London, Ontario

ADULT THERAPEUTIC COURT/ COURT SUPPORT & DIVERSION

A Review of Health Services within the Court Model

Prepared for the

South West LHIN

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Executive Summary

Since its inception the Adult Therapeutic Court and its many stakeholders have worked diligently to respond appropriately to individuals with a serious or persistent mental illness who commit minor low risk offenses. The Court's timely, appropriate intervention and follow up by way of linkages to a continuum of community-based treatment and support services requires strong and creative community partnerships, effective coordination of services and close collaboration amongst stakeholders. Much of the success of this court is built on history / people / connections. Trusting professional relationships, a shared vision of targeted outcomes, a common commitment to the diversion process, judiciary leadership and a collective desire to respond benevolently to the needs of this population drive the London model.

When benchmarked with other jurisdictions Adult Therapeutic Court exceeds best practice recommendations and offers a functional example of successful community partnerships and client outcomes.

While the court is highly effective and sustains itself with limited resources and funding, there are opportunities to improve and streamline health services and efficiencies. Based on consultations with court stakeholders and community partners, the following **recommendations** should be given careful consideration *by existing health service provider's currently dedicating services and staff to the Adult Therapeutic Court:*

1. Ensure all court support positions provide frontline services as their primary function. Frontline work and/or or clinical support is prioritized over administrative tasks.

2. Realign resources to reduce administrative responsibilities of the RN Assessor and/or re-align resources to create a second RN Assessor position. A second RN Assessor, with a solid nursing background in emergency psychiatry and mental health, could expedite assessments and linkages/re-linkages to appropriate services in the community. Likewise, reducing the administrative function of the RN Assessor could expedite these same assessments and serve to connect clients effectively to suitable services.

3. Formalize linkages with consistent psychiatrist(s) to attend or be accessible to court staff regularly.

4. Streamline services between court diversion/support program and community services by dedicating one service to provide triage, re-integration planning, housing advocacy, co-ordination of multiple community partners and evaluation of clients' needs when in or out of custody. This one service will maintain responsibility for the flow of information between partners and be a lead contact with community agencies, in an effort to reduce duplications in service.

5. Ensure the resources of the Special Needs Unit, at Elgin Middlesex Detention Centre, are dedicated to supporting inmates with special needs.

Models of mental health courts vary across the country and between the sixty-nine mental health courts in the Province of Ontario. While common elements between models do exist, there is multiplicity in police pre-arrest diversion, court diversion and mental health courts. The resources and outcomes of each court differ between municipalities as does the volume of cases and community partnerships. The primary goals of each model however, remain the same:

- To reduce contacts with the justice system for individuals with a serious or persistent mental illness (as defined by disability, duration and diagnoses) who commit minor low risk offenses, through timely and appropriate intervention and follow up by way of linkages to a continuum of community-based treatment and support services.

- To develop and implement effective and efficient strategies that link the mental health / justice systems to appropriately meet the needs and improve outcomes for individuals who, due to mental illness, come in to minor conflict with the law.

- To serve the community appropriately and safely.

The issue of mentally ill people inappropriately involved in the criminal justice system has been a social policy concern in Canada for decades. In 1976, the Law Reform Commission of Canada stated that "when dealing with a mentally disordered person, the criminal process should be invoked only when no other viable social alternative is available." However, deinstitutionalization and lack of community based services for those with severe mental illness, along with changes to the Criminal Code and Mental Health Act in some jurisdictions have resulted in increased numbers of mentally ill in the justice system [i] and has historically led to the "criminalization of the mentally ill" in Canada[ii] and elsewhere[iii]. Recent Canadian research has confirmed that a substantial number of federal inmates have a mental disorder; 7.7% of federal inmates reported psychotic disorders, 21.5% reported depressive disorder and 44.1% reported anxiety disorder. In the provincial correctional system, estimates of detained inmates who require some form of clinical intervention for mental disorders range from 15% to 20%.[iv] Many of these persons are charged with only misdemeanour offenses[v]. The typical cycle is often a "revolving door" in which they go through repeated arrests and counter-therapeutic terms in jail. In view of this trend, collaboration between the justice and mental health systems to address the issue has become increasingly important.[vi]

Diversion provides an alternative and favourable option to 'usual care' or proceeding through the justice system and a significant reduction in costs to the justice system for this population. The decrease of police complaints and complaints against this population coupled with the reduction of court appearances made by diversion clients represents a much more efficient use of resources and a cost saving to the justice sector. Similar cost savings to health care are demonstrated in the resent research from the join Mental Health and Justice Calgary Diversion Project. Utilization of Calgary Health Region emergency rooms fell by 20% and their number of inpatient hospital days was reduced by 45%, comparing 9 months after referral to the same period before referral.[vii]

