Mental Health Courts: Processes, Outcomes and Impact on Homelessness

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Summary

The *Mental Health Commission of Canada* released its first Canadian mental health strategy in 2012. In their report, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, is the alarming finding that people with mental health problems are over-represented in the justice and corrections systems, and that this trend appears to be on the rise. One of the major recommendations is to increase the availability of programs to divert people with mental health issues from the corrections system, specifically by increasing the usage and availability of mental health courts. Diversion programs (including mental health courts (MHC[1]) and restorative justice programs) were cited as measures to redirect people with mental health problems implicated in the criminal justice system by providing access to needed services, treatments and supports.

The purpose of this study was to explore such a court by examining the processes and effects of a Mental Health Court (the *Programme d'accompagnement Justice - Santé mentale* (PAJ-SM[2])), situated at Montreal's municipal court. In particular, the aim was to study its impact on preventing and reducing homelessness. While mental health courts continue to proliferate, relatively little is known about their points of entry, the nature and scope of judiciary intervention, interprofessional and intersectoral collaboration, the experiences of participants and key actors, and whether such forms of intervention enhance users' quality of life, including whether they have an impact homelessness (chronic, acute, or preventative). This project attempted to respond to these knowledge gaps and examine the effects for those who are homeless or at-risk of homelessness and gather evidence for a 'promising practices' approach.

From February, 2013, until March, 2014, the research team deployed a multi-method project utilizing semi-structured interviews with twenty participants and eleven key informants of the multiprofessional team operating at the MHC. In addition, over 125 hours of participant observation took place, observing: team meetings, courtroom proceedings and shadowing individual team members. Quantitatively, data was also collected from 100 court files during the years 2008 (the inception of the MHC) to 2012 to dress the socio-demographic, judiciary and mental health paths of the accused. As will be demonstrated in the pages to come, homeless people are overrepresented in the MHC and tend to have burdensome judicial and mental health histories, making this population difficult and complex to serve in a fast-paced and rigid environment that is frequently under-resourced. Moreover, in over half of all the cases processed, charges are withdrawn or dropped or a verdict of not-criminally responsible is found. Thus, 52% of cases are not criminalized, begging the question as to what the purpose of judiciarizing mentally ill accused serves. It is hoped that this study will address the paucity of Canadian scholarship on MHCs.

[1] Throughout this report the term MHC will be used to signify Mental Health Courts.

[2] Throughout this report the PAJ-SM will be used to signify the Programme d'accompagnement justice-Santé mentale.

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Disclaimer

The opinions and interpretations in this publication are those of the author and do not necessarily reflect those of the Government of Canada.

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1. Mental Health Courts – A Response to Mental Illness, Crime and Homelessness?

There has been a proliferation of problem-solving courts in recent years yet little is known about their functioning or effects (Schneider, 2010; Slinger & Roesch, 2010; Jaimes, Crocker, Bédard, & Ambrosini, 2009). In general, problem-solving courts refer to community courts, drug courts and mental health courts (Sirotich, 2009). They are based on a philosophy of therapeutic jurisprudence and restorative justice that offers a more "collaborative and individualized approach that differs from the traditional criminal justice system" (Slinger & Roesch, 2010: 258). Over the past decade, 'specialized' (or problem-solving) courts have emerged as an alternative to traditional punishment systems, which can be ineffective in addressing chronic and recurring forms of criminal involvement and inadequate social conditions. Specialized courts combine legal and therapeutic strategies and practices to manage individual risk of recidivism. They try to address the social, treatment, and cultural needs of specific populations using a more responsive, tailored approach. Specialized courts are based on philosophies of therapeutic jurisprudence and measured justice, yet are relatively absent of theoretical moorings to guide their work (Hannah-Moffat & Maurutto, 2012; Miller & Johnson, 2009). MHCs claim to reduce criminal recidivism among offenders (Hiday & Ray, 2010) and increase participation in community-based treatment (Goodale, Callahan, & Steadman, 2013), but others have noted that there is little empirical support for the factors that impact outcomes (Canada & Gunn, 2013) and the ways in which they promote change (Canada & Watson, 2013).

The growth of problem-solving courts is, in some ways, recognition that criminal acts are often symptomatic of much larger underlying health and social problems and inadequate resources (Schneider, 2010; Winick, 2003). However, while problem-solving courts are on the rise little evidence has been mounted to demonstrate efficacy (Wiener, Winick, Georges, & Castro, 2010). It has been levied by some that the creation of MHCs is a stopgap measure in response to failing social, health, and justice systems and viewed more largely in a historical context as a response to *mismanaged*[ii] deinstitutionalization (Otero, 2010; Hartford et al., 2004), that failed to infuse the community with requisite supports (Bernheim, 2012). The increasing criminalization[iii] of persons with mental illness who are frequently homeless is evidence of vulnerable people falling through the cracks of nations' social safety nets (Bernstein & Seltzer, 2003). Some argue that the intersection of the justice, social and health systems produce a form of re-institutionalization (Jaimes et al., 2009) or trans-institutionalization (Frappier, Vigneault, & Paquet, 2009), and posit that the tribunals are simply a form of "diversion to treatment intervention" (Wolf & Pogorelzki, 2005). In essence, these courts provide a way to circumvent failing social and health services and strong arm intervention[iv].

The mentally ill are overrepresented in the criminal justice system, and the rapid proliferation of MHCs is one response to this phenomenon. Social profiling has demonstrated that police officers are twice as likely to arrest someone who appears to have a mental illness, and the mentally ill are frequently charged with minor offences for which others are not usually subject to arrest (Bernstein & Seltzer, 2003: 143-5). Seltzer (2005: 573) found that mentally ill adults "spend more time incarcerated than similarly situated individuals; once incarcerated, they are victimized by other inmates, many do not receive proper mental health treatment, and their psychiatric conditions deteriorate." It is commonly propagated that people with mental health problems are more dangerous and violent than others, however this is statistically unproven (Crocker & Côté, 2010b; Stuart & Arbolèda-Florez, 2001; Teplin, McClelland, Abram, & Weiner, 2005). In fact, Teplin et al. (2005) demonstrated that people with mental health issues are 11 times more likely than the general population to be victims of violence, running counter to theories of perpetration. However, studies have been weighted towards characterizing people with mental health problems as perpetrators rather than as victims. This bias is frequently reinforced in the media (Lamboley, 2009; Provencher, 2010); a focus that tends to magnify them as dangerous perpetrators instead of victims of violence (Seltzer, 2005). This view is becoming more predominant and serves to reinforce stigmatizing views of linkages between violence and mental illness (Provencher, 2010). Some authors have also noted that police interventions are hallmarked by an "all citizens are equal before the law approach" or view judiciarization as a lever to access scarce resources (Laberge & Morin, 1992).

Anecdotally, it has been evoked that MHCs produce a "revolving door" phenomenon in which the 'hard-to-serve' elements of the population continue to find themselves in conflict with the law (Jaimes et al., 2009). This provides a "side door" access to mental health (Crocker, Jaimes, Braithwaite, & Salem, 2010a) and/or social services, thus, privileging services to a more marginalized part of the population. This represents a critical knowledge gap, in terms of how intervention happens, how it is experienced and whether it is effective. This study attempted to respond to these significant gaps in order to better serve the population.

While MHCs are predicated on an assumption of voluntarism there are forces of coercion at play that compel an individual to participate in treatment under threat of court sanctions (Bernstein & Seltzer, 2003). Moreover, access is frequently through police interventions (Otero, 2010). While proponents of such courts promote ideologies of therapeutic jurisprudence (Jaimes et al., 2009), they downplay potential coercive, paternalistic and/or stigmatizing effects that may inform the interventions (Comité de Vigilance, 2009, 2011; Provencher, 2010). There has been a rise in the prominence of resources consecrated to the legal-psychiatric clientele as well as an increase in police involvement as first responders; behaviours which were previously treated by health and social services now result in a judiciarization[v] of the mentally ill (Otero, 2010; Crocker, 2009). However, in the wake of deinstitutionalization and the emerging prominence of a judiciarization of people with mental health problems, a social dimension analysis has all but vanished (Otero, 2010). Critiques have been mounted that the crimes that people with

mental health issues commit are rather heterogeneous and minor, linked to poverty, homelessness and social conditions in the pursuit of survival (Jaimes et al., 2009) and exacerbated by the lack of access to health and social services (Comité de Vigilance, 2011).

These socio-political, historical and legal shifts result in a criminalization of the mentally ill, "a shifting of responsibility onto the criminal justice system for the provision of basic mental health care services" (Schneider, 2010: 202). The *Quebec Ombudsman* reports that 61% of incarcerated individuals in Quebec detention centres have had at least one psychiatric and/or substance abuse diagnosis within the last five years. And that 17,4 % of the detention centre population suffer from a severe and persistent mental illness as compared to the 1-3 % of the general population. Moreover, 30% of detainees with a mental health problem had experienced multiple probations (as compared to 9.9% of the general detained population), and more strikingly, 81% had a previous history of detention. There is also evidence to suggest that the prevalence of mental illness among federally incarcerated offenders has increased since the 1960s, in direct response to the deinstitutionalization movement. Correctional Service of Canada, that collects information on the mental health of federally incarcerated inmates, found that the number of offenders with mental disorders admitted to federal institutions in 2004 was 60% higher compared to 1967 (57% for men and 65% for women), with the inclusion of substance use the total climbs to 84%.

The medicalization of mental health problems is a particularly prominent pattern in MHCs. Trupin and Richards (2003) found that treatment with psychiatric medications was the focus of most linkage activity and that many participants had the possibility of having their charges reduced or erased (which is frequently the case), but the length of their adherence to the program and supervision was over a much lengthier time than that of most typical misdemeanants. Claims to break the cycle of incarceration of the mentally ill, reduce recidivism, proffer necessary supports and services to enhance participants quality of life, and in so doing, increase community safety, remain uneven (Boothroyd, Mercado, Poythress, Christy, & Petrila, 2005; Cross, 2011; Sarteschi, Vaughn, & Kim, 2009; Sirotich, 2009).

There is a knowledge gap due to the paucity of research on the judiciarization of the mentally ill. Studies of such tribunals which have almost exclusively been undertaken in the United States are descriptive, and a small few are evaluative (Crocker, 2009; Jaimes et al., 2009; Hartford et al., 2004). One study revealed that the impact of this form of judiciary intervention did not produce significant results for users, and that more detailed studies and of a longitudinal nature are needed to demonstrate the impact on users' quality of life and functioning (Crocker, 2009; Jaimes et al., 2009). Whilst others demonstrated that the impact of such tribunals on both recidivism and incarceration were inconclusive (Sirotich, 2009). The processes and outcomes of MHCs and certainly users' trajectories and experiences of such tribunals remain largely unknown. Canadian scholarship in this area is still in its infancy. In particular, comparative studies examining effects, and more Canadian scholarship, are sorely lacking.

There is a dearth of knowledge concerning the experiences of persons utilizing the PAJ-SM model (Provost, 2011; Crocker et al., 2010a; Comité de Vigilance, 2009; Crocker, 2009) and MHCs in general (Slinger & Roesch, 2010). MHCs have rarely been examined from the user's (whether participant or actor) point of view. More specifically, many elements have not been exhumed: the nature of interventions, the effects or processes of stigma and marginalization, the impact on social inclusion/exclusion or social conditions (Comité de Vigilance, 2011; Provencher, 2010; Jaimes et al., 2009; Kaiser 2009a, 2009b). There is a critical gap in knowledge about how these forms of intervention are experienced by the people for whom the tribunal has been established and the impact they have on their lives (Frappier et al., 2009). This project attempted to expand our limited knowledge, theoretically and empirically, of the functions and processes of MHCs and their effect on reducing or preventing homelessness. It sought to : illuminate users and key actors experiences of the tribunal, with a particular focus on stigma and processes of exclusion/inclusion; uncover obstacles in the system related to collaboration and negotiation impinging on several departments and organizations; highlight 'best' or 'promising' practices by uncovering what works best and for whom; lastly, based on this evidence provide recommendations, strategies and guidelines beneficial to the program itself but also to communities at large who operate tribunals or are contemplating the establishment of such systems.

2. Exploring the Programme d'Accompagnement Justice-Santé Mentale (PAJ-SM) MHC Model and Homelessness

As of 2009, there were 14 MHCs in Canada, 7 in the process of being established, but the PAJ-SM is the only one of its kind in Québec (Jaimes et al., 2009). Québec established the PAJ-SM in 2008 at the Montréal municipal court as a three-year joint pilot project between the City of Montreal, the Quebec Justice Department and the Quebec Ministry of Health and Social Services (http://www.douglas.qc.ca/info/pajsm-montreal). Since that time it has received ongoing funding for its operation, and its numbers have swelled, almost tripling the number of accused since its first year of operation (1st year = 1579 files, 2012 = 3883 files).

