

Process Evaluation of the Saskatoon Mental Health Strategy (MHS)

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Executive Summary

The analysis is broadly broken down into three sections: strengths of the MHS, areas for improvement, and recommendations. This overview outlines the major themes from each section and provides a summary of the findings.

Strengths of the MHS

1. **Overall positive attitudes towards the MHS:**

All interviewees expressed positive support for the existence of the MHS and its future. Several elements were praised: the MHS's ability to bring community organizations together, positive potential impact on public safety, and improved fairness. Other mental health court research supports this finding.

2. **Ample time spent on individual files:**

Discussion of the significant time devoted to individual MHS participants, and the benefits resulting from the time invested. Positive testimony from participants is referenced, along with the opinions of several community support professionals who feel the time invested brings benefits.

3. **Participant “buy-in” and commitment is better in the MHS:**

The MHS structure provides advantages in motivating individuals to address their mental illness. Improvement in this area has been noted by both legal and community support professionals. Supporting research is limited, however similar improvements have been noted in other studies.

4. **MHS improves legal effectiveness**

The MHS court provides legal professionals with more information about the accused. This information allows for better decision making, and increases the ability of the legal professionals to fulfil their respective mandates. Legal aid is able to meet needs of which they were previously unaware, the Crown is able to act with more information to better protect public safety, and judges are able to impose sentences that more fully take into account the objectives provided in the *Criminal Code*.

5. **Fostering inter-agency communication**

The MHS is an effective agent in bringing together and encouraging communication between different organizations that offer services of use to individuals with mental health concerns. This communication is especially effective due to the consistency of the MHS. Strong communication increases the efficiency with which services are offered across Saskatoon. Research shows mental health courts in general significantly increase participants' use of beneficial community services.

6. **Realistic expectations**

MHS team members have a pragmatic attitude towards the program. People are aware that organizing the MHS is a difficult endeavour that will require time, commitment, and a continual willingness to improve. The MHS court was created with much forethought and has set realistic and achievable goals.

7. **The MHS is an evolving program that is improving over time**

Problem solving courts of all kinds, mental health courts included, have no pre-determined blueprint and require a willingness to improve and adapt. The MHS has

exhibited these qualities. MHS team members actively seek feedback that can be used to improve the program.

Areas for Improvement

1. Docket Size

The large size of MHS court dockets is of concern to many team members. Comparable mental health courts tend to work with fewer individuals in a given year than the MHS. The number of files handled by the MHS is problematic for many team members. The difficulties caused by large dockets are broken into three subsections:

1.1 Large docket sizes put pressure on the MHS team members. Legal professionals involved with the MHS are placed under pressure given the amount of preparation required for dockets with a large number of MHS clients.

1.2 Pre-court meetings are of limited effectiveness with large dockets.

Meetings to discuss individuals who are appearing in the court are a key part of all mental health courts. The importance of these meetings for the MHS are acknowledged, however effectiveness is limited with large dockets that leave only a few minutes to discuss each client.

1.3 Excessive formality as a way to deal with large dockets. Mental health courts attempt to create a relaxed and informal atmosphere so the clients will feel more comfortable expressing themselves. While judges strive to accomplish this objective, the requirements of a large docket demand a level of expediency that is counterproductive.

Discussed solutions: more frequent MHS court sessions so fewer individuals need to be on each docket, intake assessments to assist individuals prior to their first MHS appearance, expanded legal aid resources to allow for greater MHS participation, or more limited criteria for acceptance into the MHS program.

2. The need for additional sessions or more frequent dockets

Closely related to the previous topic, several interviewees spoke to how additional docket court sessions could be beneficial.

Discussed Solutions: more concrete support and supervision plans for participants, more structured docket court sessions, a special once monthly docket for medication compliance issues, and a special once monthly docket for participants who are ready to be sentenced.

3. Need for a Coordinator or Point Person

Numerous interviewees spoke of the need for a coordinator or point person to assist in day-to-day MHS tasks. Tasks a coordinator could help with include, but are not limited to, scheduling appointments for MHS clients, connecting clients with community resources, assisting coordination between community resources that address different needs, intake assessments, and general administrative work.

4. Length of time to progress through the MHS

The length of time required for an individual to progress through the MHS was raised by some interviewees. This topic was mentioned frequently enough to be listed as a theme; however, discussion occurs under the sections *Docket size* and *Concerns about public safety*, as those seemed to be the underlying concerns.

5. Concerns about public safety

Concerns were raised about the possibility that a violent or unsafe offence could be committed by an MHS client while they progressed through the program. A concern was also raised about the possibility for the MHS to interfere with the work being done by Saskatoon's Domestic Violence Court.

Discussed Solutions: further restrict allowable offences or mental health conditions within the MHS, better tracking of individual progression through the MHS, not referring individuals from the Domestic Violence Court into the MHS, also more authority for the Crown to limit admittance to the MHS.

6. Requests for additional training

In response to being asked what further training would be helpful, many interviewees outlined areas for further training which could help them improve as MHS team members. Broadly, legal professionals requested more training about psychiatric conditions MHS participants may have and how to address those conditions, and community support professionals requested additional training on the legal process and how to advise individuals about what to expect in court.

Discussed Solutions: provide training if resources are sufficient. It is likely legal professionals could offer training in their areas of expertise where professionals with medical and psychiatric knowledge could offer training in their areas of expertise.

Recommendations

There are numerous suggestions for iterative improvements contained in the analysis section. Two areas of need were significant enough that this report makes specific recommendation that they be addressed.

1. Coordinator

A regular MHS team member who can coordinate communication, help schedule treatment or assessment plans, and assist with administrative work would be an asset for the MHS team. In addition to benefiting the MHS team, a coordinator could also benefit MHS clients by helping them remember and fulfil promises to the court, and performing intake assessments so paperwork is ready and the client knows what to expect before their first MHS court appearance.

2. Docket management

Many of the concerns in the areas for improvement section relate to the large docket size and the different ways it can put pressure on the MHS court. Suggested solutions were numerous and varied. While this report cannot recommend any specific solution as the single correct one, some helpful ideas were: concrete support and supervision plans with less court involvement, focused MHS court sessions in addition to regular MHS court dockets to address specific needs, and intake assessments before MHS participation. Not all these options need be used in concert; this report merely aims to provide a toolbox with some potential solutions.

Process Evaluation of the Saskatoon Mental Health Strategy (MHS)

1. The Development and Evaluation of Mental Health Courts in North America

“Deinstitutionalization” of the mentally ill began in Canada during the 1950s and 1960s.¹ The concept refers to the shift of mental health resources from dedicated mental health hospitals and institutions to community based care. Deinstitutionalization was initially framed as a solution that freed the mentally ill from the often troubling institutions of the past, all while saving taxpayer money.² In the haste to implement this policy, the number of beds available for the mentally ill in dedicated facilities declined rapidly. However, the communities that these individuals moved to were unprepared and unable to provide the levels of support and services required. Without the required professional support in the community, individuals with mental health conditions were vulnerable to a host of additional problems such as homelessness, poverty, and addictions.³ Another negative outcome was increased contact with a different type of institution: the criminal justice system. Frequent conflicts between individuals with mental health conditions and the law have resulted in high rates of incarceration for the mentally ill. In 2009, 21.3% of Canada’s prison population had a mental illness, up from 11% a decade earlier.⁴ The current situation is often described as a “revolving door” wherein mentally ill offenders are perpetually in conflict with the law due to their poverty or inability to obey court orders.

Mental Health Courts offer one strategy to break the cycle of criminal offending rooted in mental illness. As a type of problem-solving court, (based in *therapeutic jurisprudence*), mental health courts use the law to act as a therapeutic agent.⁵ When it comes to individuals with mental health conditions, acting as a therapeutic agent means providing the individual with psychiatric assessments, counselling related to their illness, and may involve securing housing and generally stabilizing the individual in society before sentencing. It has been argued that, since deinstitutionalization, the courts have largely taken over the role of mental health service provider of last resort and that mental health courts represent the most just way to meet this urgent need for services.⁶ Therapeutic jurisprudence recognizes that legal professionals (i.e., judges and lawyers) can have a large impact on individuals, and seeks to make this impact as positive as possible for a targeted group. In the case of mental health courts, this involves the balancing of legal necessities such as sentencing while accepting the role of the court in providing mental health services and addressing both the social and psychological issues that can lead to criminality.⁷ The role of therapeutic courts has been described generally:

¹ Richard Schneider, Hy Bloom & Mark Heerema, *Mental Health Courts Decriminalizing the Mentally Ill* (Toronto: Irwin Law, 2007) [Schneider].

² *Ibid.*

³ Glen Luther & Mansfield Mela, “Literature Review on Therapeutic Justice and Problem Solving Courts” (Centre for Forensic Behavioural Science and Justice Studies, December 2013) [unpublished] <<http://www.usask.ca/cfbsjs/documents/Lit%20Review%20MHC%20Saskatoon%20Academic%20Dec%202013.pdf>>.

⁴ Public Safety Canada, “Corrections and conditional release statistics overview” (2009) <<http://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/2009-ccrs/2009-ccrs-eng.pdf>>.

⁵ A.M. Odegaard “Therapeutic jurisprudence: the impact of mental health courts on the criminal justice system” (2007) 83 North Dakota Law Review 283 [Odegaard].

⁶ Schneider, *supra* note 1.

⁷ Schneider, *supra* note 1; *Supra* note 5. Moore & Wormith “Mental Health Courts: A Canadian Influence” (MA Project, University of Saskatchewan, 2013) [unpublished] [Moore].

“[s]ome problem-solving courts improve upon access to justice and supports that accused persons might not otherwise receive in a timely way. Often the drive behind their creation is a desire to see adequate resources provided in a coordinated and timely fashion so that the cycle of recidivism may be interrupted and the quality of life for the individual offender and community improved.”⁸

The *Needs Assessment of Forensic Mental Health Programs and Services for Offenders in Saskatchewan* examined the current services available for mentally ill offenders upon their release into the community and found them lacking in Saskatchewan.⁹ This report explicitly identified the need for a mental health court in Saskatchewan. At this juncture, it is important to note that there is no single blueprint for a functioning mental health court and several different conceptions of mental health courts have been used across Canada.¹⁰ The Saskatoon Mental Health Strategy (MHS)¹¹ endeavours to bridge the gap between the legal and medical needs of mentally ill offenders appearing before the Provincial Court in Saskatoon.

In 1994 Ontario’s Crown Policy Manual was revised to include “the diversion of mentally disordered accused.”¹² “Diversion”, in this sense, means diverting an accused with mental health concerns out of the regular trial and sentencing process so their additional needs can be met. In 1998, the first mental health court in Canada opened in Toronto to address the continual appearance of people with mental illnesses before the “regular” Provincial Court.¹³ Judge Schneider founded the mental health court in Toronto with the goals of expeditiously resolving pretrial issues regarding mental fitness to stand trial, and to “slow down the ‘revolving door’ or reduce the risk of reoffending” for mentally ill individuals.¹⁴ For many individuals living with mental illness slowing the rate of prison readmission is the best case scenario: alcoholism or substance abuse issues, homelessness, and chronic poverty are difficult hurdles to overcome, especially given the scarcity of resources for the mentally ill in Canada. Thus, it is unrealistic to expect the courts to completely stop the revolving door for every individual. As of 2013, there were 22 adult mental health courts in Canada¹⁵ and 10 youth mental health courts. Mental Health Courts now exist in varied locations such as Nova Scotia, New Brunswick, Newfoundland, Manitoba, and other locations in Ontario. Additionally, courts with similar goals are in the process of being developed in British Columbia and the Territories, in addition to Saskatoon. In the United States, there are roughly 250 mental health courts and the number is growing.¹⁶

⁸ Sheila Whelan, “Problem-solving and Therapeutic Approaches to Justice in Canada’s Courtrooms” (2014) 37 *Prov Judges J* 13.

⁹ A. Kent-Wilkinson et al. “Needs assessment of forensic mental health services and programs for offenders in Saskatchewan: Executive Summary” *Forensic Interdisciplinary Research: Saskatoon Team; Centre for Forensic Behavioural Sciences and Justice Studies (University of Saskatchewan, 2012)*.

¹⁰ *Supra* note 1 at 62.

¹¹ Due to the specificity of the Saskatoon MHS, it will be referred to as the “MHS Court” in this report, as opposed to the more general term “mental health court” which will be used to refer to all other therapeutic jurisprudence for the mentally ill.

¹² *Supra* note 3.

¹³ Schneider, *supra* note 1.

¹⁴ *Ibid* at 97.

¹⁵ A. Bressan “JustFacts: An inventory of mental health courts in Canada – A preliminary snapshot” (Ottawa: Department of Justice Canada, 2013).

¹⁶ C. Sarteschi et al., “Assessing the effectiveness of mental health courts: A quantitative review” (2011) 39 *Journal of Criminal Justice* 12.

Canadian mental health courts have voluntary entrance requirements.¹⁷ Defendants with a mental health condition and who have been referred to a mental health court have a choice to appear before a regular court judge, or to appear in mental health court. Some Canadian courts require individuals to plead guilty to their crime in order to remain in the mental health court. The majority of Canadian mental health courts avoid incarceration and instead increase the number of required appearances before the court and require a range of treatment options.¹⁸ This often involves the delay of sentencing pursuant to the terms of s. 720(2) of the *Criminal Code*.¹⁹ Upon completion of the court ordered treatment, the charges may be dropped due to the stigma associated with a criminal record, although sometimes a suspended sentence, conditional sentence, or period of probation may be used to ensure treatment is continued. Some courts offer services such as access to a psychiatrist or psychologist who works with the mental health court, while other courts refer participants to services that already exist in the community. Similarly, some courts accept only minor offences whereas some accept only serious offences, and some accept a combination of both.²⁰

It is difficult to evaluate the success of mental health courts as each court operates according to a different set of procedures and seeks to accomplish different goals.²¹ For instance, Florida is home to one of North America's first mental health courts, the Broward County Mental Health Court. This court does not recognize Fetal Alcohol Spectrum Disorder (FASD) as a mental illness.²² Although there are no clear statistics on the scope of FASD in Canada,²³ the assessments and discussions which led to the creation of the Mental Health Strategy in Saskatoon grew out of meetings regarding the unmet needs of FASD individuals in the justice system. Consequently, there is already an issue if one were to compare recidivism data from the Broward County court with the MHS Court in Saskatoon, since the respective courts are not accepting the same kinds of offenders. Despite these difficulties, there have been three statistical meta-analyses to date on North-American mental health courts.²⁴ Some of the articles consulted for the meta-analysis by Cross²⁵ and Sarteschi²⁶ used "pre-post" studies to evaluate recidivism. A pre-post study compares participants' outcomes before and after an intervention or the administration of a service and seeks to determine if they improve or decline. Whatever the result, it is attributed solely to the intervention or service. Such pre-post studies are limited due to a lack of control group, and constitute a relatively weak experimental design, making them ill-suited for meta-analysis.²⁷ In these pre-post studies, the reader is only informed about what happened to the group being studied, but does not have information about what happened to offenders in regular courts.

¹⁷ E. Slinger & R. Roesch "Problem-solving Courts in Canada: A Review and a Call for Empirically-based Evaluation Methods (2010) 33:4 Journal of Criminal Justice 258; see also *Supra* note 15.

¹⁸ *Ibid.*

¹⁹ *Criminal Code*, RS C 1985, c C-46 s 720.

²⁰ *Supra* note 17.

²¹ Schneider, *supra* note 1.

²² *Supra* note 3.

²³ "What is FASD?" Online: FASD Support Network of Saskatchewan
<<http://www.skfasnetwork.ca/main/learn-about-fasd/what-is-fasd/>>.

²⁴ Brittany Cross *Mental Health Courts Effectiveness in Reducing Recidivism and Improving Clinical Outcomes: A Meta-analysis* (M.A Thesis, University of South Florida, 2011); *Supra* note 16; Moore, *supra* note 7.

²⁵ *Supra* note 24.

²⁶ *Supra* note 16.

²⁷ *Supra* note 17; Moore, *supra* note 7.

Despite the methodological qualms with these studies, there are still some significant findings that are applicable to Saskatoon's MHS Court. Every previous meta-analysis found that mental health courts are statistically effective in reducing recidivism.²⁸ A 2013 meta-analysis by Moore and Wormith showed that individuals going through mental health courts were 34.1% less likely to recidivate compared to those attending regular court. However, this study was limited to available quantitative data and did not include qualitative information on the experiences of the individuals attending mental health courts. In a guide prepared for the United States Department of Justice, Steadman spoke to the value of such qualitative data.²⁹ He described how first-hand accounts from participants "can add depth and dimension to what is known about the impact of the court and how it has helped improve participants' lives."³⁰ Similarly, hearing from those working with mental health courts (e.g., judges, lawyers, social workers, health region personnel, etc.) allows for a better understanding of the court itself.

Moore and Wormith's 2013 meta-analysis was among the first of such analyses to be done in Canada. Currently, there are no peer-reviewed evaluations of Canadian mental health courts. The Canadian non-peer-reviewed evaluations that do exist do not make strong statements, as the methodologies are generally too weak to make any outright conclusions.³¹ These previous evaluations have gathered only very basic statistics, compared treatment completers with those who do not complete treatment, or asked participants for satisfaction scores.³² Further, very few Canadian mental health court evaluations have interviewed people involved with the court or conducted a thorough thematic analysis on the experiences of those involved with the court. Only one such study appears to exist, and its results were concerned more with perceptions of the court than its functionality.³³ There are several American studies where court participants were interviewed to address issues such as voluntariness of participation³⁴ and the possible impact of coercion.³⁵ Voluntariness is crucial as treatments are often legally imposed as part of sentencing. One study by O'Keefe gathered information on participants' experiences during their journey through the justice system.³⁶ Generally, O'Keefe's study found that participants felt they were treated fairly and had their voices heard. There was much praise for the judges' listening skills and they felt a greater level of respect within the mental health court compared to general criminal court. In another American study by Ferguson et al., the goal was to find out from the participants and key stakeholders (e.g., Judges, lawyers, social workers, health region personnel, etc.) what aspects of the mental health court process were successful and what aspects needed improvement. Accordingly, participants found the process lengthy, but overall they believed the court improved their mental health and addictions issues and connected them to resources they would not have otherwise been able to access such as housing and

²⁸ *Supra* note 24; *Supra* note 16. Moore, *supra* note 7.

²⁹ H. Steadman "A Guide to Collecting Mental Health Court Outcomes Data" (2005) Bureau of Justice Assistance <[https:// www.bja.gov/Programs/MHC-Outcome-Data.pdf](https://www.bja.gov/Programs/MHC-Outcome-Data.pdf) >.

³⁰ *Ibid.*

³¹ *Supra* note 17; Moore, *supra* note 7.

³² *Ibid.*

³³ Mary Ann Campbell & Stephani Lane "Representing the Client Perspective of the Saint John Mental Health Court" (Centre for Criminal Justice Studies, 2008).

