System Mapping for Mental Health and Justice Diversion Services in Peel Region

Final Report

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Prepared by the Centre for Community Based Research for the Canadian Mental Health Association, Peel Branch
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Introduction

A group of mental health and justice service organizations in Peel Region, under the auspices of the Peel Human Services and Justice Coordinating Committee (PHSJCC), have formed a partnership to review, develop, and expand services and supports for people with mental health difficulties who come in contact with the law. This collaboration strategically focuses on system changes that promote diversion of consumers, where possible, from traditional justice services. This alternative approach is based on long-standing recognition that justice services, as conventionally arranged, are unresponsive to the diverse needs of mental health consumers. This problem is greatly exacerbated by a wide range of societal barriers that keep people in a cycle of disadvantage – poverty, barriers to service access, and homelessness, for example – that lead to ongoing exposure to police, the courts, and criminal institutions. Solving complex, systemic problems such as these is challenging and requires the participation and resolve of multiple organizational partners in collaboration with the individuals and families that are living the issue.

The partnership is composed of CMHA’s Mental Health and Justice Services (Court Support, Discharge Planning, and Justice Case Management), Supported Housing in Peel (SHIP), COAST Peel, and Peel Regional Police. Members of these organizations formed the Mental Health and Justice Diversion Services (MHJDS) committee in order to guide their work, and recognized a need to evaluate their progress in modifying and improving the system. In 2006, this work began with the creation of a preliminary logic model and outline of their service model. In 2007, the committee revisited evaluation with an identified need to expand on previous work and completed an evaluability assessment of the service system with the Centre for Community Based Research.

The evaluability assessment examined the system level relationships between the MHJDS partnership organizations. The focus of the analysis was on the referral pathways between these main organizations, with specific attention paid to the range of barriers that prevent, or make difficult, effective service coordination.

While the results of the evaluability assessment were important and useful to the partners, a limitation was the lack of information pertaining to the sectors and organizations beyond the partnership that operate within the mental health and justice systems. In other words, achieving the desired outcomes of the partnership’s services relies on service coordination of many more organizations than those in the partnership. Generally, it was found that the referrals and communication between the partners functioned well and as planned, with some exceptions; however, gaps and barriers in the system more broadly were apparent and not well understood.

In 2007-2008, the evaluability assessment was extended in a new project that attempted widen the scope of relevant organizations in Peel Region. The present document is the final system mapping report. We begin with a brief description of
MHJDS partners and the roles of their organizations, followed by a discussion of the range of organizations that work within the mental health and justice system. This is followed by the main research questions that guided the system mapping and the methodology that was used to answer these questions. Subsequent sections present the research findings, implications and recommendations.

An Overview of System Mapping

Complex service delivery systems, such as those pertaining to health, mental health, justice, and so on, present a challenge for evaluation. Conventional evaluations target specific, well-defined programs (hence, “program evaluation”). Provided activities within a program are delivered as planned, it is usually straightforward to identify and measure outcomes. Systems level evaluations are inherently more complex, because systems contain a diverse array of programs across multiple agencies and sectors. Ideally, these programs are coordinated – consumers have knowledge of what’s available, what’s available meets the range of community needs in an accessible way, and there is minimal duplication. Additionally, these programs “talk to one another” in ways that make services seamless. Referrals in and out of programs and supports are consistent and function to ensure that no one gets left behind.

Real systems, however, are rarely coordinated in this highly effective way. At the same time, organizations (and their programming) within a system often share a great number of outcomes, especially those that are intermediate and long-term in nature. It is also the case that the realistic achievement of those outcomes (e.g., improved access to relevant services, improved stability of mental health and well-being) rely heavily on the interconnectedness and performance of multiple organizations.

It is a mistake, in the present case, to begin measuring mental health outcomes before understanding the functionality of the system. What referral relationships exist? Are they appropriate? Do they work well? What are the challenges? A picture of how organizations in the system interrelate is an important first step in system evaluation. In this document, we use system maps as an analytic tool and as representation of the system for the reader. Figure 1 provides an example from our last report.
In this example, CMHA staff and management provided information on referral sources (arrows from the top) and referral destinations (arrows to the bottom) for the three components of their justice focused mental health services. Using these types of diagrams, we can locate and discuss barriers in the system.

**Evaluation Purpose and Design of the System Mapping Project**

The first evaluability assessment made a number of recommendations for further inquiry. The project steering committee agreed on the following emphasis for investigation:

1) Identifying the main organizations in Peel Region that have meaningful connections to mental health and justice diversion services.
2) Understanding how key organizations and sectors interrelate in terms of their referral sources and destinations.
3) Understanding the challenges and barriers that exist in the referral practices of organizations who serve people with mental health difficulties who are also having difficulty with the law.
4) Understanding the extent to which the intake/service criteria for the main program components of the partnership (CMHA justice diversion services, COAST Peel, and Safe Beds) are known by other organizations in Peel Region.

**Design and Methodology**

To answer the above questions, we utilized several different data collection sources and strategies: an online survey, focus groups, and interviews.

**Online Survey**
An online survey was created and emailed to members of the Peel Human Services and Justice Coordinating Committee, who were also requested to distribute among relevant staff. Other key individuals in the system, as identified by the project steering committee, were also invited. The structure of the survey followed simple ranking and open-ended questions about referral sources and destinations, circumstances where services are denied, and barriers within their referral practices. The sample size for the survey was n=21. The following is the sample breakdown according to service sector (more information on sectors follows in later sections).

Mental Health = 9
Legal Services = 4
Housing = 2
Disability & Dual Diagnosis = 6

Of the mental health category, 3 were from CMHA Justice Diversion Services.

Focus groups

We conducted two focus groups. The first was to target mental health service providers from organizations sitting on the Peel Human Services and Justice Coordinating Committee. Participation was poor as only four participants were able to attend. However, the focus group was informative because participants represented long-term case management services and support for people with dual diagnosis. The general content of the questions examined program descriptions, descriptions of service relationships, and barriers and challenges faced in the system when receiving/making referrals (see Appendix A for questions).

The second focus group was with Peel Region Police. A total of 9 constables with experience in serving people in mental health crisis participated, 2 of which worked on the newly formed COAST Peel team. This group concentrated on practices, challenges and barriers in placing criminal charges or applying the mental health act to people in mental distress, as well as protocols and experiences of police in accompanying people to hospital admission (see Appendix B for questions).

