

Description

On a guilty finding, the next stage is sentencing. Sentences are based on the requirements of the *Criminal Code* (i.e. minimum and maximum sentences) and aggravating and mitigating factors. A wide variety of sentences can be handed down, including: absolute or conditional discharge; suspended sentence; fine, compensation to victim, or forfeiture of proceeds; probation order; or imprisonment for consecutive or concurrent sentences (determinate, intermittent, or indeterminate life). Custodial sentences of two years or more are served in federal penitentiaries. All other sentences are served under provincial jurisdiction. Bill C-41, recently passed by the federal government, amends the major sentencing provisions of the *Criminal Code* to clarify the purpose and principles of sentencing, as well as permit new or expanded sentencing options.

If the offender has been found not criminally responsible, the process under Part XX.1 of the *Criminal Code* will be followed to determine the appropriate disposition (see **Juncture 10**).

Coordination Protocols

Organizational Framework

13.0

Determining an appropriate sentence is a function of the judiciary. The primary coordination issue at the sentencing stage relates to information flow — ensuring that relevant information about an offender's history and psychiatric condition is provided to the court, and once sentenced, this same information is provided to the agencies that will be responsible for the offender's custody and/or management. This process will be enhanced through the development of a court-based case management process.

Target Group

The target group is people with a mental illness or developmental disability who have committed a crime that is not divertable.

Service Delivery

13.1

After sentencing, the appropriate court official will ensure that critical key documents (i.e. pre-sentence report, crown brief, CPIC report, reasons for sentencing or disposition, medical reports if any) are provided to service providers who are involved with the custody, supervision, assessment, support or treatment of the offender as a result of the sentence or disposition. At the same time, service providers have the responsibility to request material information regarding the client's history, and the courts should respond to such requests. Wherever possible, the sharing and reproducing of documentation should be expedited through the use of innovative technologies.

13.2

Facilities responsible for the care and management of forensic clients should conduct periodic audits to ensure that sentencing information about an offender is filed so as to be accessible to health care and program staff.

Evaluation

The satisfaction of victims with the sentence imposed by the court should be evaluated. Similarly, agency satisfaction surveys should be conducted periodically to measure the satisfaction of service agencies and case managers with the quality and timeliness of the information they receive relating to an offender's sentence. This should be supplemented by an evaluation of the outcomes of different types of sentences.

Comparative research should be undertaken with respect to whether offenders who are identified as mentally ill receive similar or dissimilar sentences to non-disordered offenders relative to offence severity. Such research might additionally review the kinds of conditions the court imposes when sentencing a mentally ill person and whether these contribute to successful client outcomes (i.e. whether conditions were fulfilled, if not, what were the barriers etc.), as well as basic recidivism data.

14. CUSTODY

Description

The custody of convicted offenders is the responsibility of the Ministry of the Solicitor General and Correctional Services (for carceral sentences under two years) or the Correctional Service of Canada (for carceral sentences of two years or more). For offenders who receive probation but not a sentence of imprisonment, see **Juncture 15** — Community Supervision.

Coordination Protocols

Organizational Framework

14.0

Despite diversion strategies and non-incarceration options, it is inevitable that some forensic clients will be sentenced to a period of incarceration. Responsibility for the custody and basic care of the offender will lie with the correctional system. Mental health and developmental service systems may assist in the provision of necessary treatment services by offering additional supports to the client in the correctional facility or facilitating his or her transfer to a treatment facility.

Target Group

The target group is people with a mental illness (the priority being serious mental illness) or developmental disability who have committed a crime with a special focus on the individuals who commit serious crimes.

Service Delivery

14.1

All inmates will be screened for mental disorder and/or developmental handicaps upon being admitted to a correctional facility. Correctional facilities will have trained staff in order to provide basic psychiatric services to meet the needs of prisoners. Facilities will review their programs and clinical services to ensure that, at a minimum, appropriate general treatment and case management services for mentally ill or developmentally disabled individuals in custody are available in these settings as well as suitable processes to assist in the transition of the resources used for that offender upon release to the community. This involves assessment, primary treatment, treatment coordination with outside resources, and discharge planning which are all components of a case management process. It is noted that a correctional treatment unit may be better able to meet the security and risk concerns posed by some offenders as well as address their criminogenic needs.

14.2

The vulnerability of some client groups or individuals is a generic issue that requires careful deliberation during the LSI/OR classification process. The safety and protection of vulnerable inmates should be fully analyzed before assignment within the correctional facility is completed. Notwithstanding the above, correctional policies should promote a reasonable 'migration' of services and supports into the facility in designated treatment areas for the inmate that might not otherwise be available within the facility, where the client has requested same.

14.3

While under sentence, long term planning will begin to address both the offender's and the community's needs upon the offender's anticipated release from custody. Where warranted, treatment should be initiated as soon as possible. This may involve creating linkages with other jurisdictions through both the case management and the release planning stage.

14.4

The person's case manager should continue to monitor the client throughout the custody phase in cooperation with the custodial facility.

14.5

Where an inmate requires more intensive psychiatric services than a correctional facility can reasonably provide, the expedient transfer of the mentally ill person to a mental health facility will be arranged under the temporary medical absence program. The institutional treatment agreement and guidelines concerning transfer of prisoners to psychiatric facilities noted at **Juncture 8** should apply to both sentenced and remand prisoners. Where an inmate requires specialized developmental services over and above those provided within the correctional facility, arrangements will be made between the facility and the individual's developmental services case manager to have such services made available to the inmate if he/she requests same.

14.6

For federal prisoners, before any transfer to a provincial mental health facility is approved, a funding contract will be negotiated between the Correctional Service of Canada and the proposed receiving facility.

Evaluation

Performance measurement indicators for this juncture include the development of basic database systems to compare the number of referrals for psychiatric hospitalization compared to the number of inmates transferred, and the length of time waiting.

Evaluation criteria relating to the development of an agreement between ministries about treatment services available in both health and correctional facilities may apply, as well as consistent program evaluation criteria. Outcome measures for clients should be developed and monitored. The effects of both hospital and correctional treatment programs on forensic clients should be evaluated, as well as the theoretical premises upon which such programs are based.

Agency and client satisfaction surveys should be conducted periodically, with specific reference to the quality of programming within corrections, and cooperation between mental health and correctional facilities.

