Public Safety Canada | Sécurité publique Canada

ARCHIVED - Archiving Content

ARCHIVÉE - Contenu archivé

Archived Content

Information identified as archived is provided for reference, research or recordkeeping purposes. It is not subject to the Government of Canada Web Standards and has not been altered or updated since it was archived. Please contact us to request a format other than those available.

Contenu archivé

L'information dont il est indiqué qu'elle est archivée est fournie à des fins de référence, de recherche ou de tenue de documents. Elle n'est pas assujettie aux normes Web du gouvernement du Canada et elle n'a pas été modifiée ou mise à jour depuis son archivage. Pour obtenir cette information dans un autre format, veuillez communiquer avec nous.

This document is archival in nature and is intended for those who wish to consult archival documents made available from the collection of Public Safety Canada.

Some of these documents are available in only one official language. Translation, to be provided by Public Safety Canada, is available upon request.

Le présent document a une valeur archivistique et fait partie des documents d'archives rendus disponibles par Sécurité publique Canada à ceux qui souhaitent consulter ces documents issus de sa collection.

Certains de ces documents ne sont disponibles que dans une langue officielle. Sécurité publique Canada fournira une traduction sur demande.

Canada

St. Leonard's Society of Canada
Société St-Léonard du Canada

Copyright of this document does not belong to the Crown. Proper authorization must be obtained from the author for any intended use.

Les droits d'auteur du présent document n'appartiennent pas à l'État. Toute utilisation du contenu du présent document doit être approuvée préalablement par l'auteur.

Towards an Integrated Network

Second Edition

Working Together to Avoid Criminalization of People with Mental Health Problems

prepared by
Anita Desai
with assistance from
Claire Delisle, Jackson Lewchuk and James D. Wilson
for
St. Leonard's Society of Canada

original edition prepared by Josée Tremblay for
St. Leonard's Society of Canada and Canadian Criminal Justice Association

with support from
Law Foundation of Ontario

The Law Foundation of Ontario
Building a better foundation for justice in Ontario

Towards an Integrated Network, Second Edition

Working Together to Avoid Criminalization of People with Mental Health Problems

© St. Leonard's Society of Canada, 2013

St. Leonard's Society of Canada
211 Bronson Ave., Suite 208
Ottawa, ON K1R 6H5

Registered Charitable Organization
#12894 6829 RR0001

The St. Leonard's Society of Canada wish to acknowledge the generous support of the Law Foundation of Ontario which made the production of this manual possible.

FOREWORD

As a long time deputy minister in six Ontario government ministries over 16 years working for all three major parties and for four premiers, and then as a CEO in the non-profit mental health and justice sectors for over 10 years, I have been a part of many efforts to better integrate service.

My twenty years in correctional services in Ontario was an early career lesson in how tough it is to develop integrative services that facilitate service to clients and improve opportunities for staff to develop their skills and interests with movement through the system.

Fortunately, there have been wonderful exceptions to this balkanization. Groups such as the one reporting for the second time in this document set out goals and methodologies that experts in the criminal justice field recommend. They offer examples of best practices in integration as examples and to inspire.

Whether you are a newcomer or an experienced hand, I think that you will find the reflections and recommendations in this report thought provoking and useful.

Glenn R. Thompson
MSW RSW

March 2013

ACKNOWLEDGEMENTS

Attention to the challenges affecting people with mental health illnesses in Canada has increased markedly since *Towards an Integrated Network* was published. The decision to prepare a second edition, following up on the promising practices identified in 2008, required consideration of the benefits of simply updating as opposed to researching and writing a completely new document. Much effort has been given during the last five years to creating and implementing programs and practices to avoid the criminalization of people with mental health problems and illness. This positive work merits dissemination; yet there remains much more to be achieved. The number of persons coming into conflict with the law with mental health problems and illness continues to rise. Their renewed criminalization after they have completed correctional programming remains high. SLSC hopes that, in another five years, achievements in the health and justice sectors will demand the preparation of a manual highlighting a pan-Canadian success story in the field.

The continued commitment to the issues by those who contributed to the original TAIN project has been rewarding to uncover. SLSC acknowledges gratefully the many who responded to our call to learn about their successes and challenges since 2008 and who provided guidance on the changing world of mental health and criminalization. These generous and talented people are too many to list by name, but they represent from coast to coast, justice to community to corrections to health to police to government and beyond: each bringing an expertise and generosity in sharing their advice and information.

Our advisory group, grounded in the same people who advised the original TAIN, has been an invaluable resource. In no particular order we thank Richard Brown, Crystal Dieleman, Dasa Farthing, Veronica Felizardo, Michel Gagnon, Kathy Gregory, Jamie Marshall, Diane McCarthy, and Glenn Thompson. With the excellent leadership of Anita Desai; Claire Delisle, Jackson Lewchuk, and James Wilson poured over the vast amount of material past and present and contributed to the report. The generous support of The Law Foundation of Ontario has made this project possible and SLSC sincerely appreciates its ongoing commitment to the issue.

The goal of the original TAIN was to profile elements of and a model for a community mental health strategy. Five years later, we found that several comprehensive strategies have been implemented by health and justice authorities. As these mature they provide reference points for future developments in avoiding the criminalization of people with mental health illnesses. Significant challenges remain. The aim of this second edition is to add to the toolkits of those committed to meeting the challenge. We wish them success.

Elizabeth White
Executive Director, SLSC

March 2013

TABLE OF CONTENTS

Foreword .... **iii**

Acknowledgements .... **iv**

Introduction **1**

Research Report 8

Challenges and Concerns for the Mental Health Service Delivery Network **14**

The Impact of Definitions Assigned by the Mental Health Service Delivery Network 16

Social Determinants of Health, Housing, and Homelessness 22

The Silo Effect 25

The Image of Mental Health 27

Risk Management and Comprehensive Assessments 31

Towards a Model Community Mental Health Strategy **34**

Developing a Multidisciplinary Approach to Collaboration and Partnerships 37

Communication and Information-Sharing 37

Cross-Sectoral Relations and Horizontal Initiatives 40

Program Development and Evaluations 45

Protocols and Agreements 50

Engaging People with Mental Health Problems and Illnesses 53

Providing the Individual with Information on Mental Health 54

Self-Management/Recovery-Oriented Approach 58

Voluntary Participation: Creating Trust 61

Cross-Sectoral Training and Education 64

Training 65

Education 71

Public Education and Media Relations 74

Policies Affecting the Criminalization of Persons with Mental Health Problems and Illnesses **77**

The Need for Coherence 78

Means to Enhance Coordination 79

Information sharing 82

Formal and Informal Cross-Sectorial Collaboration 84

Recovery Model/Uniformity across the Provinces 85

Towards An Integrated Network—2008 Recommendations **89**

Conclusion **90**

APPENDIX **91**

Research Report Summary (2008) 92

Works Cited **96**

INTRODUCTION

In 2006, St. Leonard's Society of Canada (SLSC) and the Canadian Criminal Justice Association (CCJA) designed a national initiative to identify the elements and means that can contribute to reducing the criminalization of individuals with mental health problems. This initiative, *Towards a Model Community Mental Health Strategy*, was an interactive community-based project that brought together service providers, researchers and academics to share experiences and knowledge about mental health programs and services.

In 2007, four fora were held in Vancouver, Calgary, Kingston and Halifax that brought together concerned experts from health, mental health, law, corrections and law enforcement. The participants met to learn, innovate, and become familiar with services in their region. During the sessions, participants also contributed to the development of a community-based approach to stimulate cohesive, integrated, knowledge-based responses that would reduce the criminalization of people with mental health problems. Participants and advisors identified a perspective of change, reduction of stigma and discrimination, development of community capacity, and promotion of a continuum of care as the core tenets underlying the necessary first steps to addressing the intersections between criminal justice and mental health. This broad-based approach, presented and explored here, must be credited to the rich dialogue and national collaboration that took place among everyone involved.

This edition of *Towards an Integrated Network* features updated information and promising practices. It also includes an updated research section as well as policy considerations which affect the criminalization of persons with mental health problems and illnesses. This section outlines some of the background issues faced by the service delivery systems, which contribute to the challenge of creating an integrated network. It is our hope that the information contained in this report will help to forge new routes towards this goal.

SLSC and the Advisory Committee hope that the information in this handbook will prove useful to individuals, communities and organizations.

GOALS

- Increase community awareness around mental health needs within the criminal justice system;
- Bring about an exchange of knowledge regarding effective interventions for people with mental health problems;
- Make available academic resources in the field of mental health and corrections;
- Promote cross-sectoral collaboration in crime prevention, with particular emphasis on engaging the voluntary and private sectors and participating in horizontal initiatives;
- Highlight jurisdictional and policy-related issues.

TARGET AUDIENCE

- Academics and researchers
- Mental health service providers
- Corrections front-line workers and managers
- Police officers and leaders
- Civic officials
- Persons with mental health problems and illnesses, and their representatives
- Members of the justice system, the health system and the social service system

DEINSTITUTIONALIZATION AND HOMELESSNESS

Beginning in the mid-nineteenth century, asylums spread rapidly throughout North America as the primary (and often times the only) form of treatment available to those living with mental health problems and illness.[1] However by the late 1970s, deinstitutionalization of mental health services was initiated with the expectation that more effective and humane care would be provided in the community. The vision was for more personal support through the efforts of local service providers and a reduction in reliance on large and impersonal institutional settings. An estimated 65,000 beds existed in 1956 in mental hospitals across Canada; by 1976 this number was just 21,000.[2] The detrimental effects of this movement have surfaced gradually over the last fifty years, generating substantive evidence of significant failures in meeting the needs of people with mental health problems and illness.

Perhaps most salient among these failures is the growing number of homeless individuals living with mental health problems and illness.[3] The discovery of psychotropic medications in the 1950s and 1960s was believed to be the solution to severe overcrowding in psychiatric institutions, but sufficient community resources did not develop as expected.[4] The Standing Senate Committee on Social Affairs, Science and Technology estimated that "somewhere between 30% and 40% of homeless people have mental health problems, and that 20-25% are living with concurrent disorders, that is, with both mental health problems and addictions."[5] The link between mental illness, homelessness, and incarceration was noted by Penny Marrett of the Canadian Mental Health Association, who in 2006 informed the Standing Senate Committee on Social Affairs, Science and Technology that prisons "... have become warehouses for the mentally ill due to funding cuts and closures in community psychiatric facilities."[6] This opinion has been echoed by many social service providers across Canada.[7]

STIGMA AND MENTAL ILLNESS

The identity of a person living with mental illness has, in recent history, been represented as directly correlated to criminal activity, rather than as a result of (or related to) one's social conditions for example, problems related to housing, employment, etc.[8] The criminalized identity that exists within the mental health service delivery network has been constructed with the use of a number of governing techniques.

---

[1] Wright, D. (1997). Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century. *Social History of Medicine,* 10 (1), 137-155.

[2] Chaimowitz, G. (2012). The Criminalization of People With Mental Illness. *The Canadian Journal of Psychiatry,* 57(2), 1-6.

[3] St. Leonard's Society of Canada has been actively involved in research in this area. For more information, see *Homes for the Hard to House: A Model for Effective Second Stage Housing* (2012). Retrieved March 2013 from: http://www.stleonards.ca/sitefiles/H2H%20MODEL%20Homes%20for%20the%20Hard%20to%20House_SLSC%202012.pdf

[4] Chaimowitz, G. (2012).

[5] Standing Senate Committee on Social Affairs, Science and Technology (2006). *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions Services in Canada*. Retrieved March 2013 from: http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/pdf/rep02may06part1-e.pdf.

[6] Marrett, P. (2005). *Sub-Standard Treatment of Mentally Ill Inmates is Criminal: Experts*. News Release. Toronto: Canadian Mental Health Association.

[7] For a recent report dealing with these issues, see MacPhail, A. & Verdun-Jones, S. (2013). *Mental Illness and the Criminal Justice System*. Vancouver: International Centre for Criminal Law Reform and Criminal Justice Policy.

[8] Fisher, W. H., Silver, E. & Wolff, N. (2006). Beyond Criminalization: Toward a criminologically informed framework for mental health policy and services research. *Administration and Policy in Mental Health and Mental Health Services Research,* 33(5), 544-557.

For example, discourses perpetuated by psy-science experts[9] have been recognized as fact rather than subjective concepts worth questioning. This stigmatization further encourages the criminalization of these individuals because, apart from the criminal justice system, there are limited options available to help those living with mental health problems and illness.

Many individuals living with mental health problems and illness who become entangled in the criminal justice system often report feeling isolated and neglected. They require a social support network which provides assistance. Yet, attorneys can face challenges with understanding mental health problems and illnesses and, in turn, may not provide their clients with services that best suit their needs. For example, the Toronto Mental Health Court Diversion Program allows for referrals to a Mental Health Court Worker (MHCW) who is responsible for developing a diversion plan to suit the needs of the client. "The cases are diverted and the charges are withdrawn. The goal is to treat the person's mental illness, to provide the support they need, and to link them to services instead of criminalizing the illness."[10] However, access to this program is only possible through referrals and must be approved by the provincial crown attorney. Stressing the importance of a more comprehensive understanding of mental health-related issues among legal representatives may reduce the number of individuals that fall between the cracks of the legal system.

Additionally, access to a client's medical information has presented challenges. Many agencies are hesitant for legal and ethical reasons to release information from their files, even though it could improve the quality of services that are subsequently offered to the individual. Divisions between direct service providers have a detrimental impact on the opportunities that are available to individuals who suffer from mental health problems. For example, a number of community-based agencies have set an exclusionary criterion for those who suffer from a mental disorder, and as a result some have gone undiagnosed or are simply neglected.

Yet the future is not so bleak: over the past 20 years negative discourses that stigmatized people living with mental health problems and illness as "lazy, free-loaders, and a burden to the system…"[11] have slowly diminished as public education has increased. A report published in 2012 by the Salvation Army found that 80 percent of the study's respondents knew a family member or friend that had mental illness or addictions, while another 80 percent agreed that mental illness causes many Canadians to experience poverty.[12] Campaigns oriented toward raising awareness, information-sharing, and listening to the voices of those affected by mental health problems and illness have sprung up across the country. At the local level, grassroots initiatives like the *Do It For Daron* campaign in Ottawa, Ontario has been effective in mobilizing community resources to encourage conversation about youth mental health in local schools.[13] Bell Canada Enterprises (BCE) Inc. has initiated the Bell *Let's Talk* project which has spread awareness at the national level, donating more than $4.8 million in 2013 to mental health initiatives across Canada. While corporate reaction or involvement that supports ending stigma has been low in this country, Bell has stepped up as leader in the corporate sector with this high-profile campaign.

In May 2006 the Senate of Canada published a report entitled *Out of the Shadows at Last*, which further documented the inadequacies present within the Canadian mental health system. This all-encompassing

---

[9] By psy-science experts, we mean those in the field of psychology, psychiatry and social work, primarily.

[10] Community Resource Connection of Toronto (May 2008). *Navigating Mental Health Services in Toronto: A Guide for Newcomer Communities*. Toronto: The Ontario Trillium Foundation.

[11] Arboleda-Flórez, J. (2005). Stigma and discrimination: An overview. *World Psychiatry, 4*(1), 8-10.

[12] The Salvation Army (2012). *Canada Speaks 2012: Mental Health, Addictions, and the Roots of Poverty*. Retrieved March 2013 from: http://salvationarmy.ca/DPresources/CanadaSpeaks2012_report.pdf.

[13] Do it for Daron. Retrieved March 2013 from: http://www.difd.com/.

report incorporated testimonials from people living with mental illness, families and caregivers of those affected, as well as an overview of the political, societal, and legal barriers to the effective treatment of mental illness. The report also made a number of recommendations, including: that community-based legal services be made available by all provinces and territories, that education about mental health be provided to students in school, and "that provincial and territorial governments work to eliminate any legislative, regulatory or program silos that inhibit their ability to deal in an appropriate fashion with the transition from adolescence to adulthood."[14]

As a result of this report in 2007, the Canadian government established the Mental Health Commission of Canada (MHCC), which at its outset had three key priorities: developing an anti-stigma campaign, ensuring knowledge exchange, and producing a national mental health strategy. The latter developed in two phases: *Toward Recovery & Well-Being* first outlined seven goals that need to be achieved for an effective transformation of Canada's mental health system. These goals encompass topics related to reducing stigma, equal access to services, and building community support for individuals living with mental illness and their families.

In 2012, MHCC published the second phase of their strategy, *Changing Directions, Changing Lives*.[15] Based on the goals introduced in the first phase, the second phase makes a number of recommendations grouped into six key "strategic directions." These directions call for a more cohesive system of mental healthcare through increased access to services, mobilization of community and government resources, promotion of mental health through campaigns and initiatives, and the incorporation of First Nations, Inuit, and Métis' voices into the fold.

The Canadian Mental Health Association (CMHA) has also endorsed the initiative for mental health reform. In March 2011, the association released results from the first phase of its three-phase research project, *Project IN4M: Integrating Needs for Mental Well-Being into Human Resource Planning*. Building on the goals outlined in MHCC's *Toward Recovery & Well-Being*, Project IN4M [pronounced "inform"] is a "… national effort to develop a needs-based human resource framework and predictive model based on current data sources and those that need to be developed in the mental wellness area."[16]

Policy Responses

In light of these federal initiatives calling for more cohesion within mental health care, a section of this report looks at the role of policy within the current mental health service structure. Federal and provincial policies play a large role in determining the kinds of services and programs available, the quality of these services, the outcomes they strive to achieve, and ultimately predict how persons with mental illness are treated in Canada.

Capacity and access are key points for analysis, as there has been growing awareness that too often vulnerable portions of the population have their first contact with mental health services through the justice system. Many people are continuing to fall through the cracks, or simply give up in frustration because of the complexity of the system.[17] The biggest challenges that mental health and addictions

---

[14] Standing Senate Committee on Social Affairs, Science and Technology (2006).

[15] Both *Toward Recovery & Well-Being* and *Changing Directions, Changing Lives* are available online at: http://www.mentalhealthcommission.ca.

[16] Canadian Mental Health Association (2011). *Project IN4M: Integrating Needs for Mental Well-Being Into Human Resource Planning. Final Report*.

[17] Select Committee on Mental Health and Addictions. (2010). *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians*.

services face are their fragmentation, their shared responsibility across several ministries, and the fact that services are offered in a wide variety of care settings.[18]

The need for a coherent system is discussed, with consideration given to whether such a system is best achieved through a centralized or decentralized provincial organizational structure. Local Health Integration Networks (LHINs) have been established in Ontario to provide regional oversight, help preserve patient choice, and enhance accountability between the provincial government, service providers, service users, and communities. However, concerns regarding the level of community engagement, their funding assessment structures, accountability, and the evaluation of services, all raise questions over the decentralized organizational structure and the remaining gaps that exist therein.

An essential underlying aspect of mental health policies are the different values from which they stem. The values behind these policies are important for at least two reasons. First, different approaches to mental health policy have an impact on the outcome that society expects services to deliver, while also affecting the forms of evaluation used to assess the quality and effectiveness of services. Secondly, different approaches change how problems within mental illness are defined, what kinds of services top the priority list for the allocation of public funds, and ultimately influence how persons who experience mental illness are treated. In this report, recovery-based approaches to mental health care policies are compared to population-based approaches. The uptake of these approaches vary widely across the provinces, and become important to assess in light of the MHCC's adoption of the recovery-based approach. A real need for public debate exists regarding the approach most capable of respecting the rights of persons with mental illness, enhance their well-being, and whether national consensus is required to ensure equitable, comprehensive, and efficient mental health and addictions services.

MENTAL HEALTH TERMINOLOGY

The complexity of identifying a suitable, non-stigmatizing term to refer to people living with mental health issues has been a towering challenge experienced by the mental health service delivery and other networks. The debate concerning appropriate terminology is a crucial component of the integrated network of services and support. Working together to avoid the criminalization of people with mental health problems by its very nature necessitates a change in how individuals with mental health problems and illness are defined, described, and perceived. Mental health and justice systems workers have interchangeably employed a multitude of terms when speaking about this population. In Canada, the Standing Senate Committee on Social Affairs, Science and Technology highlighted a variety of terms used to describe people with mental health issues in the 2006 report, *Out of the Shadows at Last,* stating:

> Traditionally, individuals with mental illness and addiction being cared for by physicians are called patients. Other health professionals often refer to such individuals as clients or service users. The individuals may describe themselves by a number of terms, commonly consumers and survivors. Consumers usually refer to individuals with direct experience of significant mental health problems or mental illnesses who have used the resources available from the mental health system.[19]

A main concern in relation to the terminology employed is to avoid further stigmatization and violation of the human rights of this particular group. Many individuals are reluctant to use the word "consumer"

---

[18] Government of Ontario. (2011). *Open Minds, Healthy Minds. Ontario's Comprehensive Mental Health and Addictions Strategy.*

[19] Standing Senate Committee on Social Affairs, Science and Technology. (2006).

since it presumes the individual has a choice in requiring services and interventions. Alternatively, the term "survivor" has also led to much debate given that it connotes that the individual has been able to manage and deal with their mental health problems and is moving towards recovery – which inadvertently excludes a large group of people. There has also been seen a return of the use of the term "patient", which seems to be supported by those proposing that individuals with a mental illness should be treated in the same vein as those with a physical illness.

In the first edition of this handbook, the decision was made to use the term "mental health consumer" based on advice received at that time, despite its imperfection. The terms "client" and "patient" were also used within the handbook. These terms were employed by experts, both during the regional fora and in additional written submissions, and were used in order to preserve the integrity of the information provided.

A more generic term was also employed to describe this population: "people who suffer from mental health problems/mental illness." The terms mental illness and mental health problems were often used interchangeably; however, a distinction can be made. Mental illness includes individuals that have been diagnosed by a psychiatric/mental health professional, whereas individuals with mental health problems include both diagnosed and undiagnosed persons. It has been recognized that "effective assessment is key to the appropriate streaming of offenders. Perhaps the first problem in terms of assessment is that some offenders have undiagnosed mental health problems, including FASD."[20] The differentiation between mental illness and mental health problems further illustrates how definitions, terminology and language are an essential part of mental health assessment and intervention.

What remains consistent, even since the original publication of this handbook in 2008, is that there is no consistency in the terminology. Rather, different areas of expertise will use varying terms to describe individuals in the way that is most appropriate to their field. However, despite the lack of a broadly-used, cross-sectoral term to describe mental health disorders, the recommendations of the advisory group for this project agreed that persons who access the mental health system in any capacity should be referred to first and foremost as, people.

Therefore, for the purposes of this project, those who were originally referred to as 'consumers', 'survivors', 'patients', etc. have been updated where appropriate to reflect that regardless of the service being accessed, they are 'people with mental health problems and illness'. This language is in line with that of the Mental Health Commission of Canada, and SLSC is supportive of a national initiative for common understanding and terminology.

> "Only by changing our perception, removing the social stigma and understanding more about mental illness can we as a society begin to improve the treatment and care provided to the people who suffer from a mental disorder."—***Anonymous Participant***
>
> **Standing Senate Committee on Social Affairs, Science and Technology (2006), Part 1, p.16**

[20] Street Crime Working Group (2005). *Beyond the Revolving Door: A New Response to Chronic Offenders*. Retrieved September, 2007 from: http://www.bcjusticereview.org/working_groups/street_crime/street_crime.asp. 43.

Towards an Integrated Network

The aim of this handbook is to update the knowledge gained from the 2007-2008 fora, and to highlight new information on promising practices. By addressing information gaps among the service sectors those who support persons living with mental health problems and illness will be better equipped to provide increasingly mindful and innovative practices that benefit the community as a whole. For direct service providers, knowledge exchange can offer a new perspective on how to effectively help those living with mental health problems and illness, as well as insight into the broader social and political context in which initiatives are implemented; for other stakeholders, information concerning the direct impact of particular governing practices on those who experience them can be made much more accessible. The goals of addressing social injustice and providing meaningful services can be one and the same through a more collaborative approach.[21]

It must be underscored, however, that in order to fully realize the vision for *Towards a Model Community Mental Health Strategy*, communities must be empowered to adopt it and adapt the promising and effective practices listed within the strategy to their own needs. The complexity of issues and experiences explored here call for an ongoing, active engagement in order to maintain a commitment to healthy, just and peaceful communities for all Canadians.

We trust that *Towards an Integrated Network: Working Together to Avoid Criminalization of People with Mental Health Problems* will serve as a catalyst for further communications, partnerships and services beyond what has been generated through the project's lifecycle to date, and we look forward to hearing how it may support the valuable work of your agency in achieving our common goals.

[21] Cullen, F. T. & Gendreau, P. (2001). From Nothing Works to What Works: Changing Professional Ideology in the 21st Century. *The Prison Journal,* 81(3), 313-338.

RESEARCH REPORT

In an effort to gain a more thorough appreciation of the road traversed since the publication of *Towards an Integrated Network* in 2008, a scan of Canadian research since that date was conducted, and this section presents some of the findings relating to the evolution of the mental health/criminalization problematic.

The Mental Health Commission of Canada (MHCC) goes some way in offering studies concerning the mental health/criminalization axis. A key priority of *Changing Directions, Changing Lives: The National Mental Health Strategy*, is to "...reduce the over-representation of people living with mental health problems and illnesses in the criminal justice system, and provide appropriate services, treatment and supports to those who are in the system."[22]

The MHCC goes on to say those with mental health issues are more likely to be victims than perpetrators of crime and despite this, they are over-represented in the criminal justice system.[23] The reasons cited for this state of affairs, over and above the perpetration of an offence, is the lack of appropriate services, treatment and support in the community. The MHCC pinpoints the nefarious consequences of deinstitutionalization on the "inadequate re-investment in community-based services."[24]

Alongside this important development, and in part thanks to its direction, people with mental health problems and illness have developed self-help groups and there has been growth in community supports. These elements come to the aid of those who struggle with mental health and who are at risk of being criminalized. More mental health courts are in operation and interdisciplinary police mobile crisis units continue to be utilized as a way to offer solutions to people who have mental health problems without having recourse to the criminal justice system. Additionally, more training and education are provided in Canadian police services, academies and colleges, than was the case even a decade ago.

Other important tasks of the MHCC include an initiative called *Opening Minds* to implement an anti-stigma campaign targeting health care providers, youth 12-18, the workforce and the media. The MHCC aims to develop awareness of the repercussions of stigma, advance knowledge exchange in mental health, and examine how best to help people who are homeless and living with mental health problems by helping to create partnerships that focus on key projects and issues, and by making recommendations for improvements including, the justice system.[25]

Such government financed initiatives represent promising developments including that of demystifying mental health problems in order to diminish the stigma surrounding these conditions among the public. There is a cautionary tale however: while such efforts by the government may give the perception that something is being done, the follow-through remains to be seen since government is not compelled to act on the recommendations. Moreover, because health is a provincial responsibility, one can see jurisdictional challenges with implementing a national strategy.