In both focus groups, attendees were given a brief presentation on the background and purpose of the project. The groups were facilitated using system mapping diagrams that related to the questions. The sessions were audio recorded, transcribed and coded for common themes.

Key Informant Interviews

The intent of the key informant interviews was to complement the focus groups by gathering similar information from key people working in the system. They were also used in part to gather more information from the mental health and dual diagnosis
sectors as well as from Hospital and Emergency services. The general content followed that of the focus groups (see Appendix A), but interviews with hospital/emergency in-patient personnel were customized further.

- 8 interviews in total were conducted.
- 3 individuals were in the Disability and Dual Diagnosis sector;
- 2 were in the Mental Health Service sectors;
- 3 were from Hospital and Emergency In Patient services.

The interviews were audio recorded, transcribed and coded for common themes. Unfortunately, we were unable to secure interviews with individuals in the housing sector, beyond those already in the MHJDS partnership.
A SUMMARY OF SECTORS AND ORGANIZATIONS

As mentioned, an evaluability assessment was previously conducted with a focus on the organizations within the partnership, whereas the present study examined organizations in Peel more broadly. In the next few sections we provide brief descriptions of the partnership organizations’ mental health and justice diversion services and the range of organizations outside the partnership. We follow with a description of our sampling approach and resulting organizational sample.

The MHJDS Partnership

The MHJDS partnership is composed of five main organizations that deliver a range of relevant programs: Canadian Mental Health Association Peel Branch (CMHA Peel), Supportive Housing in Peel (SHIP), Saint Elizabeth Health Care (SEHC), and Peel Regional Police.

CMHA Peel Branch

CMHA Peel has developed three distinct components within its justice diversion services. These descriptions, below, detail the activities that define each program and the referral sources that feed into these programs.

Discharge Planning. Upon custody release from regional correctional facilities, discharge planners connect with individuals in order to provide a transition plan to the community, based on their immediate needs. This is an often time-limited process that requires connecting individuals to available mental health supports and services, housing options, and financial supports. A crisis plan is also created. Discharge planning occurs in coordination with Maplehurst Correctional Complex, the Vanier Centre for Women, Mimico Correctional Centre and the Ontario Correctional Institute. Planners also get referrals from the Centre for Addiction and Mental Health and directly from legal counsel, bail programs, and probation.

Court Support. When individuals are required to appear in court or otherwise interface with the court system, CMHA provides needed support and information. Court Support workers coordinate the mental health court, conduct pre-screening to assess for diversion eligibility, hold meetings with the Crown, provide information and support to clients and their families regarding their case and the system in general, prepare clients for court appearances, accompany the client to court and formulate a service plan consistent with the courts concerns. Individuals are referred to court support from discharge planning and justice case management, community social services, and from different points in the legal system.

Justice Case Management. CMHA provides intensive short-term case management specifically serving individuals with mental health difficulties that have also had significant contact with the justice system. Case managers provide supports that
are reflective of case management in general, such as practical support in daily living, assessment and monitoring of wellness, advocacy, medication monitoring, housing support, income support, and crisis planning. However, these supports are provided within the unique context of individuals who are also experiencing legal difficulties. Very often community service options are different (e.g., a criminal record means they cannot access certain services), and supports around income and housing present extra challenges. This specialized case management is typically accessed by individuals via referrals from the other CMHA justice programs, other community agencies, the legal system, and from court support programs in other regions.

Saint Elizabeth Health Care (SEHC)

COAST Peel. SEHC provides mobile crisis support for people experiencing mental health crises. Additionally, they have specialized crisis support teams, called COAST Peel, for situations where a police response is required (violence, aggression, suicide risk) and where legal action and use of the mental health act is a possible outcome. The main role of COAST Peel is to provide immediate outreach support and assessment to individuals at the site of crisis, with the main goal being crisis de-escalation and problem solving. COAST Peel teams, where possible, provide follow-up support and referral shortly thereafter. The COAST Peel teams include a plain-clothes police officer, providing a far less threatening atmosphere for individuals in crisis and their families, while still protecting the legal obligations of police services (e.g., police must be present to invoke the Mental Health Act). COAST peel receives its referrals from the Mobile Crisis Unit, which in turn gets crisis calls from police, individuals and families, and other community agencies.

Supportive Housing in Peel (SHIP)

Safe Beds. Supportive Housing in Peel (SHIP) provides long-term supportive housing to people with mental health difficulties in the region. A subcomponent of SHIP is Safe Beds. Safe Beds provides temporary shelter and crisis support to people with serious mental health difficulties who are in conflict with the law. Residents stay for a maximum of 14 days, in which time staff work with them to stabilize their crisis, ensure they have access to medication if needed, meet basic and immediate needs, and formulate a plan for future referral and supports that should be in place upon their departure.

Safe Beds take referrals from agreed upon partners who are in a position to make appropriate assessments of individuals who may use Safe Beds (i.e., experiencing mental health crisis and conflict with the law). Referral partners include CMHA justice services, hospitals, and other mental health services.

Peel Regional Police

Peel Regional Police are a member of the partnership. However, at the time of the previous evaluability assessment, service agreements were still under development
and they were not included in the first analysis (although represented in part in COAST Peel). In the current project, we examined the role of police in MHJDS.

**The Broader Scope of Mental Health and Justice Services in Peel Region**

The number of sectors and organizations in Peel Region that support and serve people with mental health difficulties who also may have contact with the law is extensive. Our first step was to provide a basic listing of organizations based on five identified sectors. This listing is certainly not exhaustive, but is fairly comprehensive, and appears in Figure 2 on the page following. Our sources for this list include the following:

1) Membership organizations on the *Peel Human Services and Justice Coordinating Committee*.
2) Additional adult-serving organizations identified by the *Peel Youth Justice Coordinating Committee*.
3) Organizations identified as referral sources and destinations of organizations who participated in this research.

We have divided the organizations into the following sectors:

1) **Mental Health and Addiction Services**: Organizations that provide a range of mental health, addictions, and/or justice diversion services. This includes case management services, outpatient services, crisis and outreach support, group and day programs, consumer-run groups, etc., as well as the justice diversion services of CMHA. Emergency and in-patient services are not included in this category.