The PAJ-SM is a mental health court situated at Montréal's municipal court that targets people with mental health problems who face minor criminal charges, and are frequently homeless or at risk of homelessness[3]. The PAJ-SM is not a new judicial entity; rather it is a type of social program based on similar models of MHCs found in North America[4]. The key elements of the PAJ-SM and MHCs are to provide a rehabilitative response to criminal acts when mental illness is in play. "The objective is to get at the *root cause* of the criminality rather than dealing superficially with the symptomatology of the much bigger underlying problem. The philosophy behind the courts is extracted from the principles of therapeutic jurisprudence" (Schneider, 2010: 202). Through the deployment of a multidisciplinary team approach, judges, prosecutors, psychiatrists (in PAJ-SAM's case it is a general practitioner with specialized mental health expertise), case workers, and probation officers collaborate to provide a response, often treatment-oriented, to the needs of the individual (Schneider, 2010). The key elements of the tribunal are: a non-adversarial approach, voluntary participation, tailored intervention plans, more flexibility, a designated judge, and a separate docket for defendants[5] (Hartford et al., 2004).

In Canada, no exact estimates of incidence of mental illness in the homeless population are available due to methodological challenges of enumeration, encumbered by definitional and access issues (Farrell & Reissing, 2004; Steinhaus, Harley, & Rogers, 2004). While there has been some debate about the role of homelessness in either the etiology or exacerbation of mental illness (Ginzler, Cochran, Domenech-Rodriguez, Cauce, & Whitbeck, 2003; Spence, Stevens, & Parks, 2004), models of mental health treatment for this population remain largely unstudied (Farrell, Huff, MacDonald,

[3] http://www.douglas.qc.ca/info/pajsm-montreal.
[4] http://www.douglas.qc.ca/info/pajsm-montreal.
[5] http://www.douglas.qc.ca/info/pajsm-montreal.

Middlebro, & Walsh, 2005). Though statistics vary among studies as to the degree of mental health problems among the homeless, one recent study found that when a homeless person is hospitalized 52% of the time it is due to a mental illness[6], compared to only five per cent of the general population. In a recent article about homelessness and mental health in Montreal, it was found that roughly 50 – 75% of the homeless population experienced some form of mental health problem[7], and this finding is consistent with experiences of other cities, ranging from 30% to 75% (Power, 2008; Statistics Canada, 2002). The Montreal article noted that mental health problems are on the rise among the homeless and in tandem so is the tendency to intervene through the criminal justice system, and this trend is found elsewhere across the globe (Mayor's Task Force - BC, 2007; Smith, 2007).

According to Power (2008), people with "poor mental health are more susceptible to the three main factors that can lead to homelessness: poverty, disaffiliation, and personal vulnerability." They tend to have fewer supports which reduces coping resources, they frequent lack the ability to sustain employment which further weakens their already fragile resources, thus encouraging a cycle of sustained homelessness (Power, 2008). Homeless experiences, in turn, magnify poor mental health. Power (2008) proposes that homelessness could be drastically reduced if people with mental health problems were able to access community supports to maintain or acquire housing. The stress of being homeless, the overwhelming mental health needs in the face of a deficit of resources and diminished coping abilities may exacerbate previous mental health challenges and worsen illness which too frequently make situations ripe for criminal involvement. MHCs may provide one such avenue to community supports to maintain housing.

An Ontario study evaluated the complex association between legal involvement and mental illness, and found that about one in five consumers of formal community mental health programs had at least some contact with the legal system during the research year, and that unstable housing was predictive of legal involvement (Sheldon, Aubry, Arboleda-Florez, Wasylenki, & Goering, 2006: 249). The authors urged that emphasis be given to the social context of legal involvement, with particular emphasis on the role of poverty, homelessness and social isolation in triggering criminal intervention. They argued that "high rates of involvement with the legal system, rather than indicative of "badness", may speak to underlying social disadvantage. Without adequate attention paid to the contributory effect of social disadvantage, there is a danger of a "revolving door" between correctional, welfare and mental health systems" (Sheldon et al., 2006: 254). Data from the *Pathways into Homelessness* project, a survey of shelter-using homeless persons in Toronto, reported that 62.7% of respondents had been arrested since the age of 18 (Tolomiczenko & Goering, 2001). Substance abuse was also highly predictive of legal involvement for this population. In fact, the incidence of legal interactions (arrests and non-arrests) for people with concurrent disorders (mental illness and addictions) are particularly high and have been found to range up to 83%, adding homelessness to this

[6] http://www.canada.com/topics/photogalleries/story.html?id=9116dc4d-0a08-4c23-8851-19c5fa96868f&p=2

[7] http://www.ledevoir.com/societe/sante/350057/de-la-prison-a-la-prison

mix increased the chance of legal involvement (Clark, Ricketts, & McHugo, 1999). Clearly, there is a relatively high risk of legal involvement for this population compared to the general population; the combination of mental illness, addictions, and homeless makes for a potent mix of risk for judiciary intervention.

2.1 The Project

The project was developed in conjunction with stakeholder groups. Requests from community partners (Comité de Vigiliance) and key actors (prosecutors and Centre de santé et services sociaux (CSSS) Jeanne-Mance) had been received by the researchers to develop such a project. The study responded to the above-mentioned knowledge and policy gaps by examining, theoretically and empirically, the functioning of MHCs and outcomes by exploring the:

1) the experiences of users, in particular, whether court processes are perceived as stigmatizing, helpful or exclusionary/inclusionary;
2) the experiences of key actors implicated in the tribunal's operation to improve functioning and collaboration;
3) the effects on homelessness, mental health, and social conditions, whether court intervention influences users social and health determinants;
4) and efficacy, in order for relevant recommendations to be produced.

2.2 Evidence of Community Support

There were numerous stakeholders implicated in the development of this project. Both the key actors of the court itself (prosecutors, judges, case workers, defence lawyers, criminologists, and probation officers) and the community organizations that provide accompaniment and support services had identified that there is a lack of knowledge about the court's effects and functioning and requested such a study be undertaken. Preliminary meetings took place with the Coordinator of the prosecutors of the PAJ-SM, as well as key representatives from community organizations (Comité de Vigilance) that proffer services, to examine the viability of such a project and to lay the foundation. Critical government and community pillars are implicated in the functioning of the court and are invested in the outcome of such a project: the City of Montreal, the Quebec Justice Department, the Quebec Ministry of Health and Social Services (CSSS Jeanne-Mance) and relevant community organizations. Partnerships with community organizations, the municipal court (bridge between the city and the justice department), and CSSS Jeanne-Mance assisted in launching and maintaining the study.

Improving the junction of mental health, social service and judicial systems is crucial, particularly when attempting to reduce or prevent the predominance of homelessness among this population that is not well understood. Examining the processes and outcomes of tribunal intervention on those who are homeless or at-risk of homelessness hoped to provoke a deeper understanding of key constraints, successes and hopefully, offer some paths to solutions. This research hoped to benefit other communities who are attempting to establish such programs (in the last three years the establishment of MHCs

in Canada has almost doubled). The aim was to develop knowledge that can be mobilized and applied efficaciously to other communities grappling with similar struggles at the intersection of justice, mental health and social services systems.

2.2.3 Project Objectives

The research objectives were two-pronged. The first prong was global and involved compiling a comprehensive literature review of MHCs examining models of intervention and their impact on preventing and reducing homelessness. Exploring both published and grey literature hoped to paint a broad picture of: the relevant literature pertaining to MHC models and the intersections of justice, mental health and social services, uncovering various tribunals' functionalities, efficacy and outcomes, gleaning 'best practices'. The second prong involved launching an extensive multi-method study examining the experiences of participants and key actors implicated in PAJ-SM's work. Site visits and key informant interviews were conducted with: users of the tribunal, and actors implicated in PAJ-SM's work (judges, prosecutors, defence lawyers, case workers, probation officers, criminologists, doctor), to provide first-tier data to illuminate literature review findings. Quantitative data encompassed the review of 100 individual court files, intake and closure reports, collecting and analyzing data that has hitherto not been examined to unveil efficacy and process. This was in an effort to create profiles and paths related to: a) socio-demographic histories; b) mental health interventions, histories and effects; and c) judicial interventions, histories and effects. Qualitative data uncovered participants and team members experiences of the tribunal, the challenges and benefits of such intervention and the relevance for other communities in reducing or preventing homelessness. This data helped to triangulate and contextualize the quantitative elements and relationships between variables.

2.3 Research Questions

The research questions tackled how the PAJ-SM functions and its effects. The development of paths: the socio-demographic status of participants, the nature and scope of mental health interventions to establish their health profiles, and the trajectories of judiciary interventions, antecedents and outcomes, to examine correlations between different variables. These pathways underpinned the study's orientation and guided the research endeavour by examining interlocking systems: the mental health, justice and social service systems, directly impacting this population. The triangulation of a mixed-method design provided a cross-pollination to ensure reliability and cross-referencing.

3. Methodological Strategy

3.1 Design

The research design of the study employed a multi-method approach, integrating quantitative and qualitative elements. Quantitative data tackled the contents of participants' files, including intake and outtake forms, progress and intervention notes, data that had not been previously analyzed. All relevant data contained in court files were also examined in a second wave of data collection to dress the socio-demographic, mental health, and justice paths of participants and illuminate the health, social service, housing and justice systems, inherent to the tribunal's functioning, with a particular focus on residential status. Qualitative data captured the experiences of participants accessing PAJ-SM as well as key actors implicated in service delivery through semi-structured interviews. Lastly, participant observation of team meetings, court room proceedings and shadowing of team members occurred.

3.2 Ethical considerations

The project obtained an ethical certificate from the Université de Montréal and the CSSS Jeanne-Mance ethics committees. Prior to any data being collected, all interview questions, recruitment methods and issues of confidentiality and anonymity were vetted through these committees. All personally identifying information such as names and court file numbers were changed and given anonymous insignia. All relevant data was kept in a locked filing cabinet in the principal investigator's locked office. Informed consent was explained and the right to withdraw at any time without penalty (including no disruption to service provision tied to the mental health court) was clearly outlined and reiterated to participants.

3.3 Quantitative – Data Collection and Analysis

This section describes the data extraction methods of a 100 court files. Specifically, we extracted 20 files from each of the five years of the court's operation (2008-2012). These were extracted along three categories for each of the five years based on the advice of the crown prosecutor and administrative staff regarding the distribution of accused among the three streams of the MHC's work. The extraction of files took place as follows: 13 files from the major grouping of operation - the *follow-up and liaison* group; 5 files from the *evaluation-expertise* group; and 2 files from the *ejected* and returned to the regular criminal court system category for each year.

Each file that is opened in the PAJ-SM has relevant police records, case notes of interventions from case workers, and relevant criminal, mental health and social demographic histories. Equally, the prosecutors of the court have developed an output data form that prosecutors were completing during some of the years sampled (however, not consistently). This form examines the psychiatric admissibility to the program, the judicial antecedents, rulings and outcomes of mental health court involvement. There are roughly 5,000 closed files covering a period of 3 years (2008 – 2011). The aim was to randomly sample and analyze 100 files from this time period. Data such as age, gender, mental health history, housing and homelessness, and judicial history were collected and

analyzed using a Statistical Package for the Social Sciences (SPSS) system. Data from the files was collected to paint a portrait of participants: socio-demographic history, history of mental health intervention and treatment, history of their involvement with the justice system and the nature and effects of judicial intervention, in an effort to flesh out participants' profiles and investigate the correlation between variables. This quantitative analysis and the development of these trajectories were triangulated with the deployment of qualitative methods. The development of socio-demographic, mental health, and justice paths sought to bridge individual and collective experiences and respond to summative questions such as:

- Who are the participants that make up the MHC: what kinds of mental health and judicial histories are most often represented in the MHC? How do they experience the MHC ?

- How does the PAJ-SM affect participants' connectivity to services, social resources, does it provide a springboard for social inclusion or is it experienced as stigmatizing and exclusionary?

- How do the interlocking systems inherent in this project: mental health, social service and justice systems, intersect and function in their interaction? What are the obstacles to collaboration and how can efficacy be improved?

- What lessons can be drawn and applied to other communities in preventing and reducing homelessness for people with mental health problems?

3.4 Qualitative Research - Recruitment and Sampling

Recruitment and sampling of key informants were initiated through the Coordinator of the prosecutors at the PAJ-SM. Eleven semi-structured interviews took place with key actors of the PAJ-SM team. A minimum of one key informant for every professional role (judge, crown prosecutor, defence lawyer, case worker, probation officer, criminologist, doctor) was chosen.

