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Navigating Dual Diagnosis in the Justice System: Integrated Case Management Approaches

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What is Regional Support Associates?

Regional Support Associates (RSA) is Southwestern Ontario's specialized clinical and case management service provider for people with intellectual disabilities over the age of 18.

What Is An Intellectual Disability?

- **Intellectual disability** is characterized by significant limitations in both:
 - **Intellectual** functioning (reasoning, learning, problem solving) and
 - **Adaptive** behavior, which covers a range of everyday social and practical skills
 - Originates before the age of 18
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What Is A Dual Diagnosis?

- Intellectual disability and mental health need or challenging behavior

What Services Are Provided At RSA?

RSA provides:

- Specialized Clinical Supports
- Case Management
 - Southern Network of Specialized Care (SNSC)
 - Complex Support Coordination
 - Health Care Facilitation
 - DDJCM



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Community Networks Of Specialized Care (CNSC)

- There are 8 networks across the province. Their Mandate is to provide complex case management support to adults with developmental disabilities with high support and complex care needs, or who require support navigating the Justice System
- Since the inception of DDJCM's in 2006 they have been affiliated with CNSC

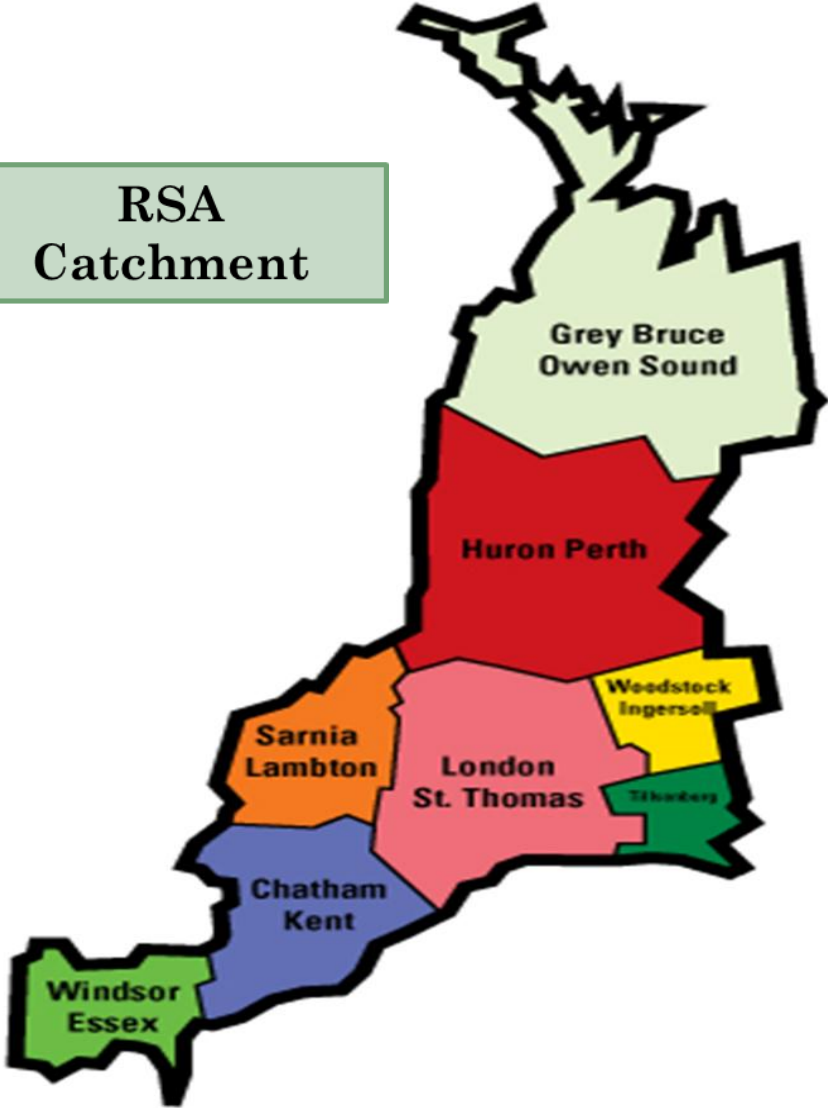
Community Networks of Specialized Care (CNSC)

- Each Network was involved in finding host agencies for the DDJCM positions. Each Network used its own process unique to their own regional culture, and as a result some DDJCM's are housed in Mental Health Agencies and some are with Developmental Services Agencies
- Regional Support Associates is the one of the Lead agencies for the Southern Network of Specialized Care
- DDJCM's are supported by the CNSC through Provincial Dual Diagnosis Justice Rounds, and the DDJC/CM's across the province meet via videoconference on a quarterly basis

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Catchment



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Who Does DDJCM Support?