2) **Hospitals and Emergency In-Patient**: Organizations that provide emergency crisis services with in-patient beds.

3) **Justice Services**: Services and programs of the legal system, including correctional facilities, court services, justice-focused community services, and Peel Regional Police.

4) **Shelters & Housing**: Supported housing and independent-living services for people with mental health difficulties. This includes emergency or other housing shelters not designed specifically for, but who regularly serve, people with mental health difficulties.

5) **Disability and Dual Diagnosis**: Organizations serving individuals with mental health difficulties and other intellectual or developmental disabilities.

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1 Source: *Peel Youth Justice System Chart*, produced by the Peel Youth Justice Coordinating Committee.
Organizational Sample Used in the System Mapping

It was beyond the scope of this research to reach each and every one of the above organizations. Instead we approached the sampling (i.e., within our survey, focus groups, and interviews) with the following criteria in mind:

- Members of the *Peel Human Services and Justice Coordinating Committee* were invited to participate in the survey and/or focus groups/interviews, with exceptions below. They were also encouraged to recommend staff from their organizations to participate.
- Members of the MHJDS partnership (COAST Peel, CMHA MHJDS, SHIP/Safe Beds) were excluded from focus groups/interviews to avoid redundancy with the first evaluability assessment.
- Organizations from the legal system were excluded from the focus groups/interviews to ensure the research scope could accommodate mental health and other community services.
- Hospitals and Emergency In-Patient Services, Police Services, and Housing were identified as key system components to be included in the research.
The following organizations were represented in the research. It should be noted that these were organizations with direct participation in the research. Additional agencies were mentioned or implicated within the research.

**Mental Health**
- Relinc Mississauga (Trillium)
- North Peel Relinc (Trillium)
- Peel Distress Centre
- Canadian Mental Health Association, Peel Branch
- Saint Elizabeth Health Care
- Friends & Advocates Peel
- Community Mental Health Clinic (William Osler)
- Psychiatry (Courts)
- Kinark Child and Family Services

**Legal Services**
- Peel Regional Police Services
- John Howard Society Peel Halton Dufferin
- Elizabeth Fry Society of Peel-Halton
- Probation Services
- Legal Aid Ontario

**Hospital & Emergency In-Patient**
- Brampton Civic Hospital (William Osler), Emergency Crisis Services

**Disability & Dual Diagnosis**
- Brampton Caledon Community Living
- Central West Network of Specialized Care
- CMHA Halton Dual Diagnosis
- Peel Behavioural Services, Trillium Health Centre
- Peel Crisis Capacity Network
- Dual Diagnosis Program, CAMH

**Housing**
- Supportive Housing In Peel

**Gaps in the Sample**

While we did manage to reach quite a large number of organizations and individuals, there were some notable gaps in our sample. This is can largely be explained by scheduling difficulties, a lack of interest or perhaps perceived relevance by some individuals. There was no representation in interviews/focus groups of the housing sector or of two of the three hospital/in-patient options in the region. That said, information about these sectors was available from the existing sample.
Findings of the Research

We have elected to organize our results around three system maps that characterize and summarize the referral sources and destinations of different sectors and organizations. The findings of the evaluation draw on our three main sources of data and are discussed in the following order, correspond to these three maps:

1) Peel Regional Police, Crisis Outreach, and Hospital/In-Patient Services. This map will display the relationship of police services to the hospital/in-patient services; and the link between in-patient services and discharge. Links to other sectors/organizations will be displayed and discussed.

2) Mental Health Services. Mental health services, which include, case management, outpatient and day programs, etc. will comprise the second map. Links to other sectors/organizations will be highlighted.

3) Disability and Dual Diagnosis. Similar to the mental health maps, organizations that serve people with disabilities who also have mental health problems will be linked to typical referral sources and destinations.

By referencing the maps, our analysis will: a) describe the organizations, in generic form, that participated in the research b) specify common referral pathways; and c) identify and comment on barriers to effective service coordination.

Peel Regional Police, Crisis Outreach, and Hospitals/In-Patient Services

Peel Police Services represents a key component of mental health and justice diversion services. In service of enhancing police responses to people with mental health difficulties, mental health awareness training programs and police integration with the COAST Peel crisis team have happened in the region. When individuals are at personal risk to themselves, police will most often interface with the mental health system in emergency in-patient departments (Credit Valley Hospital, Brampton Civic Hospital, Trillium in-patient services). In other cases, police may lay charges or may help de-escalate a crisis and pass on responsibility to COAST Peel (which includes a plainclothes officer).

Hospitals admit individuals accompanied by police to in-patient emergency services with the application of the Mental Health Act or may assess individuals and immediately discharge, with referrals, if the crisis de-escalates.
Figure 3 – MAP #1: System Map for Crisis Components: Police Services, Outreach, and Hospitals/Emergency In-Patient

Figure 3 displays the system map containing police and hospital/in-patient emergency services and their various linkages. Some of the links contain referenced numbers. These numbers correspond to the range of challenges and barriers in the system. We will discuss each of these in turn as well as examples of where things are going well.

1. **Policing at time of charge or apprehension.** In the police focus group it was acknowledged that mental health call protocols are in a period of transition as officers learn about the different options that are available to them. This primarily has to do with the introduction of COAST Peel, which is still in its early stages. Police are already noticing that mental health calls are beginning to be diverted to the COAST Peel team through police communications, and if not, COAST Peel can be summoned by other officers in the field as needed.

When it is clear that a person is a danger to themselves, Mental Health Act apprehensions are made (either by regular constables or by COAST Peel). When a serious offense has been committed, but it does not appear that the person is at risk of harming themselves, charges will be laid and the individual will be taken into custody. Mental health providers are also on site at custody. Officers reported that it is much more of struggle when they answer calls where an individual is experiencing a degree of mental health distress but there is not a clear criminal offence (or perhaps not an
offense worth pursuing) or personal risk. In these cases, police are sometimes at a loss as to what to do. These struggles are also apparent in reference to individuals who may also have a developmental disability. In such cases, decisions to charge or admit may be harder to make.

While it was certainly not painted as major problem, police also struggled with individuals who they feel may be seeking admission to hospital in order to avoid police custody (e.g., when drugs or alcohol violations are involved) or to secure a night in the hospital. Sadly, it appears that for some people, admission to hospital is favored over emergency shelters.