The CSSS Jeanne-Mance Urgence Psycho-Sociale (UPS) case workers are integral partners of the tribunal and are responsible for direct intervention with the clients, referral and linking to services, and follow-up. Access to PAJ-SM participants was made possible through these case workers who have direct contact with potential participants and are in a propitious position to link researchers to participants. Twenty participants were interviewed regarding their experiences and perceptions of their involvement with the PAJ-SM.

Participant observation of team meetings and courtroom proceedings were also carried out. Access was granted through the crown prosecutor's office. A minimum of 30 team meetings and 30 audiences (court room proceedings) were observed, as well as shadowing of some professionals (case workers), totalling over a 125 hours of observation time.

3.4.1 Qualitative - Data collection and Analysis

Participants

Twenty participants were recruited and interviewed to analyze their understanding (with the assistance of the UPS case workers) of the MHC. Data was collected using face-to-face semi-structured interviews. The data was analyzed and coded using NVivo and produced over 1115 nodes from which emerged themes from the interviews conducted in French and English. They were then cross-referenced with the quantitative data. This data was analyzed along the following paths: socio-demographic, mental health, and judicial histories. Semi-structured research questions examined:

- How do participants access the PAJ-SM?
- How do participants experience their involvement with PAJ-SM?
- What kinds of interventions do participants engage in through their involvement in PAJ-SM? How is intervention perceived and understood?
- Do participants feel their participation in PAJ-SM is beneficial? How does it impact their connectivity to resources, mental health care and social service systems? How does it impact their quality of life: housing status, access to mental health resources, and deterrence from criminal involvement?

Key Informants

Eleven face-to-face semi-structured interviews took place with key actors: judges, crown prosecutors, defence lawyers, case workers, probation officer, criminologists, and a doctor. The data was coded with NVivo and produced over 1016 lines from which emerged themes from the interviews conducted in French and English and were cross-referenced with the quantitative data. The crown prosecutor had also invited the researchers to attend team meetings and court hearings to gain a better understanding of the tribunal's proceedings and negotiations, thus, participant observation was an important method added to the project to encourage triangulation. Case workers also invited researchers to observe their interventions with participants (conditional upon participant's willingness).

Research questions for key informants included:

- How does the PAJ-SM function?
- What are its goals, objectives, criteria, approaches and activities?
- Who makes up the PAJ-SM multidisciplinary team?
- How do team members experience their involvement in the tribunal? What works well and what can be improved?
- How does collaboration happen and what assists and detracts from efficacy? How do negotiations take place and how can collaboration be improved?
- What are some of its 'best or promising practices'? What are some of the key barriers, obstacles?

The next section will describe the results of the project.

4. Results

4.1 Court Files

This section describes the data contained and extracted from a 100 court file review of the MHC. Specifically, we extracted 20 files from each of the five years of the court's operation (2008-2012). These were extracted along three categories for each of the five years: 13 files from the major grouping of operation - the *follow-up and liaison* group; 5 files from the *evaluation-expertise* group; and 2 files from the *rejected* and returned to the regular criminal court system category.

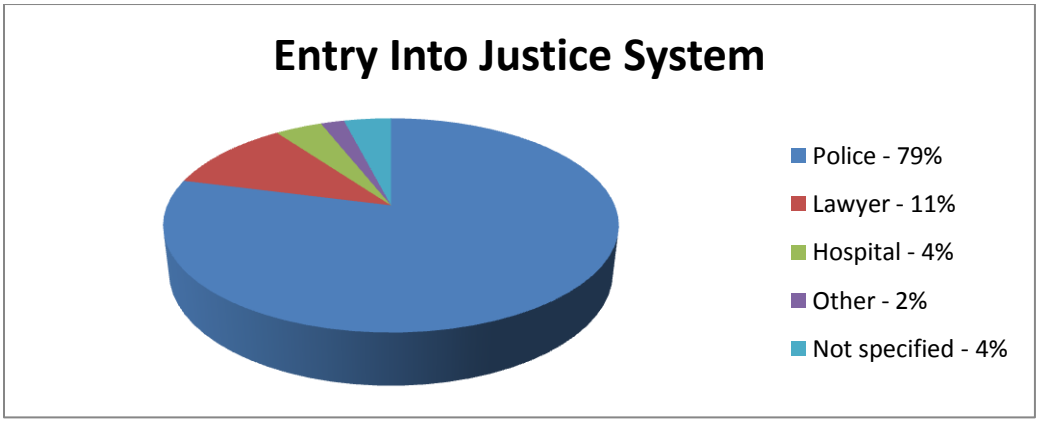
The first tables dress the socio-demographic characteristics of the population: gender, ethnicity, nationality and language. In general, the majority of the accused are white, male and francophone.

Table 1 : Socio-demographic Characteristics

Gender		Language			Ethnicity			
Men	Women	Francophone	Anglophone	NS	Canadian	Immigrant	Aboriginal	NS
82%	18%	70%	20%	10%	69%	22%	1%	8%

The large majority of the accused (almost 80%) entered the MHC through police referrals from their interventions (SPVM – Service de police de la Ville de Montréal) with the accused. Police reports frequently noted that the police officer suspected there was a mental health problem and requested they undergo a psychiatric evaluation.

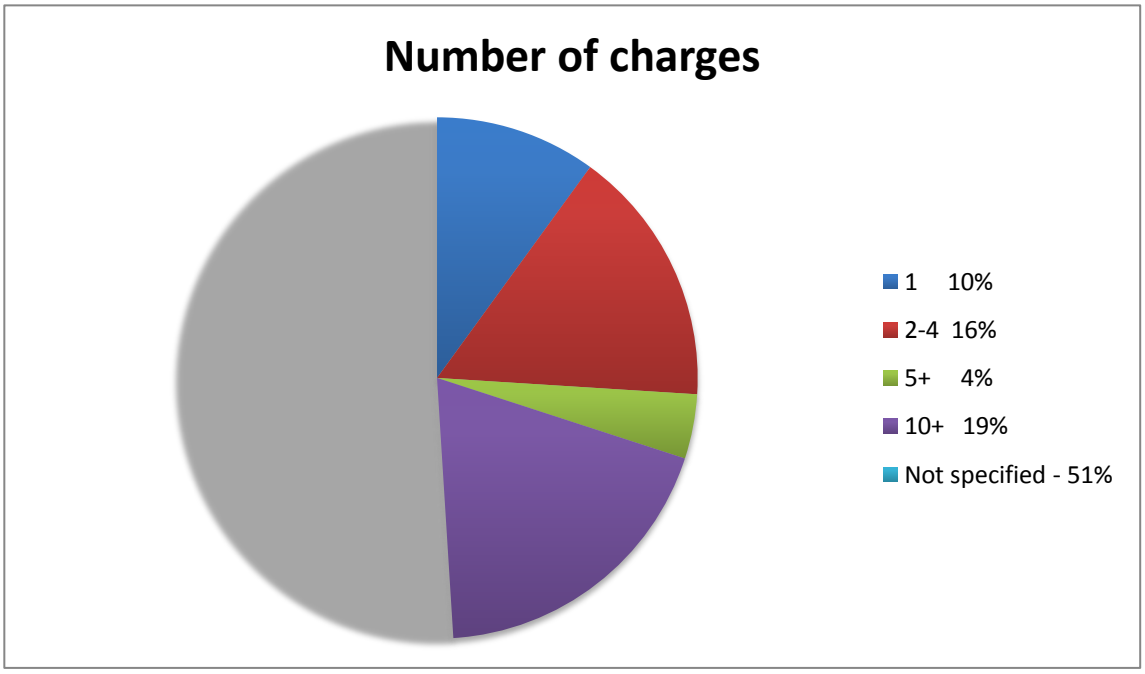
Figure 1: Entry Into Justice System



Judicial Antecedents

In terms of judicial antecedents, 54 % of offenders had prior charges, versus 46 % for whom it was their first criminal charge. Within the former group, who have already come into conflict with the law, those with numerous judicial antecedents (10 or more charges) comprise the largest group (19 out of 100). However, a large amount of information was also missing from court files in the not specified (NS)[8] category making it difficult to state this unequivocally (51 out of 100 files).

Figure 2: Number of Charge



The next table highlights the preponderance of criminal charges, as one file can contain several charges. As evidenced below, theft and assault are the more recurrent criminal charges.

Table 2: Preponderance of Criminal Charges

Charges	Responses	
	N	Percent
Mischief	15	9.5%

[8] NS will be used throughout the report to signify not-specified.

Theft	23	14.6%
Assault with a Weapon	6	3.8%
Harassment	3	1.9%
Assault	18	11.4%
Infraction	9	5.7%
Breach	5	3.2%
Threats	12	7.6%
Other	19	12.0%
NS	42	26.6%
Driving Under the Influence	6	3.8%
Total	158	100%

Moreover, 11 % of accused had already spent time in prison and 22% of these had been under probation previously. An important number again remain under-reported (not specified).

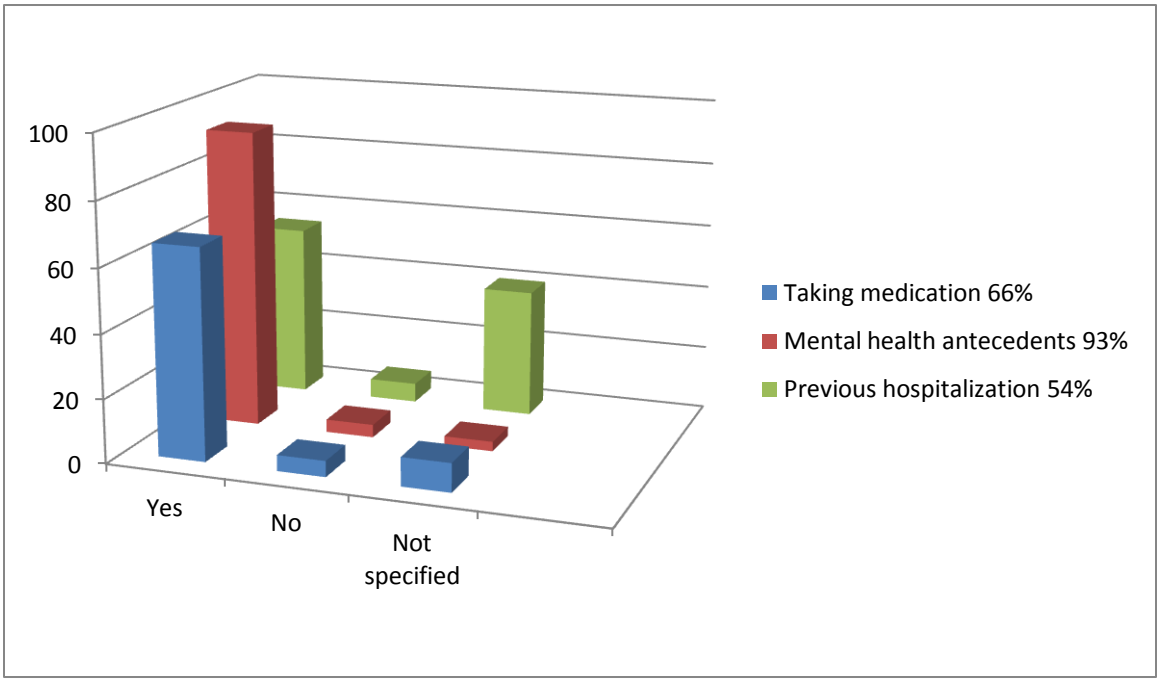
Table 3: Punishment Antecedents

Punishment	N	Percent
Suspended Sentence	23	14.6%
Probation	35	22.3%
Prison	17	10.8%
Fine	17	10.8%
Acquittal	1	0.6%