This same research demonstrated a significant improvement in clinical symptoms and aspects of quality of life such as occupational activities, social relations / support, as well as overall quality of life for clients from diversion entry to follow-up. There was a statistically significant improvement in participants' symptoms between program entry and exit. The majority of eligible clients presented with symptoms in the very mild-to-moderate range at program entry and very mild - mild symptoms at program exit. This same research has shown a withdrawal of client charges in 75% of cases and that linkages with community services were established and maintained at follow-up in 65% of cases. Typically clients who have had some involvement with diversion have shown a reduction in the number of contacts with the justice system. Overall, both complaints resulting in charges and actual charges decreased by 60%, and court appearances decreased by 74% when 9 months pre and post Diversion timeframes are compared.[viii]

102 Court in Toronto began operating in 1998 and was the first and only full-time mental health court in the country. The creation of this dedicated court was motivated by factors such as the perception of an increased number of mentally disordered accused in the criminal justice system, and the inability of regular courts to provide an appropriate response to this population, as well as the slow rate of processing these cases. The features of 102 Court include: shared space with the Ontario Review Board to facilitate fitness assessments; a psychiatrist on site five afternoons a week to conduct assessments; nine social workers and a case manager; adjoining cells, dedicated duty counsels, Crown Attorney and judges.[ix] 102 Court deals with 3000 accused each year and while the 102 Court model has been effective in the City of Toronto, police pre-arrest diversion, court diversion and mental health courts assume different formats and schedules, in different jurisdictions. In

Sudbury and Brampton mental health court sits two days per week, in Ottawa three days per week, in Newmarket one day per week and in Sault Ste Marie one day on alternate weeks. Likewise, differing definitions of success exist between communities. Charges stayed represent a successful outcome in one court, letters of satisfaction or reduced recidivism in another. Some courts decline to stay charges if the client doesn't comply with the diversion plan; some courts will not allow a person who re-offends to be diverted, while others do. A range of diversion/court support services are available across Ontario and reflect the various interfaces between the mental health and criminal justice system. Each model, in each community has differing community partners and resources, varying challenges and strengths.

Despite the differences in models, there exists common elements:

- All persons with mental illness identified for referral to community-based services are handled on a single court docket;
- A courtroom team approach is used to arrive at recommended treatment and supervision plans;
- Assurance of the availability of appropriate treatment is necessary before the judge rules;
- Appropriate monitoring occurs under the aegis of the court, with possible sanctions for noncompliance such as reinstituting charges for sentences;
- Court staff, including judges, function in accordance with the principles of therapeutic jurisprudence;
- A linkage to a varying range of treatment and support services, underpinned by inter-agency cooperation and collaboration;
- Much of the courtroom process is aimed at making an initial assessment of an individual for mental illness, and then moving the person with mental illness out of jail and voluntarily into treatment as expeditiously as possible;
- Participation of all key players from the initial planning process of the mental health court to periodic meetings and evaluation after the court is operating.

Recommendations on "best practices" for diversion programs and mental health courts place emphasis on coordination, service development and training.[x]

To facilitate the necessary coordination, best practices include the establishment of an ongoing interagency task force to: develop a comprehensive multi-agency service plan; and to develop interagency rules, regulations, policies, procedures and memoranda of

understanding for comprehensive care and treatment, service continuity, service evaluation and exchange of information.

To promote service development, the interagency group should address: early identification and disposition of persons with mental illness; establish close links with hospital and community-based services; client-centred, proactive and advocacy oriented services; easy referral; active promotion of treatment compliance by ongoing communication and collaboration with clients; case management services for those who need and request them; and mechanisms for exchange of information and continuity of care.

The interagency group should also ensure the development and implementation of continuing education for all members of the mental health and justice systems concerning the language, issues and needs of each other's systems, and on the nature and identification of mental illness.