³⁴ A. Ferguson, H. Hornby & Zeller, "Outcomes from the Last Frontier: An Evaluation of the Anchorage Mental Health Court" (Alaska Mental Health Trust Authority, Anchorage, 2008);

³⁵ O'Keefe "The Brooklyn Mental Health Court Evaluation: Planning, Implementation, Courtroom Dynamics, and Participant Outcomes" (Centre for Court Innovation, New York, 2006).

³⁶ *Ibid.*

treatment. The follow-ups on the progress of treatment were also seen as positives. The stakeholders identified positive experiences with the court as well. Stakeholders believed that, although mental health services overall may be lacking, the mental health court was beneficial due to the ability to plan treatment options given the services that are available and to follow up on treatment to ensure progress is being made. The lengthy court process was also seen as a benefit due to the sense of responsibility it gave clients for their actions. The negative issues cited were largely due to a lack of housing resources in the community for individuals who go through the court and issues with transportation for many individuals. One of the recommendations coming out of this study was that participants should be interviewed as close in time as possible to their court appearances.³⁷

As summarized by Pratt et al., mental health courts have shown positive results, “MHCs [Mental Health Courts] achieved key criminal justice goals of significantly reduced rates of recidivism, reduced time in incarceration for participants, and improved public safety outcomes.”³⁸

METHODS

2.1 History of the Saskatoon MHS Court

The Saskatoon MHS Court held its first formal sitting November 18, 2013. The current evaluation report details the MHS from the first court sitting until the end of August 2014, during which time the court had 19 sittings. The MHS Court came about as an initiative by the Saskatoon Provincial Court to address the needs of those with mental health concerns. Beginning in 2010, the forensic psychiatry division of the University of Saskatchewan commissioned a mental health court advisory committee to deliberate the possibility of establishing a mental health court in Saskatoon. This committee comprised various professionals who met over a period of time. Momentum for the court grew out of local discussions led by (now retired) Judge Sheila Whelan about individuals with FASD and other mental health concerns involved with the criminal justice system. This momentum increased after a session on FASD in the criminal justice system organized by the Province of Saskatchewan and Saskatchewan Provincial Court. Meetings were set up with the Saskatoon Health Region and other important stakeholders, and then a date was set for the first sitting of the court. The intention was to have the MHS led by the court and to avoid limited criteria for entrance into the MHS Court. The wide entrance criteria stemmed from awareness that mental health concerns are widespread among those who appear before the Saskatoon Provincial Court. The issue of broad entrance criteria was so important to the MHS Steering Committee that the following was the sole underlined sentence in the MHS interim progress notes: “It remains very important to the Court that eligibility be determined by the court and that it remain broad.”³⁹

³⁷ *Ibid.*

³⁸ Pratt et al., “Predictors of Criminal Justice Outcomes Among Mental Health Courts Participants: The Role of Perceived Coercion and Subjective Mental Health Recovery” (2013) 12 *International Journal of Forensic Mental Health* 116.

³⁹ Sheila Whelan, “Mental Health Strategy (MHS) Interim Progress Notes” (Saskatoon Provincial Courts, 2014).

The court started without any funding sources by asking participant organizations to provide personnel and resources to make the MHS feasible. To ensure the first court session was a success the following entrance criteria were proposed for the court, according to the Mental Health Strategy Conceptual Framework Paper draft:

“Accused persons with a mental health condition (MHC) will be defined as an adult (18 years and over), charged with an offence who may have a mental health condition, i.e. a mental disorder or learning/developmental/cognitive disorder, including FASD, which significantly affects their ability to function effectively in the community. Someone with a substance use disorder may qualify if he or she is also deemed to have a mental health condition. To be eligible for the MHS, the accused person with a mental health condition must not be in custody, charged with murder, manslaughter or be the subject of a dangerous/long term offender application... in order to remain in the MHS, an accused will be required to accept responsibility for some or all of his offences and agree to participate in the MHS process. An accused can withdraw from the MHS at any stage and return to the regular court process.”⁴⁰

While this definition was never formally adopted by the court, it provides a glimpse of the initial criteria that were in use as the MHS was first getting off the ground. Two versions of the MHS Conceptual Framework Paper exist, both are marked as being for discussion only and neither has been formally adopted by the court or the MHS team. The passage above appears in both the paper circulated on November 28, 2013, and the follow up framework paper circulated on December 29, 2013.

The December follow up Conceptual Framework document elaborates on the objectives of the MHS:

- “1. To effectively deal with accused persons with a mental health condition within the provisions of the *Criminal Code of Canada* and the *Mental Health Services Act of Saskatchewan*.
2. To provide the accused with an effective case management process, while maintaining a focus on public safety.
3. To hold the accused person accountable for his/her behavior.
4. To protect the rights of the public, the rights of the accused, and the integrity of the criminal justice system.
5. To develop processes for the effective gathering and sharing of information, including timely medical and psychological assessments to assist in the support and supervision of accused persons with a mental health condition.”⁴¹

Among this list, the importance of informed support and supervision is the most emphasized amongst the numerous documents circulated by the MHS team.

Referrals for the Saskatoon MHS Court are made by Provincial Court Judges, based on their assessment of the accused being a person with a mental health condition, by

⁴⁰ Sheila Whelan, “Mental Health Strategy: a Conceptual Framework: Prepared on behalf of the Ministry of Justice and the Saskatoon Provincial Court” (Saskatoon Provincial Courts, December 2013) at 3.

⁴¹ *Ibid* at 15.

adjourning the matter into the MHS docket and recording their reasons on the record. These referrals do not require consent, but participation in the MHS Court does. Once capacity has been established, a guilty plea is required and only pre-and-post plea matters will be considered, no trials are conducted. If an accused is referred to the MHS Court and there is a question regarding their fitness to stand trial or plea they may be assessed under Part XX.1 of the *Criminal Code* before entering a plea.

Legal Aid is alerted at the time of a referral to the MHS and the accused person is encouraged to apply for Legal Aid at that time. Legal Aid provides a Lawyer of the day for the MHS docket, as many MHS clients are also Legal Aid clients. All MHS clients must have their eligibility assessed before Legal Aid begins representation, although the lawyer may assist clients in scheduling their eligibility assessment. The lawyer is assisted by a paralegal from Legal Aid as well.

The conceptual framework document expands on the definition of consent as it relates to the Saskatoon MHS. Specifically,

“as the MHS requires a level of participation beyond what is expected in regular court, an individual must provide consent prior to being considered an MHS participant. An MHS participant must also provide his or her consent prior to ordering and sharing various assessments and reports. It is important that MHS participants are fully informed by legal counsel as to the implications of providing these consents prior to their signing.”⁴²

Forms have been designed for legal counsel to inform participants about the consent to share information with the MHS, and these forms must be completed and entered in court before full participation in the MHS can begin. Consent to participate in the MHS overall is a fluid issue between the accused, their counsel, and the court. The accused may withdraw their consent to participate and return to regular court process if they prefer.

If the issue of fitness to stand trial arises in the MHS, the following is the procedure as outlined in the conceptual framework:

“if, before or after a guilty plea, fitness becomes an issue as a result of assessments, a fitness hearing may be set. If the individual is found fit, he/she can continue to be dealt with through the MHS. A fitness hearing may be heard by a Judge presiding in the MHS, having regard to the importance of continuity and the support and supervision available through the MHS throughout the hearing process.”⁴³

Fitness to stand trial has not yet arisen within the MHS court itself, more commonly coming up before referral to the program if at all, so there is currently no data regarding this procedure in practice.

The case management of those who appear before the MHS was also outlined in the conceptual framework paper as consisting of the following:

“ ... the MHS team may propose an individualized MHS Plan for an accused with a

⁴² *Ibid* at 14.

⁴³ *Ibid* at 15.

mental health condition[.] MHS plans may include participation in appropriate mental health assessments and cooperation with conditions designed to provide suitable community support and supervision. Conditions may address: residency, treatment, abstinence from alcohol/drugs, etc., depending on the circumstances of the accused and the nature of the offence[.] As the MHS is a sentencing court, it is expected that before postponing sentence and developing an MHS Plan, an accused person will enter a guilty plea accompanied by an Agreed Statement of Facts[.] The MHS may, depending on the circumstances and agreement of the Crown and Defense, develop short-term support and supervision plans for the accused, pending a guilty plea being entered”.⁴⁴

The pre-court meetings that the Saskatoon MHS holds were explained as follows:

“prior to each MHS docket, the MHS Team will meet at 8:30 a.m. In Phase One, representatives from members of the Steering Committee may also attend pre-court meetings, having regard to their interest in the developing process. The Provincial Court Judge assigned to the docket will preside over the meeting. At the pre-court meetings, proposed and existing MHS participants may be discussed, having regard to: eligibility, need for assessments, support and supervision and progress, however, merits of the case will not be discussed in the presence of the Judge”.⁴⁵

The merits of the case are a matter for submissions in open court on the record when the accused person is present. Pre-court meetings provide an opportunity for the members of the MHS team to understand the unique factors present for the accused which may inform decisions about how to proceed in open court.

The Saskatoon Mental Health Strategy has three phases for its implementation. Phase One is to evaluate the MHS program at an early stage, Phase Two is to act on those evaluations and to conduct more through research on the impact of the MHS over time, and Phase Three is to modify the MHS in response to the data gathered in the first two phases. This report was produced to assist with the completion of Phase One. It is estimated that each phase will continue for a period of 6 to 12 months as determined by the MHS Steering Committee.

Phase One:

Phase One began November 18, 2013 at 9:30 a.m. in Courtroom Number 4. MHS referrals are streamed into one docket court on the 1st and 3rd Monday morning of each month. In the event of a Monday holiday, the MHS docket is moved to the following Monday morning. Discussions have been held regarding the size and frequency of the dockets.

This streaming of accused persons with a mental health condition into one docket allowed the Court to:

⁴⁴ *Ibid.*

⁴⁵ *Ibid* at 16.

1. Collect assessments in one place and obtain timely assessments for others
2. Consider individual plans for mental health programming, support and supervision
3. Monitor individual mental health programming
4. Obtain data for study and planning in Phase Two
5. Work within existing and recently committed resources
6. Promote relationships with uncommitted community resources and work to improve the effectiveness of the MHS.

In Phase One, a part-time MHS Coordinator was seconded from the FASD Network for a period of up to 6 months, but the conceptual paper states that efforts will be made to resource and hire a full-time MHS Coordinator.

Phase Two:

As stated above Phase Two is to act on the early stage Phase One evaluations and to conduct more thorough research on the impact of the MHS over time. Phase Two was envisioned to consist of the following:

1. Study Phase One data regarding possible therapeutic and diversion approaches
2. Refine and continue with Phase One initiatives
3. Identify appropriate measures of success, evaluate successes and identify gaps in the MHS
4. Engage in broad consultations with MHS and other community organizations and individuals
5. Explore new therapeutic and diversion approaches to assist accused persons with a mental health condition
6. Explore funding opportunities to facilitate these new approaches and to retain the services of a full-time MHS Coordinator

Phase Three:

As stated above Phase Three is to modify the MHS in response to the data gathered in the first two phases. The exact time the MHS will move to this stage will be determined by the MHS steering committee. This stage was envisioned to consist of the following:

1. Modify and implement the MHS based on the data and needs identified
2. Ongoing participation and consultation with community service providers
3. Continue to engage new partners interested in contributing to the MHS

The MHS Conceptual Framework paper also outlined the need for entailing:

- “Collection of data, identifying gaps in services for persons with mental health conditions and engaging in discussions about how these gaps might be met will be an ongoing process.
- At the end of each phase, a report should be prepared for the Steering Committee to include success, challenges and gaps of the MHS with a view to adjusting it and

implementing changes.

- Indicators of success from a MHS participant perspective might include: compliance with MHS case management plans, reduced recidivism; effective interventions, enhanced quality of life (may not be available until Phase Three).
- Indicators of success from a MHS process perspective might include: number of referrals, number of new partners, effective information sharing and governance tools, adoption of new therapeutic and diversion approaches (may not be available until Phases Two or Three).”

The important participants who played a role in the development and implementation of the Saskatoon MHS included:

1) **Steering Committee:** senior (decision-making) representatives from important stakeholder groups who can oversee and drive the implementation of the Mental Health Strategy.

2) **MHS Team:** This is the working group that is present at each MHS docket and works with the persons voluntarily participating in the MHS. At this time it includes: Provincial Court Judge, Crown, Defense Counsel, a nurse with mental health expertise, an FASD Support Network support person and a representative from Corrections and Public Safety. This Team meets prior to each MHS docket to discuss immediate and long-term mental health related needs based on the information available, potential community plans and responsibility for follow up.

3) **MHS Coordinator:** It will be imperative to hire and include a MHS Coordinator who will be an integral part of the MHS Team. A part-time coordinator was offered through the FASD Network for up to 6 months, but a permanent full-time coordinator reporting to the Chair of the Steering Committee would be ideal if funding for this position becomes available.

4) **MHS Network:** This network includes community-based organizations such as John Howard Society, Elizabeth Fry Society, Saskatoon Tribal Council, Saskatoon Mediation Services, EGDZ, Court workers, Radius, Saskatoon Crisis Intervention and any other group interested in improving the current system and helping accused persons with a mental health condition change their lives in order to reduce their exposure to the criminal justice system. Key members also include the Saskatoon Police Service and the Center for Forensic Behavioral Science and Justice Studies at the University of Saskatchewan, specifically J. Stephen Wormith PhD, Glen Luther Q.C., and Dr. Mansfield Mela.

2.2 Formative Evaluation

Difficulties reaching firm conclusions are common in evaluations of mental health courts. Justice Richard Schneider of the Ontario Court of Justice, a Clinical Psychologist, a founder of the Toronto Mental Health Court, and the author of *Mental Health Courts: Decriminalizing the Mentally Ill*,⁴⁶ observed that “one of the characteristics common to all mental health courts is their ‘uniqueness.’ No standard blueprint for mental health courts exists. While mental health courts apply principles of therapeutic jurisprudence, each court operates in a slightly different manner. Consequently, it is difficult to extrapolate data.”

⁴⁶ Schneider, *supra* note 1 at 62.

In fact, Schneider devoted an entire sub-section of his book to the importance of realistic expectations for evaluation of mental health courts:

“While we can predict that mental health-court evaluations will continue to emerge and increase our collective knowledge about the effectiveness of these courts, we must also set realistic expectations for mental health courts.... While there may be similarities in treatment plans within a court, these courts generally adopt an approach to justice that operates at the individual level. Inspired by the tenets of therapeutic jurisprudence, the goal is not to provide participant-blind treatment programs, but rather, through collaboration with the mental health court team, fashion a treatment program that is appropriate for the specific individual.

The implications for mental health court evaluations are clear. We must set realistic expectations for mental health courts. Numerous treatment variables will differ among accused appearing before the same mental health court, jeopardizing the ability of researchers to draw any broad conclusions as to the effectiveness of the court’s intervention. Accordingly, the very theory that has rendered mental health courts so attractive to many, accounts for some of the difficulties in studying the courts that embrace it.”⁴⁷

Bearing in mind the difficulties associated with evaluating mental health courts, the current evaluation is a formative evaluation aimed at helping the MHS understand ways to improve. The other category of evaluation, a summative evaluation, will not be used as it is not appropriate in the current context of the MHS. Summative evaluations are carried out to determine whether a program has achieved its anticipated outcomes and if it should continue to exist in its current form, continue to receive funding, or for another purpose related to program oversight. Such evaluations must be conducted using many scientifically credible methods as the results can have significant impacts. As this was not the intent of the current evaluation decisions of this nature should not be made based on the findings of this evaluation.⁴⁸ The MHS requested the Centre for Forensic Behavioural Science and Justice Studies undertake an examination of the way the Saskatoon MHS is functioning to determine whether it is functioning well and as intended. A formative process evaluation does not examine the outcomes intended by a program but examines the fidelity of a program’s implementation as it relates to understanding the how, why, and under what conditions a program functions appropriately.⁴⁹ This evaluation was undertaken to assist the MHS complete Phase One. As this project was limited in its scope and duration it would not be described as a “developmental evaluation” in the evaluation literature.⁵⁰ In relation to the Program Logic Model (as described in *Section 2.3*), the process evaluation examines the process elements (e.g., the inputs, activities, and participants) of the MHS. While the intended outcomes of the MHS may be spoken to in this evaluation indirectly, no conclusions should be made about the impact of the MHS as that is the intent of an outcome evaluation. Such an evaluation is not appropriate at this time as the MHS is still too new to Saskatoon.

⁴⁷ *Ibid* at 203.

⁴⁸ Peter Rossi, Mark Lipsey, Howard Freeman, *Evaluation: A Systematic Approach* 7th ed (Thousand Oaks, CA: Sage, 2004).

⁴⁹ J Century, M Rudnick & C Freeman “A framework for Measuring Fidelity of Implementation: A Foundation for Shared Language and Accumulation of Knowledge” (2010) 31 *American Journal of Evaluation* 199.

⁵⁰ MQ Patton, “Developmental Evaluation” (1994) 15:3 *Evaluation Practice* 311.

This evaluation received an ethics exemption from the University of Saskatchewan's Behavioral Ethics Research Board on July 4, 2014. Specifically the exemption stated that this evaluation is exempt of ethics review as per Article 2.5 of the Tri-Council Policy Statement, 2010, which states "[q]uality assurance and quality improvement studies, program evaluation activities and performance reviews, or testing within normal educational requirements when used exclusively for assessment, management or improvement purposes, do not constitute research for the purposes of this Policy, and do not fall within the scope of REB review". However, the exemption letter stated that the evaluation should be conducted in an ethical manner and that any deviation from the original methodology and/or research question submitted for exemption consideration should be brought to the Behavioral Research Ethics Board for additional review. The recruitment poster, general information sheets, consent forms, and interview questions for the evaluation can be found in Appendix A.