NCR	4	2.5%
Other	10	6.4%
NS	50	31.8%
Total	157	100%

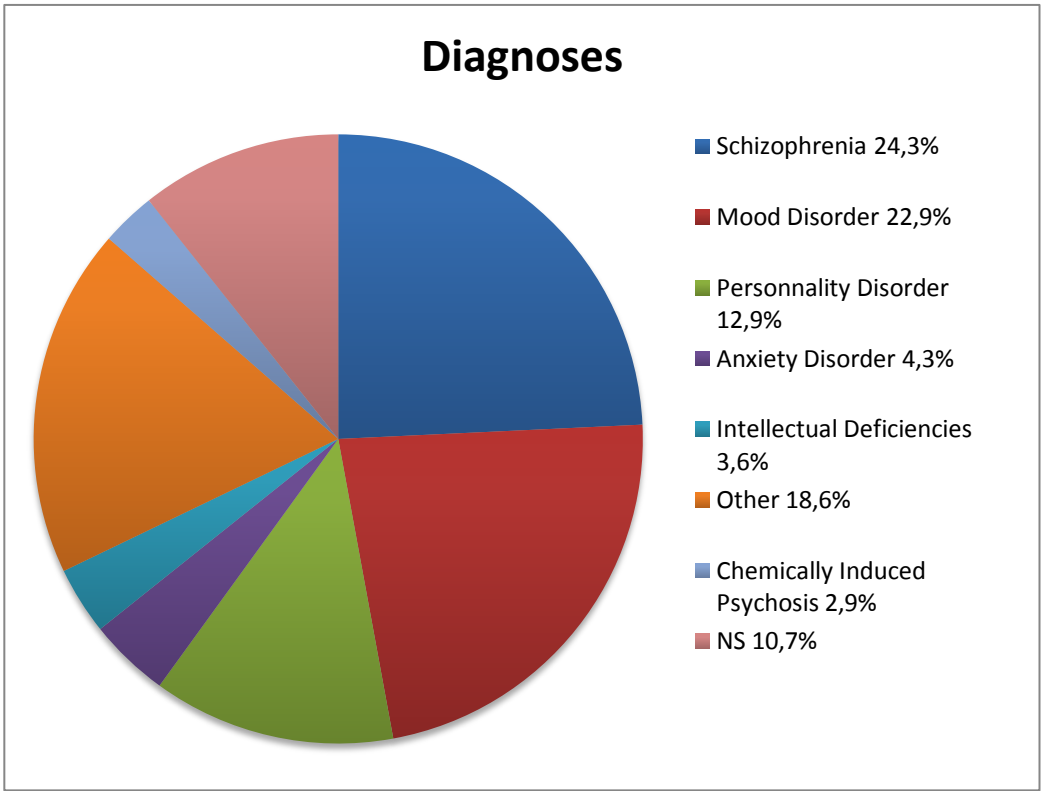
In terms of mental health antecedents, almost every file had an indicator of previous mental health involvement (93%).

Figure 3: Mental Health Antecedents



The next table identifies the kinds of mental health diagnoses that were given to accused and comprised in the court files. The principal diagnoses were psychotic (mostly schizophrenia-related) and mood disorders. The category of "other" refers to Head Trauma-related disorders, or to Pervasive Developmental Disorders (Autism, Asperger's, etc..). And 54% of the accused had experienced previous hospitalizations.

Figure 4: Diagnoses



Taking Medication

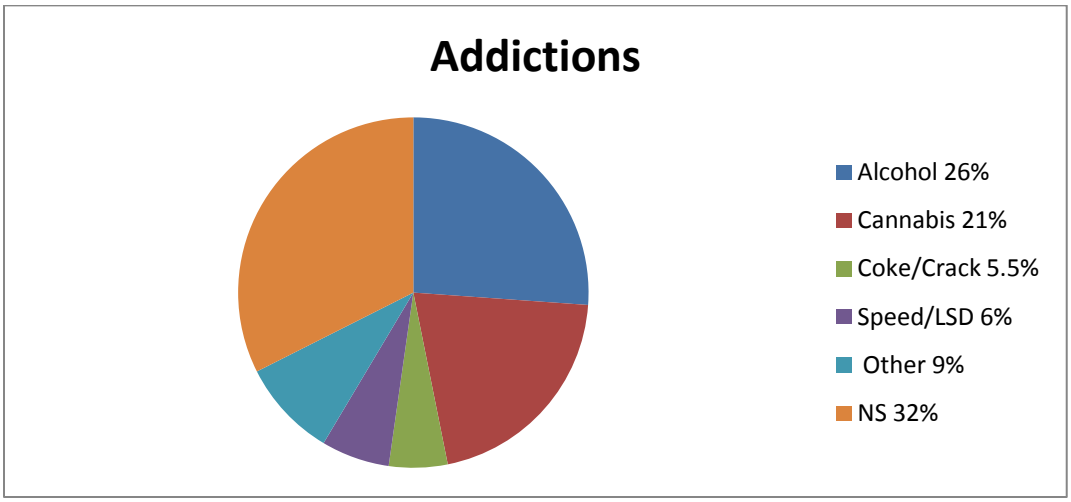
66 % of accused were, according to the files, taking psychiatric medications. It is interesting to note that 93% of accused suffered from a mental health problem. Again, in an important number of files (29%) this was not specified.

Addiction Problems

In three files, a past history of substance dependence was indicated. However, almost half of the files (48%) reported a current addiction problem being present. In thirteen cases, no mention was made of substance use.

The major addictions problems were related to alcohol, cannabis and its derivatives. The "not-specified" category was used if the person did not consume substances or if the information was not available. For all other substances that did not fit into any of the categories below "other" was employed.

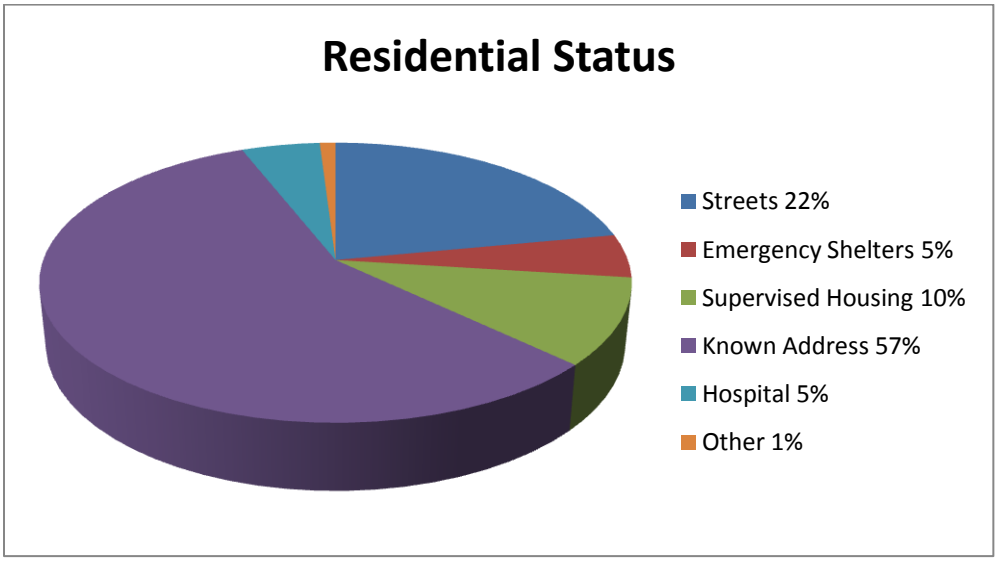
Figure 5: Addictions



Residential Status

More than half the accused had a known address in the file, living with family, a friend or a partner. However, 27% fit the absolutely homeless criteria, staying in an emergency shelter or living on the street. Those files with a homelessness designation will be further discussed in section 5 (p. 29).

Figure 6: Residential Status



Social Support

In terms of the accused's social support systems, 41 % indicated that they did have an existing social support system, whereas 49 % did not seem to have a significant one present. For 10 files, no mention was made of an existing or inexistent social support system. The majority of social support was found among family members, including parents and siblings, and this accounted for 33 % of the files. 9 % reported receiving support from their life partner. In 45% of the cases social support was not mentioned. Moreover, it was not indicated how many offenders were married or lived in common law relationships which would be pertinent in dressing a portrait of the person's social support system.

Therapeutic Interventions

It is interesting to note that 90% of the accused were receiving therapeutic (mostly psychiatric) interventions and treatments, and begs the question of whether services are accelerated for this population. The mental health resources were frequently situated in psychiatric milieus, in particular, hospitals. However, we observed in general, the accused with fewer judicial antecedents had a closer connection to their services than those with five or more judicial antecedents, who had many services mentioned but appeared to float between different service providers. Roughly a third of offenders are followed by a psychiatric department. However, it is difficult to discern whether they receive regular or intensive services, and garner their level of participation and satisfaction. Community resources (11%) and local health centres (10%) also provided services to the population. A significant portion also did not specify the kind of follow-up received (12%). Addictions resources were also mentioned at over 6%.

Additionally, requests for expert evaluations pertaining to aptitude (fitness to stand trial)[9] and criminal responsibility[10], respectively, were 20% and 38% of cases, representing quite a significant gravity of mental illness among the accused.

Reasons for the End of MHC Involvement

According to the statistics below, the principal reason for the end of MHC involvement was the withdrawal of charges (23%). Yet, if we add the number of offenders who are found not-criminally responsible[11] (NCR) (18 %) with those who received a NCR judgement and were remanded to a psychiatric facility (7 %), we arrive at 25% of offenders who receive a NCR status. Also, in 23% of cases, the complaints are withdrawn and that another 4 % are dropped because of insufficient burden of proof (needed by the Crown Prosecutor to pursue the case). In this sense, in 27 % of cases, the charges are

[9] "whether the accused has a rudimentary factual understanding of his legal predicament" (Schneider, Bloom & Heerema, 2007: 237).

[10] "a presumption that an accused does not suffer from a mental disorder that would exempt her from criminal responsibility by virute of s.16(1) of the Criminal Code" (Schneider, Bloom & Heerema, 2007: 236).

[11] NCR will be used throughout this document to signify not criminally responsible.

withdrawn or dropped. If we combine these two results: NCR and whether complaints are dropped and charges are withdrawn, gives a figure of 52 % of files that are not criminalized or that are attributed to the Québec Review Board (TAQ).

Table 4: Reasons for the End of MHC Involvement

Reasons for the End of MHC Involvement	N	Percent
NCR	18	18
Withdrawn	23	23
Suspended Sentences	6	6
Probation	4	4
Detention	1	1
Regular Tribunal	3	3
NS	7	7
Insufficient Burden of Proof	4	4
Involuntary	2	2
Conditional Discharge	4	4
Absolute Discharge	2	2
NCR + Conditions	7	7
810 Conditions	9	9
Treatment Order	2	2
Fine	1	1
Guilty + Conditions	2	2
Ejected from MHC	3	3

Suspended Sentence +Probation	2	2
Total	100	100

Consent and Defence Issues

Only 61% of files had a completed consent form signed by the participant who wilfully agreed to participate in the MHC. However, while this number is at first glance surprising, it is worth mentioning that in many cases the case worker does not meet with the accused because they are remanded for an expert-evaluation for fitness or aptitude and this is not a voluntary option. Also, in some cases the offender is returned to the regular criminal court system.

58 % of accused had a consistent follow-up with their defence lawyer. A steady and consistent rapport with one's defence lawyer has been noted empirically and in the literature as especially important for this population.

On average, accused make 6 court appearances over the length of their involvement with the MHC. In 33 files, accused made more than 6 appearances, and in 42 cases accused made less than 6 appearances.

Police Involvement

In 23 % of the cases peace officers were involved in the laying of charges. To better understand this figure we studied the case notes in court files. This will be addressed in the following section.

Pleas

In 60% of the files, the accused pled not guilty. Contrary to many MHCs in North America, the PAJ-SM does not require participants to plead guilty to be integrated into the program. A large amount of data regarding how accused pled was also missing from court files.

Accusations

The largest category of criminal charges was related to assaults (29 %), while the second largest was related to threats (20 %). Mischief, thefts and breaches represented roughly 8-9% of the files. Harassment and infractions, resulted in 7% and 6%, respectively.

Conditions of Release – End of MHC Involvement

The next table highlights the conditions of release, once the accused has finished their involvement with the MHC. Keeping the peace and being on good behaviour were the most frequent conditions (13%). However, 31 % of files did not specify the conditions of release, this information was absent from the court file. Accused frequently had more than one condition, as evidenced by the discrepancy between the number of conditions and the percentage. An important number (9%) received a condition to not consume alcohol or drugs, and this considering that almost half (48 %) had an addiction problem. In total, 166 conditions of release were noted in the court files and this despite the fact that just under half of the files did not receive conditions (NCR, withdrawal of charges, fine, and some returned to the regular criminal court). This means that for the remaining files, frequently there was more than one condition.

Table 5: Conditions of Release

Conditions	N	Percent
Keep the Peace/Good Behaviour	21	12.7%
Known Current Address	8	4.8%
Follow Treament	15	9.0%
Take Medication	9	5.4%
Abstain from Substances	4	2.4%
No Weapons	7	4.2%
No communication with plaintiff	16	9.6%
Keep a perimeter/distance from plaintiff	9	5.4%
NS	52	31.3%
Geographic Restrictions	1	0.6%
Probation	7	4.2%
Review Board Decision (TAQ)	4	2.4%

Detention	12	7.2%
Other	1	0.6%
Total	166	100%

The next section will take a closer look at court files in which there was a clear indication of homelessness status.