2. **Police and CMHA Court Support.** We asked about the relationship of police to court support programs. The general consensus was that once individuals are charged and then move on to court support, their role has ended. Once a case is in the courts, the police are no longer involved, beyond submitting a report to the Crown (which may include recommendations for diversion). There was a suggestion here that police could benefit from knowing if individuals are eligible for diversion and are actually diverted, and the outcome of the case. This extra information may aid future policing if the individual has future contact with the police. Greater integration of court proceedings and CMHA court support with the police would be required.

3. **Custody and corrections.** There was brief discussion of those cases where mental health difficulties are apparent, a criminal charge is laid, and there is no risk of self-harm. In this case, the individual is taken to custody to await a bail hearing. Officers stated that individuals have mental health support when in custody, with separate cells. Since bail hearings in Peel take place everyday year-round, the turnaround time is also better than many other jurisdictions. However, officers suspected that correctional facilities (e.g., if bail was not made) were ill-equipped to deal the severely mentally ill who were likely to be detained with the regular prison population. Obviously, this is an extremely difficult environment for individuals with severe illness.

4. **Hospital wait times.** All across Ontario, emergency department wait times are considered a pressing problem. Wait times for individuals in mental health crisis are exacerbated by the related protocols of applying the mental health act and receiving an assessment. This can be particularly challenging for police because they are required by law to accompany individuals until they are admitted. In Peel Region police spoke of wait times lasting full shifts. Additionally, wait times sometimes mean that shifts roll over and new officers must take over. This is challenging since it means the details of the case need to be communicated, and information may be lost in this transition. This will also make it difficult for the relieving officers to communicate details to the intake staff. With long wait times, the environment in emergency departments may also become increasingly stressful for individuals in crisis. Separate waiting rooms for people in crisis are supposed to available, but sometimes these are full, due to back up and insufficient staff.
There was the perception among police that wait times at Trillium Health Centre have noticeably decreased and have improved greatly in recent times. Trillium was also lauded for having a more private admissions area for people in crisis and is seen as a good model for other hospitals.

5. Hospital-Police Communication. Police expressed the frustration that sometimes there is inconsistent or insufficient communication with hospital staff regarding the circumstances of a person’s apprehension, assessment upon admission, and later discharge. Police may only have the opportunity to speak to an intake nurse, rather than the emergency doctor. Police also noted that admission decisions seem to vary across doctors, with some people being discharged and some admitted, under similar circumstances. Furthermore, wait times may mean that crisis may be reduced by the time an assessment is made, leading to discharge without a conversation regarding the circumstances that led to the apprehension. Of particular frustration for police is when individuals are discharged but then fall back into mental health crisis shortly thereafter, having reentered their original environment or circumstances.

In general, police feel they are not given adequate information necessary to improve their performance in the field. In many if not most cases, there are privacy issues, and therefore police are not privy to medical and psychiatric information. One officer commented that doctors will not even talk to police because it is a breach of privacy. In another common example, police do not have any idea how often someone has come into hospital either themselves, or with friends and family, for admission under the Mental Health Act. Again, this information is protected by privacy laws.

In-patient crisis workers we talked to expressed some communication challenges from their side. As mentioned, the roll-over of police shifts will sometimes lead to serious communication gaps between officers and staff. There is also a designated report form that police can complete to communicate case circumstances, but it is seldom used. It was also suggested that it would be useful to be able to obtain a badge number in order have follow up communication after admission. Generally, however, the intake staff we talked to felt police apprehensions were most often appropriate and have improved over the years.

6. System improvements and COAST Peel. The focus group with police demonstrated great support for the COAST Peel. As mentioned, police communications can divert mental health calls to COAST Peel rather than uniformed police officers, or to Mobile Crisis if a police presence seems unnecessary. Officers from the COAST Peel team also reported that many people in the community are calling Mobile Crisis directly, since COAST Peel and Mobile Crisis teams have been distributing the necessary information on an ongoing basis. This closes an unnecessary loop in the system. In the past, before COAST Peel, crisis calls went to 911 or to Mobile Crisis (sometimes via Distress Centres), but these two groups were not integrated. Each had to call the other to comprehensively deal with the intersection of crisis and justice.
COAST Peel also creates a needed link between police and Safe Beds crisis housing. Since Safe Beds requires a mental health practitioner for admissions, police were unable to divert people in mental health crisis to this housing. COAST Peel fills this gap.

The added value of COAST Peel is also apparent in a new infrastructure for information sharing. COAST Peel is now asking officers to report to them if an individual in crisis is not admitted so they can conduct follow up aftercare support. COAST Peel teams are also currently integrating their systems to share information with police, so police have a better background on individuals in crisis. Because COAST Peel teams contain a police officer, COAST Peel responses to crisis calls are designated (in part) as police responses. This led to an interesting debate that is likely to come up as mental health and justice services approach integration. There was some uncertainty what information should or could be shared between the COAST Peel team and the wider Peel Police databases. It appears that the lines between “crisis calls” and “police calls” have become a bit blurry. Dialogue regarding appropriate policy should be pursued to clarify issues of privacy. Aside from this issue, over time, information-sharing regarding individuals in mental health crisis will contribute to enhanced police responses.

In our online survey we asked respondents to express how confident they were in their knowledge of the intake criteria of Mobile Crisis and COAST Peel (on a 5-point scale from “not at all confident” to “very confident”). Please see Table 1 for mean ratings across sector subgroups. In general, average ratings were on the positive end of the scale, with exception of the legal subgroup, which sat at the mid-point. Subgroup ratings should not be extrapolated without more information, given their small size.

Table 1 - Confidence in Mobile Crisis/COAST Peel intake/service criteria

<table>
<thead>
<tr>
<th></th>
<th>All responses (n=19)</th>
<th>Mental Health (n=7)</th>
<th>Legal (n=4)</th>
<th>Disabilities (n=6)</th>
<th>Housing (n=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence</td>
<td>3.89</td>
<td>4.43</td>
<td>3.00</td>
<td>4</td>
<td>4, 3</td>
</tr>
</tbody>
</table>

7. **Hospital capacities and discharge.** Wait times are clear indication that hospital emergency rooms, including in-patient mental health crisis sections, struggle with capacity issues. A caveat is that we only have data from one hospital, William Osler, and it was indicated that while capacity can be stretched, there are still able to accommodate. However, discharge may sometimes come sooner than what is considered ideal in order to free up beds. This can sometimes lead to later mental health distress or crisis soon after discharge. A corollary effect is that community services at discharge may not be in place in time to meet the needs of the individual.