15. COMMUNITY SUPERVISION

Description

Offenders receiving community supervision sentences at trial will be supervised by provincial probation officers, and may receive treatment and support through provincial health and social service systems. The case management, risk assessment and release planning processes described at **Junctures 16, 17, 18** will still apply; however, these stages will be necessarily circumscribed and must occur during the pre-sentencing phase, often based on information contained in the pre-sentence report.

A probation order or conditional sentence may contain conditions of attendance or participation at various community treatment or support services if such services will reduce the likelihood of the offender coming into further difficulties with the law. It cannot however require the offender to accept treatment. In some circumstances, an offender can receive involuntary psychiatric services as a result of a power of attorney, guardianship plan or certification under the *Mental Health Act*.

Coordination Protocols

Organizational Framework

15.0

Supervision and case coordination of offenders serving probation orders will be provided by the Ministry of the Solicitor General and Correctional Services, Probation and Parole offices. The person's case manager will assist the probation officer in arranging for and following up with needed community-based mental health and other services and supports for the offender. The probation officer and case manager should work together as a team.

Target Group

The target group is people with a mental illness (with a priority being serious mental illness) or developmental disability who have committed a minor or less serious crime.

Service Delivery

15.1

The provision of community services will depend on the offender's needs and willingness to receive services. Many forensic clients do not voluntarily seek services and supports, and may be noncompliant when assistance is offered. It is understood that such offenders may be most motivated to participate in programs when this will enhance their likelihood of community release. To this end, the offender's involvement in the development of a realistic community release plan is critical, and should be negotiated prior to a decision being made by the releasing authority.

15.2

The effectiveness of probation orders with conditions requiring the offender to attend at necessary community support services depends on close cooperation, understanding and communication between the probation service and local health and developmental services and other social services. Mental health involvement in the offender's treatment and community supervision, as well as in the development of appropriate conditions of release to be specified in the probation order, should be negotiated well before the sentence is determined — this will occur at **Juncture 12** Pre-Sentence Report. The same holds true for the involvement of local developmental services providers with respect to the provision of supports available within this system. Although a specific service plan will have been developed, the probation order should specify general program and treatment conditions without naming the particular agency which is to provide services to the offender. The client may not be willing to continue to receive services from a particular service provider, or the agency may not provide services for the entire period of time specified in the order.

15.3

Information sharing procedures will be negotiated before sentence as well, and any necessary written consents obtained to permit the sharing of information between health care professionals, case managers, and the probation officer. Community programs will not force services on unwilling clients.

The offender's consent to release information must therefore outline expectations related to his or her failure to comply with the conditions of the order (i.e. a report will be made to the appropriate authority who will then determine what action should be taken.) Exchange of information and breach of condition issues must be addressed prior to offering services to the individual.

15.4

Information about treatment facilities and other supports and services (i.e. accommodation, treatment, education, supervision, crisis response etc.) appropriate and accessible to forensic clients should be available to local probation offices, and there should be a shared list of contact points with telephone numbers for each agency. This list should reside with and be maintained by the *Human Services and Justice Coordinating Committee* or its designate.

15.5

While a few specialized services are available to offenders under a sentence or disposition, an emphasis will be placed on locating generic or continuing supports in anticipation of the offender's eventual release from sentence. In many cases, staff will take on a brokerage role to find community resources and match offenders to them. Where resources do not exist, the correctional agency may contract for them during the period the offender is under correctional jurisdiction.

15.6

Where need has been determined and resources permit, a team of professional staff could be responsible for ensuring that forensic clients in particular areas are properly assessed and receive (mostly through general mental health and/or developmental and other social services) the continuing care they need. This may be tied into the case management function for forensic clients.

15.7

Appropriate community services must be available to individuals subject to probation orders. Local mental health, developmental services and other social services will ensure that such clients have access to appropriate services to meet identified mental health and/or developmental needs. With respect to the mental health service component, district and regional mental health services will be identified in DHC mental health plans. Within the developmental services sector, MCSS Area Office staff will provide relevant planning information to the *Human Services and Justice Coordinating Committee* and will facilitate service coordination activities. Presently, service planning and service coordination is carried out by local planning groups, advisory committees, and hard-to-serve committees. Any restructuring of social services that takes place will need to integrate the links between such bodies and the *Human Services and Justice Coordinating Committees*.

15.8

Needs assessments completed periodically by the Ministry of the Solicitor General and Correctional Services concerning the number of probation clients in need of mental health and/or developmental services, and what services they need, should be considered by District Health Councils or Mental Health Authorities and local developmental services planning groups in designing mental health or developmental services plans.

15.9

Probation offices and local case management agencies in conjunction with *Coordinating Committees* may enter into a formal service arrangement or memorandum of understanding defining lines of responsibility and accountability and clarifying boundaries between the responsible health representatives and the probation officer. Probation officers, correctional program staff, case managers

and others who support common forensic clients should receive shared training programs/materials and information-sharing and accountability guidelines.

Evaluation

Local mental health or developmental services plans should be reviewed to ensure that the needs of this group of clients as well as mechanisms to ensure equitable access are considered.

Agency, family, and client satisfaction surveys should be conducted periodically. As well, client quality of life indicators should be developed.

Sampling research techniques could be used to track specific cases of mentally ill and/or developmentally disabled offenders under community supervision orders to investigate client outcomes, including rates of criminal recidivism or institutionalization. The definition of recidivism should be carefully considered to avoid some of the methodological concerns of previous correctional recidivism studies.

Data regarding the costs of providing community supervision to mentally ill and/or developmentally disabled offenders should be collected.

16. CASE MANAGEMENT

Description

Case management is a general function within the mental health, developmental services and correctional systems. It is not a single clinical entity and may best be conceived not as an intervention but as a means to deliver interventions — it broadly encompasses all the interventions taken while the offender is within a particular jurisdiction, whether in a hospital or prison or in the community. Some of the functions of case management include: outreach and client identification; comprehensive individualized assessment and planning; direct service provision; service coordination and support; information gathering and sharing; interaction with the offender, observation and intervention, and preparation of progress reports; monitoring and evaluation; systemic advocacy and coordination; as well the development of recommendations for placement, transfer, future release, conditions of detention, treatment and/or supervision, programs, activities, their timing and location etc.