- Adults, 18 years of age or older
- Person has a Dual Diagnosis
- Must have current justice needs

Justice Resources

- Justice App:



Justice App

Reference

▸ At Risk of Justice Involvement

▸ Arrest

▸ Currently In Court

▸ Virtual Court

▸ Victim or Witness

▸ Forensic Mental Health System

▸ Incarceration

▸ Resources

▸ Central West Region

- Developmental Disabilities Justice Toolkit:



Fitness

- **Fitness Assessment** – also known as a Form 48
 - A psychiatrist assesses the individual on their current mental state to determine if they are able to understand the processes of court, the people involved, and if they have the ability to instruct their lawyer and understand the consequences of such instructions
 - This assessment can be completed either in or out of custody, or at a Forensic facility, depending on the case
 - The psychiatrist will then complete an assessment report informing the court of their professional opinion of the person’s mental fitness
- **Fitness Hearing** – Occurs following the fitness assessment
 - This is where the judge will make a decision on the person’s fitness or ability to stand trial, taking into account the psychiatrist’s report, as well as those submissions of the Crown and Defense Counsel
- **Unfit** – When a person is found to be unable to direct their lawyer, unable to understand the proceedings or consequences of the proceedings due to their current mental state
 - The judge may order the person to receive treatment in order to return them to a “fit” state – this is called a Treatment Order or Make Fit Order and is usually completed within a 60 day period
 - If unfit after a Treatment Order, a formal finding of “Unfit To Stand Trial” is made and the case is transferred to the Ontario Review Board (ORB)

Not Criminally Responsible

- **NCR – Not Criminally Responsible**
 - Ordered by the court
 - This means that although the individual committed an illegal act, that they are not criminally responsible due to their mental state at the time that the crime occurred
 - If found NCR, then this person's case is transferred to and reviewed at an ongoing basis by the Ontario Review Board (ORB) and the person themselves would be transferred to a forensic mental health facility

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Ontario Review Board

- A collection of professionals that are experts in both the fields of psychiatry as well as the law
- The ORB is the entity that decides on a person's disposition
- The period of time a person spends under the care of the ORB depends on their progress in treatment and if they pose a significant risk if released back into their community



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Types of Dispositions

- **Detention** - in custody in a Forensic facility or in community in some circumstances
- **Conditional Discharge** – this includes conditions placed on the person in the community and they are monitored by a Forensic outreach team
- **Absolute Discharge** – they are discharged from the care of the hospital and ORB; no further conditions placed on the person following discharge



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Handling of Charges

- **Direct Accountability Program** – this is a voluntary alternative for adults 18+ that allows the person to take responsibility for wrongdoings through community actions such as community service, counselling or programming, restitution, letters of apology, etc. Once the person successfully completes DAP, the Court withdraws the charges
- **Diversion** – another alternative where the person makes a plan of rehabilitative efforts, which could include programming, donations, community service, etc.; if the person successfully completes the plan, their charges are withdrawn and the charges won't result in a criminal record
- **Withdrawn charges** – charges will be withdrawn when there is no reasonable chance of conviction
- **Conviction** – being found or offering a guilty plea to a criminal charge
- **Acquittal** – being found not guilty through trial



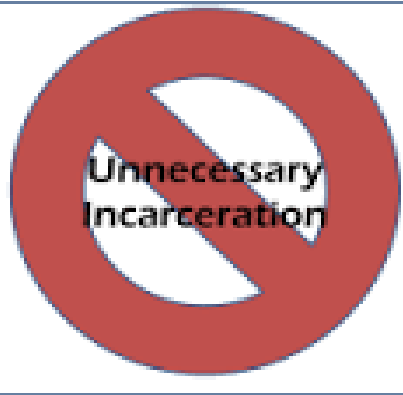
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How To Refer To DDJCM

- A referral through Developmental Services Ontario (DSO)
- Referrals can be made by: The individual, family members, Lawyers and Community Agency Partners, Correctional Facilities, Hospitals and Police
- DSO Southwest 1-855-437-6797

Goals of DDJCM

- To reduce the number of people with a Dual Diagnosis entering or re-entering the Criminal Justice System and/or support them through the justice process
- To decrease time spent in a Correctional Facility



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Role Of DDJCM

- A key responsibility of the position is to **identify**, **assess** and **facilitate** supports/services at intervention points within the Justice System.