8. **Referrals out of hospital.** Where possible, hospitals attempt to transition individuals to mental health and other community services upon discharge. For
example, short-term case management services may exist internally in order to link individuals to needed community services, including housing. We will discuss these issues in reference to the mental health services map. One gap is worth mentioning: if an individual in mental health distress is brought into hospital by police, but then discharged upon assessment, there appear to be very few opportunities for referral upon their release. Mental health distress may not have warranted a hospital stay, but difficulties may persist – or get worse – without intervention. As mentioned above, COAST Peel is attempting to fill this gap.

**Mental Health Services**

Mental health organizations composed the core of participants in the system mapping research, representing the bulk of services that organizations receive and make referrals for people with mental health difficulties who are also in contact with the law. Synthesizing the wide range of mental health organizations and their programs in a system mapping exercise is particularly challenging. Indeed, a system map that attempts to capture referral relationships at an individual organizational level would likely be unintelligible. We have divided mental health services into two broad categories:

1) **Case Management Services**: Individualized support services ranging from short-term and intensive to long-term. This category includes ACT Teams and CMHA Justice Case Management.

2) **General Mental Health Services**: Outpatient services, day programs, group programs, clubs, consumer-run initiatives, distress lines, etc.

All these organization types make referrals to each other in a variety of ways. They also all tend to make referrals to other sectors and organizations, such as CMHA court support, other parts of the legal system, the housing/shelter sector, hospitals, and variety of other community services (e.g., government supports, employment, social recreation, etc.).

Figure 4 displays the Mental Health Services system map. Referrals to and from mental health services (i.e., in addition to the referrals they make to each other) appear outside the mental health services cluster.

**Referrals between mental health agencies**

In all our research methods, we asked organizations where their referrals typically come from and, conversely, where they refer individuals to. Our concern was specifically those individuals who have mental health difficulties and who are also in contact with the law. From our analysis, we know that most mental health
organizations/programs tend to receive and make the same sorts of referrals; and the differences in referral practices between organizations are far fewer than the similarities. In this section we review a few challenges experienced by mental health organizations in reference to referral practices.

Figure 4 – MAP #2: System Map for Mental Health Services

1. Case Management. Short- and long-term case management services are provided by a number of organizations in the region including CMHA (both Justice-focused and general), William Osler Health Centre (through their CMHC), and Trillium Health Centre (through ReLinc). Case management services do not typically exclude people from support if they have been in (or end up having) trouble with the law. It is not uncommon for people in regular long-term case-management to have legal difficulties. People may be excluded from case management services if there are staff safety concerns due to a history of violence or other high risks. Additionally, full disclosure of risk information is typically required. CMHA Peel Justice Case Management also requires that a clear link can be made between a person’s illness and an offence; and they must have some insight into their illness and be prepared to actively engage in the service.

Not unexpectedly, access to case management services is greatly limited by waiting lists in Peel Region. There is a typically at least a year waiting time to access most long-term case management services. In our focus groups, waiting lists were
viewed as the main access barrier to general case management services, rather than exclusionary criteria based on a justice history.

2. General Mental Health Services. Respondents associated with general mental health services did not tend to specify any exclusionary criteria with regards to people who are in legal difficulty. Similar to case management services, there are provisions that people who are deemed “high risk” (violent, abusive, sex crimes, etc.) may not be served. The formal nature of these organizational policies communicated in the research may obscure what actually happens in practice, precisely because there is general ambiguity surrounding the definition of “high risk”. It is unclear how this definition is being applied and how service providers are making the determination of risk in the first place. Risk could be based on a label associated with a case file, clinical assessment, criminal record, or on trial periods in programming.

   It has been the experience of the partnership committee members that the criteria for exclusion among mental health agencies are unclear and inconsistent (“floating” criteria). A troublesome possibility is that mental health organizations exclude by over-applying “high risk” labels to people with criminal records, quite independent of real risk or reasonable knowledge of criminal background and behaviour. This may include making referrals out of their services on the grounds that people need special supports based on their supposed criminality – even when there is little evidence that the supports they need are any different from people with mental health difficulties that are not involved in the justice system. Psychiatrists were named as particularly difficult to access for these reasons.

   Finally, assessment of risk requires intake procedures that include “full disclosure”. This may be a significant disincentive for people to access services due to their own privacy concerns. If an individual does not fully disclose and is “found out”, services may be withdrawn. This level of disclosure may be fairly unique to mental health among the broader health service sector.

3. Referrals to Housing & Shelters

   Unsurprisingly, housing for people with mental health difficulties was viewed as a fundamental and pressing issue among respondents. The instability and stigma caused by legal troubles further narrows the housing and shelter options for people. As with most Ontario communities, housing options are limited in relation to need. The main housing providers are:

   • Supported Housing in Peel (SHIP) provides long-term residential options to people with mental health difficulties. This includes group homes, capital properties, and rental agreements with private and non-profit housing organizations in the region. SHIP also continues a partnership with Supported Housing in Etobicoke/York.
- SHIP administers Safe Beds, for short-term residential crisis for people with justice issues.
- *Peace Ranch* provides supportive housing and rehabilitation in country residential setting for up to 20 individuals with mental health difficulties. Intake is managed by SHIP.
- *St. Leonard’s of Peel* provides long-term residential support to homeless men with mental health problems and/or difficulties with the justice system.

In addition to these housing options, there are a number of related support programs delivered by housing and general mental health services and designed to secure stable housing. This could include the private rental market. Other options include emergency shelters within Peel and in the surrounding jurisdictions, such as Etobicoke and Toronto.

Respondents reported that waiting lists for long-term housing programs were exceptionally long, ranging from 4 to 10 years. Long wait lists are further complicated by a number of factors:

- Housing programs in general tend to exclude people with violent or sexual crime history. These barriers are similar in the private housing market where landlords insist on references, employment/income information, and other disclosures. The “high risk” label and its associated ambiguities may be as relevant to housing as it is to mental health services.