The term case management may be understood differently, depending on its context. In the mental health and developmental services systems, case management is understood as a means to ensure that the person's needs and goals as determined by the client are addressed in a coordinated, responsive and relevant manner. The case manager is responsible to seek out, involve, coordinate and monitor resources and supports as needed. The case manager does not necessarily perform all the functions but ensures that functions are performed as needed, often through a number of different service-providers. The case manager is accountable to the client. The role of the health case manager is outlined in the Ministry of Health's service and systems guidelines for case management. The role of case management within the developmental services sector is also described in guidelines and specific policy work is underway regarding case management and service coordination functions.

Case management is a function performed within the correctional system as well, most notably by probation officers. The primary difference is that the centre of accountability is the public interest, not client-determined needs. Correctional case managers will primarily play a monitoring and service coordination role. A trusting relationship with the client will be encouraged, but is not crucial to this function.

Additionally, there may be multidisciplinary case management teams in psychiatric, correctional, or developmental services institutions. A case manager or case co-ordinator will play a primary role in service coordination; this service however is not attached to the client, and operates primarily to further the goals of the institution.

Case management can also apply within the Ontario court system. In this context, it is seen as a system in which the movement of a case from commencement to disposition is supervised by the court and governed by specific timeframes. Emphasis is placed on early settlement discussions, availability of options for appropriate disposition, meaningful court appearances and consistent supervision. Another approach to case management within the criminal justice system focuses on the need to share offence and offender information as well as access to the proper members of the justice community.

Although it is confusing to use the same term for each of these purposes, the language of case management is widely used and understood within each of these different systems and this document reflects that reality. Case management within a particular system should be consistent with that system's overall goals and objectives.

Coordination Protocols

Organizational Framework

16.0

Shared case management models should be promoted wherever possible. While specific responsibility for an offenders' case management remains with the system that has legal jurisdiction over the offender, case managers from other systems will assist in providing appropriate service linkages and promoting a stable and healthy lifestyle for the offender in the community. Accountability for overall service coordination shall reside with the *Human Services and Justice Coordinating Committee*, as a means of preventing clients from "falling through the cracks". *Human Services and Justice Coordinating Committees* will review local needs, demands and the availability of resources to develop a case management plan for forensic clients within specific districts/regions.

Target Group

The target group is people with a mental illness (with a priority being serious mental illness) or developmental disability, who have committed a crime.

Service Delivery

16.1

The *Human Services and Justice Coordinating Committee* case management plan should address the continuum of care (including brokerage functions and follow-up support) from pre-charge to post-sentencing stages; identify case managers or lead agencies as well as referral sources; and develop strategies to educate and sensitize key stakeholders within the justice system and the community as to

the availability and means of overall coordination of case management services, as well as the goals and outcomes expected of these services. The overall goal of the case management plan should be to promote the 'seamless' delivery of services at least in part through the integration of case management services within different jurisdictions. Such a plan should therefore propose one or more methods of examining, from the individual's perspective, the complete inventory of services to be received, and how multi-system case management services will each contribute to 'seamless' service while avoiding duplication and/or delays.

16.2

In many communities, a full range of case management services will not be available immediately. The case management plan may initially address one or two key components as a priority (i.e. post charge/pre-trial court outreach services), with the intention of adding additional components as local services are reorganized to take on the target group, or additional funding through reallocation becomes available. The emphasis will be on avoiding additional costs through the realignment and reallocation of existing services.

16.3

Ultimately, case management assists the individual to live a full life in the community. This implies recognition of the role of the family, informal networks of friends or neighbours, self-help groups, generic developmental services and other social services, religious organizations, and interest-based groups in achieving quality of life. Where appropriate, these groups should have the opportunity to have meaningful involvement in the offender's care and treatment.

16.4

As with any other human services client, case managers or community workers involved with forensic clients will try to ensure that clients receive all benefits to which they are entitled, that they have access to any appropriate health or social service in accordance with their assessed needs, and that they know about other local community facilities or programs which may be relevant.

16.5

Local arrangements between police, health, developmental services and other social services, and correctional services should be developed to appropriately manage and provide care to individuals who appear mentally disordered and/or developmentally disabled both pre-trial and after sentencing. In particular, case managers who are independent from the court but available within that setting should act as a liaison between mental health services, community developmental services and other social services, and the justice system to engage, support, advocate for and link those people who are in need with appropriate services.

16.6

Case management services will range from the least to highly intensive services which include proactive outreach, relatively small caseloads, frequent contact, and 24 hour access. The level of intensity will be determined by the level of risk, expressed need, and/or the availability of other services. Case management services may take several different forms, depending on the number of individuals requiring service, the availability of local resources, and the cross-over of clients between different service systems.

16.7

Each system will establish (or where these exist already, clearly identify) case management services to work with forensic clients under their respective jurisdictions (see overall goals and objectives of the

different systems above). In terms of linkages between systems, every forensic client should be referred to a case manager from the health care or developmental services system as outlined at **Junctures 5 and 7**. Specialized case managers who work only with forensic clients may be considered in larger urban centres; in other areas of the province, case managers should be trained to work with both forensic and nonforensic populations.

16.8

In some areas, health, developmental and correctional services may decide to operate a case management program as a joint venture. For example, interministerial teams comprised of mental health workers, developmental services support workers and specialized probation officers could share a caseload of forensic clients to coordinate all aspects of the person's care and supervision.

16.9

Forensic case managers may assist in supplementing general community services and supports in dealing with forensic clients. Many service providers in both the health and developmental services and other social services sectors have the knowledge and skills required to work with forensic clients. What is required in many situations is confirmation of their skills; an opportunity to understand how the mental health, social service, and criminality issues interact; and access to back up supports during periods of transition, change or crisis.

16.10

It is acknowledged that in every system, participation in treatment is voluntary. Differentiation must be made between those who have undertaken treatment programs and benefited from them and those who have not. The benefit of the program or treatment must be seen in light of the cause of the criminal behaviour. For example, symptoms of a mental illness may be treated or developmental needs may be addressed but the criminal behaviour may not be based directly on the mental disorder or developmental disability. In this light, broadly constituted case management teams are required to ensure that both treatment and community safety goals are dealt with through a variety of approaches.