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Role Of DDJCM

Court Support

- Help the person understand the proceedings / court etiquette
- Prepare an Individual Support Plan to address the needs of the client and the justice system
- Advocate for diversion, access to specialized courts, or probation or conditional sentence when possible
- Mitigate barriers

Role Of DDJCM

Provide Education

- To the individuals supported, families, lawyers, court and judicial personnel, police, and other community partners regarding the individual and their community based options
- Represent Developmental Service Sector/Dual Diagnosis in the community through avenues such as the Human Service and Justice Coordinating Committees as well as other community tables across our catchment area and at our Provincial DDJC/CM Committee

Role Of DDJCM

Case Management

- Short-term
- Ensures all parties are kept up to date and have current information about court proceedings
- Assist in facilitating with the client to obtain appropriate documentation to access community services e.g., Health Card, SIN, Birth Certificate
- Refer to DSO for long term services (if not already connected)
- Access financial resources – ODSP; Legal Aid

Role Of DDJCM

Diversion

- Application to the Crown for diversion when a person commits a lower level offence
- Monitor and encourage adherence to diversion and treatment options
- Provide ongoing communication with the courts regarding diversion order

A Vulnerable Population

- Often have a desire to please others and to be accepted
- Often lack education about sexuality, issues of abuse, boundaries, and understanding their rights
- Have difficulty advocating for themselves
- More likely to confess – may be more agreeable just to please people or may seek approval from authority figures
- Many live with limited financial and social resources

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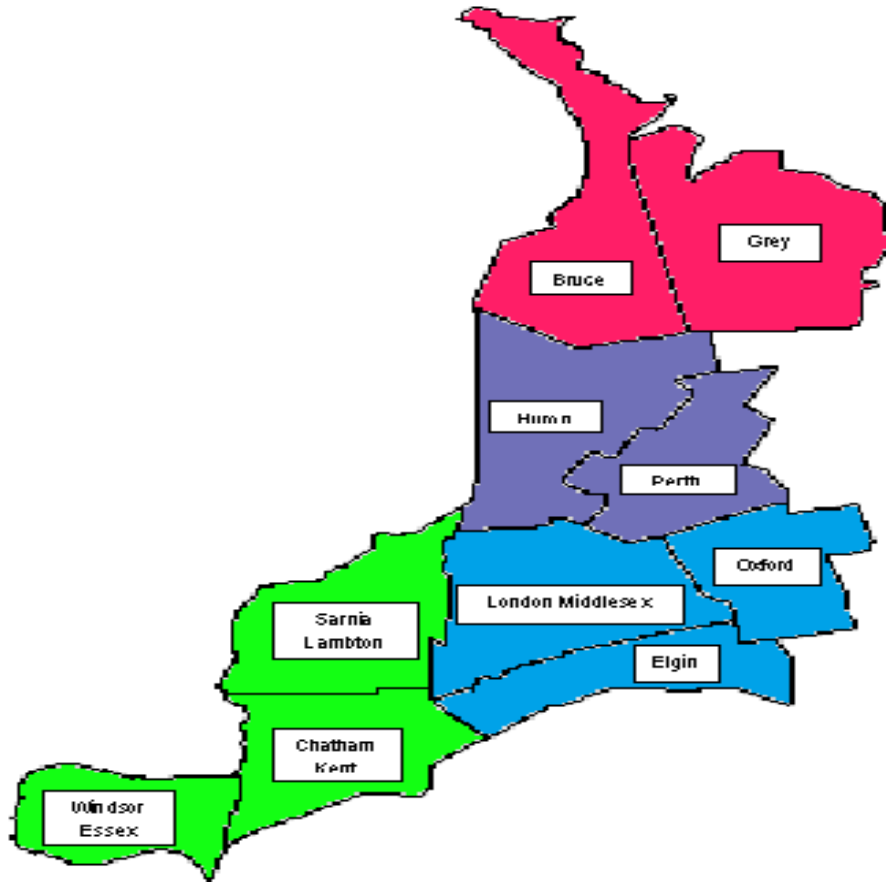
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Complex Support Coordination

Community Networks of Specialized Care

West Region – RSA Catchment Area



1. Grey-Bruce
2. Huron-Perth
3. Thames Valley
 - a) London-Middlesex
 - b) Oxford
 - c) Elgin
- d) Sarnia-Lambton
- e) Chatham-Kent
- f) Windsor-Essex

Who we are:

- A part of the Community Networks of Specialized Care. RSA is considered to be the South Western Network.
- Complex Support Coordinators are in every region of the province. All Coordinators are connected to the Network but employed by designated agencies.
- RSA has a Complex Support Coordinator in each office.