Innovation in practices and methods of avoiding criminalization has taken many forms, including diversion through mental health courts, creating and operationalizing multi-disciplinary crisis teams in police services, the continued use of Assertive Community Treatment (ACT), restorative justice, self-help groups and the overall improvement of trans-agency and trans-system communication. The MHCC's emphasis

[22] Standing Senate Committee on Social Affairs, Science and Technology. (2006). 36.
[23] Standing Senate Committee on Social Affairs, Science and Technology. (2006).
[24] Standing Senate Committee on Social Affairs, Science and Technology. (2006).
[25] Mental Health Commission of Canada. (2013). Retrieved March 2013 from: http://mentalhealthcommission.ca.

on breaking stigma and sensitizing the Canadian public is helping to slowly change perceptions about mental health problems in Canada, and increase awareness among citizens.

The literature on developments dealing with the nexus of criminal justice and mental health, however, remains sketchy, especially in the Canadian context. Two topics are covered to some extent: policing and mental health courts. Apart from the dearth of research on community supports in relation to criminalization, there is a lack of qualitative evidence from people with mental health problems and illness. The input of recipients of services is useful and accurate, and addresses client stressors and system limitations.[26] Notwithstanding, there are a couple of exceptions, notably one article on "circuits of exclusion" that deals primarily with the marginalization of women with mental health problems who are already criminalized.[27] The other treats of continuity of care in early intervention programs and court support programs.[28]

The critical piece of the puzzle, prevention does get attention from researchers. Two initiatives worthy of note are the Resilience Research Centre and the Banyan Community Services. The Resilience Research Centre, whose primary objective is to "employ methodologically diverse approaches to the study of how children, youth, and families cope with many different kinds of adversity", forms part of an international network. The Canadian branch functions out of Dalhousie University and is spearheaded by Drs. Ungar and Liebenberg. Resilience is understood to mean:

> In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways.

Among other initiatives, this interdisciplinary network of researchers partners with The National Centres for Excellence (NCE), Children and Youth in Challenging Contexts (CYCC), and the Knowledge Mobilization Network. This network focuses on violence prevention, youth engagement and "the innovative use of technology in delivering mental health services." In addition, Pathways to Resilience focuses on teenagers who have direct experience with "probation, foster care, group homes, psychologists, addictions programs, homeless shelters, alternative education centres, or correctional centres."

In the same vein, The Canadian Population Health Initiative (CPHI) held a workshop in 2009 to discuss mental health, delinquency and criminal activity in which Banyan Community Services is held up as a valuable example of mental health promotion and delinquency prevention in youth. CPHI Senior Researcher, Dr. Elizabeth Votta, reports that establishing that protective factors such as emotional capability, ability to handle stress, nurturing parents, liking school and adaptability are important characteristics and that a sense of connectedness and belonging is a key factor in preventing problems of mental health and delinquency among youth. Among the risk factors were indirect aggression, parental

[26] Nandlal, J., et al. (2010). Continuity of Care in Early Intervention Programs and Court Support Programs: Giving Voice to Service Recipients and Their Families. *Canadian Journal of Community Mental Health*, *Suppl. Special Issue* 29, 42.
[27] Pollack, S. (2009). 'Circuits of Exclusion': Criminalized Women's Negotiation of Community. *Canadian Journal of Community Mental Health*, 28(1), Spring, 83-95. This article treats the post-prison context whereas the current work concerns the avoidance of criminalization in the first instance. For other research on the post-prison context see St. Leonard's Society of Canada, 2010, 2012.
[28] Nandlal, J. et al. (2010), 41-51.

rejection, punitive parenting and hyperactivity, to name some.[29] The Banyan Community Services (BCS), a demonstration site for the National Crime Prevention Strategy, offers programs dealing specifically with youth in the area of "relationship-building, early-intervention crime prevention, diversion, self-control, problem-solving and clinical and child welfare supports".[30] The focus is on delinquency prevention in youth, in the context of mental health, using a social development model. Patricia Campbell, the BCS program manager, stresses that the role of researcher-practitioner is central to the service: "The programs at BCS use a number of clinical measures to facilitate both internal and external evaluation."[31] The use of assessment mechanisms to evaluate success and outcomes is an important and necessary part of the prevention piece: "...indicators and assessment tools not only contribute to the evaluation of program outcomes but also allow for tailoring of programs to meet the specific needs of children and youth, exemplifying the importance of data for program planning and evaluation."[32]

POLICE

For the Mental Health Commission of Canada, Coleman and Cotton (2010) and Cotton and Coleman (2008) produced a two part study on the amount and level of mental health training in Canadian police services and academies, and on police interactions with persons with a mental illness.[33] While training has taken place throughout all the police colleges and academies,[34] the authors found there is no commonly accepted Canada wide standard or curriculum;[35] there is a variance of between one and 24 hours of training on the subject for new police officers;[36] and much of the training is not self-contained in one course, but appears in other training (for instance, in courses on the use-of-force, laws and statutes, and officer safety).[37] They state that most officers-in-training have received fewer than 10 hours of training or education on this population, enough to sensitize but certainly insufficient in terms of developing the necessary skills to interact appropriately with this population.[38] Moreover, it is insufficient in terms of addressing stigma, bias, and personal attitudes.[39] The other notable issue is that, of the education and training provided, few have involved a person with an actual mental illness, and few have benefitted from training provided by those who work in mental health agencies. Lastly, the lacunae, in part, concern the

---

[29] Canadian Population Health Initiative (2009). Mental Health, Delinquency and Criminal Activity: Workshop Proceedings Report, February 5 and 6, 2009. Ottawa: Canadian Institute for Health Information, p. 5. Retrieved March, 2013 from: https://secure.cihi.ca/free_products/ihc2_workshop_proceedings_en.pdf.

[30] Canadian Population Health Initiative (2009). p. 6.

[31] Canadian Population Health Initiative (2009).

[32] Campbell P. in Canadian Population Health Initiative (2009), p. 7.

33 Coleman, T. & Cotton, D. (2010). *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing*, prepared on behalf of the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada. Retrieved March 2013, from: http://www.mentalhealthcommission.ca/SiteCollectionDocuments/PoliceProject/Police%20Learning%20Model_Jul%2023%20(4).pdf; Cotton, D. & Coleman, T. (2008). *A Study of Police Academy Training and Education for New Police Officers Related to Working with People with Mental Illness* prepared on behalf of The Police/Mental Health Subcommittee of the Canadian Association of Chiefs of Police and the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada. Retrieved March 2013, from: http://www.mentalhealthcommission.ca/SiteCollectionDocuments/PoliceProject/aa%20academy%20report-MHCC_FINAL.pdf.

[34] Cotton, D. & Coleman, T. (2008).

[35] Cotton, D. & Coleman, T. (2008). p. 4.

[36] Cotton, D. & Coleman, T. (2008). p. 5.

[37] Cotton, D. & Coleman, T. (2008). p. 9.

[38] Cotton, D. & Coleman, T. (2008). pp. 15-16.

[39] Cotton, D. & Coleman, T. (2008).

pedagogical tools used for such training. There seems to be a preponderance of knowledge transfer conducted in lecture format, to the detriment of other tools such as role-play[40] and problem-based learning.[41]

Notwithstanding the continuing challenges in standardizing and increasing mental health education and training for new police officers, some developments are promising and merit attention. Cotton and Coleman (2008) report that the Royal Newfoundland Constabulary (RNC) has one of the best programs in the country, where mental health training is concerned. The partnership between the RNC and Memorial University provides in-depth training through psychology courses, as well as the involvement of mental health professionals. The authors of this study claim that the RNC may well be "currently setting the standard in this area".[42] In addition, other police academies and colleges are singled out for their forward thinking and training opportunities. For instance, the Edmonton Police Service provides 24 hours of training, the most of any police service or police academy. The Atlantic Police Academy (APA) on the other hand, makes use of role-play, various media, and includes content on people with mental illness and mental health professionals.[43] These authors call for more comprehensive education and training, more systematized and standardized curricula across the institutions utilizing a variety of pedagogical tools and enlisting the assistance of both people with mental health difficulties as well as mental health providers to share mental health-specific knowledge.[44]

It is widely recognized that an ever-growing part of police officers' duties includes interventions which involve people with mental health problems and illnesses. Indeed, a police officer is the "primary gatekeeper" who determines whether a person will be channeled into the criminal justice, or the mental health systems.[45] The preponderance of mental health-related calls has necessitated beyond-traditional-policing responses. In part, this has taken the form of specialized multi-disciplinary teams to ensure that an appropriate response be provided. A couple of models have taken form including CITs (Crisis Intervention Teams) and mobile crisis teams. However these strategies are more or less practiced depending on the geographical delimitation. For instance, in rural areas, such teams cannot be established, and so police have better training and/or systems are developed that rely on remote access to mental health professionals.[46]

MENTAL HEALTH COURTS

There have been more articles on mental health courts (MHC) than on any other subject related to ways of avoiding the criminalization of those who have mental health needs in Canada. However, these have bemoaned the paucity of research devoted to measuring their efficacy.[47]

Hard questions remain in spite of the fact that mental health courts are generally seen in a positive light as a good way to divert people with mental health problems who come into conflict with the law, away from the criminal justice system. A number of concerns are raised in the literature. Mental health courts

---

[40] It is worth nothing, however, that the technique of role-play is used by Correctional Service Canada in its training programs.
[41] Cotton, D. & Coleman, T. (2008). pp.17-18.
[42] Cotton, D. & Coleman, T. (2008). p. 19.
[43] Cotton, D. & Coleman, T. (2008). p.19
[44] Cotton, D. & Coleman, T. (2008). pp. 20-21.
[45] Durbin, et al. (2012). Police-Citizen Encounters that Involve Mental Health Concerns: Results of an Ontario Police Services Survey. *Canadian Journal of Community Mental Health* 29 (5, sup.), 55.
[46] Durbin, et al. (2012). p. 56.
[47] See Ormston, E.F. (2010); Hiday, V.A. & Wales, H.W. (2011); Slinger, E. & Roesch, R. (2010); Kaiser, A. (2010); Schneider, R.D. (2010).

use an approach founded on therapeutic jurisprudence that targets recovery,[48] but experts question whether there is a balance between a treatment approach and rights.[49]

It warrants mentioning that the primary focus for mental health courts in Canada is to determine fitness to stand trial, and so it is not voluntary. Moreover, "[t]hereafter, once fit to stand trial, whether the accused elects to remain with the court for a bail hearing, participate in 'diversion', or resolve the matter with a guilty plea, is the accused's option".[50]

The United Nations Convention on Rights of Persons with Disabilities, signed in 2008, brought about new concerns for how diversionary measures such as mental health courts are engaged. Including persons with mental illness within the purview of the convention, and treating mental illness as a disability under the law situates the issue in a context of "rights". In this regard, Pelrin (2009) argues there are five core factors to take into account when trying to evaluate if rights have been violated. These have to do with the quality of legislation, judicial review, care, community care, and humane services. Within a rights based context, concerns include due process rights, coercion, procedural fairness, sanism, privacy, and stigma.[51]

The issue of due process rights is a weighty one. One of the foundational principles of the criminal justice system is that people who are charged with a criminal offence be considered innocent until proven guilty. Access to some mental health courts however, is only possible with a guilty plea. Kaiser (2010) says the goal of mental health courts was to remove mental health cases from the criminal justice system and divert them to an environment more conducive to treatment, bridging the gap between criminal justice and mental health, reducing costs by keeping in the community, those with mental health problems who are in conflict with the law, improving public safety by reducing recidivism, enhancing their quality of life and expediting assessments of their fitness to stand trial.[52] But he questions the concept of voluntariness and choice:

> ...the concepts of voluntariness and knowledge may be inapposite for a target population that is poor, marginalized, stressed, unstable, and stigmatized and whose only other "choice" may be to face the harshness of the conventional justice system.[53]

Archie Kaiser calls for a moratorium on their proliferation because the way they function ignores fundamental principles. Mental health courts magnify stigma, according to Kaiser, because they convey the notion that mentally disordered persons are "special" and need "extra-ordinary" institutions and controls, which goes against the rights paradigm that emerged as a result of the ratification of the United Nations Convention on the Rights of Persons with Disability.[54] He charges that mental disability law is permeated by 'sanism', akin to the treatment by police of African-Americans.[55] Instead, he argues, we should bring justice into the existing system. He charges that mental health courts were created impulsively, as an expedient solution to a complex set of problems, creating nothing more than an illusion

---

[48] Ormston, E. F. (2010). Commentary: The Criminalization of the Mentally Ill. *Canadian Journal of Community Mental Health,* 29 Fall (2), 7.

[49] Kaiser, A. (2010). Commentary: Too Good To Be True: Second Thoughts on the Proliferation on Mental Health Courts. *Canadian Journal of Community Mental Health*, 29 Fall (2), 20-21.

[50] Schneider, R. (2010). Mental Health Courts and Diversion Programs: A Global Survey. *International Journal of Law and Psychiatry*, 33(4), 202.

[51] Kaiser, A. (2010). 20-23; Ormston, E. (2010). p.7.

[52] Kaiser, A. (2010). p. 20.

[53] Kaiser, A. (2010). p. 21.

[54] Kaiser, A. (2010). p. 20.

[55] Kaiser, A. (2010). p. 20, citing Stefan, S. & Winick, B.J. (2005). Foreword: A Dialogue on Mental Health Courts. *Psychology, Public Policy and the Law*, 11(4), 507-526.

that something positive was being done.[56] The continuing gaps and shortages in community services are at the root of the problem and need to be addressed.

This sentiment is echoed by Justice Ormston when he notes government failures in providing "tools for identification, accessible person-centred care programs, housing and financial support systems". He wonders whether we would need jails in 20 years if instead of spending on prison-building, we invested in early childhood education.[57] This sentiment is shared widely among practitioners, stakeholders and analysts.

There are certainly avenues that call for various types of research to be conducted. A promising start would be to engage in more qualitative research with people who have mental health problems in order to gain a deeper appreciation of the challenges such people face, and whether alternatives to criminalization have been, in the main, helpful or not. Moreover, research should extend to direct service providers in order to better capture some of the structural problems that pose challenges for the care of this at-risk population.

In another vein, as evidenced by this scan of the literature, objective assessments of the pros and cons of various alternatives need to be engaged. In particular, attention should be given to researching other correlated social factors including a person's age, possible trauma, socio-economic conditions, to name a few, when trying to gauge the impact of diversion measures. Not only that, measurables need to include more than recidivism. As others have noted, psychosocial functioning and life satisfaction are also important when assessing success.[58] Furthermore, over and above the merits of mental health courts, we need to delve more deeply into assertive community treatment, and self-help and other community-driven groups. For instance, groups that target youth such as Across U-hub[59] in Toronto and Exceed All Expectations in Ottawa, to name but two, are organizations that aim to provide youth with learning and leadership resources, and thus potentially prevent crime and more adequately address concerns regarding mental health. Equally urgent is research that focuses on system problems, including the impediments to formal collaboration between criminal justice and mental health silos, and the jurisdictional quandaries of multi-level authority on this issue.

[56] Kaiser, A. (2010). p. 21.
[57] Ormston, E. (2010).
[58] See Kaiser, A. (2010).
[59] For more information see on Across U-Hub: http://www.acrossuhub.com/acrossuhub/Default.asp.

CHALLENGES AND CONCERNS FOR THE MENTAL HEALTH SERVICE DELIVERY NETWORK

In the last forty years, empirical research has demonstrated the detrimental effect of the deinstitutionalization of mental health services in Canada.[60] Specifically, the transfer of treatment programs from psychiatric institutions to community-based agencies has not been particularly successful. Psychiatric deinstitutionalization has led to an increased presence of persons with mental illness in urban areas, many 'falling through the cracks' of community-based services.[61] Additionally, research has shown that most community program providers are not only inadequately funded; but also, consider themselves ill-equipped to deal with this population.[62]

FACTORS CONTRIBUTING TO CRIMINALIZATION

The challenges experienced by the service system have been aggravated by the enduring stigma and discrimination directed towards individuals who suffer from mental illness. A close association between mental health and violence has been presumed to the detriment of a population particularly vulnerable to failing social conditions. According to Stuart and Arboleda-Flórez, the cornerstone of public concern and fear of individuals who suffer from mental illnesses comes from the misconception that they are dangerous.[63] The media have also contributed to strengthening this image. Most news stories focus on tragic and violent events that relate to the criminal justice system, particularly when it involves a mental health or drug-related incident. They are quick to stress a causal relation between criminality and mental health. "Community intolerance arising from this belief has adversely influenced public policy concerning the location of treatment centres and transitional housing for this population".[64] Consequently, mental health has become a major social concern within Canada, particularly in an attempt to deal with street crime and dangerous offenders.

The problem of mental health service delivery is not limited to the lack of appropriate services and trained professionals.[65] Rather than taking into account existing social inadequacies in the services available to individuals with mental health problems and illness, the Canadian population has adopted a more punitive/moral approach to crime and public safety, which has led to a consideration of the criminal as someone requiring punishment as a means of deterrence.[66] "Members of the public react to the effect of crime and disorderly conduct on their lives. It is irrelevant to them whether the conduct is criminal or non-criminal. The public expects the police to step in, regardless of the nature of the behaviour".[67] Therefore, the challenges and concerns experienced by the Canadian mental health service delivery system must take into account and address the social reality experienced by this population.

---

[60] See for example: Brink, J, H., Doherty, D., & Boer, A. (2001).
[61] Verdun-Jones, S. (2007). *The Mentally Disordered and the Criminal Justice System*. Presented at SLSC & CCJA Towards a Community Mental Health Fora, Vancouver, British Columbia.
[62] Kelly, C.A. (2003). *Challenges in the Management of Mentally Disturbed Offenders on Psychotropic Medication.* Presented at St. Leonard's Society of Canada Bolton Day Conference.
[63] Stuart, H. & Arboleda-Flórez, J. (2001). A Public Health Perspective on Violent Offenses Among Persons with Mental Illness. *Psychiatric Services* 52, 654-659.
[64] Verdun-Jones, S. (2007).
[65] Kaiser, A. (2007).
[66] Kaiser, A. (2007).
[67] BC Justice Review Task Force, (2005). p.29.

Central to original *Towards and Integrated Network* project in 2008 was the goal of providing an opportunity for experts to come together to discuss their experiences in dealing with individuals with mental health problems. Among these experiences, a number of recurring challenges and concerns were identified and were used to shape the following section:

- *The Impact of Definitions Assigned by the Mental Health Service Delivery Network*
- *Social Determinants of Health, Housing and Homelessness*
- *The Silo Effect*
- *The Image of Mental Health*
- *Risk Management and Comprehensive Assessments*

THE IMPACT OF DEFINITIONS ASSIGNED BY THE MENTAL HEALTH SERVICE DELIVERY NETWORK

DEFINITIONS OF MENTAL HEALTH PROBLEMS AND ILLNESSES

The mental health service delivery system is primarily responsible for the terms and expressions used to describe an individual with from mental health-related problems. As part of their professional responsibilities, the majority must make either a mental health assessment and/or assist the individual in dealing with his/her mental health problems, or refer the individual to services that are better suited. Meanwhile, historical evidence has demonstrated the harmful effect on individuals labelled using definitions offered by the mental health field. "Terms such as 'madness', 'mental illness' 'mental disorder', 'mental abnormality', 'mental health problem', and 'insanity' are not always equivalent; they can take on different meanings and have different implications."[68]

As noted earlier in the section on mental health terminology, SLSC is supportive of aligning our framework of mental health with that of the Mental Health Commission of Canada in order to support efforts toward a collective use of language and understanding. Additionally, the MHCC's language more accurately reflects the stage that persons with mental health problems and illnesses are at when they are involved with community-based service providers. This has meant shifting away from the traditional use of the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition-revised (DSM-IV-TR, 2000)* as was originally used for this report. As such, for the purposes of this project 'mental health problems and illnesses' has been used where appropriate and refers to the full range of patterns of behaviour, thinking or emotions that bring some level of distress, suffering or impairment in areas such as school, work, social and family interactions or the ability to live independently. There are many different kinds of mental health problems and illnesses. They range from more common mental health problems and illnesses such as anxiety and depression to less common problems and illnesses such as schizophrenia and bipolar disorder. The MHCC does not attempt to draw a firm line between 'problems' and 'illnesses,' or to resolve all of the controversies surrounding the choice of terminology. Rather, the term 'mental health problems and illnesses' has intentionally been chosen to be respectful of a wide range of views.[69]

How to best define mental health and mental illness?

Or for that matter, should we have such a definition?

Should we reduce the use of such definitions?

FORENSICS

Another significant challenge concerns the use of the term "forensics" to define an individual's mental health status or to describe the category of required services. Concerns regarding the use of the term "forensics" relate to how differently people have come to define and make use of this particular term.[70] A common misconception is that the term "forensics" is a global term that includes any mental health service for individuals with a mental disorder who has come into contact with the law.

The term forensics refers to specialized mental health services that come into play when an individual is charged with a criminal offence and the court orders an assessment to determine fitness to stand trial. It

---

[68] Petrunik, M. (2007). *Mental Disorders and Justice* (University of Ottawa, Department of Criminology course notes), p.1.

[69] Mental Health Commission of Canada (2012). *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. p.14. Retrieved March 2013, from: http://strategy.mentalhealthcommission.ca/

[70] Champagne, D. RSW, RTC-ON, (personal communication, Kingston Forum, November, 2007).

also is used when a criminal defence of Not Criminally Responsible (NCR) is pursued in a trial and/or with the services associated with the management and support of an NCR status following the trial. Technically, these services are under provincial responsibility, although there have been exceptions where the responsibility has been absorbed by federal corrections. Consequently, the use of the term "forensic services" has become too loose to include some mental health services that apply for individuals who are also involved with the justice system, whether or not they have been found fit to stand trial or found criminally responsible. In short, the term "forensic" is a legal status, and is not an accurate descriptor of a person's health status.[71]

The inconsistent use of the term "forensics" has ultimately contributed to a number of concerns. Of primary concern is the stigmatization that is associated with this legal status. If a person is misrepresented as forensic, it can close doors to much needed services to people with mental health problems and illnesses who have had justice system involvement. For those who are assigned this legal status, stigmatization makes it difficult to manage and provide services to this population when released into the community, since it can be a red flag to mental health service providers who have set exclusionary criteria for this group.[72] Therefore, a differentiation must be made between mental health services provided to individuals who have come into contact with the justice system, and services that are offered for NCR assessment and application in order to identify appropriate services and support that are available to the individual. Service providers should be cognizant of the language they use to frame their services and policies. For example, many will have a specialization in mental health and justice, but not forensics.

Unquestionably, attention must be paid to researching and evaluating effective means of providing mental health services for the variety of groups within the mental health community. Despite this challenge the mental health service delivery network should contribute to changes in contextualizing justice involvement, to ensure the least amount of stigmatization for the individual accessing the service.

How can mental health care providers better provide services based on peoples' health status, rather than their legal status?

Comorbid Disorders and Dual Diagnosis

The existing struggles in dealing with individuals who suffer from comorbid disorders, such as the combination of a mental disorder and a substance abuse problem or a mental incapacity diagnosis along with a personality disorder, have been widely experienced by service providers across Canada. The complexity in nature of some individuals' lives, given the added social and health problems such as housing and poverty, has placed a larger responsibility on service providers for improving the quality of life of people with mental health problems and illnesses. Services and support must address a large number of social problems that impede on the individual's ability to recover. As a consequence, many people who suffer from comorbid disorders or dual diagnoses have fallen between the cracks. The inability of service agencies to deal with a multitude of social problems has resulted in neglect and isolation from the available social services.

A recent report produced by the Centre for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University has attempted to address the issue of comorbidity and complex cases when

[71] Higgins, C. Team Lead, Forensic Mental Health. Ministry of Health and Long Term Care Ontario. (personal communication, March 2013).
[72] Higgins, C. (2013).

dealing with individuals who suffer from severe addictions and mental illnesses.[73] Specifically, this report focused on the effect of homelessness and the lack of housing support for this particular population. It also attempted to provide recommendations to deal with this social problem. CARMHA estimated that approximately 66,000 adults in BC have complex mental, developmental, neurological, and substance use disorders. Within this group, approximately 5,300 adults have significant and challenging behaviours such as physical aggression, inappropriate sexual and/or fire-setting behaviour. Approximately 4,430 (84%) of these individuals require an intensive level of care and supervision not currently available in BC, and an estimated 1,380 (26%) are not eligible for any services at all. Finally, approximately 1,300 (25%) individuals are estimated to have a developmental disability or neurodevelopmental disorder as their principle diagnosis (the remaining 75% have a primary diagnosis of Severe Addictions and/or Mental Illness and are thus included in our estimates).[74]

Similarly to the challenges concerning the term "forensics", further attention must also be paid to the definition assigned to individuals who with severe mental disorders in order to avoid minimizing their needs, which in turn may reduce the services and support that are available. Definitions of mental disorders should not attempt to create similarities between an individual with a mental illness and one another with a severe mental illness, particularly in the presence of a comorbid disorder or complex situation such as homelessness. These are two different cases, two different situations with particular histories and social context. A number of initiatives must be undertaken in order to deal with this challenge and allow for the implementation of an effective mental health service delivery system.

The Systems

In addition to the challenges experienced by service providers in attempting to identify suitable definitions of mental health/mental illnesses, there has also been a challenge in meeting the needs of people who are at risk of being criminalized. The challenges and incidents experienced by the mental health service delivery network in their struggle to provide adequate services has led many to turn to the criminal justice system as a means to provide support and services to this particularly vulnerable population.[75] Service providers working in community corrections are not funded to provide mental health services, and their primary focus is on reintegration. They may not have the human resources with the necessary skill sets to provide mental health care to the client. Nonetheless, because of barriers for corrections clients to community services who do specialize in mental health services, community corrections staff persons become the default mental health care provider. While some service providers are making attempts to obtain personnel with diverse experience in mental health and corrections, there is still a challenge in providing training and resources that encompasses the needs of this system.

Accordingly, the health status that is assigned to an individual when entering the system will ultimately define the services and supports that follow. How a person enters a system, and the conditions surrounding it, will also contribute to defining the person.[76] A mental health status as defined by the mental health courts, for example, may affect the perceptions and treatment offered by the hospital

[73] Patterson, M. et al. (2008). *Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia*. British Columbia: Centre for Applied Research in Mental Health and Addiction (CARMHA). Retrieved March, 2013 from:
http://www.health.gov.bc.ca/library/publications/year/2007/Housing_Support_for_MHA_Adults.pdf.

[74] Patterson, M. et al. (2008). p.27.

[75] Simpson, D. Program Manager, Psychiatric Patient Advocate Office, (personal communication, Kingston Forum, November, 2007).

[76] Justice E. F. Ormston, (personal communication, Kingston Forum, November 2007).

assigned to an individual's care. They may become stigmatized or feared by the hospital staff given an association with the criminal justice system.