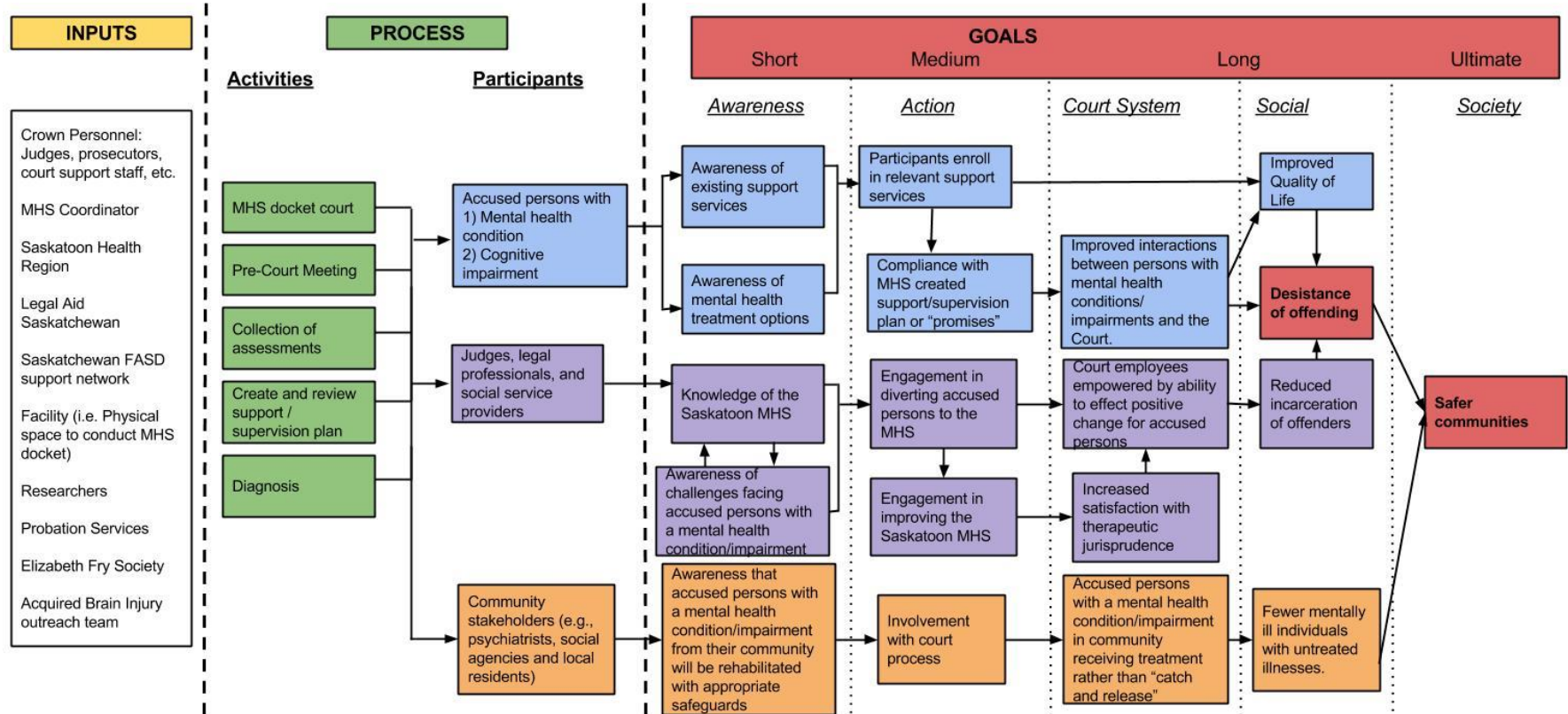
2.3 Program Logic Model

Upon review of the documents from the development of the MHS, and through discussions with key stakeholders who began the MHS, a model was designed for the MHS and definitions were provided for the model. The recognition and definition of the activities provided by the MHS was the first step to developing the Program Logic Model (PLM). These activities are presented visually in Figure 1. The design for the PLM is taken from the University of Wisconsin.⁵¹

A PLM begins the evaluation work and assists the evaluation process in many ways. It builds a common understanding of the program among the research team and the key stakeholders of the MHS and helps to clarify its intended outcomes. The definition of terms in the PLM provides a common language for all stakeholders to speak with, and therefore also increases communication. The process of designing the PLM allows for any assumptions inherent in the program to be understood. It also guides and focuses the evaluation work and reduces the likelihood of overpromising what the program (MHS) can deliver.

The PLM was designed at the beginning stages of the evaluation to allow the evaluation team to understand the process of the MHS, which involves what resources go into the MHS (see *inputs* on Figure 1), what activities the MHS performs (see *activities* on Figure 1), and who is involved with the MHS (see *participants* on Figure 1). The development of the PLM also allowed for the goals, or outcomes, of the MHS to be understood (see *goals* on Figure 1). These goals were outlined at four levels with each level being a longer-term goal than those preceding it (see *short, medium, long, ultimate* on Figure 1). It should be noted that the PLM was not formally adopted by the MHS, but was adopted by the evaluation team to guide the evaluation. The PLM was however reviewed by the Judges involved with the MHS and was presented at one steering committee meeting to receive initial feedback. Prior to the Phase Two evaluation the adoption of this, or a revised PLM, would be recommended in order to guide outcome data collection.

⁵¹ University of Wisconsin, "Logic Model" (2003), Online: Program development and evaluation <<http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html>>.



The activities performed by the MHS were defined for this evaluation as follows:

1) **MHS Docket Court.** The MHS Court is a docket court where multiple accused individuals, on a range of criminal offenses, all attend court and get their cases heard by a Judge. The MHS docket court does not handle the initial release of an accused- as individuals appear in the MHS docket court only after release into the community. The docket court handles plea and release conditions, with sentencing postponed pending the successful implementation of a support and supervision plan. The support and supervision plan can be made formal through amendment of release conditions (the undertaking or recognizance). It can be less formal when dealt with in the form of a promise. Continued participation depends upon the efforts of the individual to comply with expectations reflected in the support and supervision plan or promises. Eventually participants will receive a sentence.

2) **Pre-Court Meeting.** Meeting held before MHS Docket Court where the presiding Judge, lawyers from Legal Aid, Defence counsel, the Crown, representatives from the FASD Network and the Elizabeth Fry Society, and other support workers specific to accused persons appearing. These representatives meet to share information, discuss compliance and progress, and potential next steps on clients who will be appearing that day

3) **Collection of Assessments.** Collection of medical and psychological assessments that have been made available to the court in one place for a Judge and counsel to review. This collection acts as a central repository for assessments as there is no other method in place to trace adult assessments.

4) **Create and Review Support / Supervision Plan.** As part of assessment or sentencing the MHS Docket Court can order offenders to get different treatments or to make contact with specific support organizations. These “Support and Supervision Plans” are followed up on at the individual’s next court appearance, and can be broken down into step by step promises to help monitor progress. Orders are given only after consent to participate has been obtained.

5) **Diagnosis.** Determine if an accused individual, referred to the court due to a suspected mental health concern, has a specific diagnosable mental health condition or cognitive impairment. This can entail arranging the process by which a participant is sent to a doctor to determine if their underlying mental health concern is acting as an underlying casus of criminal activity. The doctor’s report typically includes suggestions for support and supervision to assist with rehabilitation and community safety.

The activities defined above relate to the following three participant groups:

1) **Accused persons with a mental health condition or cognitively impaired.** Sometimes called “participants” or “clients”, individuals with mental health conditions or cognitive impairments are the focus of the Saskatoon MHS.

2) **Judges, legal professionals and social service providers.** Judges are the Provincial Court Judges in Saskatoon. Legal Professionals includes the Crown prosecutor, Legal Aid representatives, and other defense lawyers. Social Service Providers include members of the Saskatoon Health Region addictions outreach team, social services employees, and probation officers. This includes members from those organizations that generally attend the pre-court meetings define above.

3) **Community stakeholders.** Refers to other people who may be involved with the MHS, such as the friends and family of the person with the mental health condition, and members of social organizations who may attend with an accused to help them in the court process. These individuals would not attend the pre-court meeting, but are encouraged to support the accused during court.

The operationalization of the goals in observable or measurable terms from the activities performed by the MHS was the second step in developing the PLM. These goals are sequential with one level requiring completion or achievement before the next. It should be noted that the goals are color-coded in Figure 1 in relation to the participant group for which they relate (e.g., blue for offenders). The short-term goals relate to awareness, the medium-term goals relate to action from the awareness, the long-term goals for the court system and society relate to the conditions that come about due to the actions happening in the medium-term, while the ultimate goal comes about as a result of long-term goals being realized. The following are the operational definitions of the established goals for the Saskatoon MHS Court used for this evaluation:

Short-Term

1) **Awareness of existing support services.** Participants are aware of the support services that exist, such as opportunities for housing or mentorship programs.

2) **Awareness of mental health treatment options.** Participants are aware of treatment options in the community, such as free or reduced cost treatment or therapy.

3) **Knowledge of Saskatoon MHS.** Participants are aware of the function of the MHS.

4) **Awareness of challenges facing accused persons with a mental health condition/impairment.** Community stakeholders are aware of the challenges that can face individuals with mental health conditions and cognitive impairments.

5) **Awareness that accused persons with a mental health condition/impairment from their community will be rehabilitated with appropriate safeguards.** Community stakeholders are aware of the community-based nature of the rehabilitation preferred by the MHS. They are aware of the limitations or requirements of community-based rehabilitation.

Medium-Term

1) **Participants enroll in relevant support services.** Participants enroll in support services that meet their needs.

2) **Compliance with MHS created support/supervision plan or “promises”** Participants are following the requirements from a support and supervision plan made in court, or in accordance with a promise made to the court.

3) **Engagement in diverting accused persons to the MHS.** Judges and legal professionals begin to actively divert accused persons with likely mental health conditions/cognitive impairments out of regular criminal court and into the Saskatoon MHS Court.

- 4) **Engagement in improving the MHS.** Judges, legal professionals, social service providers, and community stakeholders provide useable feedback on the MHS or offer their time to help improve it.
- 5) **Involvement with the court process.** Community stakeholders, family members of the individual with a mental health condition, or other supportive figures from the community can be more involved with the MHS docket court than in regular docket court.

Long-Term Court System

- 1) **Improved interactions between persons with mental health conditions/impairments and the Court.** Through following the instructions of the MHS, the interactions with the court will be improved.
- 2) **Court employees empowered by ability to effect positive change for accused persons.** Through assisting offenders to get the mental health help they require, there will be an increased sense of empowerment that a difference is being made.
- 3) **Increased satisfaction with therapeutic jurisprudence.** Satisfaction is achieved by assisting the court system improve its response to those with mental health needs.
- 4) **Accused persons with a mental health condition/impairment in community receiving treatment rather than “catch and release”.** A continuation of care is achieved by working within the criminal justice system to ensure patient care continues despite criminal justice system involvement.

Long-Term Social

- 1) **Improved quality of life.** Individuals with a mental health condition or cognitive impairment who participate in the MHS are connected with more support services and treatment options, and are subsequently able to manage their mental health conditions and enjoy a stable living environment.
- 2) **Desistance of offending.** Individuals with a mental health condition or cognitive impairment who participate in the MHS greatly reduce their rates of reoffending.
- 3) **Reduced incarceration of offenders.** Individuals with mental health conditions or cognitive impairments receive a wider range of sentences or treatment that do not involve incarceration.
- 4) **Fewer mentally ill individuals with untreated illnesses.** Individuals with a mental health condition or cognitive impairment get acknowledgement of their condition and active treatment, as opposed to remaining in the community untreated.

Ultimate

- 1) **Safer communities.** As a result of more individuals with mental health conditions being treated appropriately, and with a focus on rehabilitation from the court, fewer individuals will become repeat criminal offenders in their community.

2.4 Evaluation Matrix

As this evaluation was designed to examine the implementation and process activities of the Saskatoon MHS, the following evaluation questions, indicators, and data collection methods guided this evaluation.

Evaluation Questions	Indicators	Method & Data Source
Is the MHS meeting the expectations of participants?	Perceived expectations	Key stakeholder interviews (Qualitative)
Are the activities of the MHS functioning effectively?	Perceived ability to function well Dockets at a manageable number	Key stakeholder interviews (Qualitative) File review
Are the clients satisfied with their experience with the MHS?	Perceived Satisfaction	Key stakeholder interviews (Qualitative)
Is the MHS addressing the mental health condition or cognitive impairment concerns of participants involved with the MHS?	Perceived level of meeting concerns	Key stakeholder interviews (Qualitative)
Is the MHS receiving participants with mental health conditions or cognitive impairments?	Perceived ability to receive participants Number of participants on the docket	Key stakeholder interviews (Qualitative) File review

Future evaluations that examine whether the MHS is meeting its goals, such as for Phase Two or the MHS, may wish to examine some of the following questions:

- 1) Are participants aware of the relevant support services?
- 2) Are participants aware of mental health treatment options?
- 3) Do Judges and legal workers feel the MHS allows them to better meet the needs of individuals with a mental health condition/cognitive impairment?
- 4) Does the community feel the MHS is a valuable safeguard for those accused persons with a mental health condition/ cognitive impairment?
- 5) Are participants benefiting from relevant social services, programs, or organizations?
- 6) Is participant involvement with relevant social services, programs, or organizations due to MHS promises or support/supervision plan?
- 7) Do Judges and legal professionals notice a difference in their own engagement with the MHS?
- 8) Do participants feel more comfortable with the legal system as a result of positive MHS experiences?
- 9) Do participants report an improved quality of life as a result of social services, programs, or organizations they enrolled in as part of the MHS?
- 10) Do participants have a lower recidivism rate?
- 11) Are fewer mentally ill offenders incarcerated overall?

The current evaluation used both qualitative and quantitative data in order to evaluate the MHS. Using both qualitative and quantitative data constitutes a mixed methods approach. The inclusion of multiple forms of data in the evaluation allows for a broader understanding of how the MHS may need to improve. Similarly Steadman recommended the inclusion of qualitative data for evaluations of mental health courts.⁵²

2.5 Qualitative

The qualitative analysis component of the evaluation sought to identify trends that were observed during the key stakeholder interviews regarding the functioning, expectations and participant stakeholder satisfaction of the Saskatoon Mental Health Strategy (MHS). The results section discussing the qualitative data is broadly divided into two sections: first, the strengths of the MHS that interview participants identified are outlined and then some common suggestions for improvement are reported. Generally the analysis will focus on topics that arose frequently enough to be considered a “theme;” however, some poignant observations mentioned by a single individual will also be mentioned.

All qualitative data (i.e., interview transcripts) were analyzed using thematic analysis.⁵³ Specifically, the interviews were examined for similar patterns across interviews and then themes were developed that describe those patterns. Quotations are included as much as possible to illustrate the identified themes, which will also assist the reader to draw their own conclusions from the extracts presented.

Themes were revealed that related to strengths of the MHS. They included:

1. overall positive attitudes towards the MHS;
2. ample time spent on individual files;
3. improvement to participant “buy-in” and commitment in the MHS;
4. how the MHS lets legal professional do their jobs better;
5. how the MHS brings a network of organizations together and improves communication;
6. realistic expectations; and
7. the ways in which the MHS evolves and improves over time.

Themes were also revealed that related to areas for improvement. They included:

1. large docket sizes and the difficulties those entail;
2. the need for additional sessions or more frequent dockets;
3. the need for a coordinator or point-person;
4. the length of time needed to progress through the MHS; concerns about public safety;
and
5. requests for additional training.

Some topics, such as *ample time spent on individual files*, were mentioned as both a strength and a weakness in different contexts. These topics are covered in both sections of the analysis with the

⁵² J.W. Creswell & V.L.P. Clark *Designing and Conducting Mixed Methods Research* (Thousand Oaks CA: Sage 2007); *supra* note 29.

⁵³ Braun & Clarke “Using thematic analysis in psychology” (2006) 3:2 *Qualitative Research in psychology* 77.

aim of fully exploring them.

2.5.1 Sample

Interviews were conducted with 14 individuals who work in the fields of law, social work, health, or in some other way assist individuals with mental health conditions as a profession. These interviews were conducted either one-on-one with a researcher, or with two interviewees and one researcher. One interview was conducted with two researchers and one interviewee. Interviews were scheduled to last one hour with interview times ranging between 45 and 90 minutes. These interviews are broken into two broad groupings of “legal professionals” and “community support professionals”, where different perspectives may exist between the groups.

Two clients were interviewed, both of whom were interviewed one-on-one with a researcher. These interviews both lasted under an hour with an optional opportunity to take a break roughly halfway through.

It should be noted that as time was limited for all interviewees, not all questions were asked to every participant. However, every attempt was made to ensure that the overarching questions were asked to each participant. The interview questions can be found in Appendix A.

2.6 Quantitative

The initial and final dockets for each court session from November, 2013, to August, 2014, were collected for the study. These dockets included information on 117 accused individuals who had appeared before the court. The current status of these individuals was not included in this review as this would be included as an outcome factor in a future evaluation (i.e., sentenced, dropped out of the MHS). As well, court files for those who appeared before the court during the month of August were also collected. This August review included more in-depth information on 32 accused individuals. Court files only may have contained Informations, Recognizance forms, Police Officer Recognizance forms, Undertakings. Final dockets for the month of July, 2014 from a regular docket court, were also analyzed to allow for a comparison to the MHS dockets. All files were then transferred from the court generated format into Microsoft Excel to allow for statistical analysis. Applicable statistics generated from these files are included in the results section interspersed throughout the qualitative themes as evidence. After completion of the review all forms were returned to the court.

A summary table of all the quantitative data generated for this evaluation can be found in Appendix B.

2.7 Data Limitations:

The following concerns emerged during the data collection process. Since the court-generated files did not have a systematic manner of tracking the mental health concerns of the participants, the research team was unable to track the mental health conditions of the participants. Similarly, there was no record of the requests for psychiatric reports available in a manner where it would be acceptable for researchers to view the information. These reports could be obtained by the court through a request by defense counsel, obtaining existing reports, or ordering an assessment

and report. Regardless of how the psychiatric reports are obtained the consent of the accused is required. Also, if a person was listed on the docket but was not in fact an MHS client, notes on these cases were not kept in a systematic fashion and therefore the data may include some cases of non-MHS clients. Furthermore, the files reviewed span November 2013 to August 2014, which is not a sufficiently long length of time to observe participants throughout the entire MHS process.

Additionally, many emails and documents were sent between MHS team members regarding the launch of the court, and the parties attached varying levels of importance to the documents. Subsequently, MHS stakeholders may have different views on some matters due to the document they believe is definitive on a particular issue, and may not be aware that other stakeholders have other views. Wherever possible commonalities among documents were sought out; however, selecting internal documents to evaluate and weighting them is itself a difficult process.

The evaluation team was able to obtain a broad cross-section of community support personnel and legal professionals to participate in the evaluation. However, not every individual was available for an interview for a variety of reasons. Many quotations have been modified in order to obscure the identity of an individual or organization. Many of the participants made references to specific individuals and in these cases identifying details have been removed. As part of this effort, the pronoun “they” is used to refer to individuals in a gender neutral way to avoid the awkwardness of “he/she” language. Additionally, as the interviews were conducted orally, some edits have been made to smooth out “verbal tics”, hesitations which were not relevant to the overall meaning. An effort has been made to be faithful to all interviewee statements and to maintain the meaning and intent of the interviewees.

Arranging interviews with clients was problematic. The research team was able to speak with a small number of participants. However this was not a large enough number for a representative sample. Furthermore, there may have been a self-selection bias at play. Quite possibly, clients who had positive experiences with the MHS Court would have been more likely to be in stable situations, more easily contacted, and more willing to participate in an interview. Conversely, it is possible that participants who had less positive outcomes would have been more difficult to contact, and may have been less willing to participate in the evaluation. Where possible, issues related to the impact of the MHS on clients were supplemented with data from other Canadian studies of mental health courts.