5. Focus on Homelessness

5.1 A Second Look at Court Files with a Homelessness Designation

In light of taking a closer examination of the possible impact of the MHC on homelessness, we undertook a second wave of data collection and analysis from court files by targeting specifically the files that had a homelessness designation. This section analyzes the content of court files (N = 27) whereby there was a clear indication that the accused were absolutely homelessness (streets) and/or staying in emergency shelters. This was in a deliberate effort to answer the question: does the MHC have a positive impact on homelessness? Progress notes of MHC case workers and any medical (psychiatric) reports contained in the court files were analyzed to flesh out the accused's social conditions, mental health and living situations. These files typically demonstrate a preponderance of interactions with police resulting in criminal charges being laid and a more closely surveyed population in general, the long-term results of which are unclear. On average the accused appeared 8 times during their involvement with the MHC (as opposed to the average of 6). 9 of the files requested a psychiatric evaluation, either for fitness or criminal responsibility.

Before we begin this section, it is important to clarify some essential elements about the nature of the files studied. Firstly, 30% of the files emanate from charges laid by a police officer. On average, the accused had to appear in court a minimum of 8 times before a sentence was delivered. In the case of 13 of these files, no case worker notes could be found. As highlighted previously, in some cases the case workers could not meet with the accused because they were being detained in a psychiatric hospital to undergo a psychiatric evaluation with regards to aptitude or criminal responsibility. Nonetheless, 13 accused had no contact with a MHC case worker, despite their being an issue of residential instability. In fact, 36% of requests for criminal responsibility determinations signified homeless individuals.

In general, when case worker progress notes were available in court files, there was a fair bit of communication noted between the MHC and the accused's treating team (if applicable). The subject of communication was often to discuss the accused's MHC involvement (court appearances) and to ensure follow-up with the treating team (indications of whether the accused adhered to their medication regime, kept their appointments). Sometimes case workers would make suggestions or inquire about the person's dangerousness, unpredictability.

In one extreme example, an accused had 17 court appearances for a minor criminal charge of theft under (value 20$). Many interventions took place to link the person to community resources. In the end, the charges were withdrawn as he completed his conditions of integration into the MHC. It is not our intention here to critique the work of the MHC but to ask about its purpose in linking the accused to services. For many accused, there appeared to be a significant amount of movement between community

resources, hospitals, the streets, detention and the court, sometimes without significant gains. However, in one interview with a participant (in the next section) she did mention that the MHC (and other service providers) did result in her "getting off the streets". It appears though in general, that residential status is not front and centre as an issue among team members.

Frequently, case workers could not meet the accused if they were being detained for further evaluations. In these instances it appeared that the detainee was shuffling between court appearances and the hospital or institution where they were detained, without ever coming into contact with a MHC case worker. Equally, for accused whom were found criminally responsible and pled guilty, there was no time available for them to be in contact with the case workers as their sentences were rendered quickly, even if they suffered from several problematics such as homelessness, addiction and mental health problems. Lastly, for accused who did not want to integrate into the MHC there would be no case worker services available to them in the regular criminal court system.

In general, we observed that homelessness was not a central preoccupation of the MHC, and that the issues surrounding homelessness were dealt with in fairly spontaneous and case by case manner. For example, we observed that frequently the accused's conditions upon release were to reside at a certain shelter or give a known address (that was frequently that of a shelter). It appeared, on more than one occasion, that members of the court were not aware that the given addresses were those of a shelter or there was an assumption that the shelter could accommodate such a condition of discharge, when in fact there is no guarantee that such a bed could be given in advance. There was frequently a mismatch between the conditions given and the realities of homeless services. This will be fleshed out further in chapter seven with regards to whether MHCs are a promising practice for preventing and reducing homelessness.

The graph below cross references the judicial antecedents, with past psychiatric hospitalizations and addiction problems. Even if only 27% of the files had a homelessness designation, the complexity of their needs and their combined antecedents results in them being overrepresented in these systems (justice and psychiatric).

Figure 7: Judicial Antecedents, Past Psychiatric Hospitalizations and Addiction Problems

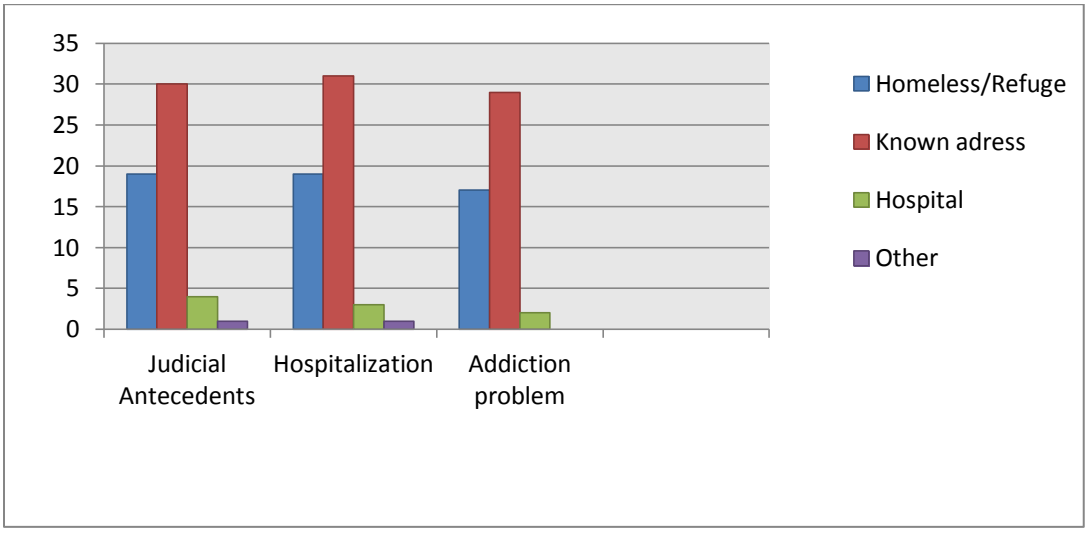
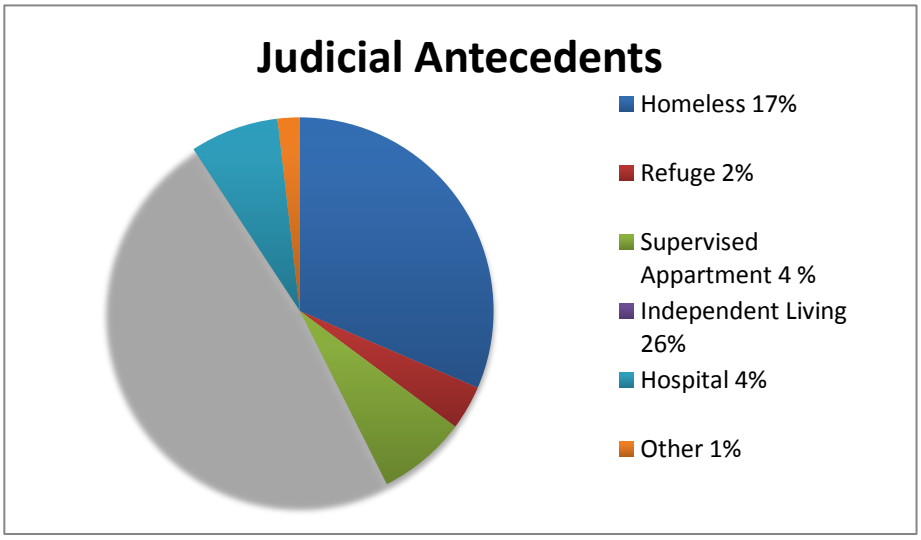


Figure 8: Judicial Antecedents



As demonstrated by the figures, the homeless are overrepresented in the criminal justice system. These tables indicate a preponderance of judicial antecedents for the homeless category, 9 of which have more heavy judicial histories with 10 or more past criminal charges (judicial antecedents).

Table 6 : Residential Status and Number of Judicial antecedents

Residential Status	Number of Judicial Antecedents					
	1	2-4	5-9	10+	NS	Total
Homeless	2	4	1	9	6	22
Refuge	1	1	0	0	3	5
Supervised Apartment	0	1	1	2	6	10
Independent Living	6	9	2	7	34	57
Hospital	0	2	0	1	2	5
Other	1	0	0	0	0	1
Total	10	16	4	19	51	100

Table 7: Residential Status and Criminal Charges

	Homeless	Refuge	Supervised Apartment	Independent Living	Hospital	Other	Total
Mischief	4	0	2	7	0	0	13
Theft	3	0	1	7	2	0	13
Harassment	1	0	1	8	0	0	10
Assault	8	4	4	24	1	0	41
Infraction	1	1	0	6	0	0	8
Breach	4	0	1	6	0	1	12
Threats	4	1	5	17	1	0	28

The next table demonstrates the accused's residential situation and contrasts it to their current and past mental health treatments and histories, as well as comorbidities.

Table 8: Residential Status and Past Mental Health Treatments, Histories and Comorbidities

	Current Medication	Clinical Services	Addiction problem	Previous Hospitalization
Residential Status	Yes			
Homeless	17	18	14	17
Refuge	2	3	3	2
Supervised Apartment	5	10	5	6

Independent Living	37	52	24	26
Hospital	4	5	2	3
Other	1	1	0	1
Total	66	89	48	55

This next table is particularly interesting because it shows the psychiatric diagnosis given and the accused's residential status. As we can see, schizophrenia and personality disorders appear to be the most prevalent within the homelessness category.

Table 9: Residential Status and Psychiatric Diagnoses

	Homeless	Refuge	Supervised Apartment	Independent Living	Hospital	Other	Total
Schizophrenia	6	1	5	19	2	1	34
Personality Disorder	6	2	2	7	1	0	18
Mood Disorder	5	2	2	22	1	0	32
Intellectual Deficiency	1	0	1	3	0	0	5
Chemically-induced Psychosis	2	1	0	1	0	0	4
Anxiety Disorder	0	0	2	3	1	0	6

The next section will highlight the qualitative results from interviews with participants and key informants.

6. Qualitative Results

Three broad categories of qualitative results can be grouped into: participants' experiences of the MHC, professionals' perceptions of their work (negotiation and collaboration), their roles (underscored by their notions of justice) and of the accused; and observations of team culture and proceedings.

6.1 Participants

Twenty participants were interviewed (5 women and 15 men) regarding their perceptions and experiences of the MHC. The participants were aged between 19 and 53 years old (half were between 20 and 35 years old). Their level of education varied between primary school and college. More than half were on social assistance and were unemployed. All but two stated that they had been given a psychiatric diagnosis ranging from schizophrenia to Tourette's syndrome (personality disorders, depression, Asperger's, ADD), with psychotic disorders being the most frequently named. Half of the participants had judicial antecedents, but most preferred to not name them. The most common criminal charge named was assault, but others included robbery, misdemeanors, and uttering threats. A quarter of participants indicated that they were under the influence of drugs or alcohol at the time of arrest. For six of the twenty participants, their charges were eventually withdrawn. Only two participants knew of the MHC prior to their arrest.

6.1.1 Experiences of Housing

Three of the participants indicated that they had experienced absolute homelessness during their involvement in the MHC. It was difficult to determine whether the MHC had an impact on their homelessness status as their accounts were not always chronological, nor causal. Three additional participants also stated that they had experienced residential instability but did not identify these periods as necessarily ones of homelessness. However, there was certainly a residential transiency evident in their responses. We have included some responses from respondents below to elucidate that residential instability was a common feature among this population, even if they did not necessarily identify it as such.

Sometimes I return to my apartment to sleep.

I was without an apartment for over a year.

I don't have my own apartment but I live with someone, but I am not on the lease, I just slip them the money every month when it is due.

I was living in a rooming house for a couple of months but I am waiting to get into a subsidized apartment with an organization.

I have only had housing since July.

I was homeless for ten years.

I was staying in transitional housing. I was only supposed to be there for 3 months but I ended up staying for two years.

So I went from living in X 3 years ago, to living at the Old Brewery Mission (shelter) for homeless people to l'Abri en ville.

I live in X with my mother and sister. I have lived there since I was born.

I was living in a rooming house but I ended up moving 8-10 times because I was using drugs and the music was too loud. Eventually I returned to living with my father.

I stay at the Men's shelter.

I have lived there for 6 months, that's good right? Demonstrates a certain stability?

I moved 16 times. After that, I was in a youth detention centre for a year and a half. Once released, I moved from apartment to apartment.

When I went off the rails in 2008, I found it really hard. I wound up homeless. I wound up in the streets because of a court decision. I owed $96 for a food allowance I never paid back, I never took care of.