16.11

Before release to the community, correctional case managers (institutional and community) should work with community case managers to develop discharge plans addressing criminogenic, mental health and developmental needs (see **Juncture 17 and 18**). The client, the case manager, and representatives from the criminal justice system should meet to discuss their various expectations and roles with respect to particular clients.

16.12

It may be desirable to increase the number of partners who contribute to the case management of particular offenders in the community, based on the individual needs of that offender. For example, there may be a need to involve officials representing housing, education, employment, mental health, parole, treatment programs etc. At the community level, *Human Services and Justice Coordinating Committees* may serve in an advisory or brokerage role for difficult to serve cases. Committees should identify community resources, break down barriers to access, provide advice to case managers as well as recommend some process for managing particularly difficult cases if the legal jurisdiction is unclear (e.g. an offender at warrant expiry).

Evaluation

Multi-agency assessments of need for community services for forensic clients and the development of indicators to measure quality and effectiveness of services are desirable.

Each case management program should undergo some program evaluation process. The evaluation will consider the effectiveness of local arrangements in meeting the needs of the mentally ill according to specific outcome criteria. Pilot projects should be considered to demonstrate the effectiveness of the program model before permanent funding is secured.

Evaluation of any joint case management approach, e.g. joint management, case conferences, special hard-to-serve teams or other methods, should be identified in the *Human Services and Justice Coordinating Committee's* case management plan to identify the success of an overall coordinated approach.

Agency, family, and client satisfaction surveys should be conducted periodically. As well, client quality of life indicators should be developed.

17. RISK ASSESSMENT

Description

At various points throughout the sentence, the risk the offender presents is assessed. Risk assessment takes place throughout the case management process but is considered here separately because of its importance for decision-making and release planning.

The assessment of risk is a multifaceted, multi-dimensional, multi-professional exercise. The tools for assessing risk (actuarial, clinical or a combination of both) may differ, but decisions with respect to risk are made in both the mental health and correctional systems. Risk can refer to the probability of future reoffending; the probability of violence; and also to the severity of harm likely to result. In terms of public safety, the risk of serious violent offences (that is, the likelihood of offences causing injury to another person) is considered the paramount concern. Service providers must manage risk so that the community and staff are protected from undue or avoidable risks. Risk can never be entirely eliminated, but reasonable precautions will be instituted. Risk management strategies adopted by service providers should not rely on a policy of service refusal to individuals who have encountered the criminal justice system.

Coordination Protocols

Organizational Framework

17.0

Sponsoring ministries should jointly consider establishing a centre of excellence for risk assessment to conduct research, disseminate information, develop core principles, and where appropriate provide clinical care. This will not limit the ability of individual ministries to conduct their own research, or to continue to develop the use of their own risk assessment instruments.

Target Group

The target group is people with a mental illness (with a priority being serious mental illness) or developmental disability who have committed a crime.

Service Delivery

17.1

It is acknowledged that mental health, correctional services and to a more limited degree, developmental services are in the business of risk assessment. Information, knowledge and tools with respect to risk assessment may be pooled and shared with service-providers in the various service systems through local or regional *Coordinating Committees*. Individual ministry protocols or guidelines should be reviewed by other partners.

17.2

Risk of recidivism should be appraised with actuarial devices and the intensity of service should be proportional to actuarially-appraised risk. Clinical assessment should be individualized, focusing on psychosocial problems and symptoms (rather than diagnosis per se) and concentrate on criminogenic needs (i.e. changeable or potentially changeable personal characteristics empirically related to outcomes, especially recidivism). Current symptoms and problems, as well as identified criminogenic needs should become treatment targets, and for each, an explicit plan should specify how change is to be accomplished and measured.

17.3

Often risk assessment is enhanced through the involvement of people from different professional backgrounds who are skilled and trained in the use of both actuarial and clinical measures. Where actuarial methods are used, staff should be trained in the standardized administration, scoring and interpretation of such instruments. Where risk assessment techniques are not available in a particular setting, staff should be able to refer clients or have access as necessary to risk assessment information from other centres.

17.4

The validity of risk assessment techniques depends on the accuracy of information — self reported information alone (about history, current relationships, circumstances of the offence, etc.) is insufficient. Information that is relevant in the assessment of future dangerousness includes the person's diagnosis, criminal history, psychiatric history, psychosocial history, clinical problem areas, and the circumstances of the index offence. Past persistent violent behaviour is considered to be one of the strongest predictors of future violence. Information about the offender relevant to these areas should be shared with the appropriate service-provider at pre-trial and sentencing stages and specifically considered by decision-makers, within the limits of existing confidentiality legislation. Sharing of relevant information will be facilitated through case management processes, and information sharing guidelines. Given their role in presenting information to court, crown attorneys should be included as partners in research on risk assessment.

17.5

Risk assessment must be linked to treatment planning, and should begin at the earliest opportunity. Overall assessment, treatment and release planning should be addressed through more effective, multi-disciplinary approaches to determine clinical needs and level of risk. The feasibility of using a broader range of professionals in addition to physicians in conducting assessments for the court or within the community should be examined. For example, case workers working with physicians could perform the

initial screening assessment as well as collect information with respect to the person's history and behaviour to facilitate a comprehensive assessment and timely completion. This same history should be used to inform all subsequent assessments.

17.6

Where the possibility of violence is considered sufficiently high, the public safety concern will to a limited extent override confidentiality protections, and risk assessment information should be shared with the police or potential victims under "duty to warn" precedents. Where the *Human Services and Justice Coordinating Committee* determines that focused awareness and training sessions regarding "duty to warn" are warranted, this should be addressed in its intra and inter-sectoral training plan.

Evaluation

If a centre of excellence is established, the evaluation of current risk assessment approaches should be a function of that institute. In particular, methods to improve risk assessment should be sought. The need for specialized tools to evaluate different types of offenders (sex offenders, psychotic offenders, spouse batterers, etc.) should be considered

18. RELEASE PLANNING

Description

At some point, an offender's release to the community will be considered. This may happen as a result of a specific court order, at statutorily determined intervals (i.e. parole eligibility dates), as a result of the successful treatment and management of the offender while in custody, or warrant expiry. Arising from the case management and risk assessment processes, some decisions will be made about how well the offender is expected to function in the community as well as the supervision, treatment or other supports required to manage the risk safely. Conditions may include residency requirements, reporting, abstention from drugs or alcohol, urinalysis, etc. It could also include issues relating to medication, though use of the medications is voluntary. The process of risk assessment and risk management is dynamic and conditions must be flexible to meet the needs of the offender that change over time.