- In addition to standard eligibility requirements, clinical assessments are also necessary to qualify for supported housing. As mentioned in the previous section, securing an assessment can prove difficult. Given the waiting lists, however, this is likely not a significant barrier.

- Lack of long-term housing means people suitable for long-term housing are referred to emergency or crisis housing instead. For example, Safe Beds needed to clarify their policy on differences between a mental health crisis (which it is designed to address) and a “housing crisis”. Emergency shelters, which can be difficult and stressful environments, receive many individuals who would otherwise be good candidates for long-term supported housing.

- A shortage of housing leads to referrals outside of Peel. This means individuals are being removed from any local resources (friends, family, workers, employment, etc.) that they might have.

- Waiting lists do not accommodate changing circumstances. If eligibility changes (such as wanting to cohabit with a partner), individuals can be “bumped” off the list. Fluctuating needs can mean “starting over”.

- Because housing is such an urgent issue, case management services are receiving referrals when the need is essentially a housing issue. Case
management priorities are for individuals needing more comprehensive mental health support.

- In general, because of life instability, it much more unlikely that people with the compounded problem of mental illness and justice problems will manage to stay on a waiting list for the full required term to obtain housing. This was conjectured by several respondents, and requires more direct clarification. Do people in trouble with the law get on waiting lists, stay on them, and obtain housing?

In the online survey we asked respondents to rate their confidence regarding the intake criteria of Safe Beds. Mean ratings are displayed in Table 2. On average, they are high and towards the high confidence end of the 5 point scale. As with ratings of Mobile Crisis/COAST Peel, the Legal subgroup was lower at the midpoint. Our cautions regarding the small n’s of subgroups similarly apply.

Table 2 - Confidence in Safe Beds intake/service criteria

<table>
<thead>
<tr>
<th>All responses (n=19)</th>
<th>Mental Health (n=7)</th>
<th>Legal (n=4)</th>
<th>Disabilities (n=6)</th>
<th>Housing (n=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.89</td>
<td>4.57</td>
<td>3.00</td>
<td>3.50</td>
<td>5, 4</td>
</tr>
</tbody>
</table>

4. Hospitals and Mental Health Services

(see Map in Figure 3, #8)

5. Referrals to Legal Services

As mentioned, direct examination of legal services in the system was not a priority for this research, while CMHA justice diversion services were covered in the previous evaluability assessment. However, our research methods included discussion of certain aspects of the legal system as it applies to mental health diversion.

In our online survey we asked respondents to express how confident they were in their knowledge of the intake criteria of CMHA justice diversion services (on a 5-point scale from “not at all confident” to “very confident”). Please see Table 3 for mean ratings across sector subgroups for Justice Case Management Services, Court Support and Discharge Planning. All three justice components were on the positive side of the mid-point for the full sample and for all the subgroups. It was encouraging that the mental health sample, while small, demonstrated high confidence in this respect, since it is a main referral source. That said, all sub-groupings are small in number and therefore the means may not be representative more broadly.

Table 3 – Confidence in CMHA MHJDS intake/service criteria

<table>
<thead>
<tr>
<th>Component</th>
<th>All responses (n=19)</th>
<th>Mental Health (n=7)</th>
<th>Legal (n=4)</th>
<th>Disabilities (n=6)</th>
<th>Housing (n=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court Supp</td>
<td>3.79</td>
<td>4.29</td>
<td>3.25</td>
<td>3.67</td>
<td>4, 3</td>
</tr>
</tbody>
</table>
In terms of referrals out of CMHA Justice Diversion services, members from Trillium case management indicated that they did not receive a lot of referrals, and were uncertain why this was the case. From their perspective, they do not exclude people with justice issues (aside from risk and safety issues) and would expect CMHA to refer. The assumption of respondents is that the Trillium case management waiting list is a disincentive for referrals, a legitimate reason (i.e., wait lists top one year). But ultimately they are uncertain of the reasons, suggesting lines of communication could be more open.

The qualitative results matched the ratings above fairly well. People were aware of the justice diversion options, which some minor caveats regarding confusion over roles and communication between organizations. Community legal agencies (e.g., Elizabeth Fry Society, John Howard Society), have an ongoing need to refer their clients to mental health supports and Justice Diversion services. Good referral relationships exist. The process for referrals perhaps needs to be further reviewed with community partners.

Two other relevant issues were mentioned by respondents:

- One respondent expressed concern that other courts are overriding diversion recommendations. For example, domestic violence courts have in the past denied diversion recommendations when the defendant was a good candidate for diversion.

- There was a feeling among some respondents that there are defense lawyers that are receptive to difficult legal cases where there is a contributing mental health issue. Mental health providers recommend the creation of list of lawyers who would be willing to take such cases and investigate the potential for diversion.

**Dual Diagnosis & Disabilities**

An additional target of cross-sector integration in mental health and justice is the area of dual diagnosis. Many people with developmental disabilities also suffer from additional mental health difficulties. When individuals also get in trouble with the law, barriers to responsive services and supports can be even more severe. Mental health and justice services (especially the former) have begun to pursue greater coordination with dual diagnosis services in the region. Map #3 in Figure 5 is a simplified map that links the dual diagnosis sector to three areas: 1) Housing & Shelters; 2) Mental Health & Crisis Services; and 3) Legal Services. It is assumed that the issues discussed in reference the Mental Health Services map (Map #2 in Figure 4) are at least equally
applicable to people with a dual diagnosis. This section describes challenges and issues specific to the experiences of organizations serving people with a dual diagnosis.

Figure 5 – MAP #3: System Map for the Dual Diagnosis Sector

1. Housing and Dual Diagnosis

Individuals with a dual diagnosis face the same types of barriers when trying to access housing as do individuals with mental health issues alone, only that it appears that they are even more pervasive and difficult. Housing dedicated to people of dual diagnosis does not specifically exist in Peel. It is therefore often difficult for support workers to decide which is the most appropriate option – housing for people with developmental disabilities, housing for people with mental illness, or independent living. Housing options are also limited by the fact that people will often require much more intensive care, sometimes full 24-hour attention. This level of supported housing is severely lacking in terms of availability and the necessary human resources and skills to meet the need.