Consequently, when assigning a particular mental health status, the following questions should be posed:

What are the possible effects of the definition?

How is the person judged and evaluated?

What limits are set given this recognized status? What services and support become accessible?

Two Samples of Service Agencies Experiencing Challenges, Specific to Dealing with Definitions of Mental Health:

Gallagher Centre and MLA Crisis Bed program

A major concern of the justice workers at SLCS is the inability to refer many of the clients to traditional mental health agencies at time of discharge from the supportive beds. The individuals that are accepted into the crisis bed program have either a suspected or confirmed diagnosis of mental health issues. Due to the use of self-identification and informal diagnosing for clients who were admitted to the crisis support beds—they are often not able to obtain medications or medical support for their illnesses. The barriers and challenges with obtaining mental health care impacts one's overall ability to function and increases the likelihood of unsuccessful discharge from the program. The impact of challenges in local healthcare and waitlists contributes to an increased need for individuals facing mental health issues in the criminal justice system. As with many new programs that develop, time and diligence can often result in resolving issues. SLCS has developed a case management program to assist with the individuals that are reintegrating into the community with mental health needs from all levels of the criminal justice system (local, provincial and federal) to ensure a more productive, successful transfer and reintegration.[77]

Alberta Seventh Step Society

The lack of comprehensive mental health assessments within correctional institutions has led to the release of a large number of offenders with mental health problems without any records of their mental health status. A large number of offenders within the community have also gone undiagnosed, or are simply neglected as a result of their mental health status. As a result, some service agencies will not take in offenders diagnosed who suffer from a mental disorder. The Seventh Step Society will take in offenders with mental health problems; however, it has set an exclusionary criterion for those who suffer from **severe** mental health disorders.[78]

A large number of health care complaints assessed by the Office of the Correctional Investigator (OCI) and Correctional Service of Canada's (CSC) internal grievance division could be considered mental health-related issues.[79] According to a recent report produced by the OCI, and in collaboration with the University of Ottawa, when looking more closely at the large number of the health complaints, a larger number could be dealt with through mental health services and treatments. "Improving outcomes in this area is critical

[77] Callender, H., Executive Director, St. Leonard's Community Services London and Region, (personal communication, March 2013).

[78] Alexander, B., Executive Director, Alberta Seventh Step Society, (personal communication, Calgary Forum, November, 2007).

[79] Zinger, I. (2007). *Towards a Model Community Mental Health Strategy.* Presented at SLSC & CCJA Towards a Community Mental Health Strategy Fora, Kingston, Ontario.

as offenders with mental illnesses continue to be segregated in response to displaying symptoms of their illnesses, and released later in their sentence."[80]

Additionally, the relation between criminality and mental health has become so blurred that it has created an increased fear of individuals with mental health problems. The Criminal Code has become an important tool in defining a person with mental health problems, which further limits the choices that are available to them. Similar to the specific criteria of the *DSM-IV-TR*, the Criminal Code has proposed criteria that are very exclusionary and restrictive. Legal and medical definitions have an important impact on people, on how they are perceived, on what they are offered, and on the reasons to justify exclusion (i.e. Community treatment Orders).

COMMUNITY TREATMENT ORDERS

The general notion behind Community Treatment Orders (CTOs) is that individuals with mental illness should be allowed to reside in the least-restrictive environment needed to avoid significant risk that the individual will cause self-harm or harm another person. In some cases, the least-restrictive environment could be the individual's community if the person is appropriately monitored and supported. By statute a CTO is put in place to ensure that when in the community the individual will take appropriate medications, follow through with other forms of treatment, or access necessary supports. The CTO can be put in place only when the individual consents to it, or when consent is obtained from a person designated to give consent for that individual. In short, the concept of a CTO is that individuals who agree to continue treatment in the community do not, as a result of their mental illness, need to be kept in hospital or other institutional settings. For individuals who have significant mental health problems and for the families of these individuals, the promise of a CTO is one of providing stability against the revolving door of hospitalization, stabilization, discharge, discontinuation of treatment, relapse and re-hospitalization.[81] The reality of CTO legislation, however, has proven to be very different.[82]

As noted, the patient must consent to the CTO being put in place and, if consent is later withdrawn, a doctor may order that the patient be taken back to hospital. A CTO can only be put in place when sufficient resources exist in the community to support the individual, and to ensure that the provisions of the CTO can be met. In rural areas and, indeed, in certain urban areas, insufficient resources exist to fulfill this statutory requirement, thus preventing even establishing a CTO.

Further, legislation such as that enacted in Ontario and Alberta allows for a CTO to be used only with individuals who have had significant hospital admissions as formal patients, that is, involuntary admissions under the terms of the Mental Health Act. A patient who agrees to be hospitalized and never faces a mental health warrant is not eligible to be placed under a CTO even if he or she wants to be so designated. Finally, there exists a problem in the legislation with respect to the consequences of a breach of the conditions of a CTO. Most of the legislation surrounding CTOs stipulates, simply, that the patient should be brought to a hospital for re-assessment. If that assessment is done in a busy emergency department, and finds that the individual, at that moment, does not pose a danger to ones or others and is unlikely to "suffer substantial mental or physical deterioration," as the Alberta legislation reads, then the individual is released and no further steps are available for the concerned family member to take. Waiting for the individual to show more deterioration becomes the likely option.[83]

---

[80] Zinger, I. (2007).
[81] Baillie, P. Forensic Psychologist, Peter Lougheed Hospital, (personal communication, February, 2008).
[82] Baillie, P. (2008).
[83] Baillie, P. (2008).

There continues to be opposition to the mechanism of CTOs, from a political and moral perspective, as they are seen as coercive, non-consensual, and designed to medicate the homeless, while disregarding the need to expand hospital-based mental health programs.

DEFINING THE INDIVIDUAL

The next step in addressing definitional challenges is to foster a better understanding of the implications to defining the problem of criminalization. How one interprets or talks about the outcome, which is to reduce criminalization, is a much larger task than to implement effective strategies and practices in dealing with individuals with mental health problems. As shown in the "Towards a Community Model Mental Health Strategy" chapter, there exists a variety of promising and effective practices in terms of services and support provisions for people with mental health problems and illnesses. Although these service agencies/programs contribute to reducing criminalization, their main priority is assist the individual in improving their quality of life. The issue of criminalization requires more extensive collaboration and partnerships between the major stakeholders, including government departments, politicians and the integration of a human rights approach within Canadian legislation.

The individual must come to be perceived as a *person,* contrary to current practices which rely primarily on mental health or criminal history in order to assign status.[84] The individual has come to be defined by their mental health status, their addiction, or their legal status rather than as a person who suffers from one or several mental health-related problems. This challenge entails further investigation to determine the most appropriate or effective practice, if any, to deal with individuals who suffer from mental health problems, notably for those who have had encounters with the criminal justice system.

Should there be a distinction between individuals who suffer from mental health problems and those who have been diagnosed with a mental disorder?

Is it necessary to consign these individuals in separate and/or distinctive boxes?

What are the benefits and the downfalls?

[84] Justice E. F. Ormston, (personal communication, Kingston Forum, November, 2007).

SOCIAL DETERMINANTS OF HEALTH, HOUSING, AND HOMELESSNESS

Research and policy-related initiatives have recognized the necessity to address homelessness in Canada, as findings have revealed an increasing number of Canadians living in poverty. These findings have helped garner support for initiatives such as establishing the Homelessness Partnering Strategy, which has played an important leadership role in providing funding and support to communities across the country. However, as noted by Gaetz (2008):

> …as inventive as these responses are in meeting the immediate needs of homeless people, the situation has not improved significantly. This, of course, raises questions about the effectiveness of our solutions. And there are solutions. Research in Canada and around the world points to strategies that work in reducing and eliminating homelessness. Put simply, we need to set aside our quest for an emergency response and focus on developing a comprehensive strategy to end homelessness in Canada.[85]

The implications for homelessness and the criminal justice system indicate that individuals involved with the justice system, whether federally or provincially, face significant challenges in obtaining safe, affordable housing options upon their release from custody.[86] In Canada, Recent estimates state that 30% of individuals incarcerated in Canada will have no homes to go to upon their release.[87] This is a costly statistic, both in financial and social terms, as awareness of the cost of homelessness in Canada emerges.[88] For example, a study of homeless people with substance abuse and mental health issues in British Columbia argues that one homeless person costs the public system in excess of $55,000 per year.[89] Alternately, if this same population was provided adequate housing and supports, it is estimated that the cost per person would drop to $37,000 per year, which would save the province approximately $211 million annually.

The challenge experienced by the mental health service delivery network in dealing with homelessness, mental health and criminalization has been markedly underlined in the CARMHA housing report:

> It is estimated that approximately **39,000** (26,000-51,500) adults in BC with SAMI are **inadequately housed**. It was assumed that the subset of individuals who are at imminent risk of homelessness are *both* inadequately housed *and* also inadequately supported – a number estimated to be **26,250** (17,500-35,500). A smaller subset of the SAMI population is **absolutely homeless**, estimated to be **11,750** (8,000-15,500) people. […] Some might assume that the predominant forms of SAMI among the homeless involve psychotic illnesses such as schizophrenia. However, the published literature and key informants in BC confirm that addiction is the most prevalent mental health problem in both the street homeless and at-

---

[85] Gaetz, S. (2008). Why are we still struggling with homelessness in Canada? *Canadian Housing Special Edition.* p 27.

[86] See for example: Zorzi, R. et al. (2007). *Housing Options Upon Discharge from Correctional Facilities.* Canada Mortgage and Housing Corporation (CMHC)*;* Stapleton, J. et al. (2011). *Making Toronto Safer: A Cost-Benefit Analysis of Transitional Housing Supports for Men Leaving Incarceration.* John Howard Society of Toronto; Kellen, A. et al. (2010). *Homeless and Jailed: Jailed and Homeless.* John Howard Society of Toronto; Gaetz, S. & O'Grady, B. (2009). Homelessness, Incarceration, and the Challenge of Effective Discharge Planning: A Canadian Case. In Hulchanski et. al. (eds.) *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 7.3. Cities Centre, University of Toronto.

[87] Zorzi, R. et al. (2007).

[88] See Gaetz, S. (2012). *The Real Cost of Homelessness: Can We Save Money by Doing the Right Thing?* Toronto: Canadian Homelessness Research Network Press.

[89] Patterson, M. et al. (2008).

risk populations, followed by concurrent disorders and, less frequently, mental illness alone.[90]

Principally, housing options should take on a different approach to mental health. A new perspective is needed in dealing with this particular group, especially for those vulnerable to encounters with the criminal justice system. Unquestionably, homelessness has become an integral part of the challenge in determining whether an individual will have access to specific programs and services. In moving towards an integrated network, adequate housing is a crucial component to successful recovery and as a means to improve the quality of life for people with mental health problems and illnesses.

Health and Social Systems

Health services have encountered many challenges in dealing with the mental health sector. A shortage of mental health professionals such as psychiatrists and psychologists has led many people to turn to their physicians to receive treatment, referrals and support. Many are provided with drug prescriptions without any additional support or services due to the limited availability of resources and interventions. Another major problem is that many people are left to fend for themselves, which means they assume the responsibility of proper medications and assessment of their condition without any standard mental health evaluation completed by mental health service providers. As a result, misusing or abstaining from medication has become very common for those without the necessary support. Other health and social service-related challenges consist of the limited services and support available to the Canadian rural population, where there is a significant gap in programs and services.

Concerns exist regarding the existence of an undisclosed two-tier system of health and social services (i.e. private sector), which operates to the detriment of a vulnerable population, which, in most cases, does not have the financial means to access these services. Moreover, the effect of family systems on an individual's mental health and mental health recovery is another element worth noting. The children of parents with mental health problems who become responsible for their own well-being and social conditions have been let down through inadequate social assistance. The present situation requires a move beyond the realms of mental health services to include other social factors such as employment, health, housing and social support. A holistic approach to mental health services is key to the individual's quality of life. Children, family members and partners are part of the individual's successful recovery and should be integrated in the process.

Transition/Continuity of Services

According to Judi Burill of the Elizabeth Fry Society, many women prefer to remain at a halfway house as it ensures a certain level of services and support that they are unable to access in the community.[91] Many women fear independent living situations given the lack of support that has been offered by the community mental health service delivery network. The quality of service and treatment available is often restricted by a person's criminal justice system-related status. Challenges experienced by the individual returning to the community include difficulties in accessing medication and treatment. Evidence indicates that the first 6 months to a year of release into the community, either from jail, penitentiaries, hospital or other, are the most crucial to the individual's successful reintegration and recovery. Unfortunately, many individuals are often placed on long waiting lists or restricted from housing options due to their criminalized background. Providing 24-hour housing for individuals who are unable to find housing or are on a waiting list for supportive housing immediately following release into the community has been quite

[90] Patterson et al. (2008). p.2.

[91] Burill, J., Elizabeth-Fry Society of Kingston, (personal communication, Kingston Forum, November, 2007).

difficult. Certainly, offering limited support is extremely problematic when dealing with high risk individuals whose successful reintegration relies on appropriate and timely interventions.

The struggle in providing continuous mental health services to the individual once returned to the community has been exceptionally detrimental for federally sentenced persons. Upon entry to a federal institution, people lose their right to provincial health services and are required to reapply for coverage upon release. This has resulted in a large number of released prisoners without health cards and medical coverage, which restricts many from obtaining medication previously prescribed and monitored within the institution. The development of an integrated strategy should take this into account and deal with this issue prior to releasing the individual into the community. A major component of the integrated network consists of closing the gaps between discharge and transitional planning as a mean to avoid individuals from falling through the cracks of the system.

> One of the most effective ways of addressing chronic street homelessness is prevention. This often involves commitment of resources to ensure housing and support services, and effective discharge planning from the many institutions that interface with homeless and at-risk people with SAMI. Some of these institutions include, but are not limited to: hospitals, treatment facilities, psychiatric institutions, correctional facilities, and sometimes Family Care Homes.
>
> In the absence of effective policies and practices around discharge, many of these institutions simply release people into local shelters.
>
> […]Discharge planning without the commitment of resources to ensure stable housing, is not sufficient to prevent homelessness. In some communities, individual agencies have created a continuum of housing options, starting with residential treatment and including transitional, permanent supported and affordable market housing, because they realized that many clients became homeless without these options.[92]

SLSC has undertaken research to address issues regarding access to community based mental health supports, as well as long term housing solutions such as second stage housing for ex-prisoners.[93]

[92] Patterson et al. (2008). p.62.

[93] For more information see: St. Leonard's Society of Canada. (2010). *Community Connections: The Key to Community Corrections for Individuals with Mental Health Disorders;* St. Leonard's Society of Canada. (2012). *Homes for the 'Hard to House' A Model for Effective Second Stage Housing (The H2H Model and Research Findings Report).*

THE SILO EFFECT

The term "silo effect" has been used widely to express the lack of communication and shared goals between the service systems but also among service providers themselves. The limited number of trained mental health professionals has severely impacted people with mental health problems and illnesses because of lengthy waiting lists. Countless individuals are waiting for services provided by a select few, heightened by agencies that have difficulty working collaboratively to ensure the most effective service provision.

As indicated by the Vancouver Police Department in their report entitled *Lost in Transition* (2008), the devastating consequences of the silo effect has constrained both service providers who are able to adequately serve this particular group, and individuals who as a consequence of the lack of communication between sectors will not receive appropriate services.[94] Subsequently, communication challenges pose a great dilemma as many service providers are unacquainted with the service agencies in their surroundings. People with mental health problems and illnesses often deal with agencies that have provided services to them prior to their contact with the criminal justice system.[95] Information management strategies to reduce criminalization have been perceived as too great a risk. In addition, the fear of public scrutiny has led many to avoid exposing their services. Many individuals are using crisis centres as a mean to obtain information on the social services that are available.

"A 17 year old client of mine with numerous suicide attempts and daily self-harm behaviours is involved with multiple service agencies – including mental health. We are attempting to help the individual through ongoing crises and managing basic day-to-day functioning. One of the service providers called me with concerns that the client didn't have a 6-month dental check-up, while the client is homeless and in my car while I am trying to secure him a place to live. The individual has been kicked out of his current home, which was a "last resort" option for housing. While attempting to have this service provider approve emergency shelter, I am informed that they cannot do that for 48 hours until everything can be reviewed. They remain upset that the client did not go to the dentist as per their agency's checklist, though this has stemmed from pressure to complete the checklists as outlined by their own protocols and those to whom they are accountable to. This example demonstrates how far apart on priorities we are, despite the fact that it is supposed to be collaborative approach. These are important issues that speak volumes about how we call ourselves "collaborative" but forget why and for whom we are doing it in the first place." – ***First-hand account of the silo effect from a mental health worker***

A major challenge involves ensuring that all the necessary information is gathered and compiled into their database as opposed to inserting only a selected few, as a guarantee for reduced accountability measures.[96] Police officers are guided by the Mental Health Act from the transportation process to the arrest of the individual. As a result, many will regulate the release of information in order to avoid any criticism

[94] Wilson-Bates, F. (2008). *Lost In Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources*. Vancouver Police Department. Retrieved March, 2013 from: http://vancouver.ca/police/assets/pdf/reports-policies/vpd-lost-in-transition-part-2-draft.pdf.

[95] Marshall, J. Supervisor, Kelowna Alcohol and Drug Services, Interior Health, (personal communication, Vancouver Forum, November, 2007).

[96] Det. D. McCarthy, Kingston Police Department, (personal communication, Kingston Forum, November, 2007).

towards the department. However, these restrictions can render their role more difficult when attempting to identify the most effective strategy to prevent future encounters with the criminal justice system.

The fear experienced by some mental health professionals of getting involved with justice-involved clients has also contributed to the silo effect. The requests made by judges often do not coincide with the training and practices of mental health workers. Most are trained to work with a voluntary population. Additionally, their role primarily involves assessing and assisting individuals in their recovery, while the court is more punitive and deters through restrictions and surveillance. Consequently, therapists and clinicians are required to opt for security *or* offender treatment. "A narrower interpretation [of rehabilitation] is that the primary goal is to prevent offending and protect society, and that offender centered goals are simply a means to this end. Here, the goal is to restrict rather than enable, and individual benefit is not a primary consideration."[97]

There are challenges experienced within hospitals, especially psychiatric units, in dealing with the needs of the mental health and justice involved population. Often, individuals are offered limited short-term support as a result of the organizational structure of hospital operations. For instance, a hospital stay is approximately 7 to 10 days in length. In most cases, individuals have access to short-term care within the facility, which primarily targets mental health and risk assessment to minimize any threats to public safety once the individual is released into the community.[98] Following this short-term arrangement, the hospital is under the obligation to release the individual unless there is reason to believe that the patient must be hospitalized for a longer period of time. The availability of services within forensic hospital settings and the available funds currently provided to them may result in an increasing number of referrals made to hospitals for mental health services as a diversion to incarceration. However, this alternative does not necessarily contribute to reducing the criminalization of individuals with mental health problems. The "forensic" label, as previously mentioned, has negative consequences both to the individual and to service providers who have undertaken the challenge of identifying services and supports that are best suited.

An important consequence of the silo effect is that little attention has been paid to evaluating the effectiveness of practices. There is little research within the voluntary sector given that most are principally responsible for program delivery and residential services. The lack of adequate staffing and research/policy training has affected the service system. Reports have indicated that programs and services would benefit from partnerships between service agencies and universities. Their role would include assessing programs and their evaluation practices, but it would also allow for research to be shared within the academic field. The gap between research and practice only ignites the existing isolation and weakens the possibility of working from a common ground. Communication with others can only encourage collaboration.

---

[97] Blackburn, D. (2004). "What Works" with Mentally Disordered Offenders. *Psychology, Crime & Law*, 10(3), 301.

[98] Villeneuve, V. Director of Southern Alberta Forensic Psychiatric Centre, Calgary Health Region, (personal communication, Calgary Forum, November, 2007).

The Image of Mental Health

As outlined earlier, the definitions used to describe a person with mental health problems have played a major role in the provision of services and support. For instance, the DSM-IV-TR has been employed to classify individuals into specific categories of mental illness. Criteria set by the psychiatric field have restricted many from obtaining services given their inability to meet the criteria for a specific or dual diagnosis. The image of mental health and mental illness has also had a significant role in how this group has been treated.

Public Opinion

As indicated by Arboleda-Flórez, stigma and discrimination have entered the realm of mental illness and have affected the experience of those who are implicated (i.e. the individual, family member, service providers). "…Patients, particularly those who manifest obvious signs of their condition either because of the symptoms or the side effects of medications (visibility); who are socially construed as being weak of character, lazy or free-loaders (controllability); and who display threatening behaviours (dangerousness) are among the most stigmatized of all social groups."[99] The negative images and perceptions that have been associated with mental illness further contribute to the increased perception that those who suffer from mental illnesses are a threat to public safety.

During his presentation at the Vancouver forum for this research, Professor Simon Verdun-Jones referred to the existence of a particular relationship between violence and mental illness. He examined the stereotypical perception that those who suffer from mental illnesses are dangerous and violent. Specifically, the aim of his presentation was to demonstrate how the image of mental illness affects public perceptions and how this image has further limited the services and support provided by the social service system. "Members of the public undoubtedly exaggerate both the strength of the relationship between major mental disorders and violence, as well as their own personal risk from the severely mentally ill."[100]

Public perceptions have constructed an image of mental illness as that of the person to be feared and controlled through means of law enforcement and punishment. Consequently, public opinion is guided by perceptions of dangerousness, violence and incapacity when talking about individuals who suffer from mental health problems. As expressed by Professor Archie Kaiser, this restrictive and exclusive image has led to a systemic discrimination towards guaranteeing services to this marginalized and disadvantaged population.[101]

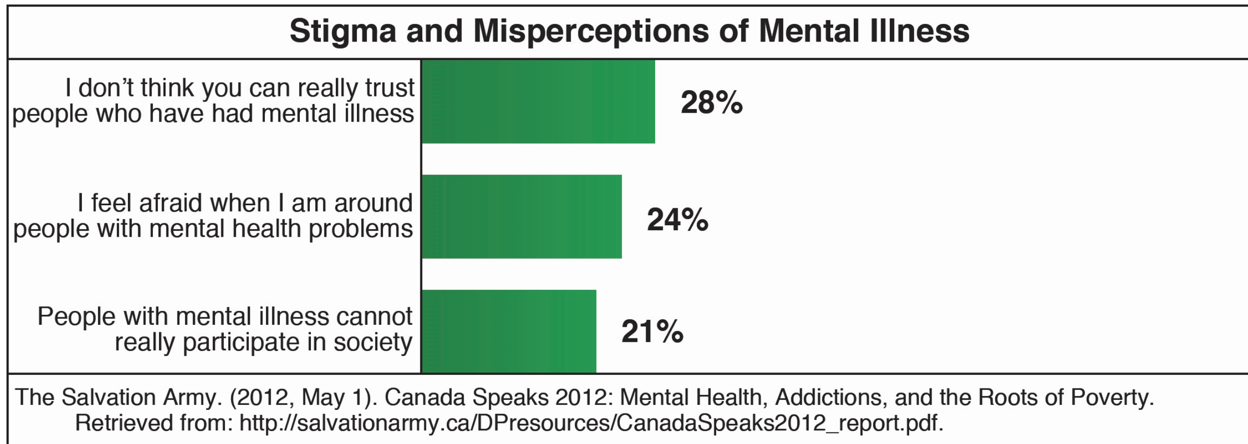
These images of mental illnesses contribute to the increased use of stereotypes to assign status to this specific group. Despite this challenge, Professor Verdun-Jones has suggested that social factors other than mental illness have had a greater effect on the probability of violent behaviour present among this particular population.[102] According to Silver (2002), several recent studies have found that people with mental disorders that have behaved, or threatened to behave violently in the recent past also report feeling threatened and, in fact, often were victims of violence. Therefore, measuring the nature and extent of the victimization experiences of mentally disordered people may ultimately help to explain their greater involvement in violent behavior.[103] The research findings presented by Professor Verdun-Jones further demonstrate the significant role of the social conditions of individuals who suffer from mental illness in identifying the services and support that best suit these individuals.

---

[99] Arboleda-Flórez, J. (2005). Stigma and discrimination: An overview. *World Psychiatry*, 4(1), p.8.
[100] Verdun-Jones, S. (2007).
[101] Kaiser, A. (2007) *Towards a Model Community Mental Health Strategy.* Presented at SLSC & CCJA Towards a Community Mental Health Fora, Halifax, Nova Scotia.
[102] Verdun-Jones, S. (2007).
[103] Verdun-Jones, S. (2007).

In 2012, the Salvation Army in Canada polled Canadians on their opinion of different mental health related issues. Data was collected via an online survey administered by Angus Reid Public Opinion. In total, 1,011 Canadians completed the survey which was made available in both English and French. The Salvation Army maintains that the data is accurate ± 3.1%. Figure 1 highlights some of the negative perceptions Canadians associate with people who have mental health issues.

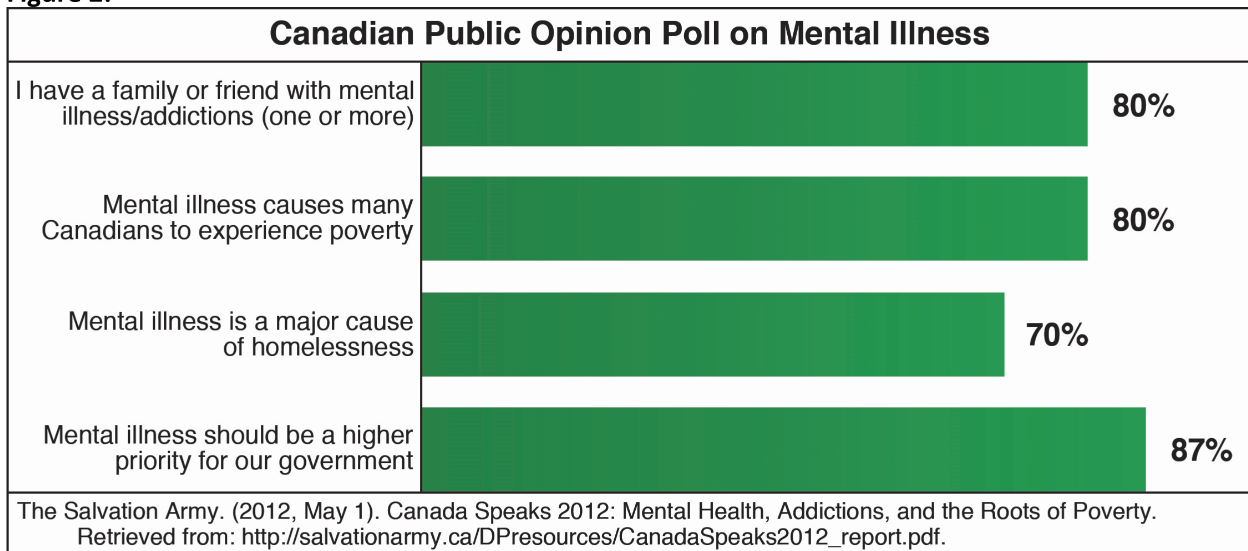
Figure 1:



The Salvation Army. (2012, May 1). Canada Speaks 2012: Mental Health, Addictions, and the Roots of Poverty. Retrieved from: http://salvationarmy.ca/DPresources/CanadaSpeaks2012_report.pdf.