For forensic clients found unfit to stand trial or not criminally responsible of an offence on account of mental disorder, release planning will occur through the Ontario Review Board process, and will be based on criteria contained in Part XX.1 of the *Criminal Code*.

Coordination Protocols

Organizational Framework

18.0

Responsibility for an offender's safe custody and release remains with the agency that has jurisdiction over the offender. Other systems will offer assistance and support as necessary - for example, jail

outreach and assistance with release planning should be an expectation of human service community support teams and/or case managers.

Target Group

The target group is people with a mental illness (with a priority being serious mental illness) or developmental disability who have committed a serious crime.

Service Delivery

18.1

Safe release from custody at the earliest opportunity will depend on the success of planning efforts beforehand which, especially when supported residential placements are involved, may take several months. Prior to discharge from institutional care, **every** person with a mental disorder or developmental disability should be offered community supports and key services necessary to maintain their health, provide a decent quality of life in the community, and prevent psychiatric relapse. In instances when the possibility of placement breakdown or crisis is not remote, service providers, family members and other supports are encouraged to develop contingency plans that can be activated quickly in order to prevent a crisis.

18.2

A community service plan should be developed prior to any consideration of community release. Housing, employment, and other determinants of health should be considered in the development of a release plan. Conditions necessary to provide for the appropriate supervision of the individual must likewise be included in a community service plan and must take into account situations where the offender does not wish to receive treatment, or is likely to discontinue treatment after release (for example, an emphasis on assertive monitoring and surveillance conditions to balance lack of progress through treatment may be appropriate in some cases). To ensure continuity of care and assessment, the individual's case manager will assess the person's needs, investigate the availability of community supports, and assist the releasing agency in coordinating all aspects of the offender's release.

18.3

Conditional release under sentence should always be recommended if possible for offenders with mental disorder or developmental disability who are suitable to be reintegrated into the community. For offenders who have been institutionalized for extended periods of time or who are considered a medium or medium-high risk, the offender should have first completed a carefully monitored and controlled community access program under conditions of gradually relaxed supervision, through the temporary medical absence or day parole programs or under conditions of the Ontario Review Board prior to community residence being recommended.

18.4

Supervision and treatment strategies aimed at preventing the offender from committing further crimes as well as maintaining stable mental health will be developed through the release planning stage. Approaches should be based on risk assessment and management with a view to holding risk at the most manageable level, thereby protecting the public. Strategies include relapse prevention programs for offenders who have completed the necessary preparatory work during treatment, vocational programs or education, counselling or other supports, monitoring, medication, residency requirements, and intervention if conditions are breached.

18.5

Every attempt should be made to link clients in need of service to appropriate generic community supports. The mental health system will provide services focused on the needs of the client who may or may not be an offender with a view to treating the anti-social behaviour while rehabilitating the person in the broader sense. Other supports may be available through community corrections programs, developmental services or generic social programs. Although a few specialized services will be available only to offenders under sentence, basic services and supports should extend beyond warrant expiry date.

18.6

An integrated approach to treatment, supervision and informed information-sharing is essential for an offender's successful conditional release. Service providers will adopt a cooperative, collaborative approach in dealing with forensic clients that builds upon their knowledge within their respective professional areas.

18.7

The recommended community release plan will include consultation with and input from the offender and his/her family, where appropriate. Any community release plan that depends on services to be provided by service-providers in health, corrections or social service systems must be developed cooperatively between agencies prior to any recommendation being put forward to the releasing tribunal. The community release plan will specify the roles and responsibilities of service-providers, clients, families and other people who are expected to deal with the offender during this phase. It should include the client's expectations, needs, and support mechanisms, as well as address the concerns of the family, victims and the community to the greatest extent possible. The plan will be updated at intervals to reflect progress toward an improved quality of life, reintegration into society, and movement toward personal responsibility and self-sufficiency. With level of risk in mind, the least intrusive, evidence-based release option for the client should be considered.

18.8

Similarly to **Juncture 2**, clients will be encouraged to sign a service agreement with community programs agreeing to provide support. The service agreement should outline the type and extent of services to be provided; information that may be exchanged with other service-providers, the police or other officials; situations in which services may be terminated; and the nature of relationships between the client, community agency staff, and representatives of the courts and/or correctional system. If necessary, the client's written consent to disclose information will be obtained and signed at this point as well.

18.9

Tribunals tasked with responsibility for making release decisions (i.e. Parole Boards, the Ontario Review Board) should be engaged in ongoing discussions/education about release planning issues.

Evaluation

Agency, client and family satisfaction surveys should be conducted periodically. Outcome measures for clients should be developed and monitored.

19. CONDITIONAL RELEASE

Description

Conditional release includes any release that requires supervision of the offender in the community under conditions. Within corrections, this includes offenders subject to escorted and unescorted temporary absences, work release, day parole, full parole, and statutory release orders. Within mental health, it includes clients under the jurisdiction of the Ontario Review Board with conditional discharge orders, or custodial disposition orders with conditions of community access.

Those responsible for release planning will have made efforts to link offenders to appropriate and relevant services in the community. Thus, the existence of and timely access to programs is of critical concern. Recognizing that risk assessment and management must be dynamic, ongoing monitoring and mechanisms to modify conditions are important aspects. It is also important that there are clearly identified interventions which can be taken by the supervising authority to deal with any increase in risk.

Coordination Protocols

Organizational Framework

19.0

Overall responsibility for an offender's conditional release remains with the agency that has jurisdiction over the offender. Service agencies from other systems will cooperate to the greatest extent possible in providing appropriate programming to promote a stable and healthy lifestyle in the community. The period under probation, parole or Ontario Review Board supervision will be viewed by mental health services and correctional workers as part of graduated community reintegration process.

Target Group

The target group is people with a mental illness (with a priority being serious mental illness) or developmental disability who have committed a serious crime.

Service Delivery

19.1

Coordination protocols under **Juncture 15** Community Supervision will also apply at this stage.

19.2

In conjunction with any service agreement between an offender under conditional release and a community agency, a protocol should be developed between the releasing authority and the service provider indicating the conditions or situations under which authorities will be informed that the service provider is experiencing problems with the client.