2. Links to Mental Health Services

Accessing psychiatric assessments is particularly difficult in Peel Region because there are not enough psychiatrists, compounded by many psychiatrists declining to serve individuals with criminal backgrounds. When there is a dual diagnosis, another challenge is apparent in that psychiatrists and psychologists do not feel they have the skills and knowledge to make a mental health assessment with the presence of disability. This is a large gap in Peel Region.
People with a dual diagnosis are also ruled out of mental health case management or other services because mental health professionals do not have experience in working with people with intellectual disabilities. Case management criteria may include “ability to have insight into illness”; this may exclude people with intellectual disabilities. In general, the combination of mental illness, developmental disability, and justice problems creates a severe pile up effect of existing barriers, making service access quite difficult.

We heard, however, that the dual diagnosis sector is much better resourced than mental health to do one-on-one support work. This is a positive system finding because customized, individualized, flexible support is exactly what is required to navigate the system and meet complex needs.

3. Links to the Legal System

People with mental health difficulties alongside developmental disabilities require highly individualized, flexible support. Workers in the dual diagnosis sector have long recognized that enhancing quality of life and community living requires is dependant upon full engagement with a person’s individual needs. Some respondents expressed frustration that they often had concrete and highly useful suggestions to police and the courts on how best to engage with and support specific individuals, but the response was unreceptive. This represents a great challenge in cross-sector coordination. Quite clearly, it is a very resource heavy and a very different way of doing things for police officers and the courts to consider the best ways to engage with people on an individual-by-individual basis. While the dual diagnosis sector is set up to provide customized, one-on-one support, the justice system is not. Since workers can often supply very rich information about an individual’s life and experience, there needs to be dialogue on how to connect people to the justice system in a way that best meets their individual needs. A related problem is that psychiatrists who can interface with the courts are difficult to find.

There was also a general suggestion that it was sometimes difficult for workers in the dual diagnosis sector to get information and communicate with mental health and justice services and supports. Respondents recommended that there needs to be significant education of people in the legal system, notably lawyers. The feeling is that there are only a few lawyers who are supportive and where the process goes smoothly. Police also need some guidance on developmental disabilities, since it was suggested that police may not know when to charge, or be disinclined to charge, when there appears to be a disability. This can send the wrong message to individuals who may continue to commit offenses.

Recommendations

Based on the research findings we have developed a set of summary recommendations to enhance system coordination within mental health and justice diversion services.
COAST Peel & Police Services

It appears that COAST Peel is making a significant impact in the crisis sector, although it has just recently been in full operation. Ongoing collection of data regarding COAST Peel, Mobile Crisis, and Police mental health calls will be able to track changing referral patterns and supply additional empirical data about how the crisis response system is changing.

COAST Peel needs to reexamine its protocols for information sharing, since it was clear in the focus group that there was some confusion about what types of information about individuals could and should be shared between police and mental health services. We see this as a natural and expected difficulty of cross-sector coordination that can be further clarified with organizational policy dialogue.

As the Police and Crisis Services achieve greater integration, what will follow is greater access to information by police. There is some tension on this point among constables. There are fairly clear protocols for arrest or apprehension based on the real time event in question, and police are usually quite comfortable in making decisions based on this information. However, when new information regarding mental health status begins to enter the system, there is some ambiguity as to how it could or should be used. One officer wondered how information about mental health should change their decision-making in the field, if at all. Others thought extra information would likely be helpful. On the whole, we recommend that police continue to have dialogue with the mental health sector in regards to how new categories of mental health information should be interpreted and used in their work.

This echoes an ongoing need for police education in general. Mental health training has been delivered to officers in Peel Region, but could be enhanced by general refreshers and inclusion of issues specifically related to Dual Diagnosis.

Mental Health Services

It was quite clear, and not particularly unexpected, that the biggest impact to be made in the system is to reduce waiting lists for case management services and housing. These are difficult problems to solve, especially housing, which requires significant changes to infrastructure and funding in a range of sectors.

Criteria for mental health services need to be clarified across the system. We hoped this research could provide such a clarification – it did not, primarily because the concept of “high risk” is not an objective term and is interpreted differently across and sometimes within organizations. Cross-organization engagement around the issue of “high risk” needs to occur, starting with case management and ACTT teams.
We also wonder what opportunities are available to develop justice case management in other organizations? Having a cross-organization and coordinated approach to justice case management services could improve the integration of other organizations’ case management with CMHA’s existing court support and discharge planning.

Housing

The concept of “high risk” needs to be similarly discussed among organizations in Peel in regards to housing access. How “high risk” is defined and applied has serious implications on housing access. We heard examples of how a criminal record, such as “assault with weapon”, can be used to deny access to housing, with little or no investigation into the context of the crime and/or elements of restitution or reform. If these criteria are not discussed, we suspect that the non-justice mental health consumers will continue to be those represented in units and waitlists, at the expense of those with justice problems.

“Shifting eligibility” for access to housing needs to be addressed. We heard that the lives of people under concern can fluctuate dramatically over time, creating periods of eligibility and ineligibility. Sometimes this can mean losing one’s place on long waiting lists.

Safe Beds was a common referral place for other organizations. However, there is still lingering confusion regarding admissions criteria. Safe Beds has taken direct action on these issues, attempting to more clearly define “crisis” and distinctions between “housing crisis” versus “mental health crisis”. These clarifications need to be broadly communicated to their referral sources, if this has not happened already.

Hospitals/In-patient Crisis

As with most jurisdictions in Ontario, hospital emergency wait times for in-patient crisis admission are long. Many of the issues lie with hospital resources and are thus difficult to impact. Aside from wait times, there are opportunities to improve coordination and communication. A police report form documenting apprehensions and hospital admission already exists, but is underused. Police and hospitals should determine if and how this form is helpful and try to increase use. More importantly, there do not appear to be any concrete procedures for follow up between hospitals and police. Such follow up would be greatly beneficial to police to know the outcome of the admission/discharge in order to assess their responses and decision making.

In a related issue, clarification is needed regarding what information regarding patients is private and what can be disclosed to police. Currently, it appears that privacy concerns have translated into little or no communication upon admission straight
through to discharge. Surely, there is some information that could benefit police that is not protected by privacy considerations. *Opportunities and limits of police-hospital communication* need to be discussed.