RESULTS

3. Strengths of the MHS

All interviewees had positive comments about the MHS. This section outlines several themes regarding successes of the MHS. These themes include the following:

1. overall positive attitudes towards the MHS;
2. ample time spent on individual files;
3. participant “buy-in” and commitment is better in the MHS;
4. the MHS improves legal effectiveness and fosters inter-agency communication and realistic expectations; and,
5. the MHS is an evolving program that is improving over time.

3.1 Overall positive attitudes towards the MHS

There is an overall positive attitude towards the MHS exhibited by all interview participants. Everyone who agreed to be interviewed was highly positive about the existence of the MHS. Even the most pointed criticisms were rooted in a desire for the MHS to be more successful. The desire to see the MHS succeed was particularly evident when discussing the formation of the MHS. One professional who was involved from the beginning stated it thusly:

“[the MHS] exceeded my expectations. I didn’t even know it would get off the ground. The part that was so rewarding is so many government and non-government groups were getting involved. You just had to extend an invitation and they were there. You just had to get them into the MHS once and they saw the importance of being there and being part of the solution.”

Another professional with significant experience working with individuals with mental health conditions in Saskatoon was also impressed by the MHS’s ability to bring together organizations:

“[t]he creation of the MHS Court has allowed all these individual and disparate organizations to have conversations they might not have otherwise had, and to make connections. The implication of that alone is fantastic. The court isn’t using formal authority to convene all these people, it was invitational, yet obviously it struck the right chord.”

These comments indicate how ready the community was to embrace a mental health court strategy, and suggest a broad base of willing community participants. This was also noted in Judge S.P. Whelan’s interim report:

“We planned to work with existing resources; without additional funding. The first and essential commitment came from the Saskatoon Health Region. However, the major partners in the MHS have contributed substantially by reorganizing existing resources and that’s made all the difference.”⁵⁴

The sheer value of gathering different organizations was praised repeatedly both by individuals from the legal community and from those who support clients of the court in other ways. One significant community support professional phrased their support for the MHS very clearly:

“I think it’s an absolutely critical court to have. And just let me say that in terms of public safety it is even more critical. We have people we work with who deny they are mentally ill, the alternative [to the MHS] is to say ‘who cares if you’re mentally ill, just go to regular jail’. The potential in MHS Court is when you show up before the court and say ‘I’m not ill’ the judge can say ‘Fine, you can hold that opinion, but your behaviour is still against the law and you must answer to us.’ ... It’s an opportunity to realize there are these issues in their life and it may be mental illness and there are people who can help them manage that.”

Among the individuals with mental health conditions who appeared before the court, or “clients” of the court, the reviews were likewise very positive. This was particularly relevant for participants who had

⁵⁴ *Supra* note 39.

past experiences with the criminal justice system. One individual described the role of the court in glowing terms:

“[the MHS] really saved me, because I was homeless for a number of years before. Through the court I got set up with a psychiatrist, a counsellor... they got me in a house, an apartment, so I have my own place now. It basically got me off the streets and gave me my life back.”

Another client was also clearly grateful to the MHS and felt that the MHS “[gave] me a better chance for me to explain myself and to understand that I’m ill, and I have an illness, and that affects my behaviour.” When speaking to a client that had been through the criminal justice system before, after being involved in the MHS, he/she was absolute in saying their experience in the MHS Court was better in every way. This client felt that “the judge looks at you more as an individual rather than just an offender.” These comments from clients are very much in line with the findings in O’Keefe’s 2006 study of the Brooklyn Mental Health Court, where “the results demonstrate a very high level of satisfaction with court stakeholders and court processes.”⁵⁵

Overall, clients of the court and professionals involved with the court were overwhelmingly positive. This positive support for the MHS is in line with conclusions from other researchers.

From the Saint John New Brunswick Mental Health Court, in a 2008 paper, *Representing the Client Perspective of the Saint John Mental Health Court*,⁵⁶ researchers contacted 22 out of the 95 participants who appeared in that mental health court between 2001 and 2007. This study also showed overwhelmingly positive reactions among participants. 67 per-cent of participants in the study had positive comments, and many spoke of the better understanding they gained of their mental illness from participating in the mental health court. Those participants without explicitly positive responses were generally neutral, saying the court “wasn’t bad” or making similar representations. Of the 22 interviewees, only one had directly negative comments about their experience.⁵⁷ Similarly, positive results were reported when participants were asked to compare the mental health court to their experiences in regular criminal court.

In terms of the attitudes of professionals, a 2012 study also from New Brunswick, *An Analysis of General Public and Professional’s Attitudes about Mental Health Courts: Predictors of a Positive Response*, showed an overall positive attitude towards mental health courts from both professionals and laypeople. Further, the study also found that the more an individual learns about mental health courts or the more professional exposure they have to individuals with mental illness, the more favourable their opinions become.⁵⁸

A November 2014 report from the 5 year anniversary of the Halifax Mental Health Court also discusses the positive feedback from its clients and court team about the mental health court.⁵⁹

⁵⁵ *Supra* note 35.

⁵⁶ *Supra* note 33.

⁵⁷ *Ibid.*

⁵⁸ Ainslie McDougall et al., “An Analysis of General Public and Professional’s attitudes about Mental Health Courts” (2012) 11:3 *International Journal of Forensic Mental Health* 203.

⁵⁹ Nova Scotia Mental Health Court Program “Nova Scotia Mental Health Court Report: Celebrating 5 years November 2014” (2014)

These three studies suggest that overall attitudes are very positive towards mental health courts and are consistent with results from the current study wherein preliminary results also revealed strong positive attitudes towards the MHS.

3.2 Ample time spent on individual files.

The amount of time that can be dedicated to a single MHS client is, in some ways, a strength of the court, but can, at times, be a liability. These concerns will be addressed in a later section (See the *Concerns about public safety* section below). Overall, comments regarding the number of appearances of a MHS client suggested there were too many. However, some clients are clearly better served by repeated appearances before the MHS. One client referred to his many visits to the MHS Court by saying:

“they’ve really not pushed me, and not ran me through it but walked me through at a comfortable pace for me... They set you up with avenues to help yourself if you have no idea what you’re doing. Everything about it has been completely foreign to me... If they had put me in jail and let me out I would be back homeless doing the same thing... They could have rushed me through it and it wouldn’t have done me any good. But they walked me through with baby steps and it really saved me.”

One professional who works with individuals with mental health conditions remarked that “[y]ou can’t even address mental health needs unless they have a place to rest their head every night, stable meals and so on ... Everything else all comes tumbling down if you don’t have stability [in housing]. Mental health is all about having a safe place to go home at night.”

This person spoke to the necessity of getting an at-risk client stabilized with housing and counselling supports before meaningful steps to address mental health issues can be taken. Even if this process takes time and leads to repeated adjournments, cultivating a base level of stability is necessary if the sentences imposed by the Court are to be followed.

Additionally, the participants can often grow more comfortable with the process and become more involved with the treatment regimes and promises with the repeated reinforcement that multiple appearances entails. A different community support professional described the process of the MHS as one that occurs over time: “the participants are more comfortable. I think that the first court docket is similar [for many participants] since it’s a new process. I think on repeated visits it strengthens the involvement of the individual... and creates a healthier environment for everyone involved.” This comment suggests that repeated involvement with the MHS allows the participant to become more involved with the process than they would if the court process was wrapped up in a handful of appearances.

Investing significant amounts of time in participants who require it is common among other Canadian mental health courts. The analysis of the mental health court in Saint John, New Brunswick showed participants staying in the court program for a significant range of durations: “The duration of the SJMHC [Saint John Mental Health Court] program for the sample [2001-2007] ranged from 4 to 24 months ($M = 12.77$ months, $SD = 4.92$) and participants appeared

before the judge as little as 2 times to as many as 26 times ($M = 11.32$, $SD = 5.92$).” This is comparable to the Saskatoon MHS. Given the range of mental disorders MHS clients may experience, the importance of regularly scheduled appearances may vary from client to client. No commentary was offered by any interviewee during our evaluation concerning the value of the structure offered by regularly scheduled appearances in court.

Using our data for the 117 accused individuals from November 2013 to August 2014 (see Appendix B), individuals appeared before the MHS court as few as 1 time and as many as 12 times, with an average of 3.2 appearances in the MHS ($M = 3.2$, $n=117$). Of those individuals who appeared 1 time, it is probable that many of them were scheduled to appear but did not because they were unlawfully at large, wrongfully placed on the MHS docket, or in custody on other matters. In July, 2014, which was the only month for which regular docket court data were available at the time of writing, the MHS docket averaged 24 accused persons with an average total of 90 charges per docket, while the regular court averaged 23.5 accused persons and an average total of 79.5 charges per docket. For more information, see *Table 5* in Appendix B.

The MHS averages can be compared with the Saint John’s mental health court data. We do not have data about the length of time all participants spent in the MHS program specifically, but overall for the 32 individuals participating in the MHS for the month of August, they spent as few as 5 days in the overall court system, and as many as 909 calendar days. On average participants for the month of August spent 229.56 days in the court system. This statistic cannot be compared directly with the Saint John’s mental health court data, as it includes often extensive involvement with the court system before beginning the MHS program (For instance, a participant who was involved for 909 calendar days, while at the time the MHS court had only existed for roughly 320 days). It should also be noted that on some occasions when participants were listed to make an appearances they may have been *unlawfully at large* or in a psychiatric facility.

3.3 Participant “buy-in” and commitment is better in the MHS.

Motivating participants to actively desire to address the problems that brought them to court in the first place is a common goal of therapeutic jurisprudence. An early analysis of therapeutic jurisprudence described common difficulties in providing assistance to mentally ill offenders:

“[t]hey may suffer from mental illness that impairs their judgment about the desirability of their continuing to take needed medication. They may be in denial about the existence of these problems, refusing to take responsibility for their wrongdoing, rationalizing their conduct, or minimizing its negative impact on themselves and others. Many of these are problems that will respond effectively to available treatment, but only if the individual perceives that she has a problem and is motivated to deal with it.... Therefore, problem- solving court judges must understand that although they can assist people to solve their problems, they cannot solve them. The individual must confront and solve her own problem and assume the primary responsibility for doing so.”⁶⁰

The article then goes on to discuss ways in which therapeutic jurisprudence can achieve the goal of

⁶⁰ Bruce Winick “Therapeutic Jurisprudence and Problem Solving Courts” (2002) 30:3 Fordham Urban Law Journal 1055.

motivating the individual to solve their own problems. The level of commitment expected from participants, and the effectiveness of demanding a level of commitment, was another theme encountered in interviews of MHS team members. One of the organizers described the philosophy regarding client participation:

“[w]e developed this agreement piece, and it’s reciprocal. In other words, you come to this court and we’re prepared to supervise you and help you with your needs to be stable, but you also have an expectation as we do so. You’re expected to work with us and keep your promises, but you’re also expected to tell us what your needs are... it’s important that the individual has buy-in and a level of commitment we don’t necessarily ask for outside the MHS.”

The legal professionals involved in the MHS, especially the judges, believe very strongly in the benefits of this system, and their belief is supported by the existing literature on Canadian mental health courts. Justice Schneider, founder of the mental health court in Toronto, discussed client agreements with the court:

“the use of such a document, while formalistic, can nevertheless serve to ‘refresh’ the memory of those accused who may not be participating fully... participants who feel they have a ‘voice’ in the process in which they are engaging are more inclined to ‘buy in,’ or comply, than those who have a procedure forced upon them.”⁶¹

Schneider’s views were directly echoed by many MHS team members, with one professional putting it simply: “by engaging the accused in the identification of the problems and the plans you’re going to get some more buy-in to solving it.”

During our interviews it became apparent that the legal professionals involved in the MHS are also keenly aware of how buy-in can cut both ways:

“[w]e’re still a court, so we can’t meet the needs of anybody who isn’t prepared to engage with the system... if someone is homeless and has a residence clause and a curfew and an undertaking, they’re going to be constantly breached. But if they’re in the MHS and they want to cooperate, we’re a lot better able to craft conditions and monitor the process to get them stabilized. If somebody doesn’t want to work to get that done, there is nothing [judges] can do... [judges] can’t do anything to help someone who doesn’t want to deal with their problem.”

These comments support the argument that the court process cannot solve the problems of offenders with mental health problems without the active participation of the client. However, this does not mean that reluctant individuals should be excluded from the MHS Court. Several community support professionals commented that certain individuals they were familiar with participated in the MHS as clients and achieved a level of success that was unexpected, with one stating: “Some of the people I thought wouldn’t do well have [improved] because of having to come back and speak to the court. It was a legal pressure thing to drive compliance.” Comparable results have been achieved in the Saint John mental health court,⁶²

⁶¹ Schneider, *supra* note 1 at 179.

“[i]nitially participants were uncomfortable at the beginning of the program when they did not know much about it. By the end of the program, participants reached a high level of comfort with the process of the program. This increasing level of comfort with the program likely reflects participants’ greater understanding of the program as they became more involved in it. It may also reflect participants’ positive response to the team’s supportive, flexible, and understanding approach.”

While not discussing buy-in *per se*, this does suggest that participants become more involved and more comfortable participating in a mental health court program over time as they gain more experience with it.

3.4 MHS improves legal effectiveness

One of the most resounding successes of the MHS was the refrain heard time and time again, specifically that the MHS allows people who work with mental health clients of the court to do their jobs better in a variety of ways. Much of the literature on therapeutic jurisprudence supports this finding. One comment from an American source references a judge who stated, “I was able, with complete fidelity to all my principles, to do a better job of being a judge in that context [of a problem-solving court] than I ever was doing anything else.”⁶³ Another American judge quoted in the same article said “At a [problem-solving court], I’m able to look up from the papers and see the person standing in front of me. It takes two or three more minutes, but I think a judge is much more effective that way.”⁶⁴ Generally, these positive attitudes of being empowered to do a better job by therapeutic jurisprudence were resoundingly upheld by the MHS legal professionals interviewed for this report.

For legal professionals, the benefits to job performance fell into three broad categories: more information available about the mental conditions of the accused allows for better decision making throughout the court process, the improved information and decision making in turn leads to sentences that are more in line with the objectives of sentencing as outlined in the *Criminal Code of Canada*,⁶⁵ and in turn upholding their duties “better” improves the administration of justice.

One legal professional eloquently summed up how this additional information improves job performance:

“[w]e know people have mental illness and, prior to the strategy, we wouldn’t delve into that background because it wouldn’t be appropriate to do so. The strategy has that aspect of giving consent for health information to be discussed so now we can get answers to questions we previously strayed away from. The effect is with better information, the bigger picture... you can make better submissions to the court. I personally think we can do a better job of addressing the public safety issue if we know better what makes this person act the way they’re acting.”

This remark shows how the additional information that is revealed in the MHS allows for

⁶² *Supra* note 33.

⁶³ Greg Berman ed, “What is a Traditional Judge Anyway? Problem solving in the state courts” (2000) 84:2 *Judicature* 81.

⁶⁴ *Ibid.*

⁶⁵ *Supra* note 19, at ss 718, 718.1, 718.2.

improved job performance and directly relates to improving public safety, one of the ultimate goals of the strategy.

A different legal professional directly described how the MHS improves job performance when asked if the MHS had made their role easier:

“I think the MHS process makes me a more effective [legal professional] in terms of handling the people with mental health conditions, because we have the benefit of more information generally. The word "easier" is it easier? I think I can do my job better due to the MHS and in particular the amount of information. I don't know if that means easier, but more effective.”

This statement affirms that the MHS improves the effectiveness of legal professionals who work with individuals with mental health conditions. Another legal professional described the advantage of the MHS as:

“...providing time and opportunity for us to learn about the person and their mental health issues. Having the resources to get information, in particular medical information, about their issues. Having the participation of community services available to get their information and get involved. All that information about the person is so important to have in order to fulfil the principles and purposes of sentencing under the *Criminal Code*... I don't think we're doing anything other than what we're supposed to do under the *Criminal Code*. But [the MHS] gives us a bigger picture.”

Comments to this effect were echoed many times by the interviewed professionals (five individuals made the point directly, and two others made statements which could be inferred as support). All of these individuals clearly took their responsibilities very seriously, and saw the ability to do their job better not only as a personal gain, but as an opportunity to better uphold the law and create safer communities.

Additionally, one aspect of improved job performance directly ties into concerns surrounding access to justice.⁶⁶ It was acknowledged that prior to the MHS, it was often difficult to give individuals with more subtle mental health conditions appropriate legal representation. One individual explained the situation:

“If the Crown is not seeking jail time or a conditional sentence order, [the accused] is generally not eligible for Legal Aid... now more clients are flagged with mental health concerns and spending time in the [MHS]. It makes people [who would normally be ineligible for Legal Aid] be accepted. And I mean they would have been accepted [by Legal Aid] if we had known about [the mental health condition], but we didn't.”

This statement shows how individuals with mental health conditions are now able to obtain a level of legal counsel that, in at least some situations, was previously unavailable. Providing legal representation for individuals with mental health concerns is self-evidently improving the administration of justice.

⁶⁶ “Access to justice” is a large body of research with in Canada. For an overview of some of the issues with access to justice in Canada see: <<http://www.cba.org/CBA/Access/main/>>.

There is supporting literature, again from the Saint John mental health court, showing legal professionals involved with other mental health courts in Canada tend to be supportive of those courts.⁶⁷ The study looked at the relationship between Legal Aid and other mental health court team members, stating that “duty counsel expressed no difficulty in reconciling the protection of client rights with the need for disclosure of information. In their view, they routinely work to protect the best interests of clients and they regard the information sharing process during the pre-trial conference as, defensibly, in the client’s best interest.” The report goes on to state that “On the whole, both duty counsel and the Crown felt that the pre-trial team conference definitely serves the best interests of the client, be that the accused or the Solicitor General, as it improves their ‘ability to effectively provide better justice.’” These observations generally mirror the statements from legal professionals on the Saskatoon MHS team: effectiveness in terms of administering justice is increased, without sacrificing the interests of individuals appearing before the court or those of the public at large.

3.5 Fostering inter-agency communication

One of the single most frequently mentioned topics was the effectiveness of the MHS in bringing together various organizations in the community that have an interest in supporting individuals with mental health conditions. Many of the factors that impact individuals with mental health conditions cannot be addressed through a single avenue. For example, they may have housing issues, addictions issues, and medication compliance issues in addition to other complex needs that require assistance from Saskatoon Crisis Intervention Service or other social service agencies or mental health needs that require psychiatric assistance or counselling. Currently, there is no mechanism for “one stop shopping” where all of these needs can be met or even where individuals may set up meetings or appointments with many different organizations. The ability to gather practitioners from multiple different already existing community and government organizations in one place is one of the greatest successes of mental health courts generally. For example the Nova Scotia mental health court has similarly been able to increase the cohesiveness of community agencies and service groups to provide support for their court clients.⁶⁸ This theme is also discussed in a book on the Toronto mental health court:

“there are many participants [team members] in the operation of the mental health court. However, when one takes a close look at the participants it is apparent that most of the same participants were engaged prior to the creation of the mental health court; what is different is that these various participants are now brought together physically and, as a result, set up to work collaboratively in a much more effective team approach.... It is the mere bringing together of the various participants that is seen by the authors as a principal reason for the success of mental health courts.”⁶⁹

The Saskatoon MHS was frequently praised for its success doing exactly what Justice Schneider outlines above, gathering many relevant stakeholders into one room where they can speak with and about individuals who need their services. One professional described the benefit they see from having many different organizations represented in the strategy:

⁶⁷ Claire Goggin, Paul Gendreau, Paula Smith, “The Saint John Mental Health Court: An Operational Review” (Centre for Criminal Justice Studies, University of New Brunswick, 2003).