Evaluation

Similar to the group of clients under probation, mental health and developmental services planning at the local level should be reviewed to ensure that the needs of the target group of clients are considered in the development of suitable programs.

Agency, family, and client satisfaction surveys should be conducted periodically. As well, client quality of life indicators should be developed.

The concomitants of criminal and violent recidivism should be studied in terms of dynamic personal, social and environmental characteristics that may prospectively predict recidivism. Sampling research techniques could be used to track specific cases of disabled offenders under conditional release orders to investigate client outcomes, including rates of criminal recidivism or institutionalization.

Any human service or correctional program that has as one its goals a reduction in criminal recidivism should achieve at least a passing score on an objective program evaluation tool such as the Correctional Program Assessment Inventory.

Data regarding the costs of providing community supervision to common forensic clients should be collected.

20. UNCONDITIONALRELEASE

Description

The offender is no longer under the jurisdiction of the criminal justice system and formal coordination, monitoring and supervision no longer takes place. With the offender again in the community, the community network noted at Juncture 1 comes into play. The diversity of services and structures creates a significant potential for lack of integration among them. Nevertheless, generic and specialized community services provide the social safety net which is depended on to provide for the needs of those in the community who must be supported, helped, maintained, treated, programmed, supervised, or simply watched.

If the release planning and conditional release phases have been completed successfully, the offender may be much more aware of his or her needs and problems and where to go for support. Some services may be continued voluntarily.

Coordination Protocols

Organizational Framework

20.0

Client needs and community safety are no longer the explicit responsibility of any ministry or program. In many cases, an offender's successful unconditional release will depend on efforts made and the results obtained at earlier juncture points. Gaps in program and service delivery are inevitable if agencies continue to operate within their strict mandates. Jurisdictional barriers must be broken down and creative solutions sought at the community level.

Target Group

The target group is people with a mental illness or developmental disability who have committed a serious crime.

Service Delivery

20.1

Coordination protocols identified at **Juncture 1** will apply.

20.2

Of particular concern to the public is the release of serious offenders to the community, particularly at expiry of sentence or mandate when the offender is released with no jurisdiction being tasked with supervision and follow up. Provincial directions as to the type of information that is shared with communities upon an offender's release, as well as the means of communication should be established. Local groups may be established to discuss high risk cases to ensure that information is shared and released appropriately and a community safety net is established. In addition, the federal government should continue to explore options with respect to post-sentence monitoring or detention of the highest risk offenders.

20.3

Multidisciplinary community programs, developed and funded cooperatively between ministries and/or levels of government, should be offered to offenders at the end of sentence who are identified as potentially high risk without very structured community supports aimed at reducing criminal recidivism. A care program approach (i.e. a system of assertive case management where one named worker has responsibility for ensuring that agreed care is offered to and accepted by an individual) should be applied to forensic clients leaving prison or referred from other criminal justice agencies. Programs should be forensic in nature and should target high risk people with mental health or developmental disabilities and criminogenic needs. Participants would likely have a history of criminal charges, a history of facility admissions, and be identified as "multi-problem" consumers. Program models include community support teams, assertive case management and outreach programs, and/or relapse prevention teams. The program would continue to systematically link clients with whatever supports are

available in the community and would not duplicate existing health or developmental services and other social services.

20.4

Police, families, consumers and community programs should be encouraged to establish a volunteer registry for the mentally ill and/or developmentally disabled similar to the registry for persons with Alzheimer's disease. A 'flag' or notation about the person on CPIC would list an emergency contact or 24 hour "on call" phone number to enable the person to receive assistance during a crisis incident, as well as indicate beneficial information about the person's history, current treatments, and/or the social service agency assisting the person.

Evaluation

If a forensic assertive case management/aftercare program is developed, the program should undergo a comprehensive program evaluation to evaluate its effectiveness, including examination of the quality of life of clients participating in the program.

Communities should identify their own high risk releases, and evaluate the effectiveness of community processes in addressing public safety concerns.

APPENDIX

I. MINISTRY ROLES & RESPONSIBILITIES

Ministry of the Attorney General

The mandate of the ministry provides for the Attorney General, as the law officer of the Executive Council, to ensure that the administration of public affairs is in accordance with the law; superintend all matters connected with the administration of justice in Ontario; advise the government and superintend all matters of a legislative nature; advise heads of departments and agencies of the government in their legal matters; and conduct and regulate all litigation for and against the Crown.[3]

The fundamental role and responsibility of the Attorney General in the process of dealing with mentally disordered individuals is not so much a concern with their illness per se, but with the consequences of their illness. The criminal justice system does not provide unique services to the forensic client: these accused, however, appear before the courts where officials charged with the administration of justice are brought together to make decisions that take into account the presence of mental disorder or developmental disability as it relates to the charge.

In terms of services to forensic clients, the Ministry of the Attorney General will:

- institute a court-based case management process;
- identify key personnel to act in a liaison capacity for mental health and criminal justice issues;
- provide relevant information within the ministry's control to other involved decision-makers and/or service-providers, where legally permissible;
- provide opportunities for training and education about mental disorder or developmental disability to crowns; and
- share educational materials about mentally ill offenders with duty counsel or legal aid defence counsel, the judiciary, and Justices of the Peace (materials and/or training sessions may be developed jointly between ministries);
- in local communities, develop a process to assess ministry needs and resources, and establish community-based partnerships to implement effective solutions.

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3. *Ministry of the Attorney General Act,* RSO 1990, c. M.17, s 5

These services are considered integral to the timely administration of justice and therefore within the ministry's mandate. Training and education responsibilities are consistent with current functions of the ministry.

Ministry of Community and Social Services

The Ministry of Community and Social Services will offer services under the *Developmental Services Act* to developmentally handicapped people in Ontario. Developmental services are received by clients on a voluntary basis.