Despite some negative perceptions that undoubtedly remain, the study also showed that Canadians may be more sensitive to the needs and issues that pertain to people with mental health problems and illnesses (see Figure 2). While stigma remains, it is encouraging to see that many Canadians would appreciate additional attention and concern given to addressing the needs of those with mental health issues.

Figure 2:



The Salvation Army. (2012, May 1). Canada Speaks 2012: Mental Health, Addictions, and the Roots of Poverty. Retrieved from: http://salvationarmy.ca/DPresources/CanadaSpeaks2012_report.pdf.

How can we focus on changing the image of mental illness if people with mental health problems and illnesses continue to be incarcerated, discriminated against and neglected within our institutions?

MEDIA

The media plays an important role in shaping the (often negative) image of people with mental health problems. By frequently excluding the social aspect of mental health, media images have contributed to creating the perception that these individuals do not socialize and that they isolate themselves deliberately. Entertainment media, through television series and movies, have constructed an image of those who suffer from mental illnesses as dangerous and unpredictable. Although the image of mental health has gone through some transformation over the years, a persistent image of mental illness has traditionally been associated with violence and irrational behaviours, such as was portrayed through the characters of Jekyll/Hyde, and Hannibal Lecter.

Historically, the characteristics that have been attached to many of the principal actors in thrillers and horror movies focus on the cause of their behaviour, primarily on how they and others explain violent and psychopathic behaviours. For example, in 2000, the popular crime drama *American Psycho* featured a wealthy Wall Street businessman and serial killer, Patrick Bateman, who explains his behaviour by stating:

> There are no more barriers to cross. All I have in common with the uncontrollable and the insane, the vicious and the evil, all the mayhem I have caused and my utter indifference toward it I have now surpassed. My pain is constant and sharp and I do not hope for a better world for anyone, in fact I want my pain to be inflicted on others. I want no one to escape, but even after admitting this there is no catharsis, my punishment continues to elude me and I gain no deeper knowledge of myself; no new knowledge can be extracted from my telling. This confession has meant nothing.[104]

This image of mental illness and of those who suffer from it has contributed to reinforcing the public opinion that public safety is being threatened by these individuals. Research has demonstrated how the public relies on the media as a source of information and entertainment.[105]

In reality, mental illness is a poor predictor of violence. As a group, mentally ill people are no more violent than any other group. In fact, people with mental illnesses are far more likely to be the victims of violence than to be violent themselves. Current research shows that people with major mental illness are 2.5 times more likely to be the victims of violence than other members of society. But media depictions of persons with a mental illness attacking a stranger do much to shape public opinion. The saliency of such high-profile crimes, despite their infrequency, makes it appear as though violent crimes committed by individuals with a psychiatric diagnosis are common and that the general public has reason to fear people with mental illness.[106]

Recent attempts to humanize mental health issues can be seen in leading Hollywood films such as *A Beautiful Mind* (2001), *Take Shelter* (2011), and *Silver Linings Playbook* (2012). However, in terms of popular media, it is apparent that psychological themes are prevalent throughout featured films in Hollywood.[107] One study of academy award winning films depicting psychological themes found that antisocial personality disorder makes up approximately 23% of all themes, and narcissistic personality disorder makes up approximately 19% of all themes.[108] The influence of the media as a source for public

---

[104] Internet Movie Database. *Memorable quotes for American Psycho*. Retrieved March 2013, from: http://www.imdb.com/title/tt0144084/quotes

[105] Baun, K. (2009). Stigma Matters: The Media's Impact on Public Perceptions of Mental Illness. *OttawaLife Magazine* (*Mental Health Series: A Friend, A Home, A Job).* February 2009.

[106] Baun, K. (2009). p.32

[107] Krauss-Whitbourne, S. (2012). Psychology's Best Movies: and the Oscar goes to…which psychological disorder? Published January 14, 2012 in *Psychology Today: Fulfillment at Any Age.*

[108] Krauss-Whitbourne, S. (2012).

information signals an urgency to use approaches that are more sensitive to reducing stigma, and which increase awareness about the reality of mental illness. "The media and criminal justice systems are penetrating each other increasingly, making a distinction between 'factual' and 'fictional' programming ever more tenuous."[109] One suggestion is to include the media in public education and awareness campaigns, such as the MHCC's *Opening Minds* campaign, that target the reduction of stigma and discrimination directed towards individuals who suffer from mental health problems. Media impact on public perceptions suggests that they should play a significant role in the initiative for change. Positive messages and success stories should be presented in the news media so as to change the existing image of mental illness.

Service Delivery System

Stigma and discrimination go beyond the community, beyond the media and into the direct services and support realm. According to Dr. Vijaya Prabhu, Queen's University department of psychiatry, stigma is also present within hospitals and universities; not only do people with mental health problems and illnesses suffer from the stigma directed by society, but service providers also have their own perception of these individuals, especially when they have been in contact with the criminal justice system. [110] Public perceptions of mental illness and violence have entered the mental health service delivery network. Public perception and media representations have had an impact on public policy, location of treatment centres and other establishments, and it has also affected those who choose to take on this career choice. In addition, the lack of cross-training and education offered to service providers has led many to integrate perceptions and attitudes similar to those expressed by public opinion in order to better understand mental health and mental illness. "... Widespread stigma persists throughout society despite many efforts to educate the general public and the health care system as a whole. It has been said that stigma is the largest barrier to change in every level of the system."[111] The challenges faced by service providers and mental health professionals in defining this particular population must include careful consideration of the attitudes and perceptions that exist within the service delivery network. Those dealing with this population should be aware of the influence of the public and the media on their own perceptions along with the impact of these onto the individual living with mental health problems.

How do we reduce the perceived relationship between mental health and violence?

How do we improve our relationship with the media?

How do we demonstrate the importance of addressing these issues with politicians/funders?

How can mental health professions be made more attractive?

---

[109] Reiner, R. (1997). Media made criminality: The representation of crime in the mass media. In M. Maguire, R. Morgan, & R. Reiner (eds.), *The Oxford Handbook of Criminology*. Oxford: Oxford University Press, p.380; Also see Surette, R. (1998). *Media, Crime and Criminal Justice: Images and Realities (2nd Ed.),* Belmont: Wadsworth.

[110] Prabhu, V. Associate Professor, Departments of Psychiatry and Family Medicine, Queen's University, (personal communication, Kingston Forum, November, 2007).

[111] Kaiser, A. (2007).

RISK MANAGEMENT AND COMPREHENSIVE ASSESSMENTS

The move towards risk assessment and management as a priority has had a direct impact on the relationship between individuals with mental health problems and police officers. Many people fear the police due to previous encounters and criminalization which occurred as a result of their interaction. The lack of mental health intake assessments have influenced the services and supports provided to people. A large number of individuals do not have access to, or are restricted from, specific services on account of their risk assessment. Risk and security-related issues have dominated the mental health service delivery network. Police officers will benefit less from identifying psychiatric disorders and should be provided with more extensive knowledge on effective responses and how to better understand actions posed by individuals with mental health problems and illness.

However, mental health-related situations are not limited to the work of police officers. Many other service providers and professionals working within the community are involved in the mental health service delivery network.

While much of the focus of police services with respect to mental illness in the community has been on crisis response, in fact mental health crises are only one of several types of situations in which the police find themselves when interacting with people with mental health problems and illness. These situations include:

- Apprehensions and other powers of police under mental health acts;
- Arrests in which the accused appears to be mentally ill;
- Minor disturbances in which a person appears to be mentally ill;
- Situations in which a mentally ill person is the victim of crime;
- Situations in which a person with mental illness (PMI) threatens others;
- Circumstances in which the public or families of PMI ask for help;
- Non-criminal or non-offence situations in which the police become aware that someone who has a mental illness appears to be at risk or in need of assistance;
- Suicide interventions;
- Situations in which a PMI provokes a reaction from police to harm or to kill them;
- Circumstances in which police become instrumental social support contacts for PMI (situations in which police provide practical assistance and support to people in need).[112]

Therefore, protocols should focus on the difficulties experienced by the service delivery system including the role of police officers and other service providers in dealing with the challenge of mental health and risk assessments. Directives have posed a challenge to service providers and psychiatric hospitals. How can they ensure that an individual recognizes that he/she is signing over the right to make choices regarding their personal health and mental health? What type of monitoring will protect the person and avoid any violation?

There is also concern regarding the use of *Section 810* of the Criminal Code, whereby an individual is required to enter a peace bond if there are reasonable grounds to believe that he/she will commit a crime or has been identified as a risk, to be managed through court orders. However, this obligation has been associated with an increase in re-incarceration, which further aggravates the revolving door syndrome. As indicated by the *Street Crime Working Group*, "persons with symptoms of mental illness make up

[112] Police/Mental Health Subcommittee of the Canadian Association of Chiefs of Police Human Resources Committee (2006). *Contemporary Policing Guidelines for Working with the Mental Health System.* p. 2.

approximately 35-40 appearances a day in Vancouver courts. They are most frequently charged with theft under $5,000, assault, and breach of court ordered conditions."[113] The lack of adequate mental health and social services, especially for individuals who have had encounters with the criminal justice system, has contributed to an increasing number of chronic offenders. As a result, challenges that target the use of risk assessment and the development of more effective mental health assessments are essential to the implementation of an effective mental health service delivery system. Identifying adequate support and services should be an integral component of an individual's assessment as opposed to using risk as the rationale for re-incarceration.

A promising practice that has emerged is the interRAI Brief Mental Health Screener (BMHS), developed to provide police officers with a tool that would help them to identify persons in the community with mental health problems and to assist them in communicating their observations to appropriate health care professionals. Core items on the BMHS were extracted from a sample of 40,000 cases in the Ontario Mental Health Reporting System database for the RAI-MH version 2.0.[114] Additional items were also identified through collaboration with police officers, hospital personnel, administrators and mental health care workers. A pilot study was conducted over an eight month period commencing in 2011 with the participation of two police services, four general hospitals and one psychiatric facility in southern Ontario.

The effectiveness of the instrument is being evaluated by testing the association between police officer ratings on the form and clinician's assessments conducted in the emergency department (ED) of the general hospitals. The ultimate goal underlying the development and use of the BMHS is to ensure that people with mental health problems who come in contact with the police receive prompt access to appropriate mental health services, reducing the risk of criminalization.[115] There is hope that this instrument will be utilized province-wide in Ontario.

At the federal level, Correctional Service of Canada is legislatively mandated to provide health care to inmates through the *Corrections and Conditional Release Act*

Section 86 of the *CCRA* states that:

(1) **The Service shall provide every inmate with**

(a) Essential health care (which includes mental health care), and

(b) Reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.

(2) **The provision of health care under subsection (1) shall conform to professionally accepted standards.**

Section 87 of the *CCRA* further states that:

The Service shall take into consideration an offender's state of health and health care needs

(a) In all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and,

(b) In the preparation of the offender for release and the supervision of the offender.

[113] Street Crime Working Group (2005), p. 25.

[114] Note: The InterRAI-MH is a comprehensive standardized instrument for evaluating the needs, strengths and preferences of adults with mental illness in in-patient psychiatric settings. This instrument allows for assessment of key domains of function, mental and physical health, social support and service use; with particular items identifying those who could benefit from further evaluation of specific problems to help prevent risk of further decline and improve functioning. The interRAI MH replaced the RAI-MH Version 2.0 as the international standard for inpatient assessment of adults in mental health settings in 2007.

[115] interRAI. (2012). Retrieved March, 2013, from: http://www.interrai.org/index.php?id=98.

(*CCRA*).[116] Federally sentenced persons are excluded from the *Canada Health Act* and are not covered by Health Canada or provincial health systems. CSC provides health care services directly to sentenced persons, including those residing in Community Correctional Centres (CCC).[117]

Based on discussions regarding the implementation of a more comprehensive mental health assessment within institutional programs and services, the Computerized Mental Health Intake Screening System (CoMHISS) was introduced in 2009 by the Health Services Branch at CSC. A pilot study conducted with CoMHISS found that 40% of incoming male prisoners, and more than 60% of incoming female prisoners would meet the criteria to be screened in for further evaluation based on a cut off score of the psychological measures.[118] There continues to be a concern for the need to address the institutional structure of penitentiaries, which often poses difficulties when attempting to develop effective services and programs to meet the needs of this population.[119]

In 2012, the Office of the Correctional Investigator expressed hope that the Mental Health Commission of Canada would address the "situation of increasing numbers of Canadians with mental illness being warehoused in federal correctional facilities."[120] The OCI added that the measures needed to reverse this situation include:

> ...investments in community MH services, inclusive of prevention, diversion (e.g., MH and drug courts), anti-stigma campaigns, and enhanced multi-sectoral services related to mental health issues (e.g., housing, education, assisted living)...[an] exploration of alternative models of delivery of mental health services which separate Corrections from health care, and security from therapeutic interventions. Acute psychiatric cases and persons who chronically self-harm should not be in a correctional setting...and endorsement of a patient advocate model in federal Corrections.[121]

In many cases, people are released into the community without any supportive network or stable housing options. In addition, evaluation programs should complement the existing services to ensure that proper assessment is being done.

Research has also focused on the onset or deterioration of an individual's mental health within correctional settings. The correctional onset of mental health problems should also prompt one to question whether correctional settings are apt to deal with the institutional onset of specific disorders. Findings reveal that this challenge goes beyond federal corrections. It has been suggested that the increasing number of chronic offenders consist of individuals who suffer from mental health/addictions and other social problems and who are not receiving adequate services and support while institutionalized. The issue of criminalizing the mentally ill has demonstrated the importance of addressing both federal and provincial correctional inadequacies in mental health services along with the challenges experienced within the community by the service delivery network.

Correctional systems need to ensure risk management and assessment consider the implications of mental health.

---

[116] While Correctional Service of Canada works with people who are criminalized, effective interventions at that point may avoid future criminalization.

[117] Community Correctional Centres are government-run transitional residences for people on conditional release.

[118] Stewart, L. A., Wilton, G. & Malek, A. (2011). *Validation of the Computerised Mental Health Screening System (CoMHISS) in a Federal Male Offender Population*.

[119] Zinger, I. (2007).

[120] Zinger, I. (2012). Mental Health in Federal Corrections: Reflections and Future Directions. *Health Law Review*, 20(2), 24.

[121] Zinger, I. (2012).

TOWARDS A MODEL COMMUNITY MENTAL HEALTH STRATEGY

The overall goal at the outset of the original *Towards an Integrated Network* project in 2008 was to work towards a model community mental health strategy. Five years later, this goal remains a benchmark for achieving success in the fields of mental health and corrections. Challenges remain and the elements originally set out in this section continue to be pertinent in developing a meaningful strategy.

This section outlines the means and the elements of implementing a community mental health strategy. Specifically, it emphasizes three main components that are central to the development of effective community practices. According to the experts who took part in this project's workshops in 2007, a community mental health strategy should:

- Develop a multidisciplinary approach to mental health services;
- Engage the individual; and
- Provide cross-training and education.

DEVELOPING A STRATEGY

Each of the three components above is supported by building blocks that assist in the development of effective community practices and protocols. Each is presented within this section, and includes examples of existing community practices that illustrate them as well as recommendations provided by experts on how to improve current practices.

The goal of this section is to examine effective community practices that contribute to reducing the criminalization of individuals with mental health problems. Such initiatives have developed as a result of gaps in providing adequate services. Many direct service providers are dealing with individuals who suffer from multiple health and social problems and who have great difficulties in meeting their basic needs. Unfortunately, a large number of service providers have judged themselves ill-equipped to deal with this group, especially for those individuals who have been in contact with the criminal justice system.

In 2008, the Institute for the Prevention of Crime released a report entitled *Homelessness, Victimization and Crime: Knowledge and Actionable Recommendations,* which demonstrates further the criminalization of vulnerable populations as a result of existing systemic inadequacies. According to their report, "certain sub-groups are disproportionately vulnerable to post-incarceration homelessness, such as people with a diagnosis of Fetal Alcohol Spectrum Disorder, poor literacy, severe mental illness, trauma-related brain injury, low intelligence, and those with a prior criminal record, addictions, or heavy drug use".[122] The lack of effective collaboration and partnerships between systems has had a significant impact on the services that are available. As a result, the relationship between the health, social and justice systems cannot be overlooked.

Stigma and discrimination within the community at large and among direct service providers has also had an impact on the social support and service networks. "Many people living with a mental illness report

---

[122] Institute for the Prevention of Crime. (2008). *Homelessness, Victimization and Crime: Knowledge and Actionable Recommendations*. Retrieved March, 2013 from: http://www.socialsciences.uottawa.ca/ipc/pdf/IPC-Homelessness%20report.pdf, p.19.

that the stigmatization of mental illness causes them more suffering than the disease itself".[123] As discussed in the media section of this report, media influence plays an important role in how people with mental health problems are stigmatized.

Despite present systemic barriers, there is evidence pointing to the success of leading cities, agencies and organizations and the capacity to develop effective practices. Core principles and values have guided the development of these initiatives. For example, the Mental Health Commission of Canada's anti-stigma campaign stems from the desire to change attitudes towards mental illness. The Correctional Service of Canada (CSC) is also targeting key priorities based on core principles and values, such as "respecting the dignity of individuals, the rights of all members of society, and the potential for human growth and development",[124] CSC has engaged in improving mental health services within their institutions by developing a mental health strategy, and engaging people beyond the institution with the Community Mental Health Initiative. Similar principles and values govern community-based organizations and have led to the implementation of community practices aimed at providing effective mental health services.

Purpose of a Community Mental Health Strategy

- Identify the elements and means of implementing a community mental health strategy that best suits one's need
- Increase awareness of effective and promising practices
- Expand communication networks to facilitate the exchange of ideas and practices
- Contribute to the key initiatives of the Mental Health Commission of Canada

Core Principles and Values

Focus on a Perspective of Change	**Encourage Initiatives that focus on Reducing Stigma and Discrimination**	**Develop Community Capacity**	**Promote a Continuum of Care**
Develop tangible protocols	Build on values of dignity and respect	Promote sustainable communities	Improve availability and accessibility
Generate flexible and amendable strategies	Focus on the individual	Identify shared goals and objectives	Incorporate the social determinants of health
Include community demographics	Promote and support advocacy	Develop an action plan	Develop a holistic approach

These core principles and values continue to be relevant towards the development of a meaningful community mental health strategy.

[123] Mental Health Commission of Canada, (2007).
[124] Correctional Service of Canada, (2007).

Sample Protocols and Programs

Considering the diversity of the Canadian population, this project recognizes that existing practices may require adjustments if implemented in a different locality, region, province or territory. These practices must take into account culture and ethnicity, along with gender and age-related differences. Accordingly, the fora took place in four different Canadian cities to account for similarities and differences that challenge and benefit the work of direct service providers. Kingston, Halifax, Calgary and Vancouver, were identified by the members of the advisory group because of their current cutting-edge work.

In addition, various participants led initiatives in several cities across Canada. For example, Dr. Arboleda-Flórez, Chair of Queen's University Department of Psychiatry and expert in the field, noted the challenges faced by Alberta and British Columbia. He originally took part in the implementation of Tele-Mental Health within Alberta, which consists of providing mental health services through a satellite clinic. This initiative was designed as a result of the limited number of trained mental health professionals, particularly for the rural population of Alberta. This illustration demonstrates the importance of addressing population differences within Canada.

Although this handbook includes community practices across different regions and provinces, it is not intended to be an exhaustive presentation of promising approaches. Further investigation of the challenges that face direct service providers working with individuals with mental health problems and illness in other parts of Canada, such as Quebec and Northern Canada should be carried out. In addition, a review of other segments of the population, such as youth, is necessary.

> *My prescription for reform maintains that an evolutionary process must begin at the level of improving Canadian mental health and social service standards as a condition precedent to stopping the human spillover into the criminal justice system.*
>
> Archie Kaiser, *Towards a Model Community Mental Health Strategy*. Presented at SLSC & CCJA Towards a Community Mental Health Fora, Halifax, Nova Scotia. 2008.

DEVELOPING A MULTIDISCIPLINARY APPROACH TO COLLABORATION AND PARTNERSHIPS

In order to improve upon social and policy responses that are inadequate in serving the needs of those living with mental health problems and illness, it is critical to recognize and identify the elements of successful community mental health strategies. It is suggested here that a successful multidisciplinary approach to collaboration and partnerships would comprise guidelines that build on information-sharing and that endorse a holistic approach to mental health services.

Collaboration and communication among mental health experts, professionals and direct service providers is crucial for effective mental health practices in order to identify upcoming challenges and set up adequate responses, but also to avoid any additional criminalization. According to Dr. Arboleda-Flórez (2007), "any new innovation to the system carries with it the seeds for future troubles. A system will never be static, it will never be perfect".[125] Consequently, this handbook intends to provide a set of guidelines for developing strategies that best suit the needs of organizations and communities. This has been based on what has worked, what is working, and what will work given the information obtained from the regional fora. As such, it is recommended that a multidisciplinary approach to mental health services should explore the following building blocks:

- Communication and Information-Sharing
- Cross-Sectoral Relations Horizontal Initiatives
- Program Development and Evaluations
- Protocols and Agreements

Each of these building blocks is explored further based on research and promising practices revealed throughout the course of this research.

COMMUNICATION AND INFORMATION-SHARING

The mental health system is made up of a variety of key partners and stakeholders that are necessary to the delivery of adequate social services. Local partnerships have been very effective in reducing the criminalization of individuals with mental health problems by taking on a multidisciplinary approach. Service teams and service agreements have focused on more effective communication strategies, information-sharing and procedural protocols that take into account not only the individual's physical and mental health, but also social environment, social network and systems of support.

Since 2007, such practices have contributed to reducing isolation experienced by people with mental health problems and illnesses. Many of these initiatives involve working with the community and with emergency care, psychiatric and/or forensic services to increase public awareness and develop a service continuity plan. In many cases however, organizations do not advertise their programs/services, which could be in part a reaction to public opinion. More effective communication strategies would not only allow for the sharing of information, but also assist service providers in learning about practices implemented in their own region, which could be beneficial to a person's recovery process. Effective

[125] Arboleda-Flórez, J. (2007). Dispossessed and Disposable. Presented at SLSC & CCJA Towards a Community Mental Health Fora, Kingston, Ontario.

communication and information-sharing have also contributed to reducing the waiting period for transfers and service delivery by integrating all partners throughout the intervention planning process.

Additional positive outcomes of effective communication strategies and information-sharing include access to information and the safety of the individual. Practices should take into account these issues when developing protocols and agreements in order to minimize risk. There should be an attempt towards a common understanding of the type of information that can be released, how, by whom, and the impact of working with competing or incompatible mandates. The initiatives presented below provide additional examples of how such building blocks have been included in developing a multidisciplinary approach to mental health service delivery.

While communication strategies are essential at the local level, supplementary strategies must be implemented that focus on maintaining effective provincial and federal collaborations. Communication among sectors can be used to promote the success stories and to address common challenges in working with specific groups (e.g. ex-prisoners as people with mental health problems and illnesses).

HOW DO WE COORDINATE EFFECTIVE COLLABORATIVE STRATEGIES?

HOW DO WE ENSURE CONTINUOUS, POSITIVE COMMUNICATIONS AMONG SERVICE PROVIDERS AND ACROSS SECTORS?

RECOMMENDATIONS:

- ☑ Work from a common language that focuses on a multidisciplinary approach to service delivery
- ☑ Utilize language that focuses on a recovery-oriented approach to service delivery
- ☑ Identify and agree upon the type of information that is disclosed and how one should proceed in providing and obtaining information from community partners
- ☑ Address and work with competing mandates and legislation. Be creative, flexible and open to compromise
- ☑ Illustrate how each contributes to the picture of Canadian mental health services;
- ☑ Do not exclude: Integrate sectors that have been neglected such as the private sector, the commercial sector, community engagement
- ☑ Acknowledge collaboration and partnerships as successful practices: Be the voice of change
- ☑ Demonstrate how existing practices take part in achieving key initiatives (anti-stigma campaign, knowledge exchange centre and development of a national strategy on mental health)

EXAMPLES OF PROMISING AND EFFECTIVE PRACTICES

The ***Crisis Outreach and Support Team (COAST)*** serves the residents of Hamilton-Wentworth who have serious mental health issues and are in crisis. This program involves a multidisciplinary team including child and youth crisis workers, mental health workers, nurses, social workers and plain-clothes police officers. This program maintains a crisis line that assists and coordinates immediate intervention and provides referrals to appropriate services. It also uses a database which includes each call/intervention/referral collected by the different acting agents (i.e. crisis support worker, police,

hospital, etc.). According to Laurie Bourne-MacKeigan[126] (*Brockville Mental Health Centre*), *COAST* and other similar partnerships have reduced the waiting time for police officers in emergency rooms.[127]

The ***Lanark County Police Services and Lanark County Mental Health, Emergency Department, Ambulance Services, Diversion*** **(L.E.A.D.) Team** is an integrated team of specially trained police officers working with emergency and mental health service providers along with community support and advocacy groups. The team is dedicated to helping emotionally disturbed persons in crisis while preserving the safety of the community and all parties involved. Through continuous collaboration and evaluative practices, L.E.A.D. has managed to develop a well-informed protocol for dealing with crisis situations. This model also includes a crisis line, similar to the COAST that is available 24/7. As part of the crisis response a mental health/psychiatric nurse is responsible for an on-site risk and mental health assessment.

L.E.A.D. Team Sample procedure:

> Based on the nature of the call, the trained dispatcher determines if a L.E.A.D. response is appropriate. As often as possible, team members are responsible for on-the-scene contact with the person in crisis. If deemed necessary by the officer, the person in crisis will be transported to a center for emergency assessment. The police officer follows detailed procedures for the transportation and admission of the person in crisis to the emergency center. If transportation to an emergency center is not necessary, the officer will determine if the person in crisis is involved with any of the community partners. If so, the officer will contact the partner for advice and assistance. If there are no connections between the person in crisis and the community partners, the officer will attempt to contact service partners and locate appropriate services.[128]

The Lower Mainland Royal Canadian Mounted Police (RCMP) Division has implemented a **Crisis Intervention Team (CIT)** in collaboration with various community partners (i.e. Vancouver Health Authority)**.** Trained officers proceed to their regular duties and in the event of a mental health-related crisis, they are dispatched as first responders.

The incidents are either resolved on site, require the person to be transported to a medical center or require a referral to a mental health service agency, as appropriate. The CIT is supported by service agreements that have been developed in order to determine the most appropriate action plan. For example, persons brought in are seen within 15 minutes, and none are refused medical and/or psychiatric attention.