The purpose of this snapshot of responses with regards to housing status is to demonstrate the transiency of their housing situations. A large majority of respondents demonstrated that their housing situation was precarious and that they moved frequently. It was difficult to ascertain however, whether MHC interventions had an effect on their housing status as events and experiences were not relayed in a chronological or causal manner. The effect of the MHC on homelessness (or more aptly perhaps the lack thereof), will be fleshed out further in the following chapter.

6.1.2 Perceptions of the MHC

On average, most participants had been involved with the MHC for a year. Some participants revealed that they agreed to participate in the MHC to avoid prison or to avoid greater legal consequences. Several noted that the MHC was more human, less formal than the regular court system, that they felt listened to and that it helped them. Many revealed that coming to the court evoked a lot of anxiety, that they found it to be very stressful, and that they did not always understand what was happening. The lengthy waits to appear and the constant reporting to a future date were seen as difficult to abide by, even in the MHC. One female participant explained that she preferred the MHC because she felt taken care of and that this experience was somewhat responsible for getting "off the streets". She stated:

For me the MHC is a good thing because I am done with being homeless, done with committing crimes and winding up at the court. I feel like things have finished well. This is a new beginning and that is a good thing.

6.1.3 Effects on Social Connectivity

In this section we asked participants if their social lives were affected by their involvement with the MHC. Two participants stated that they developed new relationships because of their participation in the MHC. Three respondents indicated that they had developed new relationships but it was difficult to decipher whether this was attributable to the MHC or not. Below are some excerpts of their responses to this exploration.

I changed all my friends, even my life style since entering the program.

Yes, I changed everything. I have new friends, a new lifestyle so I could become better, become a better citizen.

Yes, I have new friends now that I am at Maison Ste-Claire (residence).

My two roommates we have a good relationship. My job I made new friends. On the job, the boss, my boss likes me a lot. Her name is E and anything I want she does for me. Any time I need time off, she gives me. And when I'm working, when we work together she depends on me for a lot of things. She made me very important there.

This participant is referring to new relationships he has made because of his new housing situation in an apartment in a social housing unit. In his case, it was unclear whether this was because of MHC involvement or not, because he could not recall if he was already involved in the MHC before being housed, or if it was after.

Yes, I have made some new friends now that I attend groups.
In this participant's case it was unclear whether the group attendance was part of his conditions of involvement in the MHC or if he had already been attending before entering the MHC.

Yes I have made some new friends in the program, "jeunes en action". There are some people that are further along in their lives than me and others who have not come as far. Some are good influences and others are not.
Again in this participant's case it was unclear whether group attendance was directly related to the MHC or not, but we can probably assume that it was a recommendation of the court.

Yes and no. There's this guy that I met in jail. And he wasn't a really good guy. I thought he was a good guy and everything but he just took advantage of me. And I met him. Talking about a newer relation, I met him in jail. His name was X and he wasn't a great guy at all. But that's it, that's who I met.

There was a quite a diversity in participants responses to our question of whether the MHC had an impact on their social lives or not, and if so, how. In fact, the chronological aspect of this question was difficult for participants to answer and their answers were rather truncated. Thus, it is difficult to ascertain whether the MHC has an effect on social inclusion or not, and if so, in what sense. We now turn our attention to participants' perceptions of team members.

6.2 Perceptions and Understanding of Roles of Multidisciplinary Team Members

6.2.1 Case Workers

Participants viewed case workers as helpful, eager to listen, and encouraging. They also felt that case workers provided important information, such as decoding court proceedings and decorum. Some participants mentioned they felt no extra benefit or disadvantage to meeting with case workers. Participants mentioned that they had to meet with case workers prior to their court appearances and that the case workers verified information or steps taken by the accused in the community with regard to following up with treatment, resources, etc…When the court obligated the accused to follow certain steps, for example, engage in treatment at an addictions rehabilitation centre (e.g. Dollard Cormier), some participants mentioned that they had to have written proof of their visits and show this to the court or the case workers.

Participants described the case worker as follows.

Well, like as I said X take the time to listen (...) But with the X, it's good, she's paying attention when I'm talking to her. She's paying very attention, she not distracted or anything.

Yes, she's very nice, professional, everything. She took me under her wing she made me believe everything was going to be alright. You know one thing I can say about her she never seen me as a criminal. She just saw me as a guy that made mistakes and the state of my being two or three years ago doesn't necessarily tell the whole story because three or four years ago I was a different person. She treated my case like that, which means to never come back to the court.

I feel she's a good person to talk to. If I'm struggling in an area I can discuss with her and she can talk with the right people to try to get me the help that I need.

6.2.2 Lawyers

Many participants felt that there meetings with lawyers were too rapid and that they did not communicate with them sufficiently. Some mentioned that their lawyers were very directive telling them what to say in front of the judge or how to plead.

He's pretty good. Initially he wasn't. I really did not like him at first. This is just the first meeting in the court house, he wasn't fully understanding what I was saying in the sense that I wanted to be transferred to a hospital and not go to jail. I was feeling very suicidal and extremely depressed. So he wasn't fully on board with that, but then I spoke to the doctor at the court and then I spoke to a criminologist and they both agreed that hospital was a place for me so they spoke to him and together and spoke to the judge and we were able to get that arrangement. But now, since that day, he's been very good.

6.2.3 Judges

Some participants felt that the judge was purely procedural, telling them to respect their conditions, indicating the next court appearance. Sometimes participants were congratulated by the judge for the progress that had been made or for the steps that they had taken. Some participants mentioned that they did not remember anything particular about the judge, or that it was their lawyer, their case worker or the crown prosecutor that spoke with the judge. Participants did not mention anything negative about the judge.

One participant stated:

The judge said we are so pleased with your transformation we hope to never see you back here at court. And she said the only person you have to thank for that is yourself. No matter how much your family or your social worker did, you made the transformation. I made it.

6.2.4 Crown Prosecutors

Some participants were unsure who the crown prosecutor was. Some explained that they did not speak to them or spoke to them extremely rarely. Some participants indicated that the crown prosecutor congratulated them on their progress and had nothing but positive things to say. One participant stated: *The crown prosecutor had nothing but good things to say about me.*

6.2.5 Police Officers

One participant mentioned that when police officers intervene with a person who is exhibiting major mental health symptoms that they should immediately be hospitalized. Opinions were clearly divided on police interventions. One group felt that police officers were kind and understanding, while the other group was clearly more critical stating the police officers had been rough with them and had misunderstood the nature of events, resulting in faulty accusations.

6.2.6 Perceptions of Mental Health Problems

When participants were asked about prejudice and stigma faced by people with mental health problems, many spoke of their personal experience of living with mental illness. A recurrent topic was the lack of control over illness, its unpredictability and the attenuating difficulties. Some participants made distinctions about the vast nature of related problems and indicated that they were less affected by the illness than other people they knew. Societal prejudice was summed up by all participants as the lack of understanding about mental health problems and the associated (and unfounded) fear.

6.3 Key Informants

From the moment that you just take the time to listen and you allow the person to speak, often the accused have a lot of things to tell us, not necessarily legally pertinent, actually rarely relevant to the court procedures, but it is part and parcel of what the accused is experiencing in that moment of time, what concerns them. I know offenders feel listened to and understood. That finally they have someone who will take the time to just listen. I do not know the number of times when we have reached the end of MHC's involvement that the accused turns to the judge and

says: "thank you your honour, I feel like it's the first time that a judge listened to me". And I am talking here about offenders who have already been in conflict with the law several times. (Crown Prosecutor)

We interviewed eleven (11) key actors of the multidisciplinary team to understand their perceptions and experiences of the MHC and its participants. Interviews took place with: a doctor, judges, crown prosecutors, defence lawyers, case workers, probation officer, and a criminologist. The table below describes the roles of each of the key actor's functions, and their relationship to the accused.

ROLES

Case Worker	Defence Lawyer	Crown Prosecutor	Judge	Criminologist	Probation Officer Liaison	Doctor
Makes recommendations to the team. Communicates with treating teams when possible. Explains and demystifies the court proceedings to the accused. Accompanies the person in their proceedings at the court.	Defends the interests of the accused and counsels them.	Defends the victim, negotiates sentencing. Bears in mind public safety and security and justice for victim(s).	Assures that the criminal code is respected during court proceedings. Emits the conditions and sentencing.	Explores the accused's trajectory in relation to judicial antecedents. Evaluates their dangerousness and next steps (detention) in the short term.	Coordinates with probation officers to assure follow ups are carried out and conditions are respected.	Evaluates aptitude. Emits a provisionary diagnosis and notes symptomatology, mental health status.
Connection to Accused						
Meets with the person before court appearances and accompanies them through court proceedings. Permits them to express their point of view, distress, anxiety.	Explains the MHC program to the participant and assures that the accused understands the conditions and their consequences put forth by the court.	Is not allowed to and has no contact with the accused except at court appearances.	Speaks to the accused during court appearances and it depends on the nature and personality of the judge how much interaction and what kind of interaction will take place.	Interacts with the accused to garner information and to understand their perception to gauge criminal risk.	Coordinates and liaises with the probation officers to report back to the MHC team about the person's progress.	Attempts to develop a therapeutic alliance to evaluate mental health status and whether the person is apt to participate in a judicial process.

6.3.1 Relationships Between Multidisciplinary Team members

Globally, the members of the team relate to one another well and describe their teamwork in a positive manner. Some team members indicated that having multi-professional backgrounds created different points of view which enriched their work by stimulating discussion and problem-solving, with the focus being on how best to help the accused balanced against the need for retribution when victims were involved.

Respect for one another's profession was held in high regard and the lack of knowledge experienced in one domain by a team member (i.e. law or psychiatry) was viewed as complementary by another. For instance, prosecutors in general were very appreciative of the case worker's expertise in mental health and community partners (health, social services, lodging) and the amount of time they needed to coordinate plans of care, frequently referring to them as the "heart" of the MHC. While the case workers were equally appreciative of the limits of their legal knowledge and recognized that their work was constrained by certain parameters (i.e. the criminal code) for which the lawyers and prosecutors would explain and uphold in decision-making.

6.3.2 Perceptions of the Integration into the MHC

To be eligible for the MHC, accused have to voluntarily agree to participate in the program, demonstrate that they have a mental health problem, and are accused of committing a minor criminal act(s). Offenders have to give consent by signing an agreement for their information to be shared with their treating health team (if one exists) and need to be apt to participate. More specifically, the accused have to participate in the therapeutic and treatment plans emitted by the court. If the substantial problem is one of addiction the person is not allowed to participate in the MHC and is returned to the regular criminal court.

6.3.3 Perceptions of the Objectives of the MHC

The team indicated that the MHC had three major objectives, delineated by juridical, therapeutic and individual goals.

Firstly, in the judicial stream, it was felt that the MHC filled the therapeutic jurisprudence mandate by attempting to stop the revolving door syndrome of repeat offenders, that it promoted dejudiciarization - that is a decriminalization of the mentally ill, reduced recidivism and time served (including punitive elements such as detention), and assisted the person in their path through the judiciary system through the deployment of humanitarian and compassionate responses.

Therapeutically, objectives to reduce the person's stress and anxiety due to court involvement and offer a general humanitarian approach were emphasized. Specifically, listening to the person to reduce their suffering, accompany them through the judicial process and liaise with their treating team in a harm reduction or risk reduction approach were mentioned. For example, case workers mentioned that they "translated the legal jargon for offenders, so they can better understand what is happening". Another case worker stated that the MHC experience was "not to unnecessarily judiciarize people, but instead we can use this therapeutic lever to help the person to access resources so that they can have a better quality of life, take better care of themselves."

Lastly, another element considered an objective of the MHC by team members were the tailor-made responses in response to individual experiences and challenges. Appropriating a case by case approach to individual circumstances and experiences again underscores the emphasis on humanizing judicial processes. This was understood as respecting the person's rhythm, taking into consideration the person's efforts, and helping the accused conform with legal and societal expectations by ensuring they understood the consequences of conditions emitted by the court. A probation officer stated:

> *you take the person where they are, as they are, and you try to help them along, take them further than where they are able to get on their own. But you also try to responsibilize them for what has happened and in particular take stock of their mental health problems. In this way, we try to break the cycle of offending. By becoming more aware of their mental illness and the impact it has on their behaviour, we hope to stop the cycle.*

Other advantages of the MHC included assisting the accused with housing, giving more lenient sentences in response to the context, avoiding criminalization, and sometimes assisting the accused in taking stock of their mental health problems. This last point was evoked most particularly in relation to participant's willingness to follow their medication regime and keep appointments with their treating teams, very much tied to notions of success of the MHC.