These points on best practice are similar to five key elements that were associated with diversion programs that were perceived to be the most successful.[xi]
The key elements identified were:

1. all relevant mental health, substance abuse, and criminal justice agencies were involved in the program development from the start;
2. regular meetings were held among key personnel;
3. integration of services was encouraged through the efforts of a liaison person, or "boundary spanner" between the corrections, mental health and judicial staff;
4. programs had strong leadership;
5. non-traditional case-management approaches were used, with staff hired for their experience across the systems. .[xii] (p. 1620)/Calgary

In benchmarking the London court to identified best practices, London's model meets and exceeds many of the recognized best practice standards including the five key elements associated with diversion programs that were perceived to be the most successful.[xiii] Namely, London's relevant mental health and criminal justice agencies were involved in the program development from the start; regular meetings are held among key personnel; integration of services is encouraged through the liaison efforts between corrections, mental health and judicial staff; the model uses a non-traditional case-management approach and the court has strong leadership both from the

judiciary and stakeholders.

London exemplifies a best practice client-centred approach even its title. 'Mental Health Court,' is the common term for the model around the province and while London's court began with this same label, it has evolved to instead designate itself a 'therapeutic court' placing emphasis on the treatment, therapy and change function of the court, instead of the presenting condition of its population. In many ways, this sensitive shift in language reflects the culture and approach of the London model, encompassing a recovery approach and a core belief in the individual's ability to change and heal.

Adult Therapeutic Court complies with many best practice standards including the early identification and disposition of persons with mental illness; the establishment of close links with hospital and community-based services; client-centred, proactive and advocacy oriented services; active promotion of treatment compliance by ongoing communication and collaboration with clients; case management services for those who need and request them; and established mechanisms for exchange of information and continuity of care.

Best Practice standards and service delivery models are continuously evolving both in the Province of Ontario and internationally. A significant trend towards adopting clinical teams consisting of registered social workers and nurses, as primary court supports is evidenced across Canada. The Calgary Diversion Project best exemplifies this practice and a current movement towards creative, court supported service delivery. The Calgary model includes a Community Diversion Linkage Options (CLASS) team that in addition to acting as the primary liaison with mental health and psychiatric services, addiction treatment, pharmacy, medical care, accommodation, support/self-help services, aboriginal services and legal services, provides a short term 'day program' that offers time limited psycho-education, skill building and meaningful activity. Bringing these resources in effect to the court room 'door' ensures continuity of services and builds on the support services already provided. Unlike the Adult Therapeutic Court the Calgary project receives multi-sector funding and is aptly resourced. However, the London model may contemplate evolving services and the hiring of any additional staff with this best practice in mind.

Defining the target population of diversion/court support services varies across the Province. Program target population(s) have been defined in response to various factors, including Government policy/funding initiatives, local need and resources, (i.e., range of services available, integration and cooperation across local health, criminal justice and social service systems), and program capacity (i.e., program mandate, staffing expertise, etc.).

The target population for the London Adult Therapeutic Court includes:

1. Adult, 18 years of age or older.

2. Suffering from an acute brain injury, fetal alcohol spectrum disorder, developmental disability or a mental disorder: a substantial disorder of thought, mood perception, orientation or memory that grossly impairs: a) judgment; b) behaviour; c) capacity to recognize reality, or d) ability to meet the ordinary demands of life.

3. Charged with a minor low risk offence: a) assault; b) theft; c) possession of stolen property; d) fraud; e) false pretense; f) mischief- property related; g) cause disturbance; h) transportation, lodging and meal fraud; i) obstruction of a peace officer; or j) other minor charges on a case-by-case basis.

4. Crown counsel must be satisfied that the charge has a reasonable likelihood of conviction.

5. Diversion must not be contrary to the public interest, with the safety of the public being a paramount consideration.

6. A prior criminal record or diversion under the program or other programs does not preclude diversion, though both factors are relevant considerations in the exercise of the Crown's discretion to divert.

7. The accused accepts mental health diversion.

8. It is not necessary for the accused to admit guilt for the offence.

9. Substance abuse in addition to suffering from a mental disorder does not preclude eligibility for participation in the therapeutic court.

A number of justice sector partners are involved in the operation of Adult Therapeutic Court, in addition to community based agencies and health care services that provide varied front line support to clients and their families. The success of this court is largely, in part, attributable to the close collaboration between justice sector, health care and social service partners. Key stakeholders include the judiciary, the Crown Attorney, St Joseph's Health Care, Regional Mental Health Care (RMHC), Community Mental Health Association London-Middlesex (CMHA), Elgin Middlesex Detention Centre (EMDC), area police services and criminal lawyer representatives. The close collaboration between these stakeholders is essential to the current work and success of the London model.