In Ontario, The **Provincial Human Services and Justice Coordinating Committee** was set up as a "provincial leadership mechanism" in 1997 in recognition of the need for greater coordination among service providers specifically to find solutions to address issues of collaboration and streamlining among various stakeholder agencies, and the municipal and provincial levels of government.[129]

---

[126] Bourne-MacKeigan, L. Outpatient/Crisis Outreach Team Coordinator, Brockville Mental Health Centre (personal communication, Kingston Forum, November, 2007).
[127] COAST Hamilton. Website: http://www.coasthamilton.ca/index.html.
[128] McDonnell, D. Supervisor, Lanark County Mental Health (personal communication, February, 2008).
[129] Human Services and Justice Coordinating Committee. Website: http://www.hsjcc.on.ca/Default.aspx.

OTHER EXAMPLES

- *Building Capacity: Mental Health and Police Project*
  - Canadian Mental Health Association, British Columbia Branch
  - Significant Partners: Vancouver Coastal Health, Royal Mounted Canadian Police, and B.C. Mental Health and Addictions Services, Provincial Health Services Authority
- *Doorways – Wrap around Service*
  - John Howard Society Central and South Okanagan
  - Significant partners: BC Housing, Interior Health, and City of Kelowna
- *Beyond the Revolving Door: A New Response to Chronic Offenders*
  - BC Street Crime Working Group, The Justice Review Task Force
  - Significant Partners: Provincial Court of BC, Vancouver Police Department, and Community Corrections, Ministry for Public Safety and Solicitor General

CROSS-SECTORAL RELATIONS AND HORIZONTAL INITIATIVES

There is a pressing need to develop a national standard of care that consists of a system of integrated networks. Although small, local, initiatives have been most successful in reducing the criminalization of people with mental health problems and illnesses; success is contingent on provincial/federal participation. To focus on a continuity of care network is to develop services and programs that include the participation of all necessary stakeholders in order to reduce the chances that the individual will have additional contacts with the criminal justice system.

Intergovernmental relations not only allow for recognition of success, but can also bring forth additional funding opportunities. Government funding must encourage cross-sectoral/horizontal initiatives so as to reduce the competition among agencies and organizations who are attempting to offer similar and related services.

Provincial support of effective practices can contribute to reducing the existing gap between policy and research, and have encouraged cross-sectoral/horizontal initiatives that include both practical and research components. These initiatives should focus on developing empirically-based policies that also incorporate findings from effective practices operated by direct service providers.

In addition, cross sectoral relations such as those among policing agencies, the crown, provincial courts and the mental health delivery service system are essential in accessing services and support systems. To obtain services offered by the **Forensic Community Geographic (FCG) Team**[130] (Calgary and Edmonton), a referral process is necessary. The FCG team accepts referrals from the courts, probation officers, mental health professionals, correctional facilities, and others providing services to forensic clients. The purpose is to provide the rural population in Alberta with services and support and to provide a comprehensive forensic assessment and treatment services for people legally mandated in remote areas of the province.

---

[130] Northern Alberta Forensic Psychiatric Services. Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1003858.

This is accomplished via satellite clinics and by traveling to rural areas and Treaty Seven First Nation Communities.[131]

Another example of the importance of cross-sectoral relations is the work done by the **Calgary Mobile Response Team (MRT)**. The (MRT) is a Calgary Health Region professional crisis team composed of nurses, social workers and psychologists, available to the community seven days a week. It offers assistance to individuals and families experiencing crises in relation to a wide variety of issues including mental health problems, addictions, relationships or other social and personal problems. It accepts referrals from anyone and will meet clients anywhere in the city of Calgary, as well as in rural areas south of Calgary. The general public (i.e. individuals in crisis or concerned others) accesses services by calling the Distress Centre while professionals in the community can access the team directly.[132]

Furthermore, horizontal initiatives developed by the community in collaboration with the Correctional Service of Canada would be advantageous. It has also been suggested that CSC regional projects funded through CSC national should be presented to its community partners as a means of ensuring accountability. The majority of fora participants echoed these sentiments, given CSC's central role in serving and supporting people with mental health/addiction problems.

How can we produce changes if people with mental health problems and illnesses continue to be incarcerated, discriminated and neglected within our institutions?

An important issue is the lack of services or access to services when people reach their **Warrant Expiry Date (WED)**, particularly with respect to providing housing and a continuity of care. Many people are returned to the halfway house or to federal custody while waiting for appropriate services/support; despite the fact that this practice goes against policy. As an alternative, it is recommended that CSC examine this difficulty and its impact on the individual's reintegration process. In an initiative to address this issue, the CSC Federal Community Corrections Strategy points to the need for a post WED continuum of care. They also suggested that discharge and transitional planning should occur earlier on in a person's incarceration period and insists on developing a collaborative planning initiative that ensures immediate and short-term support.

In B.C., **Pharmacare support** is an excellent example of the need for adequate discharge planning, since it helps to address issues associated with access to medication upon discharge from a correctional setting. Many individuals are released with a time-limited supply of their medication, and Pharmacare support enables people to enroll in the program without a provincial health card number. Discussions are necessary to best integrate and use Pharmacare even when an individual is looking for employment. Establishing standards and outcome measurements and mechanisms such as enrolling a person before they are discharged from prison, or planning to enroll them once they are discharged, must be developed in order to support medication compliance and reduce the number of individuals that fall through the cracks of the system.[133]

---

[131] Southern Alberta Forensic Psychiatric Services, Community Geographic Team Resources. See: Calgary Health Region, Mental Health and Addictions Services, *Year End Service Summary 2006-2007.*

[132] Brager, M. & Binnema, D. (personal communication, Calgary Forum, November, 2007). *Calgary Mobile Response Team;* Also see the Halifax Mobile Crisis Response Team website: http://www.cdha.nshealth.ca/mental-health-program/programs-services/mental-health-mobile-crisis-team.

[133] For more information see: www.health.gov.bc.ca/pharmacare.

What are the benefits of horizontal initiatives and cross-sectoral relations?

How do we reduce the gap between policies and research/practices?

Recommendations

- ☑ Develop quarterly cross-sectoral roundtable discussions to address current and upcoming challenges
- ☑ Include decision and policy makers in order to establish standards of care
- ☑ Work together to establish common goals and objectives and to share outcomes: A focus on change and recovery
- ☑ Elaborate policies using evidence provided both by direct service providers and academics in the field of mental health and corrections
- ☑ Acknowledge the need for each other; involve other sectors and organizations to best serve the client
- ☑ Identify key individuals that are willing to actively participate and become the voice for the project/initiative: Leadership
- ☑ Develop a support network within the community: A collaborative intake model that is not limited to policies and legislation but that gets communities involved at the ground level
- ☑ Bring forth and acknowledge success stories through provincial and federal initiatives
- ☑ Encourage advocacy: Go beyond mental health and include housing, financial, and educational benefits

Examples of Promising and Effective Practices

The **Toronto Mental Health Court** was developed first to deal more effectively with individuals with mental health problems and to reduce recurring court appearances. The individual is *not required to plead guilty* as a condition to a mental health court proceeding and to access diversion programs. This court aims to facilitate discussion and information-sharing and focuses on identifying the components that will ensure the individual's recovery. It focuses on creating an environment of *politeness, empathy and respect*. The individual is assessed and evaluated *on site* by various clinical professionals to determine the most effective intervention plan and to reduce waiting time.[134]

The **Mental Health Court Support and Diversion Program** offered by *CMHA-Toronto* assists court referred mental health clients in locating needed services. This program also provides consultation for those who do not qualify for diversion by connecting them to appropriate mental health and support services and/or assisting to facilitate bail or with sentencing. In some circumstances, the program also provides intensive

[134] Justice E. Ormston (personal communication, Kingston Forum, November, 2007).

case management to clients.[135] The *Community Resource Connections of Toronto (CRCT)* also offers a **Mental Health Court Support and Diversion Program.**

Persons referred to this program must:

- Have a serious mental health problem/mental illness;
- Have been charged with committing a low risk offense;
- Accept mental health diversion; and
- Be approved for diversion by the provincial crown attorney.[136]

In 2009, Halifax opened the first mental health court in Nova Scotia.[137] MaryAnn Campbell (University of New Brunswick), Crystal Dieleman (Dalhousie), and Jeff Karabanow (Dalhousie) are running a pilot project investigating both the St. John, NB court and the Halifax, NS court. This pilot will serve as the basis for a larger project currently being developed looking at criminogenic risk and need outcomes, trajectories of court participants, and the everyday operations of the two courts (partnership between Justice and Health).

Vancouver Police Department's Car 87 Mental Health Car teams a Vancouver police officer and a registered psychiatric nurse to work together in assessing, managing and deciding the most appropriate intervention for people with psychiatric problems.[138] Also, the **RCMP's Car 67 program** is a partnership between Surrey RCMP and the Fraser Health Association, and pairs a RCMP officer with a clinical nurse specializing in mental health work to respond to calls involving emotional and mental health issues and to provide assessments, crisis intervention and referrals to appropriate services.[139]

As of 2013, the Ministry of Justice in British Columbia has produced a BC Policing Plan that addresses mental health and substance use services and their connection to justice. Part of the plan involves developing police-related strategies for persons in crisis with mental illness and/or addictions. The Ministry of Justice will:

- Work with stakeholders to promote best practices and expand successful policing strategies such as integrated police/health initiatives across the province; and
- Conduct a study to examine contact between police officers and persons with a mental illness and/or addictions to develop resource-efficient and effective strategies for these interactions.

A number of police and mental health integrated initiatives such as the Vancouver Police Department's Car 87, the RCMP's Car 67, Assertive Community Treatment (ACT), and Victoria Integrated Community Outreach Team (VICOT) have been successful in reaching out to people with a mental illness and/or addiction with the purpose of minimizing their involvement with the justice system. In January of 2011, in response to recommendations made by Justice Braidwood in his report, *Restoring public confidence:*

---

[135] CMHA-Toronto, Community Support Services. Website: http://www.toronto.cmha.ca.

[136] CRCT also offers an online manual to help people with mental health problems and illnesses navigate the Toronto mental health system (see reference section). Website: http://www.crct.org/services/mhcss.cfm.

[137] For more information see: https://www.gov.ns.ca/just/mental_health_court.asp.

[138] Vancouver Police Department. *Police and Community Response Unit: Car 87 Mental Health Car*. Retrieved March 2013 from: http://vancouver.ca/police/organization/investigation/investigative-support-services/youth-services/community-response.html.

[139] Royal Canadian Mounted Police. *Surrey RCMP: Car 67 Program*. Retrieved March 2013 from: http://surrey.rcmp-grc.gc.ca/ViewPage.action?siteNodeId=73&languageId=1&contentId=713.

Restricting the use of conducted energy weapons in British Columbia,[140] the Ministry of Justice launched police training on Crisis Intervention and De-escalation skills (CID). The training develops the attitudes and communication skills required to ensure police are able to intervene effectively in a crisis situation. Despite the success of integrated initiatives and the implementation of mandatory training, challenges remain with respect to the impact of mental health related calls on police resources and the overall inadequacy of a justice system response to mental health calls.[141]

SECURE TREATMENT UNIT—St. Lawrence Valley Correctional and Treatment Centre, operated by the Ontario Ministry of Community Safety and Correctional Services.

- *100 bed provincial correctional treatment facility that has been designated a Schedule 1 hospital under the Mental Health Act*
- *Located in Brockville, at the Mental Health and Addictions Resource Centre*
- *Service Agreement with the* ***Royal Ottawa Health Care Group (ROHCG****) to provide clinical services*
- *Designed to offer a comprehensive multi-disciplinary specialized assessment, treatment and post-treatment planning service*
- *Targets adult males who are sentenced to a provincial term of incarceration and who may suffer from a major mental illness*

The Royal Ottawa Health Care Group (ROHCG) focuses on developing and assuring horizontal initiatives. With over 100 partners in the mental health system, ROHCG is committed to collaborating, to developing and providing leading research, advocacy, care and education. ROHCG has expanded their mental health services beyond the city of Ottawa to communities throughout Eastern Ontario to Brockville, Cornwall, Pembroke and other communities. ROHCG partners with a variety of organizations that offer a range of resources such as education, hospitals and care centres, law enforcement, mental health support, rehabilitation, housing and community support. Providing both in-facility care and community outreach programs, the specialized services cover a wide range of mental health problems from those requiring minimal support to intensive treatment of serious illnesses.[142]

John Howard Society Kamloops developed a housing project, **The Victory Inn**. In 2001, they began taking in low-income single men and women. In 2001, the residents began to move in. A typical resident is homeless and in many cases also suffers from mental health and addictions problems and/or has had encounters with the criminal justice system. Residents also include women who have left violent relationships, seniors, transgendered individuals and individuals with HIV/AIDS.

This housing project has been very effective due to the partnerships that have been created, including BC Housing, the Real Estate Foundation, the Forensic Psychiatric Service Commission, BC Corrections and Interior Health Authority; however, it did initially meet with resistance from the community. The initiative identified several effective practices for addressing community opposition to its development, such as strategically planning a response to the community. For example, BC Housing, city staff and JHS Chief Executive Officer, Dawn Hrycun, communicated every day. They were aware of what each would be

[140] Braidwood, T. R. (2009). *Restoring Public Confidence: Restricting the Use of Conducted Energy Weapons in British Columbia*. Victoria, British Columbia: Braidwood Commission on Conducted Energy Weapon Use. Retrieved March 2013 from: http://www.braidwoodinquiry.ca/report/P1Report.php.

[141] The draft Plan was made available for review and feedback on the BC Policing Plan website at: http://blog.gov.bc.ca/bcpolicingplan.

[142] Royal Ottawa Health Care Group. Website: http://www.rohcg.on.ca/index-e.cfm.

publicly stating in order to ensure consistency among their approach.[143] A 2006 case study revealed a number of important conditions to be considered when attempting to take on a similar approach:

- Strategically plan a response to the community and be sensitive in the language you use;
- Make information available through newsletter, website, and online forums where people can ask questions and get answers;
- Keep the mayor, council and city staff informed of proponent activities;
- Ensure the political will exists to support social housing and put this position into a written policy.[144]

John Howard Society Central and South Okanagan (JHSCSO) along with significant partners (i.e. BC Housing, Interior Health, and city of Kelowna) have also invested in the development of supportive housing units, with four currently in operation, for men and women who are at risk of homelessness and who also have mental health and/or addiction problems. Opening its doors in March 2012, New Gate Apartments is JHSCSO's latest initiative, providing stable men and women that are able to live independently with longer-term housing. The building features 49 studio apartments, as well as round-the-clock staffing. JHSCSO also operates Cardington Apartments, Bedford Place, and House 22.

PROGRAM DEVELOPMENT AND EVALUATIONS

It has been suggested that restricting ourselves to assessing and recognizing best-practices can be limiting and that promising practices should also be considered.[145] We need to investigate and acknowledge findings that support emerging indicators of success from specific services and programs.

There is a need for more adaptable, individualized programs to best fit the needs of the person. A multidisciplinary approach to mental health services allows for choice when attempting to identify what best suits the individual. Given the lack and highly exclusive nature of many community-based programs and services, a large number of direct service providers have emphasized the need for programs that target those who suffer from a multitude of complex problems.

There has been some funding allocated to the evaluation of programs and services offered in the community by the academic field and these have demonstrated effective partnering and collaboration among the practical and research fields. However, additional research/evaluation that focuses on specific community-based programs and services require the direct contribution of service agencies and organizations implementing such practices and protocols. Direct service providers are the most suited to identify what is needed, what is effective and ineffective, and what should be changed or added. Specifically, such projects should attempt to teach non-governmental organizations (NGOs) how to evaluate their own work with the help and empirical support of academics. This could ensure a more generic service delivery system and also provide support to NGOs in understanding how to integrate research into their practice.[146] Rather than attempting to identify a model strategy for reducing criminalization, research and evaluation should focus on identifying what works, why it works and noting the shared guiding principles and values at the basis of these programs/services.

---

[143] Office of Housing and Construction Standards: Housing Policy Branch (2006). *Creating Housing for Homeless People: A Case Study. Featured Project: Victory Inn, Kamloops, the John Howard Society*.
[144] Office of Housing and Construction Standards: Housing Policy Branch (2006). p.6.
[145] Thompson, G. Past President, Mental Health Commission of Canada (personal communication, Kingston Forum, November, 2007).
[146] Hughes, J. & C. Dieleman (personal communication, Halifax Forum, November 2007).

The standardization of practices/programs also emerged as a significant problem with respect to the issue of criminalization. There is a need to ensure that all is accredited and completed in a manner that respects the client.[147] Program development is an important part; however, one must include evaluations/reports that include costing, planning and outcomes to further demonstrate the need and importance of such initiatives, which include inter-sectoral and integrated management.

Program development should also target youth who are at risk of developing mental health problems, as well as those who live in an environment where mental health is a common and/or occurring problem. Many children suffer because their parents are unable to or have not received adequate services and support. They are left to take care of themselves and on most occasions are not included in their parents' recovery process. Developing effective education programs that target a better understanding of mental health in the youth population is therefore a crucial component of prevention and intervention practices. The Centre for Addictions and Mental Health offer a program called *Talking About Mental Health: A Guide for Developing an Awareness Program for Youth.* A teacher who participated in the program noted, "We know that many students are experiencing stress in their lives, either because their parents or students themselves are having emotional difficulties. The program gives students permission to acknowledge that a lot of us have these difficulties, and that it's OK to talk about it."

[147] For more information on accreditation see the CHMA's Accreditation Capacity Building Project, supported by Accreditation Canada, CARF Canada and Canadian Centre for Accreditation. The Accreditation project strives to identify and close gaps in service provision. Retrieved March 2013 from: http://www.ontario.cmha.ca/capacity_building.asp?cID=1457585.

RECOMMENDATIONS FOR DEVELOPING AND EVALUATING PROGRAMS

- ☑ Use a definition of mental health/mental illness that does not hinder or impede an individual's right to appropriate services and one that is explained and understood by services providers
- ☑ Address exclusions, complex cases and dual diagnoses with integrative and multifaceted approaches
- ☑ Develop flexible and adaptable programs and services that are guided by similar principles and values
- ☑ Develop individualized programs to best fit with the needs of the individual
- ☑ Work with promising practices and moving towards effective practices
- ☑ Move beyond crisis intervention and focus on long-term care
- ☑ Focus on a continuity of care network – develop services and programs that include the participation of all necessary stakeholders
- ☑ Develop youth prevention programs but also develop programs that target family members (i.e. children) of people with mental health problems and illnesses
- ☑ Build a community development advisory group: Focus on communication between ministries but also with and within the community
- ☑ Focus on community capacity building to maintain collaboration and partnerships

EXAMPLES OF PROMISING AND EFFECTIVE PRACTICES

ASSERTIVE COMMUNITY TEAM FOR THOSE WITH A DUAL DIAGNOSIS (ACT-DD)

Brockville Mental Health Centre has developed an **Assertive Community Team for those with a dual diagnosis (ACT-DD)** that focuses on working with a population so often excluded from programs/services. This team is part of the Royal Ottawa Health Care Group (ROHCG). The team consists of professionals who are trained in specialized community rehabilitation work. An individualized treatment plan is established with each client to help meet their unique needs. The team serves individuals with a severe and persistent mental illness as well as a developmental disability in the mild or greater range, plus clients with a Pervasive Developmental Disability. Each member works with clients on a one-to-one basis and draws on the other members of the team for consultation and back-up.[148]

[148] ROHCG Assertive Community Treatment Teams for Persons Dually Diagnosed. Website: http://www.rohcg.on.ca/programs-and-services/factsheets/assertive-community-treatment-dually-diagnosed-e.cfm.

Talking about Mental Illness (TAMI)

An excellent example of mental health/mental illness awareness development directed at educating the youth population is a teacher's guide entitled, **Talking about Mental Illness (TAMI): A Guide for Developing an Awareness Program for Youth,** developed by the Centre for Addictions and Mental Health (CAMH).[149] This guide has been used with grade 11 and 12 students. This guide includes handouts and overheads to be used by the teacher as education tools. One activity has students brainstorm ideas about mental illness. The teacher uses overheads to help students recognize stereotypical thoughts, where they come from and their stigmatizing effects. Students work through case studies to learn the meaning of stigmatization and how they can change and control harmful thoughts. One particular handout has a list of celebrities with mental illnesses, used to show how they have improved their quality of life.

Community Capacity Building

Many organizations and groups (governmental and non-governmental) in health care, community and social services, and the criminal justice system are increasingly emphasizing the importance of working collaboratively to address the mental health needs of local communities. In particular, there is a growing recognition of the common risk factors and the potential within local communities for preventing criminalization of people with mental illness as well as supporting people with mental illness being released from prisons, jails, and forensic hospitals, to prevent further conflict with the law.

One promising practice out of the Halifax forum was the development of a roundtable of engaged stakeholders that were proactively invested in public and governmental awareness of evidence-informed options for system transformation in Nova Scotia. The roundtable functioned for about 3 years, bringing attention to the concerns of people with mental health problems who have criminal justice involvement and developing collaborative relationships among key stakeholders. In particular, members of the roundtable played both instrumental and consultative roles in the development of the first Mental Health Court in Nova Scotia which began operating in November 2009.

The roundtable sought ways to be active in preventing criminalization of people with mental health problems. Crystal Dieleman and Jean Hughes, both of Dalhousie University, took the lead and were awarded one year of funding from the Nova Scotia Health Research Foundation for the purpose of developing a collaborative research team with members of the roundtable.

This funding was used to prepare a funding proposal for research that would improve our understanding of the best ways to prevent involvement of people with mental health problems in the criminal justice system by enhancing determinants of health. Subsequently, this team is now part way through the first year of a 3-year research project funded by the Nova Scotia Health Research Foundation to:

(1) document the disadvantages, gaps and opportunities in social determinants of health for people living with mental health problems who are involved with the criminal justice system; (2) Determine the changes in policy, services, practices and resources needed and make recommendations to improve social determinants of health in Halifax in ways that prevent/reduce involvement of people with mental health problems in the criminal justice system; and (3) Create an action plan for addressing needed changes in policy, services, practices, and resources to improve social determinants of health in Halifax.[150]

---

[149] CAMH – TAMI, (community guide also available) download from website:
http://www.camh.net/education/Resources_teachers_schools/TAMI/tami_teachersresource.html.

[150] Dieleman, C., Dalhousie University, Occupational Therapy (personal communication, February 2013).

SPECIAL NEEDS PROGRAM

St. Leonard's Community Services—London and Region currently offers various programs and services within the agency in order to meet the needs of individuals that are involved in the criminal justice system that have mental health and addiction issues. They provide residential and case management support to men and women on conditional release at Cody Centre, Gallagher Centre and Maison Louise Arbour. Their agency also supports 3 men's and 3 women's crisis beds for persons with mental health/addiction issues that are facing unstable living conditions and are at risk of deterioration and incarceration.

The programs addressing mental health and addictions issues offered by St. Leonard's Community Services—London and Region receive referrals from a number of mental health, social services and criminal justice agencies. Their program provides all support to the individual during the duration of the residential/case management relationship. Their role is to provide assistance in establishing all necessary contacts with the community while the individual is participating in this program. They offer support and case and crisis management, planning and assistance to develop realistic, discharge and achievable goals by using strengths as guides. Their justice workers offer one to one support, structured environment, medication compliance support, crisis planning, education in substance abuse, educational/vocational networks, relapse prevention programming and life skills. For all residents—they link them to community resources and advocate for them as necessary.

Their programming includes life skills, self-esteem, boundaries, moving forward, anger management, relapse prevention, healthy lifestyles and leisure programming. As well, residents leaving St Leonard's are offered support through Reintegration Services. This program has social workers who are mentors, coaches, facilitators and advocates for residents in order to develop daily problem solving strategies, self-reliance, responsibility and accountability. We promote offender reintegration into the community, community safety and greater success within the community for the offender.[151]

VANCOUVER INTENSIVE SUPERVISION UNIT (VISU)

VISU is jointly operated by the Corrections Branch, the Vancouver Coastal Health Authority and the Forensic Psychiatric Services Commission. Community correctional staff and mental health workers provide assertive case management to a caseload of 40 people with multiple psychiatric diagnoses and addictions for periods of 6 or 12 months depending on their needs. These individuals are served beyond the end of their court order. Program entry requirements are the following:

- A willingness to participate;
- Currently under court ordered disposition;
- The individual has multiple psychiatric diagnosis, a history of mental health hospitalizations, severe non adaptive social and/or behavioural patterns;
- Is a chronic multi system user; and
- Intends to live in the Vancouver area following release.

Referrals are made by Vancouver Region Probation Officers, the Vancouver Coastal Health Authority (hospitals and outpatient), Mental Health Teams, Mental Patients Association and Correctional Centres. Clients are assisted in obtaining housing, financial management, access to health care services and access to mental health treatment providers. The overall goal is to reduce re-offending and reduce and shorten admissions to Correctional Centres, hospitals or psychiatric institutions.[152]

[151] Callender, H., St. Leonard's Community Services—London and Region (personal communication, March 2013).
[152] Green, S. Program Analyst, Government of British Columbia (personal communication, Vancouver Forum, November, 2007).

PROTOCOLS AND AGREEMENTS

Protocols and agreements are an integral part of information-sharing because they enable agencies/organizations to profit from others' initiatives but also to identify how to best implement similar practices in their own environment. Formal protocols can address and reduce existing challenges by ensuring that once an individual is transferred to an agency or establishment, there is available space to allow the person to access the services, or that an agency's exclusionary criteria does not impede the client's access to services.

Effective practices include adaptability and flexibility concerning the procedures and protocols that are implemented; they should encourage thinking outside the box; and to develop practices that focus on change and recovery. As a result, one must clearly define parameters in order to avoid situations where no intervention or response occurs due to a lack of guidance or awareness. It is crucial that protocols be developed that protect the individual from being assigned to random, unnecessary tests as a means to better manage the individual (i.e. random urinary analysis without circumstantial evidence).

As a promotion strategy for effective practices, agencies/organizations should identify several direct impact consequences of an agreement or protocol, which could also be used to attract additional partners given the promising success and immediate usefulness of such practices.