However, not all team members were convinced of the perceived benefits of MHC involvement. There was much ambivalence with regards to if the MHC responded to participant needs. Some admitted that in fact it was not the place for the MHC to respond to all of the complex needs of participants.

6.3.4 Perceptions of the Advantages of the MHC

The advantages of the MHC, according to team members, were very much tied to the objectives noted above. Most agreed that the accused had more timely access to housing, received a more lenient sentence, avoided further criminalization and were accompanied through the judicial processes. Further, most stated that once the accused became aware and accepted their mental health problem and the importance of adhering to their medication regime, that this increased the offender's benefits of MHC participation.

6.3.5 Perceptions of the Accused

Team members explained that the accused represented a plethora of complex and diverse problematics.

One of the principal recurrent preoccupations that team members viewed as an obstacle was that many participants did not accept that they had an illness. Thus, difficulties related to motivation, to mobilize resources, and to follow suggested steps for recovery, were seen as very challenging for the accused to accomplish. Adding complexity, offenders with concurrent disorders, those with a mental health and an addiction problem were seen as especially difficult to work with and had less success in the MHC.

Relational difficulties with one's family or loved ones were also highlighted as obstacles to success. Issues related to unemployment, precarious housing, stigma, isolation and social exclusion, and the lack of social services resources were highlighted as posing serious obstacles. Rising levels of anxiety related to detention and lengthy wait procedures were also mentioned. In sum, these issues are experienced individually and differentially by the various actors and team members reiterated that it was essential that the accused are provided with services equal to their needs.

Procedurally, difficulties related to court functions were described as unfavourable to therapeutic jurisprudence goals. Working within the constricted confines of judicial limits meant that team members felt restricted by the options they could provide to the accused, leaving them frequently feeling powerless. Working with other professionals outside of the team was frequently strained and did not always give the desired effect, but was viewed as necessary as the MHC's operation. In effect, it was viewed as necessary to create a working relationship with community partners, but that this alliance was often difficult to build because of differing and competing interests. For example, some crimes were committed within the walls of hospitals where the accused were already institutionalized, but these partners often wanted the accused to be 'responsibilized' for their actions through criminal sanctions and pursued legal action. However, MHC involvement did not always give the desired result to these milieus (e.g. detention).

Despite all of these challenges, the judiciarization of the accused remained the central preoccupation. While some team members were critical of the justice system interventions when mental illness was the predominating factor, others maintained that there were consequences for certain behaviours, thus, evoking that some behaviours needed to be punished regardless of the person's situation and condition(s). There existed a tension between a more humanizing approach to the desired repercussions, and a more cut and dry approach to consequences, that is, the punishment should fit the crime regardless of mental health problems.

6.3.6 Perceptions of the notions of success

In general, notions of success were relative to the person's situation and were evaluated on a case by case basis. Thus, cases were understood within contexts of subjectivity. However, the accused's level of motivation was a clear indicator of success, and many felt that the individual themselves were responsible for their own successes or failures. This was particularly so in relation to their adherence to taking medication, to following the advice of their treating team, to reducing their substance dependence, and most frequently by the accused's insight and acceptance of their illness. In effect, there was no formal model or criteria of evaluation with regard to the person's progress, and this was viewed in a very subjective light.

6.3.7 Police Intervention and Impact on Resources

Team members did not understand well the impact of the MHC's work on other systems, such as the health system. In effect, not all team members described the impact on services except for the importance of the treating team and the subsequent information exchanges about the person's trajectory. This bridging allowed for more efficient interventions and the obtaining of a more global picture of the person's situation. Some team members mentioned that the accused were able to obtain services more rapidly and this was rationalized because of the "urgent nature" of their problems.

The impact of the MHC on police interventions was not elaborated upon. One member mentioned that the police should be more sensitive and understanding of the accused situation and needs. Frequently, throughout the research we wondered why some cases were judiciarized and not referred directly to mental health resources, especially when there is the existence of the Urgence psychosociale-justice (UPS-J) team in Montréal but they did not seem to be called upon. Many cases seemed to indicate that a UPS-J intervention would have been more beneficial to the accused than a criminal justice intervention, however, UPS-J was strikingly absent in interventions.

6.4 MHC Procedures

6.4.1 Presenting the MHC, Consent, Facilitating Factors

In the majority of cases, the defence lawyer was responsible for presenting the MHC program to accused. Frequently, the case workers were also present at this time to explain their role to the accused and build rapport. From the outset, the case workers attempt to establish trust with the person and work in collaboration with the accused to facilitate the work and cooperation. Team members stressed the importance of repeating the benefits of participation in the MHC to the accused, without placing too much emphasis on reduced sentences, to ensure an informed and willing consent to participation. Due to the MHC's rising success, it has become easier for the case workers to enter into contact with the accused's treating team (if applicable) because the tribunal's work is more well-known. Case workers mentioned that the accused is free to consent and decline certain aspects of implication in the MHC, such as recommended treatments (by treating teams). However, it is difficult to understand this statement when one considers that the court recommends certain courses of action that will only serve to diminish sanctions and demonstrate that the accused is acting in good faith. It is less obvious how these types of negotiation occur and what impact they have on the accused's voluntary participation. From our observations, it appears that informed consent, in terms of presenting the risks and disadvantages of participation are not always enunciated, and that the promotion of reduced sanctions, in particular, the carrot of withdrawal of charges adds to the allure of participation.

After presenting the program to the accused, the case workers allow the person time to reflect and discuss with their lawyer before consenting to participate. Case workers mentioned that it was difficult after the first meeting to garner whether the accused understood the parameters and consequences of participation. That is why participation is often reiterated and explained again to the accused. Team members also expressed facilitating factors that enhanced the accused understanding of the MHC, such as case

workers meeting with the accused before appearances to explain court room proceedings and this seemed to diminish the person's anxiety.

As for the conditions emitted by the court, the principal responsibilities are those of the defence lawyer to explain to their client the conditions and repercussions to ensure the accused have understood the results of court proceedings. The accused is invited to phone their lawyer if there are any doubts or clarifications needed. The accused is also invited to consult their conditions sheet that they signed to ensure they understand the consequences and in some cases it is suggested that they also discuss these conditions with their treating team.

In sum, team members indicated that it was in everyone's best interest that the accused understood and respected their conditions. However, some mentioned that other measures were necessary to ensure that the accused truly understood and respected the conditions. As we frequently observed in the courtroom, some judicial actors (judges, crown prosecutors and defence lawyers) will question the accused directly during court appearances to ensure they understood the directives of their conditions. There is no formal way at this point in time to ensure the accused understands their conditions and the consequences of non-respect, which ultimately for some leads to a return to the MHC for breaking their conditions (breach).

6.4.2 Procedural challenges

The major challenge according to team members with regards to the MHC's functioning is that it is essentially an anxiety-provoking experience. Further, the consequences emitted in the context of certain conditions are difficult (not to consume substances, geographical restrictions, etc…) at times to understand, and to respect. Notwithstanding these constraints, the comprehension of court room procedures and decorum for the accused remain formidable obstacles. The formalities inherent in court proceedings represent a barrier to the accused, in a sense, as they can be difficult to make sense of, to understand, particularly for those who are struggling with mental health problems. The formalities and decorum related to a certain kind of exclusionary language and processes, coupled with the lengthy wait times to appear are seen as especially challenging for this group (and as underscored in interviews with participants). In particular, we noted that the constant reporting of cases to give sufficient time for the person's mental and social situation to stabilize meant that their follow-ups in court may occur over a lengthy period of time before the sentence is delivered.

Other points included that some defence lawyers urged the accused to plead guilty so that their cases could be expedited more quickly to the financial benefit of the lawyer, without taking into consideration the consequences of a guilty plea for the individual. Other challenges including the lengthy following that obliged the accuse to appear frequently at the court which was costly and cumbersome to the person (lawyer fees, frequent trips added transportation costs to their frequently meager social assistance incomes..). Some team members expressed their skepticism of some lawyers not taking the necessary time to explain the MHC program and to offer the accused a proper and informed defence.

6.4.3 Indicators of Improvements or Relapses

According to team members, the reliance on information from the treating team was the most trustworthy indicator of the accused's amelioration or relapse. More specifically, if the accused presented inappropriate behaviours, lacked insight, re-offended, or if symptoms ballooned, all of these findings indicated that the accused was faring worse. A defence lawyer stated: *the experts that help guide us and the accused's treatment, as well the consulting doctor, tell us that the person is faring better or that their medication is adjusted; we see it, we observe it, we feel the difference.*

Some team members emphasized the importance of taking into consideration the person's well-being in a holistic sense, and not evaluating their situation based on one indicator. Most team members embraced a harm reduction approach to intervention with the accused. Once the accused exhibited signs of recovery, this was seen as a sign of improving health and acceptance of a mental health problem (insight) which were indicators of success.

6.5 Notions of Justice

6.5.1. Perceptions of the Justice System and the Criminal Code

Team members related that the justice system is too rigid and fast-paced, and that relationships between the accused and lawyers are hallmarked by aloofness - are cold and sterile. In this sense, the MHC attempted to compensate for a milieu where lawyers are typically not acculturated to taking their time with clients, listening to the accused's concerns and explaining judicial processes, and their rights. The criminal code, procedural justice and the decorum engender a certain rigidity in the interactions with the accused.

The regular criminal court system, in contrast to the MHC, does not adapt well to individual difficulties and emits sentences more quickly as the accused personal circumstances and efforts are not taken into consideration. Moreover, for the accused, for whom anxiety represents a major challenge, no tools are put in place to accompany them through regular criminal court processes as opposed to the MHC. Specifically, there are no team meetings in regular criminal court to guide decision-making. According to team members, conditions emitted by the regular criminal court are more complicated and difficult for the accused to abide by. However, there are similarities between the two streams of courts. For example, according to case workers, whether or not the accused find themselves in the regular criminal system or the MHC, the challenges in relation to keeping their employment or their housing remain the same. In both situations the accused experiences a significant amount of frustration and discontent with the challenges they are facing, and the restrictions imposed by their involvement in the justice system. Team members felt that the criminal code was a very rigid and consequentialist tool. Essentially, members felt that it was used to denounce certain undesired behaviours and protect the security and safety of the population. One case worker stated: *but behind the criminal code lies a person. And to watch someone deteriorate to that point, it is not humane. And that is really a big debate that I have often with the lawyers.*

6.5.2 Perceptions of Access to Justice System and its Evolution

The majority of team members described problems with access to legal aid lawyers and subsequently the high cost of hiring a private defender. Accessibility was underscored as an important ingredient of a democratic system, and in particular the importance of democratizing the justice system. In other words, the members emphasized the importance of educating the general population about legal knowledge so that the justice system was better understood, in particular, useful if one came into conflict with the law. Team members reflected on the justice system and felt that ameliorations were needed, not reforms per se, but making procedures less rigid, intervening more, adapting sentences and conditions, decriminalizing processes and diminishing administrative burdens.

6.5.3 Perceptions of Mental Health Issues

The major issues concerning mental health according to team members are stigma, prejudice, and the lack of insight. For example, issues related to the non-adherence of medication regimes and the lack of insight regarding the accused mental health problems were seen as critical challenges to the participant's success. The lack of adapted mental health resources, the lengthy and often fluctuating and unclear diagnoses, the lack of information available from treating teams and the financial difficulties and overwhelming precariousness offenders faced were highlighted as major obstacles.

6.5.4 Perceptions of Mental Health and Justice Issues

The central issues highlighted by team actors made reference to the lack of psychiatric resources, or their inflexibility, the impact of the treating team, and the central and overriding importance of adhering to psychiatric treatment namely, medication regimes. In particular, team members highlighted their dissatisfaction with the lack of mental health resources, and a lack of bridging and communication with treating teams. Most team actors had a critical outlook on these weaknesses and felt that the accused were doubly stigmatized because of their criminal acts and that this enhanced a view of them as violent and dangerous. They advocated for a more holistic approach viewing the person behind the criminal offence.

7. Are Mental Health Courts a Promising Practice?

Exploring how MHCs function, their effects and whether they are a promising practice to meet the needs of the mentally ill and homeless, is no easy feat. Our study found that the prudent approach to this question is to address it in four dimensions that are encapsulated by four contexts: homelessness, multidisciplinary practices and resources, entry into the criminal justice system, and finally, exit from the MHC.