⁶⁸ *Supra* note 59.

⁶⁹ Schneider, *supra* note 1 at 180.

“The bulk of the people are systems people, they work for social services, for addictions services, for the court, for corrections services, for the health region, and I think there’s a real place for community based organizations in this vision. It may be that we need to do more education among ourselves about what kind of things we can help out with... knowing some of the folks in that circle has been helpful in terms of finding things that I wouldn’t know how to find.”

The benefit of bringing a diverse team together is not just in locating services, but also increasing overall efficiency. This was clearly explained by one respondent:

“We immediately realized it was going to make [the Health Region’s] life easier to have someone on the team ... because at any different time the Health Region could have 2 or 3 support personnel in ... the same building in different court rooms, and they didn’t always feel like they could speak or contribute.”

Once professionals feel they can get involved, they can contribute to the MHS team in significant ways. One support professional spoke about their experience after becoming part of the MHS team:

“The value of the consistency within the team is that it opens up opportunities for great communications, so that the team members that are somehow potentially relevant to the individual have a bit of knowledge about that individual and know how to connect with that individual. It allows the team to provide the judge with the information to really make an informed decision about what factors led to that criminality, led to where we are now, and what changes are truly needed.”

The majority of comments about interagency communication were similarly positive, with respondents excited about the ability to get more information about the individuals with whom they work and either better support them or make better decisions in relation to them.

Mental health courts have been shown to increase the levels of treatment and access to support services for the accused individuals. In a study of the Anchorage, Alaska mental health court, individuals with mental illness before coming to court were seeking treatment 42.3% of the time, and receiving support services 53.8% of the time. During their mental health court involvement those numbers spiked to more than 90%, but then decreased to 76.9% and 80.8%, respectively, in the following years.⁷⁰ Overall these data demonstrated that mental health courts can be effective in making enduring connections between the individuals and the support networks that already exist.

There were a handful of critical statements stating that inter-agency communication could be more effective if it was more structured. Some interviewees believed that more formal coordination would be helpful. Others felt that there was insufficient time during MHS docket sessions to engage in fulsome communication. These criticisms are discussed below in the *Need for a Coordinator* and the *Docket Size* sections, respectively.

3.6 Realistic Expectations

⁷⁰ *Supra* note 34.

The pragmatism of the MHS is crucial to any sort of enduring success. That is, the goals of the program should be realistic and tied to what the court system can reasonably achieve. Justice Schneider outlines several common objectives that inspire mental health courts, of which the first two are particularly relevant for the Saskatoon MHS:

“Increased public safety: by reducing future criminal activity and lowering the high recidivism rates for individuals with mental illness who become involved in the justice system.

Improved quality of life for individuals with mental illness: by ensuring that individuals with mental illness and co-occurring substance-abuse disorders who are involved in the criminal justice system are connected to effective community-based treatments and supports that help encourage recovery.”⁷¹

Individuals with mental health conditions face a number of chronic challenges that cannot feasibly be resolved through the criminal justice system alone; one of the reasons the involvement of community supports is so critical. The goals referenced above make no reference to a complete desistance of offending, but rather aim to reduce reoffending and encourage recovery. Most MHS team members we spoke to acknowledged limitations of what can be done through the court system. However, it is reasonable to strive to lower recidivism significantly, and indeed research suggests this is likely;⁷² although, it is naive to expect that all individuals appearing before the MHS will never recidivate.

One legal professional framed the issue bluntly:

“I don’t think the MHS can meet all the needs of people with mental health conditions. We’re only one part of what has to be a broader community system. I don’t even think we’re the primary point where we want to deal with people with mental health issues. It’s just those that are facing criminal charges and we want to treat those people fairly. It’s a broader issue than the Provincial Court, which is obvious as we look to community service providers.”

Another legal professional discussed goals surrounding public safety and just sentencing, before concluding: “Cure is nowhere in there; management and assistance [are the goals].” These remarks illustrate the limitations of what the legal side of the MHS can reasonably accomplish, and generally the important stakeholders are aware of these limitations and try to be pragmatic. A community support worker described their views of the goals:

“I think that, very simply, recidivism rates wouldn’t be non-impacted. I’m hopeful that clients who have received the process and gone through everything will not return to the system; or for an extended period of time would have more stability. That would be the success, that

⁷¹ Schneider *supra* note 1 at 86.

⁷² 65 A 2005 study of the Clark County Mental Health Court looked at 368 individuals who had gone through their program. It found that individuals who “graduated” from the program had an overall reduction in crime by a factor of 4, with the majority of participants not seeing rearrest, and a 62% drop in probation violation. Individuals who had “graduated” the program were 3.7 times less likely to reoffend when compared with “nongraduates.” Herinckx et al., “*Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program*” (2005) 56:7 *Psychiatric Services* 853.

people are managing in the community in a successful way because of the people and the process they became involved with.”

Here, we see the end goal is not a complete cessation of involvement with the criminal justice system, but rather an extended time of successful functioning and stability, and contacts that will help the client stay stable. However, it is underscored by the knowledge that, given many of the issues faced by participants (addiction, suggestibility, etc.) it is inevitable that some will recidivate. Thus, the task of the court becomes one of “slowing the revolving door”, or increasing the time before that individual appears again.

It is also important to acknowledge the degree to which success depends on the mental health concerns of the individual. For some high functioning participants, valuable community contacts and treatment for their illness can steer them back towards stability, employment, and generally becoming a positive member of society. One participant described his situation:

“[t]hey’re in the right direction. They got Housing First involved... and Housing First is amazing. They helped me out, they keep me in check. I have [mental health issue] but now [Support Professional] is helping out. [Support Professional] got me on the SAID program [(Saskatchewan Assured Income for Disability)], helps me with my finances and my bills. There again, Housing First, what they offer is safety and security. Not just putting you in a home but they help you learn the process. I have a TV and a phone and I’m paying bills... because of being homeless forms and that [Shrugs, implication they had never filled out forms or paid bills].”

In further discussion the interviewee mentioned they had also obtained some employment with the help of the Support Professional and are using that money to pay for their bills with an eye towards eventual financial independence, with the help of some Government assistance. Overall, it was a positive and dramatic improvement wherein MHS involvement allowed an individual to significantly improve their life and their contribution to society. However, it is important to recognize that not every individual who appears before the MHS shares this same level of capacity. For some participants, breaking the cycle of offending by obtaining some treatment and enduring contacts with support professionals may be the most realistic outcome. Two “front-line” community support professionals described their definitions of success:

“[s]uccess would be the regulars in and out of the regular justice system no longer showing up because they go to the MHS and hopefully get treatment and help so they’re not going through the same cycle. A failure would be the reverse: not the appropriate people making it into the court and [remaining] in the regular system. Or if they are [individuals with mental health conditions] not being given the right treatment or the right conditions [in sentencing].”

and:

“[s]uccess would be reducing crime in general. People are not going to keep reappearing if they’re getting treatment instead of going to jail and cycling through. It would reduce crime. Failure would be for things to just remain the same. For people that are unconnected now and don’t have advocates to remain in the regular system because they don’t have anyone to help them.”

Both these individuals took a pragmatic approach that did not focus on individuals becoming fully

participating members of society, but rather on breaking cycles, reducing crime by creating positive connections, and receiving treatment for their illnesses. The goal of public safety and the reduction of crime as the most realistic goals was also shared by legal professionals closely involved with the MHS. One stated. "I do believe the work we're doing in the strategy is going to reduce risk to public safety, and that's really what it's all about. I do think we're helping." In the interests of disclosure it should be noted that this participant's next comment was critical in nature and highlighted an occasion where the goal of public safety was not better met by the MHS, this will be explored more in the later section *Concerns About Public Safety*.

Overall, there is a very strong trend among the professionals involved with the MHS towards setting realistic goals and expectations, and focusing on the big picture as opposed to individual cases. Almost everyone recognizes that many of the individuals will not completely cease offending, but rather that the rate of reoffending can be significantly reduced and public safety can be significantly improved by the existence of the MHS. Some legal professionals viewed this improvement as being due to their ability to obtain more information and better prepare cases or judgements, whereas some community support workers saw the opportunity to make connections and reinforce connections with individuals who are otherwise very susceptible to "falling through the cracks." It was noted that the correctional system does have the potential to successfully intervene for individuals with mental health conditions but, on the whole, there was a consistent attitude that most individuals who received short sentences for petty crime would not see any meaningful improvement from being sentenced to time in a correctional facility, and would be on the streets of Saskatoon again shortly after their release, and back in court shortly thereafter.

Furthermore, based on many professionals' accounts, it seems many of the shortfalls and low expectations for participants are tied to issues that Saskatoon is actually very capable of addressing. Numerous legal professionals spoke of difficulties coming up with any sort of treatment for participants because they lacked community supports needed for that treatment, while in turn many community professionals spoke of being able to help with those needs but not having the opening required to become involved in providing assistance. These are issues that the MHS can assist with by fostering communication and networking between the stakeholders. More on the role of the MHS in fostering communication can be found in the section on *Fostering Inter-Agency Communication*, and the section on the *Need for a Coordinator or Point-Person*.

3.7 The MHS is an evolving program that is improving over time

A key facet of problem-solving courts is their flexibility and ability to change and self-regulate over time. Justice Schneider discussed how developing a mental health court requires adaptability:

"mental health courts have avoided a preset blueprint for program implementation and design, preferring instead to develop courts that are fine-tuned to local needs and resources. For those interested in developing a mental health court, this reality can be both encouraging and daunting at the same time. It is encouraging because it is accepted that mental health courts, as a concept, are flexible and compatible to the individual circumstances of each community... however the absence of a mental health- court model is daunting... in most instances, establishing a mental health court requires building from the ground up."⁷³

⁷³ Schneider, *supra* note 1 at 166.

Given that mental health courts lack any ready-made blueprint and must adapt to the circumstances of their community, it is encouraging to see that the Saskatoon MHS is aware of its own need for flexibility and continuous refinement going forward. The willingness of the MHS to have the current evaluation done speaks to the strategy's drive for improvement.

A theme among many of the interviewed professionals was that the MHS has changed and is continuing to change over time. Put simply by one respondent: "it's still in its infancy stages so it's an ongoing process. So in that sense... we're still in the start-up phase. It's going to be ever evolving. We're still trying to figure out what's working and what's not working and how do we make things better. There's no end of challenges." Another professional who was involved in the organization of the MHS expressed some concerns about this evaluation for that reason: "I think it's too early... Problems pop up every week. What we're doing today might not be the same thing we're doing in 2 months."

This clearly shows a commitment to change and improvement. The need to take time to improve was echoed again by many community support professionals, one of whom said the following of the MHS:

"[t]here are many, many advantages. The advantage for the taxpayer is that we're not criminalizing the mentally ill [and paying to incarcerate them]. [The MHS is] going to take time, it's really young, all the various disciplines involved around this will take time in learning how to roll out [the MHS] with more impact. I believe it's grounded in fundamentally wonderful principles and offers a better form of attending to these folks than conventional incarceration."

Another community support professional described their view of how the MHS keeps improving:

"[w]e're still learning, we're learning as we're going. And everyone is open to change which is great. If someone has an idea for how to do it better everyone is very open and that's encouraging. We're not having any resistance from anyone in particular."

The openness to change alluded to in these comments suggests the Saskatoon MHS is upholding a key feature of mental health courts in Canada. During the preparation of this report, the researchers found numerous communiques between a psychiatrist who was conducting assessments for the MHS and several key MHS organizers, the purpose of which was to improve the monitoring of client progress through the MHS. This is a reassuring example of devotion to improve the MHS amongst its stakeholders.

The Nova Scotia mental health court is another example of the ever-evolving nature of mental health courts as they implemented a random drug and alcohol testing process in order to better understand the addictions needs of their clients. This process was implemented after they realized that addictions issues of clients were not being fully addressed by their original court processes.⁷⁴

As noted in the *Methods* section, the MHS is still in Phase One of its implementation and, as such, it is too early to determine any definitive measures of success beyond those found in this document. It is up to the organizing committee to decide when Phase Two will begin.

⁷⁴ *Supra* note 59.

4. Areas for Improvement

This section will speak to some of the criticisms raised by interviewees, as well as some suggestions for improvements that were put forward. Criticisms are grouped into the following major themes:

1. docket size (with sub-categories);
2. the need for additional sessions or more frequent dockets;
3. the need for a coordinator or point-person;
4. the length of time to progress through the MHS;
5. concerns about public safety; and,
6. requests for additional training.

4.1 Docket Size

This was perhaps the most frequently cited area of concern amongst interviewees, and it touches upon numerous other issues with the court. In some ways the large dockets seen in the Saskatoon MHS can be taken as a positive factor that illustrates the value of the MHS. Once it was established, it almost immediately started running at full capacity, and likely significantly over that, indicating that the service was sorely needed. Furthermore, our research has suggested it is likely that more individuals in the criminal justice system in Saskatoon could be eligible for participation in the MHS. Currently, a small handful of judges were responsible for nearly all the referrals to the MHS. However, as docket size was not a specific focus of the evaluation, there is insufficient information to draw any conclusions on this matter.

The number of individuals appearing on dockets is a common point of concern for Canadian mental health courts. The mental health court in Saint John, for instance, reviewed 190 cases between 2000 and 2007, and accepted 115 cases into the program over that same time period.⁷⁵ The Saint John mental health court normally meets twice per month, and has an extensive team meeting (often lasting 2 hours) before moving on to a formal court setting.⁷⁶ This is very comparable to the meeting schedule for the Saskatoon MHS, with the notable exception of a longer pre-court meeting. By comparison, between November 2013 and August of 2014, the Saskatoon MHS has worked with or is continuing to work with 117 defendants, more than the number of cases handled by the Saint John court over almost 7 years. Although it is risky to make comparisons between mental health courts because of their diversity in organization and format, it certainly appears that the Saskatoon MHS has done an exceptional job handling such a large volume of participants in such a comparatively short time.

For the purposes of the above comparison, for example, it is important to note the Saint John mental health court has a slightly different format, with a 2 hour pre-court meeting during which individuals appearing before the court are discussed, and in addition individuals who have been recommended to appear before the court are discussed to determine if they should be accepted. A similar process is in place for the Nova Scotia mental health court as they streamlined 687 referrals to the court into 232 eligible participants, from 2010 to 2013, through an intensive pre-screening process by their

⁷⁵ *Supra* note 33 at 9.

⁷⁶ *Supra* note 67.

MHC team.⁷⁷

Simply put, the sheer number of files involved in every MHS docket court date is putting significant pressure on the legal members of the strategy, and is likely hampering the positive effects of the court and reducing overall effectiveness. One organizer summarized the issue with large dockets:

“[w]e recognize we have to provide an atmosphere that is more nurturing and inviting. It’s the only way you’re really able to gain trust and information and are really able to work with people. In other courts where it’s a busy docket, we can’t do those things and finish by the end of the day. Some of it is just about slowing it down and getting better quality information. I don’t see it working if it gets so busy it’s just like any other docket.”

From the first MHS Court day in 2013 to the end of August, 2014, the average docket size was 20 individuals, with the largest docket having 35 individuals and the smallest having 9 individuals. Most of the criticism stems from the fact many team members feel the docket is still too large for the MHS to function with the efficiency of which it is capable. To some extent, this is a “growing pain” inherent in creating a new court and getting a feel for how much time individuals with mental health conditions may require. One legal professional who is very involved with the MHS described their surprise at the difficulty created by the docket size:

“I thought that there would be fewer people in [the MHS] than we have, at least initially. I’m surprised at the volume. I’m surprised, I guess, at the number of things that have to be considered in creating and running a new court. I’m used to them running smoothly because they’ve been running forever.”

The number of individuals appearing on the docket is causing several distinct issues:

1. Pressure on MHS team members
2. Pre-Court Meetings are of limited effectiveness due to the large dockets
3. Over-Formality is adopted as a way to deal with large dockets.

Fortunately, there were numerous suggestions offered to address these issues and many are feasible with limited resources, or with a reorganization of current resources. However, for the MHS to be sustainable on a long-term basis, the bi-weekly docket will likely need to change. This section will expand upon the issues outlined above in terms of the difficulties created by the large docket size, and then will move on to look at proposed solutions.

4.1.1 Large docket sizes put pressure on the MHS team members

Legal professionals who are involved with the MHS described significant preparation required for any given court appearance. Two legal professionals estimated the time required to prepare for the MHS was two work days per MHS court date, two other professionals estimated roughly 12 hours per MHS court date, whereas another two professionals estimated one work day of preparation or less per MHS court date. Although there is a significant range in these estimates, it is safe to say that the MHS is placing a significant demand on legal professionals. One of the highly involved legal professionals described preparing for the court with some frustration saying they “could

⁷⁷ *Supra* note 59.

easily spend 3-4 days a week on [the MHS]... [a client] waited for me outside [my workplace] and just waited for me... we're social workers too. We spend extra time during the week because they see us as someone they need to talk to." Another professional added: "the ones doing well in the court stop by more often. They really rely on us... we always stop to deal with them no matter what we're doing because we have no idea what's going on with them [psychologically]."

A legal professional in a different role described the time required per file:

"[o]n average it takes me at least an hour to prep a file for court, if there are reports. I'd say 1 to 2 hours, if I need to make calls and inquiries. I would ballpark it at 1 to 2 hours for every file for the initial review. So then even after you [prepare the initial file] you're still prepping it because we're adjourning so many. We're adjourning 6 weeks down the road so you need to refresh your memory. On average it's probably 30 minutes per accused to refresh and prep for the next appearance."

From these quotations, it is easy to see how dockets that averaged over 20 clients per MHS Court date can quickly create a very high volume of work for everyone involved. It is worth noting that the interviewed judges also reported high volumes of work. However, they have established a rotation system that spreads the work out over the course of multiple docket sessions to reduce the volume to more manageable levels. In general, our interviews revealed that most legal professionals had found ways to manage the additional workload associated with the MHS.

The one notable exception was Legal Aid. In some ways, Legal Aid takes the brunt of the volume of work associated with the MHS. Legal Aid must spend significant time preparing the files in manners similar to those outlined above, and meeting with the clients of the MHS. Given the volume of the MHS dockets and the frequent addition of new names, meeting with MHS clients can quickly become a sizable time commitment in addition to all the preparation required by the files themselves. Furthermore, some clients of the court have capacity issues and Legal Aid must intervene to set up appointments or the like as required by promises to the court in order to help that client remain compliant with the MHS. While some of these pressures on Legal Aid could be resolved by a full time coordinator who ensures clients are connected with the right resources, some are unavoidable aspects of their role in the justice system. It is recommended that further conversations with Legal Aid occur to determine what options exist to expand their MHS involvement. Legal Aid is a crucial member of the MHS team, and it would benefit the MHS court if their resources were increased to allow for greater MHS involvement.