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What we do:

- Coordinating supports and services within and across sectors to address people's complex support needs;
 - Acting as a direct resource to service agencies, Developmental Services Ontario (DSO), and local system planning tables (including urgent response and service solution/case resolution);
 - Assist referrals to identify goals and determine pathways to reach their goals.
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Referral Criteria:

DSO will identify adults as appropriate for a referral to RSA for Complex Support Coordination based on whether they meet the following target population criteria, and are in need of complex support coordination:

- Those with extraordinary medical and/or behavioural support needs: determined by scores on SIS sections 3A (medical; scores of 7 or greater) and/or 3B (behavioural; scores of greater than 10); and
- High overall support needs: individuals with overall SIS percentiles of greater than 70%; and
- Safety concerns: the primary caregiver (family members and/or paid support persons) has concerns about the person's safety due to his/her medical and/or behavioural support needs (ADSS s6.3 and 6.5); and
- Only to be applied for people with exceptional medical support needs: the person must require overnight support (individuals with extraordinary behavioural support needs do not necessarily need to require overnight support in order to meet the HSCCN definition).

Some people may not fall under the above criteria but are referred under reasonable grounds.

A referral for Complex Support Coordination can occur any time after a person turns 18.



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Our Process:

- Complex Support Coordination is a non-mandated and voluntary service.
- Meet with the person and their support system to assess and determine gaps in service and potential goals that the person has for their life.
- Work with the person and their support system to consider steps/a pathway to achieve the goals identified and determine what the involvement of the Complex Support Coordinator will look like.
- Make contact with services and supports connected to the person, as appropriate.
- Collaborate with the person's team and support system to ensure that the lines of communication are open.
- Work together and facilitate ongoing meetings and conversations in order to assist the person with finding a path to their goals.

Who we collaborate with:

After obtaining consent and determining the need to do so, we connect with others that provide a service/support to the person or who are an important part of the person's life. We take part in purposeful communication and collaboration with the team, typically around goals that the person/support system have identified.



Limitations:

- We cannot assist with finding housing and do not have an the ability to change priorities within housing registries.
- We do not have access to funding.
- We can advocate for people but cannot change wait list times.
- We cannot advise people on medical matters, mental health matters, behaviour supports etc. however we can assist with getting referrals to these resources.
- We cannot duplicate a service that the person already receives.

Making Files Inactive:

- When all goals identified in the Complex Support Plan are considered complete or no longer applicable, the file may be placed as inactive.
- This decision is made in consultation with the Complex Support Coordinator, their manager and most times the person/their support system.
- A file is only closed if a person passes away, or moves out of province.
- When a file is placed inactive, the person/their support system is notified and they are encouraged to connect back with RSA if there are new attainable goals in mind. The ability to reactivate the referral will be prioritized however will be based on the Complex Support Coordinator's capacity at the time of the request of reactivation.



Case Example

- DDJCM/CSC have a referral for a 45-year-old women. She has struggled with her mental health for many years. She has had several instances where she has been incarcerated or hospitalized for extended periods of time
- She has natural support from her father, but he struggles with the systems and locating adequate support for her. He is also suffering from caregiver burnout
- She has been asking for treatment for quite sometime and is often calling emergency services on herself to get help



Case Example Continued

- Resources that have been explored:
 - Forensics discussion
 - She could not go there as she was aware of the charges, and this would have to come through the court
 - An ACT referral has been completed; it was not eligible as she does not have a consistent diagnosis in her hospital records
 - It was asked by CSC if they could reconsider with information from another healthcare facility - the second referral was also not eligible
 - She has a monthly injection that needs to be monitored.
 - Mental Health referral and referral for injection clinic
 - The referral was accepted but they did not have the staffing complement to support her, so her file is still open, but she has no active support. She also needs to engage with support.
 - The injection clinic is only short term, so this was not eligible
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Case Example Continued

- Referral to release from custody/reintegration program
 - She was not eligible for this program as she is high risk
 - Recidivism Prevention Program
 - Too complex, she was not eligible for the reintegration program
 - Referral made to Health Care Team
 - They are going to take her on upon her release but as a walk-in client as they have a doctor on leave right now.
 - They can provide her injection and monitor medication
 - Dual Diagnosis Program
 - She needs a letter of referral from a physician and does not have a family doctor. The hope is that the health care team might be able to do this. This must be done before the referral can be submitted.
 - Psychotherapy
 - This was something that she requested as a goal.
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Case Example Continued

- Housing referrals:
 - She has had referrals done for housing support, but she has a history of arson while with previous housing, so this has been challenging
 - A referral was submitted for Transitional housing – she is on the waitlist for this
 - Community Support
 - Third party agency that can provide 2.5 hours of support per week with passport allocation
 - APSW x 2 but they are remaining open for advocacy
 - They are unable to meet with her in person due to safety reasons
 - DDJCM for court support and case management
 - Transfer Payment Agency manages her passport allocation
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Questions?