Strategies should go beyond crisis intervention. While it is important and effective, there is a pressing need to develop long-term priorities. Effective practices should focus on community capacity building. While the use of effective and promising practices is essential for direct service providers, there also exists a need for the additional support that would be achieved by developing a more macro-level agenda. The Mental Health Commission of Canada has addressed this as one of its key priorities, and has undertaken efforts to create ways for Canadians to access information, share knowledge, and exchange ideas about mental health through their Knowledge Exchange Centre.[153]

RECOMMENDATIONS FOR CREATING PROTOCOLS AND AGREEMENTS

- ☑ Develop strategies and practices that are adaptable
- ☑ Establish formal protocols and agreements: Focus on defining the parameters (procedures, acting agents, inclusion/exclusions, exceptions, etc.)
- ☑ Identify mutual short-term and long-term priorities: Shared objectives and expected outcomes
- ☑ Acknowledge direct impact consequences as a promotional strategy
- ☑ Develop strategies that go beyond crisis intervention into community capacity building
- ☑ Require support from provincial and federal government departments towards the development and use of manuals and protocols (i.e. the Ontario Police College (OPC) continues to offer the *"Not just another call"* resource within their training for recruits)
- ☑ Implement policies that focus on the continuity of care: Ensure immediate, short-term and long-term assistance
- ☑ Hospitals as part of community and continuity care initiatives along with integrating the correctional system both in prevention and community capacity building strategies

---

[153] Mental Health Commission of Canada. *Knowledge Exchange Centre*. Retrieved March, 2013 from: http://www.mentalhealthcommission.ca/English/Pages/KnowledgeExchangeCentre.aspx.

Examples of Promising and Effective Practices

Canadian Association of Chiefs of Police

Contemporary Policing Guidelines: The Central Tenet

Each police organization should foster a culture in which mental illness is viewed as a medical disability not a moral failure, and in which Persons with Mental Illnesses (PMI) are treated with the same degree of respect as other members of society.

The Canadian Association of Chiefs of Police (CACP) has introduced guidelines for police officers dealing with individuals with mental health problems. This document was prepared by the Police/Mental Health Subcommittee to the Human Resources Committee.[154] These guidelines are comprised of ten guiding principles that when applied by all police forces would contribute to reducing criminalization. They "identify general principles, which can be implemented by any police service or police detachment, regardless of size or geographical location. The manner in which the principles are operationalized will, of course, be dependent upon the unique culture of the community served. But the principles are the same".[155]

> **Principle 5: Each police organization should have a clearly defined policy and procedure by which personnel can access mental health expertise on a case-by-case basis.**[156]

Not every officer will have proper knowledge and training to deal with people who have mental health problems. The utility of such officers can be enhanced if they are aware of the services to contact and have a guide for when contact is appropriate.

Calgary Mobile Response Team (MRT)

The following is an example of how formal protocols guided by shared principles and values facilitate immediate crisis intervention when dealing with individuals with mental health problems.

> During the initial phone contact we gather cursory information to determine the presenting concern and to assess for imminent high risk situations requiring emergency services, which if present will lead to a 911 call. This cursory information also enables us to obtain information from the client's Calgary Health Region health record, if it exists (i.e. previous hospitalizations).The usual outcome of the initial phone contact will be to arrange a 'mobile', where teams of two go unobtrusively into the community to meet, assess, and refer the client, appropriately. If a client referral to MRT is from a concerned other and the identified client is unwilling to meet us, we then offer our services to support the concerned other.
>
> The goal in meeting with clients is to help improve their quality of life by successfully referring them to the most suitable treatments or resources. This requires an accurate assessment of the presenting situations and needs, matched with knowledge of available recourses. We also assess a client's capacity to accept responsibility for themselves and their situations; a major factor in

[154] Dr. Dorothy Cotton, Clinical Neuropsychologist, Co-chair to Police/Mental Health Sub Committee (personal communication, Kingston forum, November 2007).

[155] Police/Mental Health Sub Committee of the Canadian Association of Chiefs of Police Human Resources Committee (2006, July). p.3.

[156] Police/Mental Health Sub Committee of the Canadian Association of Chiefs of Police Human Resources Committee (2006, July).

> determining referral options. Where possible our team will take steps to enhance a client's capacity to accept responsibility. In a mildly confrontational way we may pose questions of choices and consequences. Of the referrals made by MRT, counseling is the most common. We also routinely make ourselves available to clients by inviting them to call us in the future as needed, thus providing long term support and a backup plan.[157]

SERVICE SYSTEMS ADVISORY COMMITTEE OF THE MENTAL HEALTH COMMISSION OF CANADA

The MHCC's Service Systems Advisory Committee addressed mental health service systems issues to facilitate the development of accessible, accountable, effective services which support the recovery of people living with mental illness. The Committee placed priority on supporting the implementation of promising practices with particular emphasis on the community mental health services which support recovery. Accordingly, priority initiatives of the Committee included a major national study of housing and the steps which are necessary to develop an adequate supply of housing in the provinces and territories.[158]

Other priority projects focused on such issues as diversity, primary care and peer support. There are several publications now available: *Turning the Key* (2010) focuses on housing; *Improving Mental Health Services for Immigrant, Refugee, Ethno-Cultural and Racialized groups* (2009) focuses on diversity; and *Making the Case for Peer Support* (2010) focuses on peer support. The committee was restructured into an Advisory Council and Network of Ambassadors in January 2013, and are working towards new projects featuring best practices for people with mental health problems and illnesses.

[157] Brager, M. MSW, & Binnema, D. R.N., B.N. (personal communication, January, 2008).

[158] Higenbottam, J. Member of the Service Systems Advisory Committee (personal communication, January, 2008); Update provided by Marr, K. MHCC, March 2013.

ENGAGING PEOPLE WITH MENTAL HEALTH PROBLEMS AND ILLNESSES

BACKGROUND

Over the last few decades, there has been major support towards an initiative for change on behalf of the mental health delivery system. Researchers, academics and the social service system have endorsed this approach. Recent reports from the Mental Health Commission of Canada (Changing Directions, Changing Lives, 2012; At Home/Chez Soi Project, 2013), the Canadian Mental Health Association (Project IN4M, 2011), and the Standing Senate Committee on Social Affairs, Science, and Technology (Out of the Shadows at Last, 2006) have shown a greater amount of collaboration between government agencies and community resources in improving the state of mental health in Canada.

This section provides information for engaging people with mental health problems and illness in their own recovery process. In order for this to be achieved, the following three strategies should be explored:

- **Providing the Individual with Information on Mental Health**
- **Self-Management/Recovery-Oriented Approach**
- **Voluntary Participation: Creating Trust**

Living with/caring for and about a person afflicted with a mental health issue such as **Fetal Alcohol Spectrum Disorder (FASD)** is a challenging, exhausting, and frustrating process for both the care provider and the person who suffers from a mental illness.

With **FASD**, for example, unless the mother is known to have been drinking during her pregnancy and thus the doctor is aware of potential problems, there can be a significant lag time in getting a diagnosis. There also remain the conjoined issues of jobs and housing for those adults with mental illnesses who have been unsuccessful in learning a viable job skill, and getting and retaining gainful employment.

Those who turn to crime to feed a drug dependency that originated through untreated or undiagnosed mental illness have an even more difficult time, as do their families.

In my opinion, dealing successfully with FASD requires a multifaceted and far-reaching, well-funded community approach.

As long as babies afflicted with FAS/FASD are still being born, and as long as our prisons are full of people suffering from this and other mental health maladies, I think we can safely say that we've got a long way to go towards understanding, preventing, and satisfactorily dealing appropriately with Fetal Alcohol Syndrome Disorder, and in helping those who must face every day with its significant limitations.

What I Learned Through Fostering Children and Youth Diagnosed with Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder—Merrikay Snelgrove

PROVIDING THE INDIVIDUAL WITH INFORMATION ON MENTAL HEALTH

How individuals talk about their health, their problems and experiences may help or hinder their recovery. Comprehensive knowledge of mental health problems and illness provided to a person can be beneficial, as they become better at identifying and describing their personal needs, identifying and making links between social situations and mental health states, and so on. It is important to emphasize and ensure that people understand their own mental health in order for them to best accept their situation and understand how it affects their quality of life rather than pushing them towards service treatment that may not be best for them.

Engaging a person in a discussion about mental health and how they come to define and talk about personal problems provides assistance to service providers attempting to complete adequate assessments that might otherwise result in assigning the individual to a static label. Mental health should be accepted as is rather than transformed or molded into an ideal format to be applied by professionals and direct service providers. The person's voice should be heard, acknowledged and valued. We must recognize success stories and encourage champions to share their stories. These individuals may be more apt to provide help and guidance to others. Specifically, people with mental health problems and illnesses should be encouraged to share the elements and means used to improve their quality of life. Peer support should focus on recognizing strengths and promoting discussions as opposed to affirming fears and supporting stigmatization.

> *Connections Clubhouse members identified long ago the key component of empowerment for them:* ***BEING HEARD***
> *This leads to more involvement of members in the design and delivery of support in the mental health system and in the community.*
>
> Connections Clubhouse, Halifax, Nova Scotia

RECOMMENDATIONS

- ☑ Provide comprehensive information to individuals about their mental health and other health-related and social problems
- ☑ Accept mental health as it is rather than attempting to create a mold into which it should all fit
- ☑ Acknowledge that those in need of support are people first, followed by someone who has a mental health problem or illness
- ☑ Improve the quality of life and the protection of human rights
- ☑ Use similar terms that are comprehensible to people with mental health problems and illnesses
- ☑ Make use of motivational interviewing
- ☑ Encourage discussion between the individual and their families, direct service providers and civic officials
- ☑ Encourage people to publicly discuss their stories as a tool for reducing stigma and discrimination
- ☑ Portray people with mental health problems and illnesses as champions! Acknowledge and promote success stories
- ☑ Focus on, and recognize individual differences and diversity

Examples of Promising and Effective Practices

Strategies for Families Dealing with FAS/FASD Behaviours

The following strategies were taken from *What I Learned through Fostering Children and Youth Diagnosed with Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder* presented by M. Snelgrove (2008):

Be patient	Concentrate on life skills
Keep the family routine the same each day as much as possible	Repeat everything you say, and use short, specific phrases (e.g. "stop" and "think")
Changes in routine should be announced well in advance, and reminders given	Give the youth/child many chances to do what you ask
Care providers and other family members must take the time and create opportunities to re-energize themselves	Make sure the youth/child understands the house rules, and be firm and consistent in enforcing those rules
Investigate medication options and counseling	Keep tasks and instructions simple, and give them one at a time
Offer structured routine activities	Give positive feedback
Use concrete examples	

Building Capacity: Mental Health and Police Project

Hallucinations and Delusions: How to Respond

Recognizing and Understanding Hallucinations

The most frequent hallucination involves hearing, and often includes hearing voices which tell the person to do something (known as command hallucinations). You may recognize that the person is suffering from auditory (hearing) hallucinations when he or she appears preoccupied and unaware of their surroundings, talks to themself, has difficulty understanding or following conversations, and misinterprets the words and actions of others. The person may also isolate themselves or use radio or other sounds to tune out the voices. A person experiencing other types of hallucination (visual, tactile, smell, taste) are usually identifiable by the person's interaction with the hallucination: visual focus on something you cannot see, touching, scratching or brushing things off themselves, sniffing or holding their nose, spitting out food, etc., when there is no apparent reason to do so.

Recognizing and Understanding Delusions

Some delusions may seem relatively harmless in the short term, such as delusions of being a rock star, royalty, or a religious figure. These delusions can be potentially harmful, however, if they include or lead to delusions of having special abilities or characteristics such as flying, walking on water, or invincibility.

Most common, however, are paranoid delusions: the belief that someone or something is going to harm the person in some way. Paranoid delusions are usually evidenced by extreme suspicion, fear, isolation, insomnia (for fear of being harmed while asleep), avoidance of food and/or medication (for fear of poisoning), and sometimes violent actions. A person experiencing paranoid delusions has extreme difficulty trusting others, will frequently misinterpret others' words and actions, and experience ordinary things in his or her environment as a threat.[159]

---

[159] Canadian Mental Health Association, British Columbia Division (2005). *Hallucinations and Delusions: How to Respond*. Fact Sheet. Retrieved March, 2013 from: http://2010.cmha.bc.ca/files/6-hallucinations_delusions.pdf.

> Efforts to avoid power struggles and the impact of the stigma of mental illness are made by trying to empower our clients to make positive choices and by pointing out that we are not meeting with the client to force them to do anything they don't want to do.
>
> **We offer options but the clients make the choice.**
>
> - Calgary Mobile Response Team

PSYCHOSOCIAL REHABILITATION

Connections Clubhouse is based on the psychosocial rehabilitation approach to mental health problems and the mental health delivery system. It can be defined as "a range of social, educational, occupational, behavioural, and cognitive interventions for increasing the role performance of persons with serious and persistent mental illness and enhancing their recovery".[160] This model strives for a long term transformation of the client into a self-sufficient member of society.

Connections Clubhouse accepts individuals who experience the effects of a long-term mental illness (schizophrenia, mood disorders and other diagnoses). Membership is voluntary and open to those over the age of 18.

The Clubhouse work, necessary to successfully operate the Clubhouse, is carried out by members and staff working together in an inclusive, mutually supportive environment. The collective work helps form genuine, dynamic, meaningful and trusting relationships between staff and members and facilitates the development of confidence, and a sense of belonging. Through actively participating in the work and life of the Clubhouse, members learn or relearn roles and responsibilities, and discover or rediscover a myriad of talents and abilities that benefit them.[161]

MOTIVATIONAL INTERVIEWING (MI)

Motivational Interviewing is a client centered approach that encourages internal motivation to change. It is a popular technique for people suffering from drug and alcohol problems, mental health problems and criminal behaviour. A key feature of MI is that the client, rather than the counselor recognizes the need for change and initiates the process.[162] St. Leonard's Community Services London and Region has implemented this practice within their programs in order to best identify the needs and challenges recognized by the individual.

A COMPREHENSIVE WOMEN-CENTRED MODEL OF SERVICE DELIVERY

Women on conditional release both in community residential facilities and in the community have been identified as having significantly low functional abilities, higher than normal rates of mental health disorders, depression, low self-esteem, and significant skills deficits in areas of daily living, communication, and self-regulation. Women identified having (but not limited to) the following types of disabilities: psychotic disorders, mood disorders, developmental disabilities, acquired head injury, organic brain damage, substance related disorders, dual diagnoses, and concurrent disorders.

The Elizabeth Fry Society of Kingston promotes a comprehensive women-centred model of service delivery. This approach integrates the woman into the planning and decision making process as a means

---

[160] Barton, R. (1999). Psychosocial rehabilitation services in community support systems: A review of outcomes and policy recommendations. *Psychiatric Services*, 50(4), 525-534.

[161] Health Systems Research Unit of the Clarke Institute of Psychiatry (1997). *Best Practices in Mental Health Reform: Discussion Paper*. Canada: Minister of Public Works and Government Services Canada. Retrieved March, 2013 from: http://www.phac-aspc.gc.ca/mh-sm/pubs/disc_paper/index-eng.php.

[162] Miller, W.R. & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change 2nd edition.* New York: Guilford.

of ensuring that her needs are met and in order for her to gain a better understanding of her situation and how she can contribute to improving her quality of life. Some of the measures include:

- Skill teaching and support services for women with significant functional disabilities, both in the residence and the community focusing especially on long term stable housing with supports;
- Assistance in accessing and maintaining appropriate mental health counseling and support in conjunction with CSC mental health nursing personnel, a social worker and agency personal support workers; and
- Coordination of wrap-around services within the agency, community, and institutional setting and assistance in education and training in conjunction with CSC support services. [163]

HEALTHY MINDS COOPERATIVE

Grounded in the Canadian Mental Health Association's *Framework for Support,* the program outputs of the Healthy Minds Cooperative will ultimately be that people with serious mental health problems are living meaningful lives in the community.[164] It is made up of people who are committed to improving mental health in their communities. This organization consists of members who have experience with mental illness or mental health issues. Healthy Minds Cooperative aims at providing public education to reduce stigma; it also offers peer support and assists in connecting to community services. Another aim is to acknowledge the person's voice and include him/her in identifying the changes needed to address issues of advocacy, peer support, transition and discharge planning.

Priorities of the Healthy Minds Cooperative:
A Blue Horse Initiative

- Better access to mental health services
- Public education on mental illness and brain disorders
- More extensive participation of those with living experience in the design development, delivery and evaluation of mental health services
- Providing peer support and advocacy services for end-users of mental health services and families
- Developing better connections to existing community services

[163] Crawford, T. Executive Director, Elizabeth Fry Kingston (personal communication, Kingston Forum, November 2007).
[164] Healthy Minds Cooperative (2007). *A Blue Horse Initiative*. Retrieved March, 2013 from: www.cdha.nshealth.ca/.../healthy-minds-cooperative-brouchure.pdf.

SELF-MANAGEMENT/RECOVERY-ORIENTED APPROACH

The individual must be included in the decision making process, by providing them with the necessary tools and knowledge available to make the best informed decision. They must take part in the reintegration plan which focuses on community planning and identifying both short-term and long-term needs and goals. As an example, CSC's discharge mechanism, which consists of a five-year gradual release plan, focuses on risk reduction, decision making and informed consent that builds on the success of the individual and that is adaptable to future successes and failures.[165] This practice has been implemented so as to ensure the individual's continuity of care is in line with their needs and contributes to improving their quality of life.

Agencies that provide services beyond mental health (i.e. housing, employment, peer support) are also essential to improving the quality of life of people with mental health problems and illnesses; they assist the individual attempting to complete daily tasks, to obtain employment services and to create a social network.

RECOMMENDATIONS

- ☑ Encourage people to be aware of their rights
- ☑ Assist the individual to be empowered and thus, to take on a significant role in planning the community management strategy
- ☑ Provide the individual with the means to identify and use the tools and practices that are available
- ☑ Encourage improvement in their quality of life and focus on a recovery-oriented approach
- ☑ Create purpose and meaning for the development of a positive sense of self
- ☑ Educate people regarding the importance of connecting with all community social networks
- ☑ Promote self-management by focusing on the individual
- ☑ Communicate: It is a key component

EXAMPLES OF PROMISING AND EFFECTIVE PRACTICES

THE ACCOMPANIMENT SUPPORT PROGRAM AT REGIONAL TREATMENT CENTRE—ONTARIO

This program is an integral part of the Clinical Release Planning Process for Federal Offenders with a Mental Disorder. This service complements the correctional case management release process by addressing the complex needs and sensitivities of this designated vulnerable offender population to contribute to the enhancement of public safety through improved continuity of care strategies. Accompaniment support, as a natural extension of the institutional clinical discharge planning process, is first and foremost a voluntary clinical service requiring the offender's consent to participate. Accompaniment support also ensures the safe and timely travel of an offender from institution to release destination. More substantially, it provides an opportunity to accompany people to first appointments in the community intended to address prioritized discharge needs, often including components to address housing, financial needs, replacement of personal identification, and health care follow-up.[166]

---

[165] Champagne, D., RSW, RTC-ONT (personal communication, Kingston Forum, November, 2007).

[166] Champagne, D. & V. Felizardo CSC-RTC (O) (personal communication, Kingston Forum, November, 2007).

LakeCity Employment Services Association

LakeCity Employment Services Association is a non-profit agency assisting individuals who have experienced difficulties with their mental health. The agency uses a client-centered approach that encourages clients to build on skills that are necessary to sustain themselves in employment. They provide employment services and education services, a woodworking operation, mobile organization and provide support on an on-going basis to ensure a more comprehensive understanding of their situation and what is required of them to hold down a job.[167]

Motivation, Power and Achievement Society (MPA)

The MPA Society assists people with mental health problems and illnesses with court-related matters, such as custody hearings and effective communication with counsel/crown, and with community-related matters, such as finding appropriate housing and connecting with service providers. These services are offered by court and in-reach workers.[168]

Psychiatric Patient Advocate Office (PPAO)

The PPAO provides advocacy services to individual patients (instructed and non-instructed), addresses facility-based or provincial systemic issues impacting on patients' rights, rights advice services, public and health care professional education through speaking engagements; and it publishes reports and media releases. The services/programs offered by PPAO originate from the following vision, values and principles:

- people can and do recover from mental illness
- people have the right to pursue personally defined goals for recovery and well-being
- advocacy and rights protection play vital roles in recovery and continued health and well-being
- advocacy is most effective when it is independent and free from actual or perceived conflicts of interest
- people can function and live in the communities of their choice with adequate supports and services
- people have the right to access effective services which are both needed and wanted
- consultation with people is essential to building responsive and effective services
- people have the right to information that is necessary to make informed choices
- people have the right to be involved in all decisions affecting their care, treatment and lives

Supported Independent Living Program (SIL)—Gallagher Centre

SIL provides services to adult males with a developmental disability and/or a concurrent psychiatric condition who have been involved, or are at risk of being involved, in the criminal justice system. The client profile is based on the need for a structured environment with consistent supports and interventions within the community to support individuals. Their client population includes sex offenders that are often known to the police, and who frequently have a very high profile in the community. As a client population they typically do not fit the mandate of traditional community-based programs; partly due to their developmental disabilities, but also because of their offending behaviours and their high risk to re-offend.

The SIL program is an intensive community support program. As part of the Healthy Lifestyle program, the SIL Program focuses attention on developing an individualized program to improve the client's quality of life and improve their self-esteem by enhancing their skills through such activities as educational

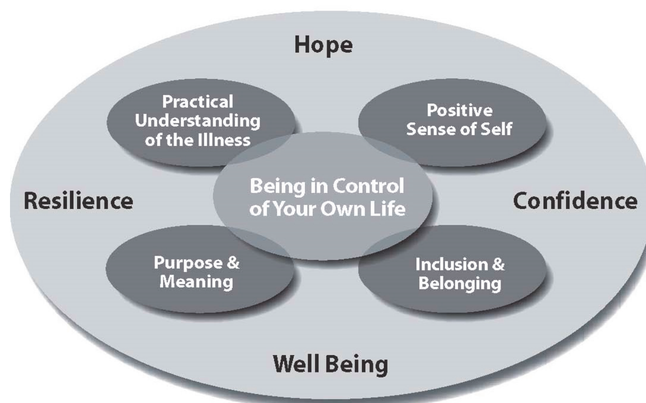
[167] Lake City Employment Services, see website for information: http://www.lakecityemployment.com/.
[168] Judas, J. Motivation Power and Achievement Society (personal communication, Vancouver Forum, November, 2007).

upgrading, learning employment skills, and money management. The program also teaches clients how to develop pro-social contacts and leisure activities that assist in enhancing their sense of self-worth.[169]

Among the services offered by the PPAO, people with mental health problems and illnesses are offered self-advocacy techniques. They are taught to speak and stand up for themselves, to make decisions, and to solve their own problems as they progress towards recovery. PPAO also offers info-guides to assist people with mental health problems and illnesses who are attempting to improve their quality of life. As an example, PPAO offers the *Four Steps to Successful Self Advocacy* info-guide, which consists of teaching people how to define a problem, develop an action plan, carry out the action plan and evaluate the results. An explanation is provided with each of the four steps, including a series of questions for individuals to ask themselves while completing the step.[170]

Developing a Personal Resource Base

CMHA's Framework for Support (2004) includes the Personal Resource Base (PRB) component, which includes the following building blocks:



"The Personal Resource Base is based on a balance between the reality and challenge of illness and the resources that are needed to deal with it and live a full life. It graphically represents a fuller view of people with mental illness by emphasizing more than just their mental health problem. The components, taken together, describe someone who feels a *sense of control* over their life – a critical element of mental health for all people. In this way the PRB directly reflects the approach to recovery that has been developed by consumers."[171]

---

[169] Callender, H., St. Leonard's Community Services—London and Region (personal communication, March 2013).
[170] Psychiatric Patient Advocate Office (January, 2009). *Info-guide: Four Steps to Successful Self Advocacy* Retrieved March 2013, from:
http://www.sse.gov.on.ca/mohltc/PPAO/en/Pages/InfoGuides/1Advocacy_B.aspx?openMenu=smenu_Advocacy.
[171] Trainor, J., Pomeroy, E. & Pape, B. (2004). *A Framework for Support* (3rd Ed). Toronto: Canadian Mental Health Association, p. 16.

> *Develop a positive rapport with the client and provide ongoing supportive counseling regarding issues which affect the client's day to day lives. Develop and maintain direction in their lives by working with the client to set short and long term goals (i.e. education, vocational, interpersonal, mental and physical health, leisure and independent living).*
>
> **Metro Community Housing Association, Halifax, NS.** Objectives of Case Manager and Service Workers

VOLUNTARY PARTICIPATION: CREATING TRUST

Maintaining good relationships between service providers and people with mental health problems and illnesses is not easy. A variety of challenges has impeded the development of a trusting and respectful environment. Particularly, individuals with mental health problems face many challenges when attempting to access services/support from service agencies as a result of the pervasive stigma and discrimination that exist within the system, and as a result have become very cautious when dealing with others. Another major consequence of ongoing discrimination and stigmatization is that some professionals may perceive the person's health situation as a risk factor for criminality rather than as a point of intervention for recovery. Therefore, many people will limit the information that is shared with professionals in order to avoid the potential of being subjected to additional restrictions.

As a result of this project's findings, a trusting relationship is facilitated when service agencies put into place a number of important conditions, such as consistent personnel, clearly defined relationships with boundaries, the use of discretion and the creation of a respectful social environment. Consistency of personnel can help to ensure that an individual is provided with an intervention plan that is best tailored to personal needs rather than being tailored to the knowledge of the direct service provider regarding available services and prior experience. In addition, personnel could consider taking on a client centered approach that focuses on dignity and respect. Their role might include promoting self-confidence in one's ability to actively participate in improving their quality of life. As such, service agencies might be better suited to endorse staff empowerment and self-confidence in their decision-making abilities. Service agencies can also encourage the use of discretion among individual cases in order to best suit the needs of the individual as opposed to using static options that are less adequate.

Conversely, when establishing a relationship, service providers should take care to define concrete boundaries around the relationship, including what is acceptable and what is not. Many people have little contact, if any, with their families as a result of their illness/behaviours and for that reason have a limited social network. Therefore, service providers may need to establish a clear definition of their relationships. People with mental health problems and illnesses need to be able to connect to the real world outside of support groups in order to gain greater self-confidence and independence. The individual should have the opportunity to focus on the self, on independence and on how to live in the community and share with others.

Recommendations For a Client-Centred, Recovery Oriented Approach

- ☑ Encourage people to be aware of their rights
- ☑ Encourage and work towards stability of personnel within service agencies
- ☑ Offer a client-centered approach: Promote confidence, dignity and respect
- ☑ Encourage staff empowerment and confidence in their decision making abilities
- ☑ Encourage effective communication and active listening on the part of the direct service provider
- ☑ Differentiate voluntary from involuntary access to services/programs: Identify different means of working with the individual
- ☑ Communicate a clear definition of the relationship: Establish concrete and visible boundaries
- ☑ Set a "time frame" at the start of the relationship: From the start, people must be prepared for the ending of the relationship
- ☑ Create psychological boundaries: the person needs to connect to real world
- ☑ Include family members who want to be a part of the process

Examples of Promising and Effective Practices

Metro Community Housing Association

This association provides support and residential services to individuals with mental health problems and illnesses including group homes, supportive housing and independent living opportunities. A staff person is also available to visit or reside within housing units (ranging from 24hrs per day to weekly visits). The individual is involved in the planning and decision making process from the moment they make contact with the organization. Metro Housing also provides community support services, especially those who have had encounters with the criminal justice system.