4.1.2 Pre-Court meetings are of limited effectiveness with large dockets

Overall, the majority of MHS team members stressed the importance of pre-court meetings. However, a theme emerged of not having enough time to deal with every name on the pre-court meeting with the necessary level of detail. With the average of 20 individuals per MHS court date, that leaves the court with only 3 minutes to discuss each individual ahead of time in the hour long pre-court meeting. With dockets sometimes stretching to 30 or more names, the amount of individual attention MHS clients receive in the pre-court meeting can often be measured in seconds.

One community support professional summed up the problem with pre-court meetings: "Time is always a factor. The dockets are way too big. Therefore, I think some of the people who need a little

more time are not having their needs met.” Some comments from legal professionals on pre-court meetings include: “We’re always in a hurry. Sometimes [for a few MHS clients] we really want to broach the subject of case management meetings but at the pre-court meeting we only have 2 minutes per client.” And “I think pre-court meetings in general are not effective. I think a post-court meeting would be more effective.” And:

“I’ll be very frank: I don’t really see a lot of merit in the pre-court meetings... the majority of information that comes out of the pre-court meeting I can do that outside of court... right now what we’re doing isn’t really helpful, we just do a dry run of the docket then turn on the tape recorder and do the actual docket.”

However, the same individuals making these comments sees potential in the pre-court meetings with fairly slight modifications. One suggestion was to have the pre-court meeting a few days in advance so more can be done with the information that comes out: “[m]aybe do pre-court meetings half a week before, on a Thursday or something... then we could spend Friday working on the files after having some sort of conversation about what needs to be done on it.”

Another professional was critical but offered a suggestion at the same time:

“[y]ou have a bunch of [lawyers and judges] running the show. We’re not the experts when it comes to mental health... I think the mental health people should have a bigger role in the court, but they’re not because it’s a court. [Name of community support professional] is there, he’s just a fantastic resource, but I think he’s underutilized. I don’t think he’s doing enough, and that’s not a criticism of him, we haven’t empowered him to do enough. There’s probably more he could do [in regards to providing legal professionals with information]... and then your 8:30 [pre-court] meetings might be more productive.”

The issues with pre-court meetings seem to all boil down to having too many names on the docket, and not enough time to address each client fully. If the length of time dedicated to pre-court meetings could be increased, or if the overall docket size could be decreased, the pre-court meetings could incorporate more voices and become more effective.

4.1.3 Excessive formality as a way to deal with large dockets

A recurring theme among community support professionals was a sense of unnecessary formality in the MHS Court, paired with a ready admittance that the MHS is still far better than regular criminal court. One such professional phrased the issue clearly: “I expected it to be less formal, and more of an interactive process with the participants and the team. It has, to use the phrase, ‘lightened up a little’ but it’s still a very formal process... but it’s a court, and a legal thing, so I get it.”

The dangers of formality is addressed in the literature surrounding mental health courts generally. One essay introducing therapeutic jurisprudence in a law journal stresses the importance of judges treating the accused individual with respect:

“the judge and treatment personnel must act so as to give the individual the perception that they are empathic, accepting, warm, and willing to permit self-expression... Even though they have engaged in wrongdoing, a special sensitivity to the individual’s pain, shame,

sadness, and anxiety in coming to terms with the existence of the psychological or behavioural problems that have produced criminality and the victimization of others is called for in the judge-offender interaction.”⁷⁸

Similarly, Justice Schneider described the ideal judge as one who possesses “general qualities that have been recognized as essential: patience, a sense of humour, and an ability to read the law in a rather ‘elastic’ manner.”⁷⁹ An article from 2000, when mental health courts were new to America, went so far as to list 12 desirable attributes in mental health court judges:

“[t]he model MHCT judge should possess the following attributes: (1) appropriate judicial temperament, (2) compassion and sensitivity to the client’s therapeutic needs, (3) tolerance for remission, (4) knowledge of the DSM-IV categories of mental illness and their treatment, (5) an ability to objectively assess the value of expert medical testimony and scientific literature, (6) complete understanding of medication effects, (7) a willingness to effect therapeutic change in law enforcement procedures, (8) excellent interpersonal skills, (9) the willingness to represent the goals of therapeutic jurisprudence to the public, (10) a philosophical commitment to treatment and rehabilitative objectives, (11) the perception to recognize preconceptions or biases in him or herself and others, and (12) the capability to efficiently supervise court-mandated treatment plans.”⁸⁰

While this exhaustive list likely defies reasonable expectations for judges, it is worth noting that the traits tend towards exhibiting sensitivity to the clients’ needs, and not towards rigidity, formality, or speed.

The judges of the MHS have been largely successful at living up to the lofty standard imposed by advocates of mental health courts. Comments are overwhelmingly positive, with clients and professionals alike praising the role of judges in changing the tone. One MHS team member stated: “I think our judges are all incredibly engaged. It’s fantastic... they do everything they can do. You can tell they go out of their way to make this court work.” A different team member stated “I really appreciate how much time the judges give the individual to articulate themselves. It can be very challenging. And [when the accused] has been through court systems in the past and may not have had the best experiences, [then] I think the [judges’] approach is very well done.” And yet another MHS team member stated “I think the participants are more comfortable... I think on repeated visits it strengthens the involvement of the individual. Creates a healthier environment for everyone involved.”

Overall, the comments regarding the role of judges specifically were highly positive, as the above indicates. The comments regarding the formality of the MHS Court were directed at the court process itself. It is likely that the problem of over formality will correct itself to a large extent if docket sizes decrease and the MHS judges have adequate time to use their lauded interpersonal skills to engage with individual MHS clients.

4.2 The need for additional sessions or more frequent dockets

⁷⁸ *Supra* note 60.

⁷⁹ Schneider, *supra* note 1 at 174.

⁸⁰ LeRoy Kondo “Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders” (2000) 24 Seattle University Law Review 373 at 407.

One of the obvious solutions to the problem of overcrowded dockets is the creation of additional MHS sessions beyond the twice monthly docket court. These sessions need not take the form of a traditional docket, and MHS team members have numerous suggestions for how additional MHS Court sessions could be structured. One community support professional wondered “if there might not be a need for more than the 2 days a [month] they have now?”

A legal professional raised the issue pointedly: “I think we have too many people on the docket and we’re not doing enough work on the files... I think the dockets need to be structured differently so we can do some more significant work on the files. Right now, mostly what we’re doing is adjourning.”

There were a few suggestions from interviewees to address this need in inventive ways. One suggestion is to create “more concrete treatment plans or clinical plans for people when they leave, so they know things will go differently.”

Another suggestion was to have more focused dockets for specific issues within the MHS framework, as one interviewee suggested: “maybe one docket a month for medication compliance issues and make the docket specific to them, and maybe have more focus on their support networks being there. Again, it’s the size and formality of it [that makes normal dockets less efficient for medication compliance issues].” Similarly, another MHS team member suggested that a docket just for sentencing occur on a semi-regular schedule.

Another suggestion was to have one or two occasions per week where an MHS intake worker could meet with defendants shortly after they are diverted to the MHS stream. The intake worker could then brief the MHS participants on what they can expect for the first day in court, could help them set appointments with Legal Aid, and could assist in filing the required consent forms and other paperwork. Assistance with those steps in advance has the potential to reduce the demand placed on docket days by new MHS participants who may not have legal representation or the correct paperwork in order. The intake worker could hypothetically be the MHS coordinator described in the following section.

4.3 Need for a coordinator or point-person

The single most frequent request for improvement was to hire a coordinator to cover the numerous small tasks that are currently being handled by judges, clerks, Legal Aid, or community support professionals going outside of their mandate to meet needs on an ad-hoc basis. A coordinator could handle issues such as scheduling appointments for clients with capacity issues, connecting clients with resources in the community and connecting the resources with each other, intake assessments, and general administration of the MHS. The coordinator position was first identified as a need in November, 2013, when the MHS was established.

In regards to the appointments that are often required as part of ongoing treatment, frequently these appointments are made by Legal Aid or by the Health Region (which is outside of the mandate for either organization) and often there is no one to remind individuals of their appointments, which can be problematic for clients whose symptoms include significant memory issues. A legal professional described the problem:

“It puts a burden on Legal Aid to contact them and let [the clients] know. You need a contact person to let them know. If a doctor needs to change an appointment how do they let them know? When you collect assessments it seems... so much more difficult than it needs to be. Collecting the information [from the] assessments and getting information sent to the medical person [is overly difficult]... A coordinator would be lovely...”

Additionally the numerous services offered by different team members can be difficult to monitor. Having a single individual who is familiar with all the different community organizations would be invaluable in ensuring clients are connected with the right organizations. Further, there are many services that are offered according to an irregular schedule (for example a psychiatric clinic held once a month) that the MHS cannot reliably take advantage. There is however an identified lack of services for individuals who service the needs of the MHS clients in the community generally, therefore the importance of reaching out to those services that do exist is all the more important. If there was a coordinator aware of such services, they could help the MHS utilize those resources. One organizer described the need for a coordinator:

“What needs to be done is more coordination with resources in the community... What can we tell people who come to the MHS about what your organization has to offer?... that’s really the next step right now, engaging organizations in the community and getting them involved. There are a real host of resources out there and the big difficulty is knowing who they are. Otherwise you just develop [the MHS] more slowly and with less coordination... These organizations are really important. It’s something you’d really need a coordinator for to crystalize things. A paid coordinator, even just a half-time position is ideal for that sort of thing.”

Another organizing member of the MHS stated this same need:

“Again this comes down to the wishlist of a coordinator... I’m thinking of [the] drug treatment court in Regina, they have a coordinator that meets with the accused when they come in the door. They do an intake assessment: “what did we do last week?” “where are we this week?”, and they can assist with small details like arranging transportation to appointments. I’m not sure we would need the full pre-court meeting if some of [those arrangements] could be done with the assistance of a coordinator prior to court. We would still have a pre-court meeting but it would be different than what we have now... I think if some of the details were done by a coordinator, if that meeting with the accused is held, then the judge’s role becomes one of encouragement or not as the case may be, and formalizing a plan for the next days.”

Another legal professional described the need for a coordinator and the improvement that has been seen even with a clerk spending a small number of hours assisting the MHS:

“We need a better system of how to do [assessments]... or where we can set up appointments [for clients], because we’re losing people. The court orders an assessment and the accused gets the paper and pffff. They’re mentally ill people who are living outside. It’s impressive they even come to court. We’ve talked about a coordinator position, and we have [a clerk] who clerks for the strategy and I’m starting to see some improvement now that [the clerk is] there. Now I’m getting contacted by [the clerk] and [the clerk is] liaising with the doctors and it’s

definitely better. There could be something structured there.”

The clerks have clearly been very helpful with the coordination they contribute to the strategy, although they are not full time employees of the MHS and their duties are wide-ranging. It would be short-sighted to rely on these contributions over the long term.

Additionally, many of the concerns regarding docket size could be alleviated by a coordinator doing intake assessments in a manner similar to the drug treatment court in Regina. This intake process would help orient the accused and ensure paperwork that does not require a lawyer is completed prior to their first appearance. Monitoring the progress of individuals through the MHS would also streamline the dockets as less time would be required to follow up on what happened since the previous court date. Coordinators are crucial components of therapeutic jurisprudence initiatives in Saskatchewan such as the Drug Treatment Court and the Domestic Violence Court. For comparison, the Drug Treatment Court has a full time manager and two half-time administrative assistants; these positions are funded in part by federal government contributions. The MHS should join these other courts in having a coordinator.

There are numerous other quotations from our interviews that state the same thing, but one legal worker succinctly summed up the need: “If you want this strategy to function you need somebody who is a point person for everybody. If you want the MHS to function in the court system... it’s necessary.”

In the interests of comparison, it should be noted that the Saint John Mental Health Court in New Brunswick does not have a full time coordinator, and instead relies upon professionals from other organizations assisting with their court as needed. This is essentially how the Saskatoon MHS is operating now. The Toronto Mental Health Court also does not have any paid administrative staff, however it has two dedicated court clerks who help with the paperwork associated with the daily court functioning. The largest difference between the Saint John Mental Health Court and the Saskatoon MHS seems to be the volume of cases undertaken (with Saint John seeing 115 cases over 7 years, and the Saskatoon MHS taking on 117 cases within its first year).⁸¹

The addition of a paid coordinator to the MHS team has the potential to improve the strategy in many ways. This has been outlined in this section, and will be addressed further in the *Conclusion* section of the report.

4.4 Length of time to progress through the MHS

Apprehension regarding the length of time required for an accused to progress through the MHS was mentioned by a number of individuals interviewed. However, these comments are discussed under *Docket size* or *Concerns about public safety*, as overall those seemed to be the concerns underlying the comments. Additionally, some relevant comments can be found in the section *Ample Time Spent on Individual Files*.

The 117 defendant who appeared before the MHS from November 2013 to August 2014 appeared

⁸¹ Email Correspondence.

a total of 381 times in the MHS. On average the participants appeared 3.2 times ($M=3.2$). The maximum number of times one person appeared before the MHS court was 12 times ($n=1$), while 46 people had only appeared one time before the MHS court. A detailed table of how many times defendants appeared before the MHS can be found in Appendix B.

The paper files for MHS clients for the month of August were reviewed in detail. In these files were the forms from each court appearance the client has made since entering the court system in relation to the charges for which they are appearing in the MHS, and included times they were scheduled to appear but did not. For the 32 individuals for the month of August who were appearing before the MHS court they made 380 total appearances since they began their court process. The greatest total number of appearances up to August 18th was 35 for one person, and smallest number was two times, for 3 individuals. On average the 32 clients appeared 11.88 times during their entire court process related to their matters. See Appendix B for a complete overview of the statistics from the August file review. It should be noted that some appearances were related to re-arrests during the MHS time, similarly for some scheduled appearances the individuals may have been “unlawfully at large” or in a psychiatric facility.

Another analysis was done to examine the number of court appearances the 32 clients made before appearing in the MHS Court. In total the 32 clients made 201 appearances before their first appearance in the MHS court. The most appearances one person made was 20, while 5 people only had one appearance before appearing in the MHS court. On average the 32 clients made 6.28 appearances before being referred to the MHS Court. Again it should be noted that some scheduled appearances were related to re-arrests during their MHS time, similarly for some scheduled appearances the individuals may have been “unlawfully at large” or in a psychiatric facility.

An analysis of the length of time spent in the court system was also done. On average MHS clients were involved with the court for 229.56 calendar days in relation to their court matters. The most days one client was involved was 909 days, while one client was involved for only 5 days in relation to their matters. It should however be noted that the MHS court had only existed for roughly 320 days for the participant who was involved for 909 calendar days. The mental health conditions faced by MHS clients can cause difficulties following through with obligations, resulting in failures to appear for court and delays in moving through the MHS process.

The Saskatoon Domestic Violence Court (DVC) Annual Data Report for 2012-2013 found that from the time that the Court’s domestic violence programming began to completion took an average of nine months for the 165 participants reviewed. This does not include the time in the criminal justice system prior to the DVC programming commencing.⁸²

Examining the Judges who referred these August individuals to the MHS, of the 32 clients, one Judge made 6 referrals, while the average referral for the 15 Judges who referred clients was 2.13 clients. Examining the Judges’ reasons for referral, the most common theme in the comments was related to a fact about the client having a diagnosed mental health concern. 14 client files did not have any reference for the Judge’s reason for referral to the MHS court. This

⁸² Ministry of Justice, Strategic Initiative and Program Support Branch, *Saskatoon Domestic Violence Court Annual Data Report 2012-13*, (Saskatchewan, 2014).

lack of recording of reasons for referral to the MHS is another task a coordinator could do, which would enhance the research abilities of the MHS to track the characteristics (e.g., psychiatric diagnosis) of those appearing in the MHS.

4.5 Concerns about public safety

While the vast majority of cases before the MHS are mostly for “petty” crimes, or offenses related to failing to adhere to undertakings and probation orders, several individuals raised concerns about some of the more “serious” offenses a small number of clients in the MHS have committed. The MHS was created with broad eligibility criteria so as to avoid having people who need the strategy “fall through the cracks” due to not meeting formal entrance requirements. This is an incredibly difficult issue to deal with, given the wide range of mental illnesses that can come under the umbrella of the MHS and the different effects of those illnesses. The specifics of certain psychiatric conditions an accused may have, combined with the circumstances of their offense, can create serious difficulty in determining whether an individual is suitable to become a MHS client. It should be noted that every mental health court creates their own entrance criteria, which makes establishing precedence for entrance criteria for a new court difficult. There were also several references by legal professionals as to how being more effective in bringing cases to the MHS and sentencing offenders increases public safety overall. In fact, every legal professional quoted in this section made some reference to the importance of public safety and stated that overall they felt the MHS improves public safety. These concerns were all raised in terms of how the MHS could be further improved; there were no statements that overall the public is less safe because of the MHS.

Out of the 117 defendants who appeared before the MHS (88 male, 29 female; average age of 32.1 years) the five most common *Criminal Code* sections on the 1557 Informations handled by the MHS included condition breaches (s. 145 (3)- Failure to comply with condition of undertaking or recognizance, $N=373$; s. 733.1 (1)- Failure to comply with probation order, $N=206$; s. 266- Common assault, $N=117$; S. 145 (2)- Failure to attend court, $N=111$; S. 145 (5.1)- Failure to comply with conditions of undertaking, $N=94$). More detailed statistics related to the offences handled by the MHS court can be found in Appendix B.

145 (3)- Failure to comply with condition of undertaking or recognizance	373
733.1 (1)- Failure to comply with probation order	206
266- Common assault	117
145 (2)- Failure to attend court	111
145 (5.1)- Failure to comply with conditions of undertaking	94

Nevertheless, concerns about the offenses committed by some MHS clients were mentioned frequently enough to merit discussion. One legal professional stated:

“We have had some instances where a couple of people have reoffended in a bad way, and that’s not good from [my view] on public safety. The longer you keep them in [the MHS] with no treatment plan and nothing productive happening with mental health, I think that’s a dangerous thing.”

This concern regarding participants reoffending during the MHS process clearly ties in with the aforementioned issues of busy dockets and numerous appearances before sentencing. However, this concern was expanded on by other comments from a legal professional:

“[t]he other concern I have is the domestic violence therapeutic court we have. We have a lot of people coming from DV [(Domestic Violence court)] into our mental health strategy and we have concerns about that. The DV model is meant to address the safety of the victim and address the offending behaviour. Once you put them into the MHS that is lost. Maybe we can pick it up in several months when we get to sentencing but I think we’re working contrary to that court, and that court has proven to be very effective in reducing recidivism.”