One dedicated Crown Attorney staffs the Adult Therapeutic Court and historically one dedicated Justice has presided. This has ensured continuity and maximized effective decision-making with this special population. Likewise, a dedicated registered nurse Assessor from RHMC, together with three designated community support staff, or 2.5 full-time positions, from the area CMHA branch and consistent representatives from EMDC and the defense bar attend weekly; ensuring constancy and familiarity with matters, clients and their families. The consistency of the individuals, in their various roles, helps to increase the clients comfort level, decrease their anxiety and provide a largely unchanged environment in which to return to during the court process. The services provided by the court's support staff and RN Assessor are geared towards stabilizing participants' mental illness, increasing their capacity to live successfully in the community and reducing their likelihood to re-offend and to become acutely ill. Court services are intentionally short-term and include: thorough assessment; linkage or re-linkage of clients to appropriate services in the community, such as mental health services, secure housing, income, employment, meaningful activity, and education. Linkages are the 'heart' of the court program; they are what help establish or re-establish connection to services and thus stability in the community.

Because there exists no formal partnerships, or dedicated court funding, outside of service agreements with the Community Mental Health Association London-Middlesex and Regional Mental Health Care, the effectiveness of adult therapeutic court hinges on the commitment of its various partners, the trusting relationships established between partners and a collective willingness to work creatively to best serve clients presenting in court. Community based partners and services include St. Leonard's Community Services, WOTCH (Western Ontario Therapeutic Community Hostel), Dale Brain Injury Services, John Howard Society, Salvation Army, Mission Services of London, London Health Sciences Centre PEPP (Prevention & Early Intervention in Psychosis), Streetscape, Community Care Access Centre (CCAC), ACTT (Assertive Community Treatment Team) and Regional Support Associates. These services, with the exception of St. Leonard's, typically attend court on a semi-regular basis, when supporting a current or active agency client, or when required. St. Leonard's has designated a social work coordinator to attend court weekly, to support current clients, provide assessments, accept referrals and/or liaise with court staff and other community programs.

Court stakeholders indicate that they creatively access differing community services depending on the needs of the client. Resourceful efforts are made to link clients with relevant supports, regardless if an agency or service is directly connected with or is a primary partner of the court. Illustrating this point is the court's recent engagement of Rehoboth Maternity Home & Clinic for a woman requiring those particular services. The court depends heavily on community resources and the goodwill of agencies to prioritize and assist.

Court stakeholders credit the positive personal relationships between the courts RN Assessor, court support workers and community partners, in successfully facilitating services, housing and supports. In discussions with agency service providers they consistently revealed a high degree of satisfaction with court staff and the services they provide. Partners particularly valued: the competence, dedication and professionalism of the staff; the client-centred approach, the collaborative culture, shared vision and positive working relationships.

All stakeholders indicate the primary objective of adult therapeutic court is to deal with mentally disordered accused sensitively, effectively and expeditiously. This core objective is the mainstay of their collaborative philosophy and informs their approach and decision-making.

The expected outcomes at the program level include effective linkages between mental health and justice systems, provider / community agency satisfaction and creating a community of acceptance that serves to de-stigmatize mental illness. The expected outcomes at the client level include improved psychiatric status, improved quality of life, stable housing, improved employment/meaningful activity, effective linkage to community agencies and client satisfaction. The expected outcomes at the system level include reduced recidivism, reduced hospital admissions and ED visits, and increased use of community mental health services.

The ultimate target outcome is to obviate the need for a therapeutic court and diversion program in the City of London.

Informants specified that this court, while effectively dealing with individuals in conflict with the law, is in essence responding to a myriad of pervasive deficiencies in the health care system(s). This court, and others like it, are a reflection of larger system and service gaps in provincial mental health care. The criminalization of persons with mental illness for minor offenses is an unintended consequence of deinstitutionalization and inadequate community-based treatment. Informants suggested a genuine investment in pre-arrest diversion strategies and mainstream mental health care would idyllically preclude the need for the London court and other mental health courts across the province.

Seventy-five to one hundred clients are presently diverted per year in Adult Therapeutic Court. The RN Assessor completes three-four assessments each week and while not each of those clients is eligible for diversion, an average of five-six clients are diverted monthly. Approximately two hundred individuals come through mental health court annually. Thirty five – forty cases are on the docket each week and stakeholders indicate these

numbers have consistently increased since the court's inception.

Because there is diversity amongst mental health courts in different jurisdictions there is much variety in the volume of cases and court utilization rates around the Province of Ontario. Municipalities similar in size in London are reporting a range in volume and court utilization. The Kitchener mental health court reports dealing with 160 accused last year, Sudbury 130, Ottawa between 90-120 and Toronto, a full-time well-resourced court, dealt with 3000 individuals.