Metro Community Housing Association attempts to make the programs fit the client rather than vice versa. The referral process and thorough assessment results in the best possible match of person with housing option. The staff take on a team approach to offer support and supervision. They also assist clients in taking advantage of resources in the community so that they can set up their own networks.[172]

Circles of Support and Accountability (CoSA)

People convicted of sexual offences are often held in prison to the end of their sentence despite research that a gradual, controlled and supervised release is the safest and most effective approach for community reintegration. By doing so, the community and the individual being released are deprived an opportunity to benefit from the support and treatment in the community that encourages positive change and reduces victimization.

Circles of Support and Accountability (CoSA) originated in the 1990s through an ad hoc response of citizens in Southwestern Ontario who were concerned about the safety of their community. With the help of the

---

[172] Metro Community Housing Association. Website: www.mcha.ns.ca.

Mennonite Central Committee and the Correctional Service of Canada's Chaplaincy branch, a group of parishioners 'circled' high-profile individuals to pick up where CSC left off: to provide the wrap-around support and resources that were needed to keep everyone safe. Years later, CoSA continues to assist individuals who have served a sentence for a sexual offence in their effort to re-enter society, both across Canada and the world.

Based on restorative justice principles, a CoSA circle involves a group of three to six trained volunteers who commit themselves to support and hold accountable a former sex offender, the "core member," who is in turn supported by service providers and partners. Similar to the Circle volunteers, the core member's participation is voluntary.[173] Together, they contribute to community reintegration by facilitating the core member's practical needs (e.g. accessing social services, housing or finding employment); providing a consistent network of emotional support; by developing pro-social solutions to everyday problems; by celebrating successes and challenging any negative attitudes and behaviours. Key components of CoSA's effectiveness are communication, openness and trust.

> **We are not trained to be their friends. Our role consists of providing support and assistance to individuals trying to reintegrate in the community.**[174]

[173] Circles of Support & Accountability (2008*). A Reintegration Program that Works* [pamphlet]. Retrieved March, 2013 from: http://www.stjohnsottawa.ca/pages/cosa.html.

[174] Love, S. Program Coordinator (personal communication, COSA-Ottawa, NAACJ-CSC Consultation Meeting, February 2008).

CROSS-SECTORAL TRAINING AND EDUCATION

A community stakeholder of the British Columbia Street Crime Working Group expressed that, "the community needs to become more involved if we want to change the justice system. People think it isn't their problem: others are frustrated with the justice system. Without the support of the community, it will be more difficult to make changes to the justice system".[175] Consequently, and in conjunction with the views of the Mental Health Commission Canada (MHCC), the initiative for change must be sparked by social concern, a social problem which all work together to solve; there must be a national consensus endorsing changes within the mental health delivery system in order for change to occur.

In February 2008, the Federal government allocated $110 million to the Mental Health Commission of Canada to find ways to help the growing number of homeless people who live with a mental illness. The MHCC developed the At Home/Chez Soi project. It was officially launched in November, 2009.

Program founders based the research demonstration project on the Housing First approach. The project specifically involves people who have been homeless and living with a mental health issue.

The Housing First approach in this case means providing people with housing, along with support services tailored to meet their needs. With the participation of over 2000 homeless people across the country, projects are underway in Moncton, Montreal, Toronto, Winnipeg and Vancouver, and each site is exploring issues related to various sub-populations. Approximately half of them are receiving housing and support services and approximately half have access to the regular supports and services available in their communities. The project is providing meaningful and practical support for hundreds of vulnerable people.

The information obtained from this project will help inform related planning and policy development across the country. Data from this kind of extensive research does not currently exist in Canada. The research projects will end in 2013, and will collectively develop a body of evidence to help Canada become a world leader in providing services to homeless people living with a mental illness. Presently there are reports of early findings available through the MHCC website.[176]

---

175 Street Crime Working Group (2005). p. 40.

176 Mental Health Commission of Canada. *At Home*. Retrieved March, 2013 from: http://www.mentalhealthcommission.ca/English/Pages/homelessness.aspx.

Mental Health Commission of Canada's Knowledge Exchange Centre:

As part of the MHCC, the Knowledge Exchange Centre (KEC) aims to help improve the lives of people living with mental illness by creating ways for Canadians to access information, share knowledge, and exchange ideas about mental health.

The KEC has two major goals:

- To enhance knowledge exchange with regard to critical ideas and practices identified by the MHCC mental health strategy; and
- To enhance capacity for knowledge exchange throughout the Canadian mental health system.

Three themes underlying the KEC's activities:

- Share
- Collaborate
- Support

To learn more about the online activities MHCC is building to share knowledge, facilitate collaboration and help support knowledge mobilization visit www.mentalhealthcommission.ca.

Guidelines for Cross-Sectoral Training and Education

In order to reduce stigma and discrimination and ensure a more effective mental health delivery system, the recommendations from this research suggest that the following building blocks should be explored:

- **Training**
- **Education**
- **Public Education and Media Relations**

Training

There is concern regarding the lack of mental health training provided to police officers. Their mental health training focuses primarily on crisis intervention and risk assessments. As indicated by the experts in Calgary, police officers deal with behaviours, not mental health problems. They would benefit from more extensive training on how to distinguish between the two; the impact that mental health has on behavior; and the alternatives that are available to avoid criminalizing individuals with mental health problems. There are great examples of promising and effective practices that focus on training police officers in mental health and integrating mental health professionals into the frontline work of police officers; several are mentioned in this handbook.

The lack of appropriate cross-sectoral or other training among services providers has affected crisis response time and the access to services and support for individuals with mental health problems as well, especially when the individual suffers from complex mental health problems (i.e. addictions, mood disorders, intellectual disability and homelessness). Many community-based agencies do not have the resources and funding to develop their own training and are left to their own devices in dealing with this particular population. There is a need for training that is easily accessible and available to community-

based agencies and organizations. Government has a role to play in the provision of this training; for example, the Correctional Service of Canada for community residential facility staff, provincial health departments for shelters and other social service agencies.

Training should focus on a multidisciplinary approach to services and integrate the various key players into the developmental and implementation phases of training. It would further encourage and allow for better communication among sectors and encourage the development of strategies for dealing with this population. Training sessions should address mental health definitions and its impact on the individual, and focus on a recovery-oriented and holistic approach to service delivery. For example, some offer mental health training twice a week, for 3-4 months. The lack of psychiatric nurses has been a major challenge for service delivery and institutional programs dealing with individuals with mental health problems requiring health and mental health support. As a result, nursing programs should consider including more extensive psychiatric training possibilities and promotion of psychiatric/correctional careers such as knowledge in dealing with difficult and complex cases, especially with involuntary patients, offenders and institutional work.

Training should also address issues such as language use, definitions and labels assigned to this particular population. It should aim at facilitating discussion by promoting the use of a common language between direct service providers that reduces confusion or misrepresentation among service providers and professionals. It should focus on changing the parameters in developing policies and guidelines by using a common language that takes on a recovery-oriented approach to mental health service delivery. Additionally, training should also consist of stress reduction and stress management programs to assist service providers and professionals in their work. Such programs could also contribute to reducing the high staff turnover rate and present such professions as more appealing and manageable to potential recruits.

There has also been some discussion regarding the implementation of liaison staff whose role includes connecting the different sectors and service providers; maintaining community relations in order to be aware of the development of new programs and services; and a gate keeper whose priority is to maintain and strengthen the relationship between service providers with government departments. Liaison staff would also be responsible for developing more effective partnership and protocols in order to ensure more efficient and adequate service delivery. Their role would include identifying overall goals, common goals and objectives with the collaboration of all partners.

> *Recruited officers receive forty hours of mental health training, including information-sharing and effective relationships with its partners. Trained officers proceed to their regular duties but in the event of a mental health-related crisis will be dispatched as first responders.*
>
> Constable Lara Davidsen, 2007. Crisis Intervention Team Trainer, RCMP-Lower Mainland Division.

RECOMMENDATIONS

- ☑ More comprehensive mental health training, particularly for police officers and other criminal justice professionals (i.e. crown counsel, public attorney, legal aid, judges)
- ☑ Cross-sectoral training for mental health, health service providers and professionals (i.e. homelessness, employment, criminal justice involvement, etc.)
- ☑ Increase understanding of voluntary versus involuntary and awareness of the different practices and strategies to be used to the benefit of the person
- ☑ Institutional training (i.e. institutional parole officers, correctional officers, case managers, etc.) on dealing with individuals with mental health problems
- ☑ Develop national training programs accessible to community-based agencies/organizations
- ☑ Develop a strategic plan for promoting psychiatric nursing, especially in dealing with individuals who have had encounters with the criminal justice system
- ☑ Develop a recruitment campaign that targets mental health and corrections as a career choice
- ☑ Implement liaison staff primarily responsible for connecting the different sectors and services: A community relations roles
- ☑ Engage in regular and on-going training (language and definitions, diversity, individual differences, gender-differences, age differences, awareness of the different illnesses and related-behaviours)
- ☑ Funding available for core training programs and evaluation, especially those developed and implemented by the service system
- ☑ Create collaborative and multidisciplinary training programs: Sectors to learn from each other's challenges and concerns

EXAMPLES OF PROMISING AND EFFECTIVE PRACTICES

INTEGRATED MOBILE CRISIS RESPONSE TEAM (IMCRT)[177]

> *The ability to have plain clothes police officers attend with IMCRT clinicians allows the team to respond to critical psychiatric emergencies while respecting and maintaining the dignity of both the client and the family member who may be involved. Many times the officer is never identified; therefore, the potential for escalation in the individual's behavior is reduced. Introduction of plain-clothes police officer has resulted in positive initial feedback from other service providers and families, related to the level of intrusion.*
>
> Review of Pairing Police with Mental Health Outreach Services, Integrated Mobile Crisis Response Team (IMCRT), Prepared by Dr. Edward P. Baess, September 2005

The **Integrated Mobile Crisis Response Team (IMCRT)** program serves the Capital Region that includes Victoria BC, and has trained officers to effectively address crisis situations for every individual in need.

[177] Baess, E. P. (2005). *Review of Pairing Police with Mental Health Outreach Services, Integrated Mobile Crisis Response Team (IMCRT).*

They operate as an integrated team comprised of nurses, social workers, child/youth clinicians, and police officers, facilitating links to community service providers which diverts people in crisis from hospitalization. By having direct contact with the team, police officers who encounter an individual in need of intervention have better resources to assess the most appropriate balance of clinical/law intervention.

Clients sometimes respond to uniformed officers with stress, anxiety, escalated behaviour and aggression. In these cases, hospitalization may be perceived as the best response. Plain clothes officers provide a calmer environment where clients and families have reported being treated with respect and dignity. The client's confidentiality is better respected in the absence of patrol cars and uniformed officers on scene and in hospital waiting rooms. These officers also reduce wait times for police response and improve coordination for more efficient use of community services. Examiners can also safely conduct more thorough assessments when the officer is present, which leads to more appropriate service dispositions.

Highlights of the program include:

- IMCRT has helped develop and deliver a one-day training for front-line patrol officers related to crisis intervention and has worked in partnership with the BC Schizophrenia Society to have people with lived experience of mental illness participate in a panel discussion with the patrol officers. Officers were surveyed and they reported the experience to be quite powerful in terms of developing more empathy/understanding related to mental health issues.
- Police officers continue to work in plain clothes. They do not attend every call, only those with significant potential imminent risk to self/others. They do identify themselves as a team police member unless the situation is so potentially volatile that it is better that they not be identified initially as police. They always identify themselves clearly as police officers if/when they are required to intervene under the Mental Health Act or other law enforcement duties.
- Referrals to the team have increased every year, a growth of 48% in calls for service since 2008.
- The IMCRT has access to a psychiatrist who can consult with the team on particularly challenging cases, and who can conduct pre-arranged visits with the team into the community when a person is clearly deteriorating, unwilling/unable to access help, and does not meet the criteria for the emergency provisions of our mental health act.[178]

Community Mental Health Initiative

One of Correctional Service of Canada's (CSC) five priorities is to improve the capacity to address the mental health needs of prisoners. Since 1997, there has been an 85 per cent increase in the number of people identified with a mental health disorder at intake. To assist these people in making a safe return to the community, CSC has implemented the Community Mental Health Initiative (CMHI).

The CMHI is part of CSC's overall Mental Health Strategy, which is aimed at ensuring comprehensive mental health services for the duration of an offender's sentence. The CMHI offers a range of services to avoid gaps in care during the transition from the institution to the community, and while the offender is on conditional release in the community.

[178] Lynn, D. Program Coordinator SI Access & Integrated Mobile Crisis Response Team (IMCRT), Vancouver Island Health Authority. (personal communication, March 2013).

Key elements of the CMHI include:

- identifying the individual needs of offenders with mental health disorders and developing a discharge plan;
- Supporting offenders with mental health disorders under community supervision;
- Providing training to staff; and
- Working with local agencies to provide specialized support for offenders with mental health disorders within the community.

Additionally, approximately 50 new positions were created across Canada as a part of the CMHI. These include:

- Clinical Social Workers (Discharge Planners) to assist in planning the institutional release of offenders with mental health disorders by determining their specific needs, and building a plan for support in the community.
- Clinical Social Workers and Nurses (Community Mental Health Specialists) to work directly with offenders with mental health disorders at selected parole sites to provide support in the community. These specialists also participate in multidisciplinary teams, provide training for front-line staff and develop partnerships with local agencies.
- Coordinators to manage the Initiative in each region, to help new staff work with existing services to enhance mental health support for offenders in the community.

The CMHI provides funding to local agencies, organizations and specialists, enabling CSC to offer a range of services to offenders with mental health disorders, such as specialized psychiatric assessments and personal support workers. These organizations also address the unique needs of Aboriginal and women offenders diagnosed with mental health disorders.

Additionally, CMHI staff delivers two-day mental health awareness training to front line staff at selected parole offices and community correctional centres on the Fundamentals of Mental Health training. The training was delivered to 1,366 staff in fiscal year 2010-2011 and to 2,438 staff in fiscal year 2011-12.[179]

CRISIS INTERVENTION TEAM (CIT)

The RCMP's **Crisis Intervention Team (CIT),** implemented at the British Columbia Lower Mainland Division, is based on the Memphis CIT. This model brings together experts from social, legal, medical and police agencies to provide a holistic approach to individuals with mental health problems within the community. Recruited officers receive forty hours of training on mental health issues, such as understanding mental disorders, the role of police and the community, developing effective communication skills, and suicide intervention. This training also works towards promoting effective communication and liaison among service providers and with service agencies. The RCMP provides refresher courses that allow trained officers to address challenges and concerns they have encountered.[180]

The CMHA-BC completed an evaluation project regarding the assessment of police officers chosen or assigned to Crisis Intervention Team training. Officers who volunteer for crisis intervention teams are

[179] Felizardo, V. Senior Project Officer, Federal/Provincial/Territorial and Mental Health Partnerships (personal communication, March 2013).

[180] Davidsen, L., Constable. CIT Trainer, RCMP Lower Mainland Division (personal communication, Vancouver Forum, November, 2007).

screened to make sure that they exercise good judgment and maturity. Skill testing and structured interviews are suggested as reliable screening tools.[181]

> **The program looks for officers who demonstrate enthusiasm and excitement for the work and they select officers who demonstrate empathy, calmness, creativity, intuitiveness, and willingness to try new techniques.**[182]

Selected officers go through training where crises are staged and officers learn to respond on a continuum ranging from minimal intervention to non-lethal and lethal force. Officers learn to recognize the situation and respond quickly and appropriately.

THE SECURE TREATMENT UNIT

Staff at the St. Lawrence Valley Correctional and Treatment Centre (STVCTC) engages in a multidisciplinary approach to service delivery. Its Clinical Team consists of a Deputy Head, a Clinical Director, an Administrative Director, Service Coordinators, Psychologists, Social Workers, Chaplain, Recreational Therapists, Vocational Counselor, Addictions Counselor, Dietician and Nurses. The members of this team are part of the Royal Ottawa Health Care Group (ROHCG). Specifically, the day to day supervision and care is provided by nurses rather than correctional officers while the overall site security and community escorts is provided by the Ontario Ministry of Community Safety and Correctional Services (MCSCS). Research evidence has supported the positive response of having implemented psychiatric/nursing intervention. The following include some of the findings in support of this type of intervention within correctional settings:

- Opportunity to provide clear diagnosis and access to crisis intervention
- Differentiate between behaviour management problem and illness
- Successful stabilization resulting in integration with resident population and participation in group programming
- Increased access to treatment intervention (i.e. short-term sex offenders)
- Less incidence of suicide attempts and significantly less time spent in segregation or secure isolation
- Partnership of MCSCS and ROHCG has resulted in successful management/and intervention with very difficult and challenging residents

[181] Adelman, J. (2003). Study in Blue and Grey: Police Interventions with People with Mental Illness, A Review of Challenges and Responses, *Canadian Mental Health Association, British Columbia Division,* p.14.
[182] Adelman, J. (2003).

EDUCATION

According to University of Ottawa Criminology Professor Michael Petrunik,[183] correctional programs (i.e. criminology, law, police academy) require a wider variety of courses that focus on mental health. Alternatively, social workers, psychologists and other health professionals should also be required to take law and corrections-related courses if this is their career of choice. Similarly, some content should also be included in general mental health, health, and corrections educational courses to make students aware of the existing choices and possibilities that are available if one chooses this direction.

Courses should consider going beyond prevention and changing public opinion, focusing on reducing stigma and discrimination on behalf of service providers who have developed their own perceptions and images of mental health-related behaviours. Lawyers have had limited education in the field of mental health and have encountered many challenges when dealing with such an individual.

General practitioners and family physicians may also benefit from more extensive mental health training as they are in many cases responsible for referring people to programs and services that target mental health problems. Educational programs should focus on changing existing attitudes and perceptions towards mental health and corrections on the part of health care workers. Another major issue is the need to educate local businesses and private agencies on mental health-related issues (i.e. panhandling and mental health, homelessness). By developing a wider social service network, partnerships that focus on developing strategies to deal with homelessness and mental health related issues can be better facilitated.

> A police officer answers a call. The individual (John) is known to the police officer and has little or no violent behaviour history.
>
> John refuses to enter the car. Rather than forcing John into the car, the officer asks why he is reluctant to enter the cruiser.
>
> John states that there is a snake in the vehicle.
>
> The police officer proceeds to remove the snake.
>
> John enters the car without resistance.
>
> **Vignette, Calgary Forum**

Courses should address addictions and mental health issues separately, rather than attempting to cover both within a limited time period, especially within university departments. Often field and community courses will include and discuss issues that are not addressed at the university level but could be beneficial to students' education. Consequently, universities should allow for/require students to take courses offered by service providers/professionals outside of the university, and not be limited to those within a placement or internship program.

Family-related issues and challenges (i.e. children of parents with mental illnesses) also merit inclusion. Educating families may differ from the education offered to service providers, agencies and organizations given the different types of challenges and concerns that are experienced by family members and partners. Such programs may also allow for a better integration of this group in the intervention planning process. It may also initiate additional advocacy-related projects on behalf of families that are in better control of their needs and more apt to describe and explain their concerns and challenges with the mental health delivery system.

[183] Petrunik, M. Professor, University of Ottawa, Department of Criminology, (personal communication, Kingston Forum, November 2007).

Recommendations

- ☑ Continued education throughout career –especially with respect to criminal justice and mental health and its interaction
- ☑ Educational programs should address mental health, health, and justice related subjects and challenges (i.e. corrections class for psychologists and mental health courses for lawyers)
- ☑ Educate private and local businesses on mental health-related issues as a starting point to creating a wider social service network
- ☑ Courses should address addictions issues and mental health issues separately
- ☑ Allow courses offered by agencies/organizations to be included in degree requirements
- ☑ Education on cultural diversity and ethnic differences among those with mental health problems
- ☑ Include, family-related issues and challenges in course material

Examples of Promising and Effective Practices

Enhanced Skills Training Approach

This initiative was implemented to assist general practitioners (GPs) to treat individuals with mental health problems. The goal is to ensure that they are able to assess an individual and determine, if necessary, concurrent diagnoses and arrange for appropriate interventions/referral to be taken. It also intends to provide GPs with an alternative tool to prescription medication.[184]

Two psychiatrists and two Vancouver Interior Health Authority (VIHA) therapists deliver an on-site, manual based Enhanced Skills Training module to GPs. The goal is to enhance their skills in diagnosing, doing differential diagnosis and becoming familiar with the *Cognitive Interpersonal Behavioral (CIB) Skills* manual, thus enhancing their skills and treatment choices.[185] The CIB skills manual aims at changing negative thinking patterns. Interpersonal skills are also consistent with first line evidence based treatment while behavioral skills involve changing the behavior of patients. This type of intervention results in changing the feelings/mood of mental health and addictions patients. The modules focus on diagnoses that are most common in GP practices: depression and anxiety disorders.

[184] Weinerman, R. Vancouver Island Health Authority. (personal communication, February, 2008).
[185] Vancouver Island Health Authority. (2009). *Cognitive Behavioural Interpersonal Skills Manual*. Retrieved March 2013 from: http://www.gpscbc.ca/system/files/MH_CBIS_manual.pdf

Objectives of the Enhanced Skills Training Module for General Practitioners

1. To improve satisfaction with access to consultation by a specialist whether direct (face to face) or indirect (patient not present)
2. To improve satisfaction with the quality of mental health and addiction services
3. To improve satisfaction with communication
4. To improve satisfaction with accessibility of resource information
5. To increase the feelings of competence for primary care providers in working with the mental health and addictions population
6. To improve the skills of the GPs working with Depression and Anxiety around diagnosis, differential diagnosis and the use of CIB skills Made Easy tools

—Rivian Weinerman, Vancouver Interior Health Authority

The CBI Skills manual's modules are designed to be user friendly for both GP and patient, and overall they continue to be desirable objectives.

Changing Minds

This training program originated from CMHA-Newfoundland/Labrador and has since been implemented in various other provincial CMHA's (e.g. Nova Scotia, PEI, and NB). This program attempts to reduce stigma and discrimination among the public and service providers by providing a better understanding of mental health, and awareness of the impact of stigma and discrimination. It is offered by two certified Canadian Mental Health Association facilitators and is available in three different formats (two full day sessions, four half day sessions or eight two-hour sessions). "It is based on the premise that we can learn to understand mental illness better when we get to know about the individual and learn how the illness affects him or her. Each module contains video stories of people who have major mental illnesses or complex mental health problems. We are able to see that mental illness is part of the broad range of human experience—something that can happen to any of us."[186]

Sample: Module 7 – Understanding Complex Mental Health Problems[187]

Goal: To understand how people develop extreme coping mechanisms in order to express their needs.

Objectives:

1. To understand the impact of traumatic experience on a person's development
2. To understand the limitations of diagnostic labels for people with complex mental health problems
3. To understand how society responds to people who have complex mental health problems
4. To learn about the concept of personality disorders
5. To better understand our reactions to people who have complex mental health problems
6. To better understand how to maintain boundaries in a positive way

Communication Component

Reflection: Recognizing our own feelings

Response: Stabilizing the interaction

Key Message: There are reasons for behaviours

---

[186] CMHA-NFLD/LD *Changing Minds* promotional pamphlets. For more information see: http://www.cmhanl.ca/minds.aspx?id=11.

[187] CMHA-NB, Training session information pamphlet, download from website: http://www.nb.cmha.ca/bins/site.asp?cid=284-1007&lang=1.

PUBLIC EDUCATION AND MEDIA RELATIONS

Educational campaigns that focus on changing public opinion should involve all Canadians in the move towards a better mental health service delivery system. This type of campaign should focus on working together as a means of strengthening our voices and making ourselves heard. It should also identify people willing to tell their story, their experiences and why they feel that they were able to overcome such challenges as opposed to so many others who continue to struggle. It needs to emphasize that community is part of the problem as well as part of the solution. Regular meetings and continuous education should also be viewed as significant factors ensuring continued discussions among the various groups and advocacy for mental health services.

There is a need to challenge how language on mental health is presented to the community at large in order to reduce the existing conservative approach that has been taken when speaking about mental health and corrections. The initiative for change requires a cultural shift which focuses on demonstrating the global impact of resistance to openly addressing mental health needs, which simply aggravates the situation. A common reality must be created.

Stakeholders assert that stronger media relations are a key concern.[188] While the media has a huge impact on public perceptions, most news stories remain focused on tragic and violent events that relate to the criminal justice system, particularly when it involves a mental health or drug-related incident. The news media are quick to stress a causal relation between criminality and mental health, which in turn reinforces the stigma that is associated with mental health. More effort must be made to foster good relationships with the media. These should target the distribution of positive news stories in order to break down the association between mental health and violence. For example, stories of successful community reintegration/personal recovery with the help of service providers should be distributed for publication.

> Working with rather than against the media by educating and providing them with success stories and a more comprehensive explanation to the issue of mental health may assist in changing the way stories are publicizing and sensationalizing when talking about those who suffer from mental health problems.[189]

RECOMMENDATIONS

- ☑ Work the media: Educate and provide success stories
- ☑ Engage the community as part of the solution: Regular meetings and continuous education
- ☑ Challenge how we talk to the community: Develop awareness and educational campaigns
- ☑ Develop a media campaign that supports the work of direct service providers
- ☑ Encourage advocacy within the community: Develop pro-active community participation
- ☑ Create a common reality

[188] Veresh, T., Executive Director, John Howard Society of Lower Mainland of British Columbia (personal communication, Vancouver Forum, November, 2007).
[189] Baillie, P. Forensic Psychologist, Peter Lougheed Hospital, (personal communication, Calgary Forum, November, 2007).

Examples of Promising and Effective Practices

Quebec's Provincial Mental Health Strategy 2005-2010

The Quebec provincial government has invested in a public education campaign aimed at understanding mental health and reducing stigma towards individuals dealing with mental health problems. Among their initiatives, a website and television campaign has been developed, focusing on mental health problems as an illness. "A mental illness is not a personal weakness. There is a reason it is called an illness, because that's exactly what it is […]. The best offence against prejudice is education. That is what this site is all about, providing a wealth of information, on the many types of mental illnesses; what they are, how to prevent them, and how to treat them."[190] However, as Quebec was not part of the fora for this project, more research on the Quebec experience would help to develop practices and strategies that work towards an initiative for change.

Emanating from the 2005-2010 mental health strategy and action plan, Quebec established the Institut universitaire en santé mentale, in 2009. This institute is located in Quebec City, is affiliated to the Université Laval, and works in partnership with other psychiatric hospitals and mental health agencies around the province. The Institute is geared toward recovery, social integration and improving quality of life.