This concern is predominantly tied to the interaction between the MHS and the Domestic Violence Court, which is a notable issue in its own right. Referrals from Domestic Violence Court to the MHS are only accepted when the Domestic Violence Court believes mental health concerns are present to an extent that their treatment cannot succeed. Given that the average time to progress through the domestic violence court is roughly 9 months (see above), and there is no guarantee that accused individuals from the domestic violence court would not have reoffended regardless of the program they participate in, it is impossible to draw any conclusions about the comparative effectiveness in improving public safety between the MHS and the Domestic Violence Court. It should be noted that evaluations of the effectiveness of domestic violence treatment programs have shown mixed results.⁸³

Furthermore, some concerns were raised regarding public safety and the selection criteria to participate in the MHS. One professional we spoke with said incredulously: “some of the crimes are a little more than low level... I mean robbery with weapons?” Currently the MHS only prohibits individuals who are “charged with serious offences such as murder or manslaughter”⁸⁴ or who are subject to a dangerous or long term offender application. However, applying for a dangerous or long term offender application under the *Criminal Code* sections 753(1) and 753.1(1) respectively is not a trivial process or one that prosecutors should undertake lightly. Yet, this is the sole method for the crown to exercise discretion on who is eligible to be an MHS client. One of the legal professionals we spoke with addressed this point:

“[w]e feel strongly that there should be some criteria as to who comes into this courtroom... we have a lot of people committing thefts because they’re depressed. I don’t think that’s an MHS case.... we’re taking away from [names of some clients] who are really struggling in the community and truly need some intervention. We’re taking time away from them. I think the court needs intervention in terms of what charges come in. The Crown needs more authority in terms of saying no.”

While this statement clearly challenges the openness of the court in terms of the wide range of individuals and mental health conditions that will enter the MHS, all interviewees did not share this position. Some participants directly challenged the view that the MHS should be limited in any

⁸³ L. Feder and D.B. Wilson “A Meta-analytic Review of Court-mandated Batterer Intervention Programs” (2005) 1:2 *Journal of Experimental Criminology* 239.

⁸⁴ “Saskatoon Mental Health Strategy” online: Courts of Saskatchewan <<http://www.sasklawcourts.ca/index.php/home/provincial-court/adult-criminal-court/saskatoon-mental-health-strategy>>.

additional ways.

One community support professional spoke about the tie between depression and petty crime:

“I have a support group for people with habitual shoplifting. They’ve taught me what it’s about. It’s about depression and anxiety and a layer of addictions and abuse, sexual abuse and residential schools and the generational impact of the schools themselves... one of my interests is habitual shoplifting but I also have an interest in supporting people with mental health issues through the criminal process, whether the mental health issues lead to shoplifting or whether they lead to being drunk in a public place or whatever the charges may be.”

In this professional’s view, there can be a clear link between anxiety disorders or mood disorders and crime, justifying a rather expansive eligibility criteria. Additionally, one of the organizing members of the MHS spoke to the importance of “as much as possible sticking to the original plan where eligibility criteria are very broad and inclusive. The focus should be on more resources for everybody.” This remark shows that the breadth of eligible participants was actively considered during the formation of the MHS, and a conscious decision was made to keep the criteria as broad as possible.

Overall, the concerns about public safety seem to be “growing pains” of the MHS that can be resolved without significant overhaul. The concern regarding the length of time taken for individuals to progress through the strategy and the potential risk to safety has been acknowledged by many key players and steps are being taken to address it. For example, a psychiatrist involved with the MHS has been working with the judges to help develop a tool to assess the progress of MHS clients in an effort to alleviate concerns regarding the number of individuals on the docket. The development of such tools for specific tasks undertaken by the court could assist the court enhance its efficiencies in other ways as well. Solutions to the issue of individuals progressing through the MHS slowly could, in turn, address the issue of entrance criteria—if individuals are able to progress through the MHS more easily then more clients could be admitted without limiting entrance criteria. However, the point about the MHS interfering with the progress of the Domestic Violence Court should be carefully considered, although minor adaptations may be sufficient. For example, either sharing some resources for individuals who fall into both camps to ensure the victims are protected in similar ways, or simply not referring individuals from Domestic Violence Court into the MHS could largely eliminate this issue.

The concern about the wide breadth of eligibility highlights the limited resources available. This issue could largely be resolved by allocating more time for the MHS and expanding the number of docket days. A coordinator could potentially streamline the dockets significantly and thus reduce the time MHS clients take to progress through the system. Alternatively, the eligibility criteria could be narrowed to reduce the number of individuals appearing on any given court date; this proposal runs counter to the initial goals of the MHS as outlined above, but was mentioned by several professionals we spoke with as a potential solution. As a comparison, the court in Saint John has the following requirements:

- “(a) an accused be diagnosed as suffering from a mental illness or intellectual disability.
- (b) the offence(s) alleged are as a result or related to such illness or disability.
- (c) the accused accepts all responsibility for the offence(s) and
- (d) the accused is fit to stand trial and criminally responsible.

Cases which do not meet eligibility are returned to the regular court process.”⁸⁵

Despite having very similar criteria to the Saskatoon MHS, the Saint John court still sees fewer clients on average, which illustrates that restrictive entrance criteria are not essential to more controlled docket sizes.

4.6 Requests for additional training

The researchers thought it would be prudent to ask if members of the MHS felt they needed any further training to more effectively participate in the courts. Unsurprisingly, almost all the professionals that form the MHS team are curious individuals who place a high value on education and learning, and so they all had suggestions for areas of training which could provide them with more knowledge and improve their job performance. It is important to keep in mind that this theme was directly prompted by the researchers, and it should not be interpreted as a shortfall of the MHS, or the highest priority issue to address. Rather, it should be seen as a comparatively low-cost way to further improve the skills of those who are involved in the MHS team.

To date the MHS has held three separate training sessions for team members on topics including FASD, cognitive concerns, psychiatric conditions, and practical skills to use when working with persons with mental health concerns.

The general trends in terms of suggested training were very straightforward. Legal professionals requested more training with mental health issues, and community support professionals requested more training with legal structures and processes.

One of the legal professionals involved requested:

“[s]ome training in mental health conditions and speaking to people with mental health conditions. I don’t think it’s one size fits all by any means. A question I often have, if you get someone that’s schizophrenic and off their medications and doesn’t think they need their medications, is: what might you say to that person to change their mind? ... how best to communicate with people who have mental health conditions of different types?”

While a different legal professional stated:

“[w]e could probably use a little psychiatric lesson as to what these different diagnoses were really about. That would benefit us. To understand the difference between bipolar, schizophrenia, paranoid schizophrenia. It would help us better understand what’s going on.”

It was also suggested that:

“[p]robably a lesson on HIPA [Health Information Protection Act] wouldn’t hurt... most people aren’t appreciative of how important it is to comply with HIPA. Sometimes we don’t have consents filed and we start talking about health information. Maybe not so much for the lawyers, but we have some people who aren’t lawyers who need to appreciate what

⁸⁵ “Process” online: Mental Health Court Saint John <<http://www.mentalhealthcourt-sj.com/process.html>>.

it's all about.”

This comment hints at the requests by community support professionals who admit a need for additional legal training. One stated:

“I think the most important [area of training] for my work would be to have a better sense of what the possible outcomes could be for sentences. It would be better to articulate what is realistic and what might not be realistic for the clients I serve... what's required, and the length of time it takes to get certain assessments completed. Maybe those time parameters need to be articulated better.”

And another community support professional spoke broadly about their organization:

“[i]t would potentially be useful for those support agencies, and ours is included, who aren't justice based to have some sort of development around the language and legal pieces of the strategy so we have a clearer idea when talking to our clients, and giving feedback that's in line with what can actually be done in terms of justice policy and procedure.”

Overall, the legal half of the team wants to know more about the mental health conditions with which MHS clients may be struggling and what it means to have such a condition, whereas the community support half wants more information about the legal system that they can pass on to their clients. There were some outlying suggestions that more training for the police would be highly beneficial, as they receive information about individuals with mental health conditions during their initial training but that it is not always reinforced sufficiently. Additionally, there were some requests for more information about what the psychiatrists involved with the MHS can offer. Also of note, some individuals involved with the MHS team were applauded for having significant knowledge that stretched well beyond their professional practice area; however, as these comments inherently identify individuals, they are not included.

Generally, these requests are consistent with the requests for training at other Canadian mental health courts. In an evaluation of the Saint John mental health court, the researchers found that “many of the mental health professionals suggested they would benefit from greater knowledge of the workings of the criminal justice system. Similarly, members of the judiciary voiced interest in better understanding the nature of mental illness and its treatment (i.e., pharmacology, skills training, etc.).”⁸⁶ This supporting evidence shows it is expected that MHS team members would request additional training in areas that are outside of their professional expertise.

Due to the offsetting nature of the training requested, an easy way to tackle these requests would be to have team members with mental health backgrounds provide training on that front, and then to have team members with legal backgrounds provide training in that area. That said, the priority and importance of additional training is a matter best left up to the MHS team.

5. Recommendations

Based on the preceding analyses, it is concluded that the Saskatoon MHS has had a very

⁸⁶ *Supra* note 67.

successful first year of operation, particularly under its existing circumstances. Despite operating with no budget, assembling a support team in a short time frame, and having some important members of the team move on to other endeavours, the strategy has taken on an exceptional number of clients and has performed in a manner comparable to other Canadian mental health courts. This report has outlined many potential avenues for improvement, and the authors are confident the MHS will continue to adapt and improve going forward.

There are two identified overarching areas of need that the researchers suggest should be addressed soon for the continued success of the MHS. These areas of need are:

1. The need for a coordinator or point-person. This person would keep lines of communication open among MHS team members, assist MHS clients in managing their treatment, and assist the MHS team with recordkeeping.
2. A change in how dockets are managed to increase the amount of time spent on individual files, and to reduce the length of time an accused spends progressing through the MHS.

Each of these recommendations is discussed below.

5.1 Coordinator

A regular paid team member who can coordinate communication between the many different MHS team members, and who can help MHS clients understand and remember support and supervision plans, would be beneficial for the continued success of the MHS. The need for a paid coordinator is discussed more extensively in the section *Need for a Coordinator*.

As a point of comparison, in writing about the Toronto mental health court, Justice Schneider contemplates multiple paid positions that exist to facilitate the mental health court,⁸⁷ and describes these roles as essential. As mentioned above the Toronto court has two dedicated court clerks to assist them. While multiple paid MHS team members devoted to the strategy may be ideal, having even a single person who can consistently be counted on to help facilitate the MHS would be a monumental improvement. There are no shortages of ideas from the MHS team about how a coordinator could be effectively put to work.

Unfortunately, no documentation about the prevalence of coordinator positions in Canadian mental health courts generally was found. The reason for the lack of data is likely tied to comments from *The MHS is an evolving program that is improving over time* section, which emphasizes how mental health courts have no set blueprint and tend to be flexible structures that cater to the needs of the local community. Given the overall ambition of the Saskatoon MHS project, taking on 117 clients in under a year, compared to 115 over 7 years for a program that meets with comparable regularity in New Brunswick, the addition of a coordinator to the team could be a huge asset to the Saskatoon MHS.

5.2 Docket management

Given the aforementioned large number of clients currently in the MHS, docket management has

⁸⁷ Schneider, *supra* note 1 at 173.

become a crucial issue. The problems of a large docket are: high pressure on MHS team members to deal fairly with a large number of clients each court date, limiting effectiveness of pre-court meetings, and encouraging over formality in addressing clients and their supports. Several suggestions for the issue of large dockets can be found in *The need for additional sessions or more frequent dockets* section. The suggestions include more concrete treatment plans, smaller dockets in addition to the regular MHS dates to address specific issues like medication compliance or sentencing, and someone taking an MHS intake role to get preliminary work done ahead of time (likely by the coordinator that will hopefully be brought on board with the MHS team soon). These suggestions are not “either/or”, and all of them could be implemented in concert, or individually, as the MHS adapts to the needs of a large docket. Additionally, one of the suggestions in the section *Concerns about public safety*, was to limit the criteria for individuals hoping to become MHS clients to certain enumerated forms of mental health conditions or to restrict the kinds of offenses which can lead to the MHS. This suggestion is somewhat at odds with the MHS’s founding principle of inclusivity; however, it could be a very effective tool in reducing docket size.

As discussed previously, there are various options to address the large docket size during MHS court dates. Our evaluation does not endorse any specific option, but rather we hope the MHS team will be creative in tackling this problem and will find at least some of the suggestions fruitful.

6. Conclusion

In the process of compiling this report, the research team has had an opportunity to look behind the scene to examine how individuals with mental health conditions fare in our justice system. Many strengths of the MHS were identified, and several areas for improvement were highlighted. If the MHS can secure a coordinator and deal with the concerns surrounding docket sizes, most other issues can be addressed with strong communication between MHS team members and some creative thinking.

Future research is being organized for the years ahead to gather more quantitative data with an eye towards client outcome on various measures including recidivism and quality of life indicators. As noted in the methods section, this current evaluation is of a formative nature and was not designed to make any decisive comments about the success of the MHS as this would require gathering data over a prolonged time frame and comparison data from a non-mental health court in Saskatoon to draw any valid conclusions.

Additional research might also include an investigation into the MHS referral process to determine how clients are ending up in the MHS, and if any individuals with mental health conditions are still “falling through the cracks” by not connecting with the MHS even after they enter the Saskatoon Provincial Court. Furthermore, research into the specific kinds of mental health conditions most frequently encountered by the MHS and strategies specific to those conditions could be fruitful.

We hope, given the limitations, this report is still helpful for decision makers and those steering the MHS. Our interviews and statistical data suggest that the MHS represents a positive innovation for the City of Saskatoon. It is meeting the expectations of participants and satisfying those involved with the MHS, while diverting participants with mental health concerns and cognitive impairments to address their needs. While the MHS process is functioning well, it requires some realignment in order to continue to meet the needs of MHS participants in Saskatoon.



- Do you go to the Mental Health Strategy Court?
- Do you have something to say about your experiences with the Mental Health Strategy?

If so, we would like to include you in our research!

The Centre for Forensic Behavioural Science and Justice Studies at the University of Saskatchewan is currently looking for persons to tell us about their experiences with the Mental Health Strategy. This includes:

- Judges
- Lawyers
- Community support workers
- those who are asked to attend the Mental Health Strategy Court

We will ask questions about your experience with the Mental Health Strategy and collect some basic information about you. Your answers will help us see if the way the Mental Health Strategy operates works well for everyone involved.

Your information will be kept confidential. Your name will not be given to others or written in any report.

If you are interested in participating, or would like more information, please contact Keith Barron or Craig Moore by phone at 306-966-1605, or email at keith.barron@usask.ca or craig.moore@usask.ca

Keith Barron and Craig Moore will also be at the Saskatoon Mental Health Strategy Court at each court session in the front row. You are welcome to talk to them then to find out more and to participate in an interview.

Your help with this study is much appreciated!

General Information Sheet- Professionals

What is the purpose of this project?

The Saskatoon Mental Health Strategy began in November 2013 with the creation of a Mental Health Strategy Court (MHS Court) that is held every second Monday. The Centre for Forensic Behavioural Science and Justice Studies (University of Saskatchewan) has been asked to study the operation of the MHS to determine how well the Strategy is operating and make suggestions for improvements. To accomplish this, students from the Centre will be interviewing as many people involved with the Mental Health Strategy as possible. These interviews will be reviewed to identify the factors that are crucial to making the Saskatoon Mental Health Strategy a success, and those factors which could be improved to make the Mental Health Strategy even better. Our goal is to provide feedback on how the Strategy has functioned for the first year and to create a framework that will allow the Strategy to continue collecting feedback every year.

Who will be included in the interview process?

Anyone who is professionally involved in the MHS Court such as the Judges, Lawyers, and community support professionals will be interviewed regarding their involvement so far. We will also interview the clients of the MHS Court themselves to obtain their feedback on their experiences.

The researchers have obtained permission from the Saskatchewan Ministry of Justice, and the Ethics Review Board of the University of Saskatchewan to conduct this study. A consent form will be provided to everyone who agrees to be interviewed.

What am I being asked to do?

You are being asked to share your feedback on the needs and goals of the Saskatoon Mental Health Strategy.

If you have any questions, please contact:

Craig Moore,

(306) 966-1605

craig.moore@usask.ca

Keith Barron, JD(C)

keith.barron@usask.ca

Stephen Wormith,

(306) 966-6818

s.wormith@usask.ca

Glen Luther, QC

(306) 966-5887

[glen.luther@usask.c](mailto:glen.luther@usask.ca)

General Information Sheet- clients

What is the purpose of this project?

The Saskatoon Mental Health Strategy (MHS) began in November 2013. The Mental Health Strategy Court (MHS Court) that happens every two weeks on Mondays is part of the Mental Health Strategy. The Centre for Forensic Behavioural Science and Justice Studies at the University of Saskatchewan has been asked to study the operation of the Strategy. This project will try to see if the Strategy is working as well as it could. It will involve interviewing as many people as possible who have a connection to the Mental Health Strategy. What people say in these interviews will be used to help the Strategy learn about what it is doing well and what it can do better.

Who will be included in the interview process?

Anyone who is professionally involved in the MHS Court such as the Judges, Lawyers, and community support professionals will be included. We will also interview people like you, the clients of the MHS Court, to hear what you have to say about your experiences.

We have received permission from the Saskatchewan Ministry of Justice and the University of Saskatchewan to conduct our interviews. A consent form will be provided to everyone who agrees to be interviewed with more information about the project. Everything that you say in an interview will be kept confidential and you will not be identified by name in any reports.

What am I being asked to do?

You are being asked to share your experiences with the MHS Court which was created through the Saskatoon Mental Health Strategy.

If you have any questions, please contact:

Craig Moore,
(306) 966-1605
craig.moore@usas.ca

Keith Barron, JD(C)
keith.barron@usask.ca

Stephen Wormith,
(306) 966-6818
s.wormith@usask.ca

Glen Luther, QC
(306) 966-5887
glen.luther@usask.c

***Interview Professional
Consent Form***

Project Title: A Program Evaluation of the Saskatoon Mental Health Strategy

Investigator:

Craig Moore, BA, Psychology Graduate Student, Centre for Forensic Science and Justice Studies, University of Saskatchewan, 306-966-1605, craig.moore@usask.ca; Keith

Barron, Law Student, University of Saskatchewan, keith.barron@usask.ca. **Supervisor:**

Stephen Wormith, Professor of Psychology, Director of the Centre for Forensic Science and Justice Studies University of Saskatchewan, 306-966-6818, s.wormith@usask.ca. Glen Luthur, Law Professor, Executive Member of the Centre for Forensic Science and Justice Studies University of Saskatchewan University of Saskatchewan, 306-966-5887, glen.luthur@usask.ca

Purpose(s) and Objective(s) of the Project:

You are being asked to participate in this project to evaluate the Saskatoon Mental Health Strategy (MHS), and to create a framework for evaluations that can be used to monitor the Strategy going forward. Specifically, the goal of this interview is to identify what is and isn't working with the current mental health strategy, and to identify what metrics are important to measure going forward.