In considering the possible realignment of existing resources to further enhance the court's effectiveness the following possibilities were noted during consultations:

- Court stakeholders applauded the effectiveness of the frontline CMHA court support staff in providing information, referrals, support and advocacy to clients and their families. The skill set of these staff were acknowledged as exemplary and well matched to the changing needs of the clients and the court model. As the volume and needs of the clients continue to increase and evolve it is noted that a third frontline community support worker would be a valuable addition to the existing model. Expanding the role of the CMHA Team Leader to encompass more frontline client work and a larger housing advocacy function, while lessening the administrative purpose of this position, may effectively resolve the need for a third community support worker and grow the already excellent service, support and advocacy currently provided by CMHA.

- Key informants acknowledged the court model relies heavily on the RN Assessor function and stakeholders have indicated that the skill set of the current RN has been critical to the court and client's success. Clinical assessment is critical to the model, as are the linkages to health care and community services made by the RN. At present the RN Assessor is completing 3-4 assessments per week, requiring up to 6 weeks to complete an assessment. The evolving nature of this position has created a workload that can be onerous for a single professional. Ideally relieving this position of some administrative tasks would allow the RN Assessor to provide additional clinical services. Introducing an administrative position to assist the RN would expedite assessments and/or adding a second RN to the model would enhance the services currently provided by the single RN. It is important to note that key informants advised a second RN Assessor would need to have a solid nursing background in emergency psychiatry and mental health, an understanding of the court model and a work ethic and skill set similar to that of the current RN.

- Formalize linkages with consistent psychiatrist(s) to attend or be accessible to

court staff regularly. At present, time is misspent attempting to make linkages to psychiatric care and is dependent upon the random availability of psychiatrist(s) to provide assistance. This informal arrangement is time consuming, inconsistent and disparate to the court's interest in responding proficiently and effectively. The establishment of a consistent psychiatrist(s) between court and EMDC/Special Needs Unit would allow the physician to interface with many of the same clients and provide continuous care.

- Effectively establishing a lead agency to coordinate multiple services and assume leadership for service planning would ensure that a sole agency is the consistent access point to support services for the client, freeing up other agencies from attending court regularly or duplicating services. Streamlining services between St. Leonard's Community Services and the CMHA diversion program could effectively achieve this. Together they could allocate the work of evaluating clients' needs while in in custody, assume management of re-integration planning and act as a single primary liaison with friends/family and/or her community agencies. In this way the Team Leader or the social work coordinator could co-ordinate the other community services, establish weekly agency contact, maintain a crisis housing or bed registry and oversee communication with community partners. Expanding the role and function of the social work coordinator from St. Leonard's Community Services may also achieve these outcomes, together with the CMHA Diversion Program. It is advisable for all health service providers to examine resources dedicated to court for observing or wait times.

- Encourage regional forensic facilities to developing and/or streamlining telepsychiatry capacity/linkages.

- Improve coordination between the court and hospital to allow for easier access to regional forensic beds in an emergency. Review hospital admission practices related to these beds and transform policies to allow for improved access to forensic beds in urgent circumstances.

- Establish standards for waiting periods for transfers to forensic beds. Transfer wait times vary from one area of the province to another and represent inequitable access. In London, clients can wait as long as 60 days in custody for an available forensic bed.

- Develop linkages with family and primary care physicians to enhance continuity of client healthcare.

- Provide education and training to hospital based staff to better allow a meaningful exchange and understanding between court stakeholders and health care providers and between health care providers from different hospitals.

- Increase information sharing between community court support and clinical court support staff. At present, there appears to be some duplication in the intake screening and quarterly reports generated by the CMHA court support staff and the RN Assessor. Both partners acknowledge that some data is protected by privacy legislation or by hospital or agency confidentiality policies and as a result exempt from sharing. However, streamlining the collection and sharing of appropriate data between the two court services would eliminate duplication and encourage a relationship of mutual aid and reliance. Likewise, some community partners indicate they too collect much of the same data and indicate that while a shared database is available to some community supports it is not accessible to all community partners. An inclusive and streamlined consent to release template used or recognized by all community partners would once more eliminate duplication and allow for an improved sharing of information.