In terms of services to forensic clients with developmental disabilities, the ministry will:

- identify key personnel to act in a liaison capacity for developmental and criminal justice issues;
- provide relevant information within the ministry's control to other involved decision-makers and/or service-providers, where legally permissible;
- in local communities, develop a process to assess ministry needs and resources, and establish community-based partnerships to implement effective solutions; and
- through facility and community-based transfer payment agencies, and based on individual developmental needs:
  - provide case management services within the developmental services system;
  - support, and where appropriate, enhance case management functions specific to other systems (e.g., mental health, courts) so that people with a developmental disability whose needs are unmet are assured of the same access to services as the rest of the population;
  - educate clients in their understanding of the mental health, legal, and justice systems;
  - provide supports to access assessment, treatment, rehabilitation, and discharge planning services offered in the mental health and justice systems;
  - regularly review developmental and support needs;
  - provide a range of services that address the residential, vocational, behavioural, cognitive, community support and family support needs of people with a developmental disability;
  - set expectations, including those around professional development, for developmental service providers regarding planning and service delivery;
  - assist in educational initiatives for service providers from other sectors about the needs of people with a developmental disability;
  - work collaboratively with the justice and mental health systems at provincial and community levels to manage a balance between risk to public safety and meeting clients' needs.

In addition, the Ministry of Community and Social Services will arrange for/offer appropriate treatment, supports, and accommodation to all clients who are affected by institutional closures. With other partners or individually, the ministry will ensure that appropriate settings are available to deal with client needs and level of risk, as well as protect public safety.

Ministry of Health

The mandate of the Ministry of Health is to oversee and promote the health and physical and mental well-being of the people of Ontario. The ministry is responsible for developing, coordinating, and maintaining comprehensive health services and a balanced and integrated system of health facilities in the province. In addition, the ministry funds health services, controls charges made to patients, and trains and educates health professionals and the public about health matters.[4]

Ontario's health care system, like other provinces, is undergoing fundamental change. The Minister of Health has introduced a number of aggressive expenditure management initiatives, facilitated a shift from institutional-based services to the community. In mental health, the Ministry of Health currently manages the provincial psychiatric hospitals, although the ministry's business plan speaks to shift in the future from a direct service role to being primarily a systems manager. As system manager, the ministry will be the funder, will continue to develop policy and provincial direction, will provide leadership and support with regard to mental health reform, and will oversee the evaluation of reform.

In terms of services to forensic clients, the Ministry of Health will:

- fund and ensure the provision of a seamless range of mental health services that are responsive to client needs. This will include: community-based mental health services and supports such as case management, 24 hour crisis response, and consumer/survivor, family or joint initiatives; institutional treatment programs for all severely mentally ill offenders in need of **hospital-based** care (except for those offenders serving a sentence in a federal penitentiary); and programs for NCR and unfit patients at various levels of risk;
- identify key personnel to act in a liaison capacity for mental health and criminal justice issues;
- provide relevant information within the ministry's control to other involved decision-makers and/or service-providers where legally permissible;
- provide opportunities for training and education to institutional and community mental health staff, and may assist in training service-providers from other sectors about the needs of consumers with mental disorder (materials and training sessions may be developed jointly between ministries); and
- in local communities, develop a process to assess ministry needs and resources, and establish community-based partnerships to implement effective solutions.

In addition, the Ministry of Health will arrange for/offer appropriate treatment, supports, and accommodation to all clients who are affected by institutional closures. With other partners or individually, the ministry will ensure that appropriate settings are available to deal with client needs and level of risk, as well as protect public safety.

These services are consistent with those already provided by the Ministry of Health. While most mental health services are generic in the sense that they are not targeted to people with a particular legal status, service responsibilities to forensic clients will place a special responsibility on the ministry to ensure that this group of clients are not excluded from otherwise suitable programs. Some enhancement to existing service capacity may be required (e.g. case managers to assist courts or probation officers in working with the mentally ill).

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4. *Ministry of Health Act*, RSO 1990, c. M.26 s 5

Ministry of the Solicitor General and Correctional Services

The *Police Services Act* is administered by the Solicitor General. The Solicitor General monitors police forces to ensure that adequate and effective police services are provided at the municipal and provincial level, and that police forces comply with prescribed standards of service. The ministry will develop and promote programs, statistics, and research to enhance professional police practices, standards and training, including programs for community-oriented police services. In addition, the ministry operates the Ontario Police College for the training of members of police forces. Law enforcement and crime prevention at the municipal level is however the responsibility of Police Services Boards.[5]

The Ministry of the Solicitor General and Correctional Services is also responsible for providing correctional services. Its function is to supervise the detention and release of inmates, parolees, probationers, and young persons, and to create for them an environment in which they may achieve changes in attitude by providing training, treatment, and services designed to afford them opportunities for successful personal and social adjustment in the community.[6]

In terms of services to forensic clients, the Ministry of the Solicitor General and Correctional Services will:

- provide support and direction to policing services, including advice regarding police response to people with disabilities. This should include support and direction about the development of linkages between police and service agencies. Where need has been determined, the ministry may also offer advice about the establishment of mental health crisis response teams;
- provide general treatment, rehabilitation, and discharge planning services as well as institutional case management services for all offenders serving sentences in a provincial correctional facility;
- provide overall case coordination to released offenders through the probation/parole system which should be delivered through a case management process, including follow- up with community-based services and supports which will be addressed through human service ministries' case management systems;
- identify key personnel to act in a liaison capacity for disability and corrections issues;
- provide relevant information within the ministry's control to other involved decision-makers and/or service-providers, where legally permissible;
- provide opportunities for training and education about mental disorder or developmental disability to police and corrections staff (materials and training sessions may be developed jointly between ministries); and
- in local communities, develop a process to assess ministry needs and resources, and establish community-based partnerships to implement effective solutions.

In addition, the ministry will arrange for/offer appropriate treatment, supports, and accommodation to all clients who are affected by institutional closures. With other partners or individually, the ministry will ensure that appropriate settings are available to deal with client needs and level of risk, as well as protect public safety.

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5. *Police Services Act*, RSO 1990

6. *Ministry of Correctional Services Act,* RSO 1990, c. M.22, s 5

These services are consistent with those already provided by the ministry. The responsibility to provide general treatment and rehabilitation services to mentally ill prisoners (but not hospital-based care) has been clarified, and is likely to require some expansion to program capacity. The role of the probation officer working in partnership with a community case managers has also been enhanced which should reduce some workload pressures on that system.