Procedures:

You are being asked to reflect on your experiences with the Saskatoon Mental Health Strategy Court (MHS Court).

The interview should take approximately one hour. The questions will be about your experience with the MHS Court. A researcher will take notes on your responses during the interview. With your consent, the interview also will be recorded to ensure that the information you impart is accurately recorded. The recording will be destroyed once notes are checked for completeness and accuracy. If you prefer not to be recorded, no audio recording will be made.

Please feel free to ask or e-mail any questions about the procedures and goals of the evaluation.

Funded by: This study did not receive funding from any organization.

Potential Risks:

There are no known or anticipated risks to participating in this evaluation.

Potential Benefits:

The findings of this study will allow the MHS Court steering committee to improve the Court process.

Confidentiality:

The data gathered from this project will be published in a report and presented to the MHS Court, and may also be presented at conferences or published in academic journals. However, your identity will be kept confidential throughout. Although we may report direct quotations from the interview, all identifying information (e.g., your name, job title, position, ethnicity, etc.) will be removed as data will be aggregated.

No names of individuals being interviewed will be included in any report. However as the research team has interacted with you, it may be possible for them to identify you based on

what you say.

The consent forms will be kept in a separate secure location from the data to ensure confidentiality.

Additional staff outside of the research team may be asked to transcribe or analyze the interviews.

Storage of Data:

Interviews will be kept on a password protected and encrypted computer for a minimum of five years following the publication of the final report by Stephen Wormith.

Once the interviews are no longer required they will be deleted beyond the point of recovery.

Right to Withdraw:

Your participation is voluntary and you only have to answer those questions that you are comfortable with. You may withdraw from the evaluation project for any reason, at any time without explanation or penalty of any sort. Whether you choose to participate or not will have no effect on your position, access to services, or how you will be treated (i.e., to you or anyone connected to you by the Provincial Courts or Ministry of Justice). Should you wish to withdraw, your interview data will be fully deleted.

Your right to withdraw data from the project will apply until the results have been given out publically at the end of November, 2014. After this date, it is possible that some of the project findings will have already been given out publically and it may not be possible to withdraw your data.

Follow up:

To obtain results from the evaluation, please let the researcher know now, or e-mail the researchers above.

Questions or Concerns:

If you have any questions that you were not able to ask at the time of the interview, please contact Craig Moore at 306-966-1605, craig.moore@usask.ca, Keith Barron at keith.barron@usask.ca, Stephen Wormith, 306-966-6818, s.wormith@usask.ca, or Glen Luthur, Law Professor, University of Saskatchewan, 306-966-5887, glen.luthur@usask.ca This program evaluation project has been given an ethics exemption by the University of Saskatchewan Research Ethics Board due to the program evaluation nature of this project. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office, ethics.office@usask.ca, (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Consent:

Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the evaluation project. A copy of this Consent Form has been given to me for my records.

Name of Participant

Signature

Date

Researcher's Signature

Date

Interview Participant Consent Form

Project Title: A Program Evaluation of the Saskatoon Mental Health Strategy

You are invited to participate in an evaluation of the Saskatoon Mental Health Strategy Court. Please read this form carefully. Take as much time as you need, and feel free to ask any questions. If you are unhappy with anything please let the researcher know.

Researchers:

- Craig Moore, Graduate Student: 306-966-1605, craig.moore@usask.ca;
- Keith Barron, Law Student: keith.barron@usask.ca.

Supervisor:

- Stephen Wormith, Director of the CFBSJS, University of Saskatchewan, 306-966-6818, s.wormith@usask.ca.
- Glen Luthur, Law Professor, University of Saskatchewan, 306-966-5887, glen.luthur@usask.ca

What is the Saskatoon Mental Health Strategy Court?

- The Saskatoon Mental Health Strategy operates a criminal court for individuals with mental health conditions, such as yourself.
- The Mental Health Strategy Court attempts to resolve criminal charges in a casual way where everyone's voice is heard.

Why is this Evaluation taking Place?

- The Saskatoon Mental Health Strategy Court is new, and the people who run it want to know how it can be improved.
- We want to interview you to learn about what went well, and what did not go well during your involvement with the Mental Health Strategy Court.

What am I being asked to do?

- Go to an interview with the researchers to talk about your experience in the Mental Health Strategy Court.
- You do not have to answer any interview questions you do not want to.
- The researchers will take notes and record your answer during the interview.
- With your permission, the researchers will record the interview. The recording will be destroyed once notes are checked to make sure they correctly noted what you said.

What are some of the possible risks or harms if I take part?

You may find some of the questions asked to be personal. You can skip any question you do not want to answer. We will NOT ask about your criminal history. If you tell the researchers about any criminal history that information could be requested by a Judge or Lawyer in the future.

Your privacy will be protected by these steps:

- Your name will not be used in any reports.
- The notes from your interview will be kept in a locked file in a secure location.
- Any forms that have your name on them will be stored in a different location than where your interview forms are kept.
- The information recorded from these interviews will be stored for five years. After that it will be destroyed.
- Only people doing research will see your interview answers. These answers will not be given to anyone who runs or helps out at your Mental Health Strategy Court dates.

Do I have to take part in the Evaluation?

You do not have to take part in the Evaluation. Participating is your choice, and you can quit at any time.

- If you do not take part, nothing you say during the interview will be used in the report.
- You can stop the interview at any time. If you decide you do not wish to continue just tell the researchers.
- You will not be punished in any way if you choose not to take part in the interview. You can still take part in the mental health strategy court.

Questions or Concerns:

If you have any questions please contact

- Craig Moore: 306-966-1605, craig.moore@usask.ca;
- Keith Barron: keith.barron@usask.ca,
- Stephen Wormith, 306-966-6818, s.wormith@usask.ca;
- Glen Luthur, glen.luthur@usask.ca

Consent to Participate in Mental Health Strategy Court Evaluation

- I have read and understood the information on this consent form.
- I have had the chance to ask questions about this evaluation.
- I have had all of my questions about the evaluation answered.
- I understand that I can quit the interview or evaluation at any time, without any penalty.
- By signing this form I consent to allow my information to be used for this evaluation.

Name of Participant

Signature

Date

Researcher's Signature

Date

Saskatoon Mental Health Strategy Interview Guide- Professionals

Sample questions for legal professionals and community support professionals.

Program Involvement:

- How would you describe your role in the mental health strategy court?
- Why did you (your organization) get involved in the MHS?
 - What issues or concerns prompted your involvement?
 - When did you (your organization) get involved? (e.g., planning stage)
- Did you (your organization) have any involvement in the development or implementation of the MHS?
 - What was your involvement?
- What is your (your organizations) background with the criminal justice system and mental health? (i.e., social worker, Addictions Services)

Questions about your job:

- On average, how many hours per week do you spend working on mental health strategy court related issues? How many hours, on average, per mental health strategy court case?
 - How often do you attend the pre-court meeting?
 - How often do you attend the docket court?
 - How many clients do you have that are part of the MHS?
 - How often do you meet with clients who are part of the MHS?
- How has the MHS impacted your own job (your organization)? (i.e., made it easier to carry out, more difficult, etc.).
- Thinking about your job, has your job satisfaction been impacted by involvement with the Saskatoon Mental Health Strategy? In what ways?
- How does what you do now for this clientele differ, if at all, from what you did before?
- What did you expect from the MHS when you became involved? (e.g., how it would function)
- How has your experience of the MHS compared to your expectations of it? Do you have any suggestions on how it could better meet your expectations?
- If you had the opportunity for additional staff training, which three areas of need would you designate as being the most important in your work with mental health strategy court clients?
- What advice would you offer someone taking over *your* position regarding working with the mental health strategy court and the clientele?
- In what ways, if any, does the MHS allow you to meet needs of individuals with mental health conditions that you would not be able to meet in the regular court system?
- Are there any needs, that you know of, that aren't being met?
- Which do you feel takes precedence in working with mental health strategy clients: addressing their mental health needs or addressing the factors in their life that lead to crime (i.e., criminogenic needs)?

Program Implementation

- How would you describe the mental health strategy program's philosophy?
- How would you describe the mental health strategy's operation?
- What do you believe are the strengths of the MHS?
- In terms of your expectations for the pre court meetings, how are the meetings going?

- Any suggestions to make them better?
- In terms of your expectations for the collection of assessments by the strategy, are they being met?
 - Any suggestions to make it better?
- In terms of clients receiving a diagnosis, how is the strategy doing?
 - Any suggestions to make it better?
- Are your expectations being met in terms of the treatment plans being created and reviewed by the strategy?
 - Any suggestions to make it better?
- Thinking of the bi-weekly docket court how is the court going?
 - Any suggestions to make it better?

Program Relationships

- How would you describe the rapport between the judges, in their role with the mental health strategy, and the other members of the multi-disciplinary support workers?
- How would you describe the rapport between the judges, in their role with the mental health strategy, and those who appear before the court as accused individuals?

Program Planning

- What advice would you give to someone seeking to improve the MHS? (i.e., weaknesses that need to be improved).
- How would you define *success* and *failure* in terms of the mental health strategy program?
- Do you have any stories to share that could demonstrate how the strategy is performing at this point in time?
- Do you think this is the appropriate time to conduct an evaluation of the mental health strategy implementation? If not, when would you suggest would be an appropriate time?
- [Give them the program logic model and a few minutes to review it] do you think the outcomes, and connections between the process and the outcomes, are accurately represented by this program logic model?
 - If not how would you suggest changing the model?
- What would you suggest we collect information on in an evaluation of the mental health strategy's effectiveness/outcomes? (Phase 2 will be approved in coming months)
- What other comments do you have about the MHS that we have not yet discussed?

Saskatoon Mental Health Strategy Interview Guide- Clients

Sample questions for MHS participants

Program Involvement:

- Tell me a bit about what the Mental Health Strategy has been like for you?
- What has been your experience with regular criminal court?
- How do you like the Mental Health Strategy Court compared to regular court?
- What brought you to this criminal court to begin with?
- How often do you attend the Mental Health Strategy Court?
- How often do you meet with support staff that is part of the MHS?

Program Experience

- Before appearing before the mental health strategy court what were you expecting it to be like?
- So far has the court met your expectations?
- What was it like for you when you had to actually get into the courtroom and appear before the judge?
 - For example, how did you feel? Were you angry? Anxious? Happy?
 - What was going through your mind that day?
- If you were describing the Saskatoon Mental Health Strategy to a friend, how would you describe it?
- What do you remember most about the Mental Health Strategy?
- What kind of things were you required to do in the Mental Health Strategy?
- Were you given any conditions that you have to comply with or treatment plans?
- What services has the Strategy provided to you? (e.g., mentor, assistance with finding housing)
- What were the most difficult or challenging parts of the Mental Health Strategy?
- What were the most helpful or rewarding parts of the Mental Health Strategy?
- Do you have any stories to share that could tell us how the MHS has been for you?
- What do you see as the role of the Mental Health Strategy Team Judge?
 - What was your personal experience with the Judge?
- What do you see as the role of the Mental Health Strategy Team Prosecuting Lawyer?
 - What was your personal experience with the Prosecuting Lawyer?
- What do you see as the role of the Mental Health Strategy Team Probation Officer?
 - What was your personal experience with the Probation Officer?
- What do you see as the role of the Mental Health Strategy Team Community Support professionals (e.g., social services, community nurse)?
 - What was your personal experience with the Community Support professionals?
- When did you complete the Mental Health Strategy program? (if applicable)
- Do you have any suggestions on how to make the Mental Health Strategy program better?

Appendix B – Data summary

Table 1
Dockets

This table relates to all dockets from when the court began in November 2013 to August 2014 when the report concluded its evaluation.

	Total
Total number of docket court sittings	19
Largest number of docket participants	35
Smallest number of docket participants	9
Average number of docket participants	20
Most frequent number of docket participants (mode)	15
Number of males who appeared before the court	88
Number of females who appeared before the court	29
Number of companies listed to appear in the court (Note: these were put on the MHS Court dockets by accident. Data for the companies was excluded from all other analysis)	2
Total number of persons who appeared before the court	117
Average age of male docket participants Note: age was only available for 80 participants	31.5 (n=80)
Average age of female docket participants	33.6 (n=29)
Average age of all participants	32.1 (n=109)
Most frequent age of male participants Note: age was only available for 80 participants	24 (n=80)
Most frequent age of female participants	29
Most frequent age of all participants	24 (n=109)

Table 2
Appearances

This table uses the dockets from November 2013 to August 2014. The information below relates to the 117 accused persons who appeared during those dockets. Appearances are defined as times scheduled for appearing before the MHS court. It should be noted that some appearances were related to re-arrests during the MHS time, some scheduled appearances the individuals may have been “unlawfully at large” or in a psychiatric facility

	Total
Number of appearances made by all participants	381
Average number of appearances per participant	3.2
Most frequent number of appearances per participant (mode)	1
Maximum number of appearances made by a participant (Number of people that appeared this amount of times)	12 (1)
Minimum number of appearances made by a participant (Number of people that appeared this amount of times)	1 (46)
Number of participants who made 12 appearances in the court	1
Number of participants who made 11 appearances in the court	2
Number of participants who made 10 appearances in the court	1
Number of participants who made 9 appearances in the court	3
Number of participants who made 8 appearances in the court	7
Number of participants who made 7 appearances in the court	3
Number of participants who made 6 appearances in the court	7
Number of participants who made 5 appearances in the court	8
Number of participants who made 4 appearances in the court	5
Number of participants who made 3 appearances in the court	17
Number of participants who made 2 appearances in the court	17
Number of participants who made 1 appearance in the court	46

Table 3
Informations

This table uses the dockets from November 2013 to August 2014. The data below relates to the 117 accused persons who appeared during those dockets. Informations are defined as official court documents that outline the offences that a person is accused of committing. One individual may have several Informations. The offences listed below relate to the number of counts of each offence listed on an Information. For example a person may be charged on an Information with 3 counts of 145(3).

	Totals
Number of Informations handled by the court	1557
Ten most Prevalent <i>Criminal Code</i> Sections	
145 (3)- Failure to comply with condition of undertaking or recognizance	373
733.1 (1)- Failure to comply with probation order	206
266- Common assault	117
145 (2)- Failure to attend court	111
145 (5.1)- Failure to comply with conditions of undertaking	94
334 (b)- Theft of property under \$5000	88
430 (4)-Mischief to property under \$5000	72
264.1 (1)(a)- Uttering threats to cause death or bodily harm to any person	64
145 (5)- Failure to comply with appearance notice or promise to appear	59
Number of Offences handled by the court	2529
Ten most Prevalent <i>Criminal Code</i> Sections	
145 (3)- Failure to comply with condition of undertaking or recognizance	776
733.1 (1)- Failure to comply with probation order	341
145 (5.1)- Failure to comply with conditions of undertaking	174
430 (4)- Mischief to property under \$5000	172
266- Common assault	143
145 (2)- Failure to attend court	111
334 (b)- Theft of property under \$5000	102
264.1 (1)(a)- Uttering threats to cause death or bodily harm to any person	69
145 (5)- Failure to comply with appearance notice or promise to appear	59
355 (b)-Possession of property obtained by crime, under \$5000	56

Table 4
August File Review

This table refers to only those participants who were before the court in August. This data only uses the information from their court files. Court files only may have contained Informations, Recognizance forms, Police Officer Recognizance forms, Undertakings. It should be noted that appearances for this group also refers to appearances they had before the MHS.

	Totals
Number of participants for August	32
Total Court Appearances on Current Matters	380
Average number of appearances on current matters	11.88
Most frequent number of appearances per participant (mode)	10
Maximum number of appearances on current matters (number of people who appeared)	35 (1)
Minimum number of appearances on current matters (number of people who appeared)	2 (3)
Number of appearances BEFORE the MHS Court	201
Average number of appearances during the MHS Court	6.28
Most frequent number of appearances per participant (mode)	4
Maximum number of appearances on current matters (number of people who appeared)	20(1)
Minimum number of appearances on current matters (number of people who appeared)	1(5)
Number of appearances DURING the MHS Court*	179
Average number of appearances during the MHS Court	5.59
Most frequent number of appearances per participant (mode)	5
Maximum number of appearances on current matters* (number of people who appeared)	21(1)
Minimum number of appearances on current matters (number of people who appeared)	1(5)
Calendar days spent in court system on current matters	
Total calendar days spent by the 32 participants in the court system	7346
Average number of calendar days spent by participants in the court system	229.56
Maximum number of calendar days spent in the court system by 1 participant (date of first appearance on current matters)	909 (2012-02-21)
Maximum number of calendar days spent in the court system by 1 participant (date of first appearance on current matters)	5 (2014-08-13)

*some appearances were related to re-arrests during the MHS time, some appearances the individuals may have been "unlawfully at large" or in a psychiatric facility

**Table 5
July Dockets**

This table refers to July 2014 Monday morning court dockets. This data uses information from court supplied Final Dockets for Courtroom number 4- the Courtroom where the Mental Health Strategy court takes place. Two Mondays listed below, July 15 and 28 are regular docket court sessions. Two Mondays listed below, July 7 and 21 are MHS court days. This comparison allowed for a better understanding of the differences in the type and frequency of offences handled by the MHS court and a regular docket court.

	Totals
July 15 (Regular Docket)	
Number of defendants	28
Number of offences on the docket	103
Five most frequent offences on July 15 docket	
253- Operation of a motor vehicle while impaired	19
145 (3)- Failure to comply with condition of undertaking or recognizance	13
CDSA 5 (2)- Possession for purpose of trafficking	11
CDSA 4 (1)- Possession of substance	10
86- Careless use of a firearm	10
July 28 (Regular Docket)	
Number of defendants	19
Number of offences on the docket	56
Five most frequent offences on July 28 docket	
253- Operation of a motor vehicle while impaired	11
355- Possession of property obtained by crime- exceeding \$5000	10
CDSA 5 (2)- Possession for purpose of trafficking	4
145 (5)- Failure to comply with appearance notice or promise to appear	4
145 (3)- Failure to comply with condition of undertaking or recognizance	3
July 7 (MHS Docket)	
Number of defendants	26
Number of offences on the docket	110
Five most frequent offences on July 7 docket	
145 (3)- Failure to comply with condition of undertaking or recognizance	27
733.1- Failure to comply with probation order	19
334- Theft of property under \$5000	9
266- Common assault	8
145 (5.1)- Failure to comply with conditions of undertaking	8
July 21 (MHS Docket)	
Number of defendants	22
Number of offences on the docket	70
Five most frequent offences on July 21 docket	
145 (3)- Failure to comply with condition of undertaking or recognizance	18
733.1- Failure to comply with probation order	10
145 (5.1)- Failure to comply with conditions of undertaking	5
334- Theft of property under \$5000	4
266- Common assault	4