- Encourage the Special Needs Unit (SNU) at the Elgin Middlesex Detention Centre to give priority to housing and serving identified special needs inmates, with a focus on advocacy and continuity between the Adult Therapeutic Court and the SNU. It was noted that transforming the SNU to more closely resemble the Secure Treatment Unit at the St. Lawrence Valley Correctional & Treatment Centre would represent a move towards an effective best practice model of service. The St. Lawrence model provides comprehensive specialized multi-disciplinary assessment, treatment and post-treatment planning services by combining correctional expertise with mental health expertise.

- Increase community services, such as housing, forensic beds and treatment facilities. The addition of supportive and secure accommodation options for high risk category patients, as an alternative to hospital, would reduce time in custody. Informants consistently identified the shortage of forensic and community beds as a constant challenge for the Adult Therapeutic Court. This shortfall in housing, acute care, home, residential drug/alcohol treatment and forensic beds is an obstacle in decreasing time in custody for this population and creates numerous challenges for Therapeutic Court in expeditiously and effectively linking clients to appropriate and needed services. Outside of short

term crisis beds at Mission Services of London, there are 3 male and 3 female crisis beds in the community, managed by the St. Leonard's Community Services. Clients can stay a maximum of 30 days in these beds and while St. Leonard's works diligently to respond to court referrals the beds are not dedicated specifically to the court and as a result their availability is random. St. Leonard's reports that court referrals accounted for 15% of referrals to Gallagher House and 13% of referrals to Maison Louise Arbour during the period between January 2008 and December 2010. The average length of stay in these beds is 20 days for males and 30 days for females. Typically clients are then discharging to the streets or back into the community with no formal supports or fixed housing in place. Without appropriate and available local beds clients may be remanded to custody; discharging from custody without re-integration planning or supports; waiting as long as long as 60 days for a forensic bed and/or transported to forensic beds in communities as far away as Penetang, Milton or Ottawa.

While pervasive system and service gaps pose barriers to the court's effectiveness and to the health and wellness outcomes of some clients, the court works collaboratively and creatively to surmount these challenges. Much of the success of this court is built on history / people / connections. Trusting professional relationships, a shared commitment to the court's target outcomes, judiciary leadership and a collective desire to respond benevolently to the needs of this population drive the collaborative partnerships and success of this model. Adult Therapeutic Court is exceeding many best practice expectations and exemplifies a best practice model for many other jurisdictions in Ontario.

This report reflects many voices from the Adult Therapeutic Court. The development of this document is built upon the best available information from court stakeholders and community service providers and included:

- A review of more than 500 pages of research.
- A series of consultations and key informant interviews were conducted with 17 people using a semi-structured interview process. The interviewees included representatives from the following: the Judiciary, Crown Attorney, St Joseph's Health Care, Regional Mental Health Care, Community Mental Health Association London-Middlesex, Elgin Middlesex Detention Centre, London Police Service, WOTCH, St. Leonard's Community Services, Mission Services of London and criminal lawyer representatives.

[1] Zoffman, E. (1999). Criminalization of the mentally ill. British Columbia Medical Journal, 41:384-389.
[1] Teplin, L. (2000). Keeping the peace: Police discretion and mentally ill persons. National Institute of
Justice Journal, 9-15.
[1] A Program Framework for Mental Health Diversion/Court Support Services. February 2006.
[1] Torrey, E. (1997). Out of the Shadows: Confronting America's Mental Illness Crisis. Toronto: John Wiley and Sons.
[1] Simpson, L & Gardner, L., et al. (2006). Calgary Diversion Project: A Final Evaluation.
[1] Simpson, L & Gardner, L., et al (2006). Calgary Diversion Project: A Final Evaluation.

[1] Simpson, L & Gardner, L., et al (2006). Calgary Diversion Project: A Final Evaluation.
[1] Hartford, K et al., (2004) Evidence-Based Practices in Diversion Programs for Persons with Serious Mental Illness Who are in Conflict with the Law: Literature Review and Synthesis.
[1] Schnapp, W., Johnson, J., and Nguyen, T. (1996). Offenders with mental impairments: What is to be
done? Administration and Policy in Mental Health, 23:455-458.
[1] Steadman, H., Morris, S., and Dennis,D. (1995). The diversion of mentally ill persons from jails to community-based services: A profile of programs. American Journal of Public Health, 85: 1630-1635.
[1] Simpson, L & Gardner, L., et al (2006). Calgary Diversion Project: A Final Evaluation.
[1] Steadman, H., Deane, M., Morrissey, J., Westcott, M., Salasin, S., & Shapiro, S. (1999). A SAMHSA research initiative assessing the effectiveness of jail diversion programs for mentally ill persons. Psychiatric Services, 50:1620-1623.