II. ROLES & RESPONSIBILITIES OF KEY ORGANIZATIONS

Health Sector

District Health Councils/Mental Health Authorities

The Minister of Health asked the District Health Councils to lead the implementation of mental health reform at the district and regional levels. Implementation Planning Guidelines give District Health Councils the authority and clearly describe their lead role in planning, as well as the role of the ministry in support. Councils will work collaboratively with the stakeholders involved in mental health — consumers/survivors, families, advocates, volunteers, interested citizens, service providers — in the development of multi-year regional and district imple-mentation plans which will guide the mental health system. Recent
directives from the Hospital Restructuring Commission recommend the development of a Mental Health Authority for the North West Region that will assume mental health planning responsibilities from DHCs in that area, as well as have financial accountability for the delivery of an appropriate mental health service system within the region.

In terms of forensic clients, District Health Councils (or Mental Health Authorities where available) will have the lead role at the district and regional levels in providing planning advice to guide the development a mental health plan that will address the needs of the mentally ill before the courts, in psychiatric facilities, or at the point of discharge from a psychiatric or correctional facility through community based and/or institutional mental health services and supports. DHCs will facilitate the establishment of community-based *Human Services and Justice Coordinating Committees* and will participate in activities of the committee that may relate to health planning matters.

Psychiatric Facilities

Psychiatric Hospitals

Psychiatric hospitals will provide specialized treatment, rehabilitation and reintegration services for people with long-term psychiatric problems that are difficult to manage. Hospitals will deliver specialized

programs at the hospital site and within the communities they serve. The community role will include but will not be limited to the provision of consultation and support to programs throughout the mental health system, including the general hospital and community programs also serving people with serious mental illness/severe mental health problems.

The role of each psychiatric hospital will be region specific with provincial parameters. The specific type of services provided and population served will be determined largely through the regional mental health planning processes. Psychiatric hospitals will offer a range of service including assessment, diagnosis, treatment, rehabilitation and continuing psychiatric care. A safe and secure setting will be available as a component of this service delivery system. Research, training and education, program consultation, and advocacy will be included as essential functions.

Specific psychiatric hospitals will be identified to provide regional forensic psychiatric services which offer a continuum of care from a locked, secure setting to out-patient services to people with a mental disorder who are a risk of violent criminal reoffence and who require more intensive management or specialized treatment than is normally available through the general mental health system. In addition, psychiatric hospitals will provide specialty and tertiary care programs to forensic patients who are integrated into the general mental health system.

General Hospital Psychiatric Units

General hospital psychiatric units will serve people with severe mental illness/severe mental health problems; and people who suffer from acute episodes of mental illness that are of short duration but very disabling. The core services that these units must provide include: emergency services; short-term inpatient assessment; stabilization and short-term treatment; discharge planning; consultation; day hospital and out-patient services for people whose medical and psychiatric care should be integrated and for people who require multiple hospital services. There are a number of additional services that a general hospital may provide, the specifics of which will be addressed through district mental health planning processes. Certain general hospitals fulfil dual roles of community and teaching hospitals.

Forensic clients with severe mental illness/severe mental health problems or who suffer from acute episodes of mental illness but who are **not** considered to be a significant risk of violent offending will be integrated with other psychiatric patients in these settings. Currently, forensic clients are served primarily through provincial psychiatric hospitals or specialty psychiatric hospitals.

Community Mental Health Programs

Community mental health programs will assist in improving the quality of life and level of wellness of individuals experiencing severe mental illness/severe mental health problems and increase their potential to live in their own preferred community as continuously and as long as possible. This is accomplished through a range of services that may reduce the level of disruption that these individuals often experience on a daily basis. Programs comprise a range of services with the priority on case management (including supports for housing), 24-hour crisis response, and consumer/survivor and family and joint initiatives. These services and supports may be offered on a local or district basis, the specifics of which will be determined through the planning process at the district level.

Forensic clients will not be excluded from otherwise suitable community mental health programs because of their legal status. While community mental health programs will be accessible to all consumer/survivors who need and want such services, some community mental health programs may develop a unique role in providing case management services or other supports specifically to forensic clients where there is a recognized need in the community for this type of service.

Developmental Services Sector

Community Developmental Services Programs

The role of Developmental Services — funded transfer payment agencies — is to provide services and supports that allow people with developmental disabilities to participate in community living. Within this project, their active participation in prevention, education, case management and cooperative service coordination with other sectors will be strongly encouraged. Their leadership in spearheading services and supports that allow for diversion initiatives to take root will be a factor in facilitating community living for lower risk individuals.

Contribution of services and supports for higher risk individuals will be strongly encouraged, however the ministry acknowledges its limited mandate and the finite capacity of community based service providers to manage risk. The ministry does not expect service providers to alter their practice of prudence when planning for, and providing, services and supports to people with a developmental disability who encounter the criminal justice system. As in all community living arrangements, careful planning from service providers will be required to ensure the likelihood of successful long-term community integration.

Developmental Services Facilities

The ministry has a long term policy of downsizing its Schedule I facilities. Their role in management of problem clients is governed by the Facility Admissions Protocol which is designed as a measure of last resort — and emphasizes a "no admissions" philosophy. Until they are completely closed, efforts within facilities will focus heavily on planning for community placements of residents that remain. All placement plans will take into account the client's risk level and only when suitable supports can be put into place will placement occur. For people with a developmental disability, the ministry's mandate and practices reflect a policy of minimum intrusion and individual choice, so the remaining facilities, as with community-based services, are limited in their capacity to manage risk, and depend heavily on the client's consent to participate in programming.

Local Planning, Advisory or Focus Groups

These groups may be specific to developmental services in some areas and may be cross-sectoral in other areas of the province. In all cases, they are voluntary, community-focused (i.e. they may be established at county or community levels, not just the area-level). Ministry staff participate on these committees in an ex-officio capacity. These groups are designed to provide a forum that brings service providers, ministry staff, and other involved community stakeholders together at the local level to address service delivery issues. Within the scope of the project, such groups may provide candidates for representation on the *Human Services and Justice Coordinating Committees*, but will be considered with other established mechanisms for this purpose.

Hard-to-Serve Committees

As with local planning/advisory groups, Developmental Services "hard to serve" committees are voluntary and sector-specific. Their exact functions and focus vary by area. The term "hard-to-serve" may reflect a scarcity of service or expertise in an area; in other instances, may reflect difficulty in coordinating several services for the same individual. As with local planning groups or advisory committees, these committees may provide candidates for *Human Services and Justice Coordinating*