7.1 Context of Homelessness

One of the defining characteristics of homelessness is its variability. The diversity of the population and the variance in its application means that much confusion surrounds its definition; it is a polysemic term. This means that the character of homelessness is complex, varied and often temporal. As researchers with a keen interest in homelessness, we embrace a large definition of homelessness (at-risk, precariously housed, etc...) and this dovetails with Gaetz, Donaldson, Richter and Gulliver (2013) who make the point that the homeless are not a monolithic group. Homeless experiences are not linear, nor uniform, and they underscore the fluid nature of homelessness; that people cycle in and out of different types of homeless categories (Gaetz et al., 2013). The one common binding feature is the lack of secure and safe housing, and that homelessness reflects "an intricate interplay between structural factors (poverty, lack of affordable housing), systems failures (people being discharged from mental health facilities, corrections or child protection services into homelessness) and individual circumstances (family conflict and violence, mental health and addictions)" (Gaetz et al., 2013: 3). We make this point because it is essential to understand why homelessness appears to be infrequently considered in the MHCs work either by the team or even by the lack of identification by participants who frequently experience homelessness themselves. In essence, the richness of context juxtaposed the rapid and rigid pace of the court, does not allow for the context of the accused's life to predominate in the team's work. The court tends to be focussed on a delicate balance of public safety/retribution for the victim(s) versus the mental status of the individual and diminishing the risk of recidivism. This leaves little room for the consideration of the complex lives of individuals, the fluid nature of homelessness, and the unveiling of the accused's often overwhelming and untreated needs, including housing needs, to be addressed.

In general, during team meetings, little discussion of homeless status tended to occur. In a few instances, it was noted that the accused appeared to commit crimes as a temporary but immediate response to their homeless situation. For example, one clearly psychotic offender who had just arrived from Saskatoon broke a window of a car so he could sleep inside the car for the night as he had just arrived in Montreal and was disoriented and unaware of available services and shelters. This example also reflects what psychiatry refers to as the disorganized thought and deficient executive functioning processes (lack

of problem-solving ability); cognitive abilities that are hampered by major mental illness. However, despite these instances, the team rarely discussed the offender's housing needs but tended to focus their energies on the criminal act, the mental health status of the individual and the risk of recidivism or danger to public safety. In essence, the primary focus of intervention was maintaining a balance between the public safety/justice for the victim agenda vs. the mental health needs of the individual. Case workers naturally were more sensitive to housing needs and the social conditions of the accused but due to time and resource constraints had difficulty intervening in this domain.

That being said, on occasions when housing status was taken into account this tended to be during court appearances in front of the judge when release was imminent and an address had to be given. As stated previously, many addresses of a shelter or a community organization were given to satisfy the need to provide an address to the court. For example, addresses of community organizations that provide services to the homeless were frequently given, though these are not in fact residential addresses. Many makeshift residential addresses were also given, such as couch-surfing at a friend's, or an address that was really used for other purposes and was not substantially a residential one. The quality and nature of the addresses given were not evaluated and remain questionable as to their viability. At these moments, rarely was there a deeper investigation as to whether the address was an actual residence, whether the accused did indeed have access to this residence and moreover, whether it was adequate. For example, one accused mentioned he was going to live in his sewing studio; a small simple room that only had a couch and a sewing table, had no kitchen, no bathroom and was in a block of an industrial warehouse. The rapid nature of the court's work and the constraints on professional resources being what they are make it difficult to address housing needs in any feasible manner.

7.2 Context of Multidisciplinary Practices and Resources

As homelessness was not necessarily a primary focus of the team's work, in consideration of the reasons listed above, communication with other institutions such as hospitals and detention centres tended to seldom address this issue as well. Based on our observations of collaboration it appeared that housing status was discussed infrequently and minimally. In our interviews with twenty participants, it is clear that a large proportion experienced high amounts of residential instability including absolute homelessness but the court's efforts are not deployed in this direction. Social conditions such as poverty, homelessness, weak social resources, are not easily addressed nor taken into consideration, even when it appears criminal acts appear to be a direct consequence of these conditions. For instance, in many cases the accused had stolen food or articles precisely because they found themselves on the streets or in precarious housing situations.

As highlighted earlier, the MHC also suffered from a constant lack of professional resources with which to carry out its work. Over the course of the research period, three case workers left the team that is composed of two, generally-speaking, social work professionals. These "intervenants sociaux" are the professionals most likely to take into consideration social conditions, in particularly poverty, homelessness, and

social resources. With the team being in constant need of replacement it is clear that this element of focus could not easily be a priority as there were not sufficient resources to deal with the complexity of the needs and the high demands.

The case workers also highlighted in their interviews that it was often difficult to establish a working relationship with their colleagues in other institutions, notably psychiatric milieus due to conflicting interests. In many instances the accused committed a criminal act while hospitalized and the hospital staff wanted punitive measures to be brought forward. For instance, there were several examples of assaults of health care professionals and destruction of hospital property while the accused had been involuntarily admitted. In many of these instances the hospital professionals wanted an immediate punitive consequence and proceeded to have the accused charged so that they could be managed within the criminal justice system and removed from the health care system (or at least their place of work). However, the MHC team views their mission in much more of a restorative justice approach. In these kinds of examples, very little focus, if any, would be concentrated on the offender's housing status and there was much more interest in dealing with the person's dangerousness risk and finding an appropriate punishment and compromise within these competing frameworks.

7.3 Context of Entry into the Criminal Justice System

The large majority of the accused (almost 80%) enter the MHC through police referrals, a direct result of the accused's intervention with police. We believe that this outcome of police intervention represents a special form of social profiling and a turning point in terms of bringing the mentally ill, in particularly the homeless mentally ill into the criminal justice system. In the context of the homeless mentally ill accused, 30% of the files emanate from charges laid by a police officer. In fact, the research team heard of cases in which the defendant asked the police to take them directly to the emergency because of experiencing a mental health crisis, yet the situation escalated to the point that the defendant struck the officer and was charged with assault. In several instances where a mental health problem was clearly indicated, the research team wondered why the mobile crisis unit (Urgence psychosocial-Justice (UPS-J)) was not called; because this special team was created as a collaboration between police and the mental health team from CSSS Jeanne-Mance (from where the MHC case workers are deployed) to deal with these kinds of crises. This supports our next line of inquiry with regards to entry into the MHC.

Police reports also frequently noted that the police officer suspected there was a mental health problem and commonly requested the accused undergo a psychiatric evaluation. This is interesting because despite the lack of interaction with UPS-J (mobile crisis team), there is a recognition that mental illness is potentially at play. This is not only the fault of the police per se, but perhaps because emergency health systems are perceived as overburdened, under-resourced and judiciarization may appear on the surface to be the only viable lever to access scarce psychiatric resources. This investigation is necessarily under-explored for our purposes but is an important line of inquiry that deserves more attention and exploration than we can provide here.

7.4 Context of Exit from the MHC

In conducting our file review, we found that in 27 % of cases, the charges are withdrawn or dropped and a large portion are also given a NCR status, resulting in a figure of 52 % of files that are not criminalized or that are attributed to the Québec Review Board (TAQ). When we consider this result and how the accused enter the system, most frequently through police interventions, it begs the question of whether the MHC is an efficient use of resources.

Housing status does not appear to be a central preoccupation of the team's work and this is evident in their collaboration, court appearances and even in court files and the conditions of release. In fact, as noted previously, frequently the accused are 'discharged' from the MHC to a shelter but in fact there is no way of knowing that the accused will be able to access a bed at this stated address or whether the addresses given are viable and adequate. There appears to be a much greater emphasis on the individual's psychiatric obligations (taking medication, follow-up with treating team) and their obligations to 'keep the peace and be on good behaviour', namely to diminish recidivism. It seems that the MHC is not set up to deal with the 'bigger picture' of the offender's life, namely their social conditions and housing situations as sufficient resources and focus do not appear to be deployed in this direction.

In sum, it is difficult to take a position either supporting MHCs as a promising practice to prevent or reduce homelessness, or a position against, as there were some examples of successes where the accused's quality of life improved as a direct result of their involvement. Certainly, there appears to be a need for some important work to be done at the level of sensitizing police officers to mental illness and improving intervention skills, and recent events can attest to this phenomenon (e.g. several homeless mentally ill killed by Montréal police over the past couple of years). Moreover, as the case workers are constantly over-burdened with work yet under-resourced in terms of human resources there is a maximum to what they can do, and certainly more complex needs that require sustained attention are not conducive to a rigid and fast-paced environment that tends to be rather singularly focussed in its work. There is perhaps a limit to what the justice system can do with regards to the social needs of the accused. It remains to be seen whether a stable and reinforced team could better respond to complex needs, and further whether it is the place of a MHC to respond to social needs in this way or whether enhanced mental health resources and social housing are more apt responses.

Conclusion

To date the biggest limitation of research on MHCs, and subsequently this project's major contribution, is to provide a platform for participants and actors experiences of the tribunal to be uncovered. Curiously, tribunals and problem-solving courts in general, continue to grow without evidence of efficacy or impact. Longitudinal and mixed-method studies are all but absent, thus rendering findings scattered, incomplete and ambivalent. There is no systematic data analysis related to users of the PAJ-SM MHC and it is one of the resounding resolutions that such an endeavour needs to be undertaken (Provost, 2011). Without some overarching analysis of the data it is difficult to draw conclusions about the tribunal's efficacy and operation (Crocker, 2009; Provost, 2011), and certainly the experiences of its main beneficiaries and for whom the services have been established remain starkly unexplored (Frappier et al., 2009). This study aimed to begin to fill these gaps.

Major outcomes of this study include but are not limited to: enriching the knowledge base of MHCs, understanding how they function, what they do and what kind of effect they have particularly on reducing and preventing homelessness; and uncovering the experiences of users and key actors involved in their operation. Indeed, one of the surprising findings of this project is the preponderance of homeless people who are caught up in the tribunal but who are consistently under-represented in concerns or the focussed energies of the team. For instance, team members consistently did not recognize that many accused are homeless and did not see this as a central preoccupation of the court's work, however, our study found that over a quarter of the accused were in fact homeless. Moreover, these homeless accused tend to have more complex needs with heavier mental health and judicial pasts but again this is not taken into consideration in the team's reflections or actively taken up in their work except for on a case by case basis. This project supports the need for more services to be put in place in the MHC to assist with their complex needs and recognizes that a significant number of the accused find themselves in these precarious social and living conditions. In particular, there was a consistent issue regarding the under-resourcing of case workers (3 case workers left during the time we were present), who are the professionals that typically take charge of this group's complex needs. In particular, more case workers are needed to effectively assist this population in finding and maintaining housing and accompany them through the burdensome judiciary system. The homeless accused appeared to float between different services that case workers and treating teams put in place, but few of these accused actually experienced success and stability. One of the hoped for results is that this exposure will allow for effective solutions to unfold to better address the needs of people with mental health problems who find themselves in conflict with the law and struggle with homelessness. By uncovering the theoretical and empirical underpinnings tribunals play in responding to homeless risk, these results hoped to showcase the diverse and complex ways to reduce and prevent homelessness.

At a local level, this study provoked dialogue within key sectors in the Montréal community to contribute to solution building with regards to how this population can be

best served. By taking a broad-based approach and interviewing various actors with a diversity of experiences implicated in the justice system for people with mental illness who are frequently homeless, it sensitized key actors and systems to the complexity and precariousness of this population's needs and experiences. By uncovering blockages in differing systems, discovering how court interventions can be best matched to the individual, and opening pathways to communication between various departments and organizations, the project hopes to spur recommendations that will propose solutions of how further homeless experiences can be avoided and judiciarization can be minimized.

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[i] Le Comité de Vigilance is comprised of these organizations: Action Autonomie, AQPAMM (Association québécoise des parents et amis de la personne atteinte de maladie mentale), Diogène, Projet PAL et Centre Denise Massé, RACOR en santé mentale (le Réseau Alternatif et Communautaire des Organismes en santé mentale), and some provincial organizations: AGIDD-SMQ (Associations des groupes d'intervention en défense des droits en santé mentale du Québec), RRASMQ (Regroupement des ressources alternatives en santé mentale du Québec), AQIS (Association du Québec pour l'intégration sociale).

[ii] Author's emphasis

[iii] Abramson (1972) coined the term 'criminalization' in response to the phenomenon of the deinstitutionalization of the mentally ill. "If the entry of persons exhibiting mentally disordered behavior into the mental health system of social control is impeded, community pressure will force them into the criminal justice system of social control" (Abramson, 1972: 103).

[iv] "the goals of mental health courts, then, are: 1) to break the cycle of worsening mental illness and criminal behavior that begins with the failure of the community mental health system and is accelerated by the inadequacy of treatment in prisons and jails; and 2) to provide effective treatment options instead of the usual criminal sanctions for offenders with mental illnesses" (Bernstein & Seltzer, 2003: 148).

[v] increased recourse to court intervention, resulting in increased rates of court use (Campbell, Springate, Trocmé: 2008)