*Pressures that exist for “earlier than ideal discharge”* need to be examined. Hospital capacities may be accommodating intake rates, but may be sometimes doing so at the expense of discharged patients who could otherwise benefit from a longer stay. Understandably, there is no objective information on “earlier than ideal” discharge, because hospital staff making such decisions would never formally make this determination. Certainly, minimum requirements for discharge are being duly observed, but in some cases it is unclear if these requirements are sufficient.

This issue has as much to do with the environments external to the hospital to which people are returning. This is a complicated issue that could be better understood if we knew the contexts and outcomes of discharge. The system would benefit from asking “what happens to people after discharge?” and “how do different circumstances of discharge affect these outcomes?” While discharge practices may be completely appropriate for someone going home to safe environment, they may be less appropriate if one is discharged to the street with no place to go. The latter could engender renewed crisis.

**Dual Diagnosis**

As mentioned, systemic barriers to services and supports in Peel are as relevant to people with a dual diagnosis as they are for people with mental health difficulties. In some cases, barriers are can be even more difficult, especially when the mental health side of the system is unable to meet the needs of people who also have a developmental disability. While it is clear that the dual diagnosis sector has needed its own designation, infrastructure, and dedicated streams of funding to ensure that specialized needs are met, a drawback has perhaps been a division that prevents integration. Future development of the system could consider greater integration of dual diagnosis into existing mental health organizations and programs. *Developing dual diagnosis expertise and resources within mental health services* represents a more seamless and integrated approach to community support. Examples exist in some parts of the system, such as ACT teams.

Finally, education in the courts regarding the special needs of people with dual diagnosis is necessary to make justice diversion services fully inclusive.
Conclusions

The risk of poverty is greatly increased in the presence of mental health crisis and long term mental health difficulties. The combination of poverty and mental illness also tends to put people at risk of entering the justice system. If one also considers the contributing factors of intellectual disability and addictions, that risk becomes even greater. That the justice system is often ill-equipped to handle the complex needs of people with mental health difficulties is the impetus behind developing mental health and justice diversion services.

The current examination of the relevant systems and organizations in Peel Region demonstrated that significant barriers still exist in the system to promote diversion and meet the needs of the most vulnerable. There is also reason for optimism, as certain areas of the system are developing in a thoughtful way to meet these complex needs. But underlying the need for diversion appears to be a general problem of stigma and misunderstanding about the “mental health justice population”. On the whole, there is little reason to believe that people in trouble with the law can be meaningfully separated from other people with severe and persistent mental illness who are not, currently, in trouble with law. However, mental health and other community services assume that these differences are definable and functional. In a minority of cases, where there is significant violent pathology for example, this may be true. But on the whole, people who suffer from mental illness are at risk for homelessness, poverty, and unfortunately, run-ins with the law. Essentially, there is not a “justice population” – there is merely a population of people with mental illness who all, more or less, fall within the service mandate of mental health organizations. People in trouble with the law do not typically require specialized mental health services, although they do require specialized justice services. This is a crucial distinction and broad advocacy efforts need to be made to change public and professional perceptions of the so-called “mental health justice subgroup.” Alongside education and dialogue, partnerships in Peel Region are moving forward with innovative ways to divert people with mental health difficulties from the justice system into more responsive supports and services.
Appendix A – Focus Group Questions & Probes, Mental Health

• CCBR conducted an evaluability assessment of MHJDS in reference to several organizational partners
  – CMHA
  – COAST Peel
  – Peel Region Police Services
  – Safe Beds
• The goal of this project was to assess the barriers and challenges within the system of mental health and justice services and supports
• This was important to understand before moving to evaluation of outcomes.
• *We want to expand the discussion beyond the partnership and speak to a wider range or organizations in Peel.*

Three Main Questions for the Focus Group

1. What are the referral practices in your organization and the system to meet the needs of people with MH difficulties who are having difficulty with law?

2. What are the barriers to successfully coordinating services and referrals? What are the service gaps?

3. What recommendations do you have to remove/reduce barriers?

Tell us about your organization

First, let’s hear about what your organization does – the people you serve, the services you provide, and how your organization fits into the area mental health and justice diversion services in Peel Region.

Building our list of MHJD services in Peel

We have a printout of a *range of organizations* (not exhaustive, but fairly comprehensive). We want you to think about and refer to this list as we go through the focus group questions regarding referrals sources and destinations. One question to keep in mind: Who are we missing?

Referrals into your organization
1. How do people get connected to your services? From which types of organizations do you typically receive referrals? Remember we are talking about people who have mental health difficulties and who are in (or have been) in conflict with the law.

We are going to talk about specific referral types in turn.

2. What sorts of barriers does your organization experience when receiving referrals from other organizations?
   i. Inappropriate referrals (unable to provide services, don’t fit your criteria)
   ii. Inadequate information

Referrals out of your organization

3. What are some of the more common referrals that you make for people? To which types of organizations do you make referrals?

We are going to talk about specific referral types in turn.

4. What sorts of barriers does your organization experience when making referrals to other organizations?
   i. Not sure what other organizations exist to meet the need
   ii. Specific problems in getting people connected to other organizations.

Current and recommended practices to enhance service coordination in Peel

5. What are you currently doing to try to improve referral practices to and from your organization? Can you give some real examples?
   i. Policies and procedures
   ii. Referral tracking

6. What else could be done to improve system coordination in Peel for this consumer population?
   i. Information sharing
   ii. Partnerships
   iii. Reducing overlap

Our next steps
Appendix B – Focus Group Questions & Probes, Peel Regional Police

Peel Regional Police comes into contact with people with mental health difficulties under many different circumstances.

1. What are the main steps police take to handle mental health related calls for service? When police are handling calls involving people with mental illness, what options do they have to best serve individuals and the community?
   - MHA – hospital
   - Charge.
   - Diffusing situation
   - Mobile Crisis
   - *Links to the courts, court support*
   - Links to MH services, without MH

2. What are some of the main challenges police experience when exercising these options?
   - are there times when it is difficult to know if/when to try to divert? MHA is only recourse?
   - Disincentives to go to hospital?
   - What happens at hospital?

3. What recommendations do you have to address these challenges? What types of support or training do police need to improve their ability to respond to these types of calls?

4. What procedures do police use to document and track mental health related calls for service?

5. What information do police need or want to better understand how the system is working to divert people with mental health difficulties from the justice system?