In 2011, the Institute published its strategic plan, 2011-2015. Of the 88 objectives elaborated in the 2005-2010 mental health strategy, 75% of them have been reached. The work that still remains to be done includes the consolidation of inter-disciplinary work, and better collaboration between professional resources and client programs.[191]

> *These prejudices stem from thousands of years of misinformation, and to this day still hinder people afflicted with the disease to seek the help they so desperately need. The campaign is aimed at ridding the false images of 'cowardice', 'weakness', and 'laziness' so often associated with mental illness.*
>
> **Mental Health Action Plan 2005-2010**
>
> Ministry of Health and Social Services, Quebec

Talking about Mental Illness (TAMI): A Guide for Developing an Awareness Program for Youth

Given the growing prevalence of depression and suicide among younger children, it has been suggested that educational programs start as early as grade 4. When targeting youth, prevention programs should also be implemented in order to reduce the number of children and teenagers that are currently dealing with addictions. Too often service providers deal with individuals who suffer from comorbid disorders/dual diagnosis (mental health and addictions) due to a lack of early intervention.

---

[190] Quebec Health and Social Services, Provincial mental health action 2005-2010. (2007). Retrieved March 2013, from: http://www.towardmentalhealth.com/.

[191] Québec. Institut universitaire en santé mentale de Québec. (2011). *Plan stratégique 2011-2015.* Québec: IUSMQ.

The **TAMI** program focuses on discussing the impact of stigma and labelling and providing young students with a better understanding of mental health and mental illness. It also aims at addressing fears related to speaking out about a similar situation either experienced by themselves or by a family member due to fear of being judged, bullied or isolated by their peers. Teachers can adapt the format of the program to suit their classroom and the amount of time they have available. The structure of each component is flexible. The way teachers' use the activities and resources will depend on several things:

- The particular course into which the program is being incorporated;
- The time the teachers have available; and
- Where they are in the course outline when they take part in the program.[192]

STAND UP FOR MENTAL HEALTH

David Granirer, a person with lived experience, Counselor and stand-up comic, offers a mental health course where people with mental health problems and illnesses turn their stories into performing acts that are presented at conferences, treatment centres, and various mental health organizations.[193]

---

[192] Centre for Addiction and Mental Health (2001). *Teachers Guide. Talking About Mental Illness: A Guide For Developing an Awareness Program for Youth.* Retrieved March, 2013 from: http://www.camh.ca/en/education/teachers_school_programs/resources_for_teachers_and_schools/talking_about_mental_illness/Pages/talking_about_mental_illness.aspx.

[193] Stand up for Mental Health. Retrieved March, 2013 from: http://standupformentalhealth.com/.

Policies Affecting the Criminalization of Persons with Mental Health Problems and Illnesses

The focus of this section is to identify policy gaps within mental health care services affecting the criminalization of persons experiencing mental health problems and illnesses. Capacity and access are primary starting points for analysis, as there has been growing awareness that far too often vulnerable portions of the population have their first contact with mental health services through the justice system. Subsidiary analysis covers a structural look at the provincial models for service delivery, personal health information sharing policies, formal versus informal collaboration, recovery versus population-based approaches, before finally highlighting policy concerns in need of further research.

Policies regarding the provision of mental health care services are both mottled and diverse. This range of diversity is important to reveal in demonstrating the complex interplay between jurisdictions, initiatives, and mandates. Mental health policies are often developed by different stakeholders and for different purposes. Policies may be constructed at the provincial/territorial, regional, or facility levels, and may cover a vast range of areas such as standards for service delivery, program eligibility, staff conduct, information sharing protocols, procedures for patient handling and transfer, the regional distribution of services, program funding and operation, inter-organizational collaboration, and more.

Not only do mental health policies cover a wide variety of areas, but they also reflect different intentions, priorities, and at times, competing values. One of the more meaningful divisions between provincial approaches to mental health policies is whether they take a recovery-based or population-based approach.[194] A recovery based approach has a long history in Canadian mental health policy tracing back to the ex-patient and consumer movements of the 1960s and 70s. This approach is made up of three pillars: choice, community, and integration services.[195] Recovery-based policies strive to focus on empowerment, equality and the social justice aspects of mental health care services. A reiteration of this approach can be seen at the national level in the 2006 report, *Out of the Shadows at Last*, as well as in the Mental Health Commission of Canada's framework for a National mental health strategy.

In contrast to a recovery-based approach to mental health policy, there is a population-based approach. This focuses on enhancing well-being for specific groups as opposed to individuals, and has been described as providing psychosocial rehabilitation models that represents the perspective of mental health professionals.[196] Population-based approaches have been adopted throughout BC, Alberta, and Ontario, while a recovery-based model is most notably seen in New Brunswick, Manitoba, Newfoundland and Labrador, Prince Edward Island and Québec.[197]

---

[194] Piat, M. & Sabetti, J. (2012). Recovery in Canada: Toward Social Equality. *International Review of Psychiatry,* February, 24(1), pp. 19–28.
[195] Standing Senate Committee on Social Affairs, Science and Technology. (2006).
[196] Piat, M. & Sabetti, J. (2012). p.21.
[197] Piat, M. & Sabetti, J. (2012). p.22.

THE NEED FOR COHERENCE

In the past 10 years, reports such as *Out of the Shadows at Last*, and the original publication of *Towards an Integrated Network* have demonstrated a growing awareness of the need for more coordination among mental health care services. In 2011, *Open Minds, Healthy Minds. Ontario's Comprehensive Mental Health and Addictions Strategy* noted that one of the "biggest challenges is that mental health and addictions services are fragmented, spread across several ministries and offered in a variety of care settings."[198]

Since 2008, there has been observable progress in regard to policy, such as the establishment of the national Mental Health Commission of Canada, the transfer of more responsibility to Local Health Integration Networks (LHINs) in Ontario for service delivery, and the abolition of Alberta's Regional Health Authorities in favour of a more centralized body, Alberta Health Services. However, gaps in the system's coordination and fluidity are still being documented throughout the literature and continue to challenge service providers. These gaps present further difficulties for clients who require streamlined access, and for those who may have otherwise avoided encounters with the criminal justice system.

Without a clearly defined system, the array of programs and services can be confusing for individuals, families, and service providers, leading to accessibility challenges. Currently the Ontario service delivery model is composed of five main services implemented through regional call and information resources, close to 100 varied psychiatric health care service facilities, self-help supports, community integrated mental health teams, and other specialized services. Coordination within this system is complicated by the fact that no single body organizes the fluidity of these services.

Increasing the complexity of this system is a plethora of ministries involved in the mental health and addictions strategy. These ministries include Aboriginal Affairs, the Attorney General, Children and Youth Services, Citizenship and Immigration, Community and Social Services, Community Safety and Correctional Services, Culture, Education, Finance, Health and Long-Term Care, Health Promotion, Labour, Municipal Affairs, Training, and finally, Colleges and Universities.[199]

Ontario's mental health and addictions system is just one within Canada lacking sufficient coordination. According to an Ontario Select Committee report on Mental Health and Addictions in 2010, services were being funded or provided by at least 10 different ministries, while community care is delivered by 440 children's mental health agencies, 330 community mental health agencies, 150 substance abuse treatment agencies, and approximately 50 problem-gambling centres.[200] According to the Select Committee's observation, many people are continuing to fall through the cracks, or simply give up in frustration because of the complexity of the system.[201]

---

[198] Government of Ontario. (2011). *Open Minds, Healthy Minds. Ontario's Comprehensive Mental Health and Addictions Strategy*.p.6

[199] Caplan, D. (2009). *Every Door is the Right Door. Towards a 10- year Mental Health and Addictions Strategy*.p.7

[200] Select Committee on Mental Health and Addictions. (2010). *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians*.p.3

[201] Select Committee on Mental Health and Addictions. (2010). p.3

MEANS TO ENHANCE COORDINATION

GOVERNANCE

Nationally, the MHCC is seen as a step forward in promoting key recommendations, awareness, providing structural oversight, and the sharing of information. The scope of the MHCC may be to provide guidance on broad policy standards; however, implementation ultimately resides with the provinces that allocate specific funding, set up programs, and ultimately determine the conditions for access to services. In 2010, a Select Committee for the Ontario legislative assembly recommended the creation of a new organization—Mental Health and Addictions Ontario (MHAO)—which could be responsible for overseeing the entire mental health and addictions system. Establishing this organization is intended to mend policy, oversight, and communication gaps that exist in the service delivery network. The report that tabled this recommendation was the result of 18 months of research, 30 public hearings that received testimony from 230 presenters across Ontario, and over 300 submitted briefs, journal articles and DVDs, as well as from information gathered from numerous visits to community mental health and addictions facilities.[202]

Although the establishment of MHAO has not been adopted, its recommendation was intended to address issues of comprehensiveness, coherence, and to streamline service delivery policy.[203] Accordingly, MHAO would be accountable to the Ministry of Health and Long-Term Care and would act as a single body responsible for designing, managing, and coordinating the mental health and addictions system, ensuring programs and services are delivered consistently and comprehensively across Ontario.[204]

The strength of this recommendation comes from the fact that its structure has been successfully implemented in other health arenas. The structure is based on Cancer Care Ontario, a provincial agency responsible for continually improving cancer services.[205] They oversee the allocation of public funds, act to improve diagnostics and screening programs, work with professionals to improve quality and standards, as well as monitor the use of electronic information technology to support health professionals regarding safety, efficiency, accessibility and accountability.[206] Alberta is an example of a province that has recently moved toward such a centralized health authority.

In 2008, Alberta dismantled the regional health authorities and established the single largest health authority now in existence in Canada, Alberta Health Services (AHS). A central board oversees AHS, and is responsible for co-ordinating the delivery of health supports and services across the province in support of the mandate of the Ministry of Health to improve access to care. Local health concerns are voiced through 12 Health Advisory Councils. These Councils often consist of 10 to 15 members, including a chair, and each council represents a different geographical area. The central governance structure allows the Provincial Advisory Council on Addiction and Mental Health (PACAMH) to give advice on addictions and mental health services provided by Alberta Health Services. Furthermore, the council's recommendations draw on evidence and information provided by Albertans in obtaining local consensus and representation. A similar type of central governance structure has been envisioned by the Ontario Select Committee on Mental Health and Addictions to ensure a core basket of services are available in all regions of Ontario, and to enhance oversight over primary care standardization and performance accountability requirements.

---

[202] Select Committee on Mental Health and Addictions. (2010). p.3.
[203] Select Committee on Mental Health and Addictions. (2010).
[204] Select Committee on Mental Health and Addictions. (2010).
[205] Select Committee on Mental Health and Addictions. (2010).
[206] Cancer Care Ontario. (2013). Website: https://www.cancercare.on.ca/about/who/vision/.

In addressing mental health and addictions policy reform, changes within the governance structure for services delivery is a substantial topic, and one that requires further analysis. For the purposes of this project, a basic comparison of centralized versus de-centralized service delivery was deemed appropriate. Further, this section strives to raise the question of whether streamlining service delivery through governance can enhance access, and decrease the chance that persons with mental health problems and illnesses will obtain treatment only after encountering the justice system. Criticism remains as to whether a "one size fits all" approach is an adequate solution, and whether having regional decision-making bodies will increase competition for resources among local mental health service providers. More research and debate is warranted.

LOCAL HEALTH INTEGRATION NETWORKS (LHINS)

In 2006, the Ontario government moved forward with the implementation of 14 regional Local Health Integration Networks in an attempt to establish equitable access based on patient need.[207] These authorities were intended to help preserve patient choice, measure outcomes, and enhance accountability between the provincial government, service providers, service users, and communities. This strategy has been part of an overall attempt to implement a people-centred, community-focused system of care that responds to local population health needs.[208]

LHIN COMMUNITY ENGAGEMENT

Through a review of publicly available LHIN documents, one study found that most LHIN Community Engagement (CE) evaluation activities focused on "superficial assessments, such as the number and satisfaction of participants."[209] Furthermore, it was found that no common CE evaluation framework existed that can be shared across all 14 regions.[210] This points to gaps in how the LHINs conceptualize CE, and further indicates the need to develop and implement better evaluation frameworks.[211]

CMHA Ontario has noted that for decentralized planning to work for community mental health services, Community Engagement must be meaningful, and include individuals, families and service providers.[212] According to the Ministry and LHIN Accountability Agreements (2007), LHINs are expected to "engage the community" along with providing evaluations of the "effectiveness" of these strategies through the use of a "common assessment tool".[213] The CMHA has stated that this aspect is crucial as a best practice for individuals and families to have the power to influence services, and to be included in the planning and delivery of services.[214] In so far as community engagement falls behind in achieving an accurate representation of local service needs, the structure may lose its justification in favour of more centralized decision-making body.

---

[207] Jabbar, A. M. & Abelson, J. (2011)*. Development of a framework for effective community engagement in Ontario, Canada. Journal of Health Policy*.
[208] Rachlis, M. M. (2004). *What are LHINs and What Will They Mean to Toronto Health Organizations?* November 29, 2004. Retrieved March 2013 from: http://www.michaelrachlis.com/.
[209] Jabbar, A. M. & Abelson, J. (2011)*.*
[210] Jabbar, A. M. & Abelson, J. (2011)*.*
[211] Jabbar, A. M. & Abelson, J. (2011)*.*
[212] Canadian Mental Health Association Ontario website. Retrieved March, 2013 from: http://www.ontario.cmha.ca/policy_and_research.asp?cID=22997.
[213] Government of Ontario. Ministry-LHIN Accountability Agreements. 2007. Retrieved March, 2013 from: http://www.lhins.on.ca.
[214]Canadian Mental Health Association Ontario website. Retrieved March, 2013 from: http://www.ontario.cmha.ca/policy_and_research.asp?cID=22997.

LHIN Evaluations and Funding

Increasing community engagement is not the only gap to address in improving mental health service standards and quality. According to a 2010 follow up by the Office of the Auditor General Ontario, many of the LHINs were still focused on policy and program implementation, and had yet to focus on measuring outcomes.[215] In reference to where LHINs sit in the sphere of service delivery, this report further noted that formal co-ordination and collaboration among stakeholders, including community mental-health service providers, relevant ministries, and LHINs, was continuing to be an area in need of improvement.[216] This lack of collaboration means that the Ministry and LHINs do not have sufficient information to adequately assess the community-based care that people with serious mental illness are actually receiving.[217]

If LHINs are facing challenges assessing the quality of services being delivered it is reasonable they would also have difficulties allocating and assessing adequate funding for providers. The AGO report has touched on this issue while also highlighting the concern that LHINs themselves may be underfunded.[218] Even though the Ministry transferred responsibility for delivery of community mental-health services to the LHINs on April 1, 2007, funding of community mental-health services have been based on past funding levels rather than on a current assessment of needs, or up to date per/capita assessments.[219] Funding allocation that does not take population growth or demographic change into assessment may fall out of step with meeting the needs of the region. Further to this point, the report noted that the Ministry was not yet close to achieving its target of spending, ensuring that 60% of mental-health funding is spent on community-based services.[220] Both points signify that community based mental health services themselves may be underfunded or in need of better assessments.

In 2008, the AGO recommended the need to establish provincial standards, performance benchmarks, and outcome measures for the most critical programs against which the quality and costs of services can be evaluated.[221] In 2011, Multi-Sector Service Accountability Agreements sought to achieve this by establishing performance measurement and improvement tools. Furthermore, the agreements have been reported to successfully link community care access centres, health centres, community mental health and addictions providers, as well as community support service providers.

These initiatives show the LHINs demonstrate gradual responsiveness to recommendations and development of standards. Considering the relatively recent establishment of the LHINs, and the even more recent use of 2011-2014 Multi-Sector Service Accountability Agreements, a wholesale attack on the effectiveness of LHINs to provide regional oversight for mental health care service requirements may be premature at this time.

---

[215] Jabbar, A. M. & Abelson, J. (2011).
[216] *Annual Report of the Office of the Auditor General Ontario*. (2010); Ministry of Health and Long-Term Care. *Community Mental Health. Follow-up on VFM section 3.06, 2008 Annual Report*. Chapter 4 section 4.06.p.329.
[217] *Annual Report of the Office of the Auditor General Ontario*. (2010). p.330.
[218] *Annual Report of the Office of the Auditor General Ontario*. (2010). p.330.
[219] *Annual Report of the Office of the Auditor General Ontario*. (2010). p.330.
[220] *Annual Report of the Office of the Auditor General Ontario*. (2010). p.332.
[221] *Annual Report of the Office of the Auditor General Ontario*. (2010).p.332.

INFORMATION SHARING

Policies regarding the use and transfer of personal health information present challenges for establishing a continuum of care within service delivery, and lead to concerns about privacy rights. The CMHA has been prominent in its position on information collecting and sharing policies; specifically related to police conduct. The policy issue is whether information collected by police during non-criminal contact regarding persons experiencing mental health problems should be made available through a police-records check. A criminal records check differs from a police records check in that the latter does not involve a criminal wrongdoing or charges. The fact that this medically related information can be shared with others raises issues of discrimination.

For practical purposes, the use of personal health information is at times quite useful, especially in instances where it is used by police to assess the risks and backgrounds of persons they encounter in escalated situations. Prior assessment of individuals before contact can often be a critical tool to enhancing sensitive interventions. The concerning consequence of this need is whether, and to what extent, the collection of personal health information should be shared with third parties, especially in instances where the third party may use it for discriminatory purposes.

The Mental Health Police Records Check Coalition has argued this practice to be discriminatory pursuant to the *Mental Health Act,* where the effect of disclosure affects a person's ability to pursue certain volunteer, career, or educational opportunities.[222] The CHMA has noted the need for police to access personal health information in their 2008 submission to the Standing Committee on Social Policy. Accordingly, interventions by police to support an individual in accessing health care should be regarded as health care interventions and be governed under the terms of the *Personal Health Information Protections Act,* 2004 (PHIPA).

PHIPA stipulates that the collection, use and disclosure of personal health information may only be given with the consent (expressed or implied) of the individual to which it pertains.[223] The disclosure beyond consent may only be done with the expressed purpose of reducing "serious risk to bodily harm".[224] When PHIPA was reviewed in 2008 by the Standing Committee on Social Policy, Ontario's Information and Privacy Commissioner recommended that the language of the Act be amended to clarify that health information may be disclosed to reduce the risk of "serious psychological harm," as well as bodily harm.[225]

This wider treatment may enable officers who encounter a person experiencing mental health problems to access personal information (ideally shared between mental health providers) and better address, mediate, and resolve a situation. More importantly, this wider treatment does not widen the use to the point of allowing the sharing of personal health information with third parties who wish to conduct a police records check without consent. An area of contention is whether the police encounter should be entirely disclosed due to the medically sensitive nature, or whether non-medically relevant information about the interaction can be released in police records checks without violating the person's health information rights.

A next step for research debates may be to question whether the sharing of person health related information can be streamlined, resolved, or ameliorated under a centralized service delivery model with

---

[222] *Mental Health Police Records Check Coalition Statement*. (2008). CMHAO, PPAO, OAPC.
[223] *Personal Health Information Protection Act*, (*2004) s.40.1*
[224] *Personal Health Information Protection Act*, (*2004) s.40.1*
[225] Select Committee on Mental Health and Addictions. (2010). *Final Report. Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians*. 2nd Session 39th Parliament, 59 Elizabeth II.p.17.

more uniform approaches to consent, or whether the LHINs may aid by playing a policy role for enhancing consent policies among their mental health affiliates.

Currently, British Columbia's legislation permits the release of personal health information to health care professionals, family members, and others involved in a client's care without the client's consent, for the purposes of "continuity of care", and if it is in the best interests of the client.[226] The Select Committee reported that families have often struggled with the consequences of Ontario's more strict consent-based system, where many people have reported frustration of "being emotionally and financially responsible for their loved ones, while not being considered a partner in care by the health care system."[227]

[226] Select Committee on Mental Health and Addictions. (2010).p.17.
[227] Select Committee on Mental Health and Addictions. (2010).p.17.

FORMAL AND INFORMAL CROSS-SECTORIAL COLLABORATION

Another challenge for mending policy gaps within mental health service delivery involves cross-sectoral collaboration. Throughout the mental health service industry, many internal operating policies for service providers lack formalized collaboration policies. This can often force caseworkers and service providers to rely on informal networks to overcome occupational challenges to act in the client's best interests. The lack of formal collaboration policies could be due to information sharing restrictions, issues of liability within client services, or it could be an issue of overall capacity or lack of a cohesive organizational policy.

Although the literature suggests increasing collaboration is essential, formalized collaboration can risk a tipping point, where multiple organizations dealing with a single client are concerned with fulfilling their own mandates rather than considering the person first. For cross-sectoral collaboration to be optimal, organizations must be cognizant of unnecessarily complicating the efficiency of getting the correct services and resolutions for the individual.

Informal collaboration between agencies and client workers is often used when formal collaboration does not exist, or where a collaborative network involves many different stakeholders (such as, Children's Aid Society, ODSP, probation officers, jails/hospitals/ treatment centres, physicians, psychiatrists…etc.). An informal network of "teammates" are often relied upon to achieve what is in the client's best interest. Policy questions surround the ability to enhance formal collaboration without violating confidentiality, as well as enhancing informal collaboration given challenges of front line staff turn-over or the time it takes to develop reliable relationships.

RECOVERY MODEL/UNIFORMITY ACROSS THE PROVINCES

So far, there has been discussion on whether centralized or decentralized policy oversight for mental health services play a role in enhancing the quality, efficiency, and responsiveness of services provided. There has also been discussion on the organizational and governance structure therein, and to what extent privacy policies and formal collaboration complicate or resolve matters. The report now turns to the provincial and federal values that determine how policies prioritize services and treatments, influence expected outcomes, and effect the types of evaluation used to measure their effectiveness. This section discusses the contrast between a recovery-based approach to provincial mental health policy and a population-based approach.

WHAT IS "RECOVERY"?

The 2006 report entitled *Out of the Shadows at Last* defines recovery as "a journey of healing that builds on individual, family, cultural and community strengths, and enables people living with mental health problems and illnesses to lead meaningful lives in the community despite limitations imposed by their condition."[228] Based on this definition the MHCC has states "recovery must be placed at the centre of mental health reform."[229]

Recovery is used several ways throughout the literature. One study found that mental health consumers often defined personal recovery as 'getting better' from mental illness, but also as living a full life despite the persistence of illness.[230] Recovery has been described by persons with lived-experience in terms of hope, choice, personal responsibility, the establishment of meaningful relationships, (spiritual and interpersonal), and the redevelopment of a valued self. Recovery orientated practice is concerned with issues such as individual self-determination, empowerment, and civil rights.[231] An early recovery-orientated policy statement by the Canadian Mental Health Association's Framework for Support argued that persons with mental illness need more control over their affairs.[232] This use of recovery is seen by Trainor et al. to challenge the government's "almost exclusive recognition, and financial support, of formal services, to the detriment of consumer-run alternatives."[233]

THE USE OF RECOVERY

Researchers have noted that uptake of recovery-based approach in provincial and territorial mental health policy since 2006 has been mixed.[234] In terms of overall orientation, provincial policies tend to take either a recovery or population-based wellness approach to providing care. The approach adopted for mental health policies is important for at least two reasons. Firstly, different approaches to mental health policy have an impact on the outcome that society expects services to deliver, while also affecting the forms of evaluation used to assess the quality and effectiveness of services. Secondly, the approach is important from a definitional and procedural respect. A different approach to services may ultimately change how problems within mental illness are defined, what kinds of services top the priority list for the allocation of public funds, and ultimately influence how persons who experience mental illness are treated.

---

[228] Mental Health Commission of Canada. (2009). *Toward Recovery and Well-being: A Framework for A Mental Health Strategy For Canada*.p8
[229] Mental Health Commission of Canada. (2009). p8
[230] Piat, M., et al. (2009b). What does recovery mean for me? Perspectives of Canadian mental health consumers. *Psychiatric Rehabilitation Journal*, 32.
[231] See: Piat M. & Sabetti, J. (2012); Anthony, W. et al., (2003); Davidson, L. et al., (2009); Tanenbaum, S.J (2006).
[232] Trainor, J. et al. (1999). *Building a Framework for Support. A Community Development Approach to Mental Health Policy*. Toronto: Canadian Mental Health Association.
[233] Trainor, J. et al. (1999).
[234] Piat, M. & Sabetti, J. (2012). pp. 19–28.

In provinces with a strong recovery orientation, consensus emerged around the recovery concept as the key to system transformation.[235] Recovery has been described as the 'corner stone' in the 7-year plan for New Brunswick, as a 'key pillar' in the Manitoba plan, and the mental health system's 'fundamental aim' in the Prince Edward Island strategy.[236] In contrast, mental health plans in Ontario, British Columbia, Nova Scotia, and Alberta, take a different approach from several respects. The 2010 British Columbia plan, as well as the 2011 plan for Ontario and Alberta, have deemphasized the recovery orientation of their policies in adopting the population-based wellness approach. As such, the identification of priorities within the mental health system in relation to different population groups marks a critical distinction between the recovery and wellness approaches.[237]

Summary Analysis

Population-based strategies depart from a recovery orientation in several respects, most crucially in defining population groups from a medical perspective, and addressing the needs of populations as opposed to individuals. The conflicting values behind these two approaches are further seen through the population-based policies that favour quantifiable findings determined by the medical community, whereas recovery based polices incorporate subjective outcomes in both research and practice. Alberta policies are one example whose plans address mental health problems in terms of genetic, biological, personality, and environmental factors affecting the basic architecture of the brain.[238] Population-based policies are generally profession-centric. They tend to view formal mental health services as a resolution for addressing the entire range of health and social issues, both inside the mental health system and in the community, and generally do not acknowledge specific role for service users to direct their own recovery.[239]

There is a need for debate over the adequacy of a population-based approach for the specific demographic this report has in mind, and whether it provides sufficient rehabilitative hope for persons at risk of coming into conflict of the law. Concerns have been raised over a recovery-based approach as well. Research suggests that 'recovery' may not relevantly address the needs of youth, seniors, persons with degenerative conditions, or that the language of recovery may be inappropriate for these demographics. One strength of a recovery-based approach is its consensus at the national level, and the fact that these policies have been viewed as the catalyst for system transformation. Recovery-based approaches have led to stronger funding commitments for peer support and other consumer led services within the community. Whether these types of services reflect the political values that affect how persons with mental illness are treated should be separate from values that seek a scientific evaluation of whether these services provide a 'cure'. Nonetheless, the requirement for more community based, consumer led services, is in line with the AGO's 2010 recognition that the MOHLTC has yet to divest the required proportion of mental health care spending into these types of services.[240] Further benefits from a recovery-based approach are exhibited by the fact that in provinces where recovery-based policies are employed family doctors are more engaged with providing mental health services, have greater anti-stigma campaigns, and more effective community engagement aimed at transforming policy. From this brief analysis a strengthening of Ontario's mental health service delivery could be expected as both the

---

[235] Piat, M. & Sabetti, J. (2012). pp. 19–28.
[236] Piat, M. & Sabetti, J. (2012). pp. 19–28.
[237] BC Ministry of Health Services, 2010, p. 12.
[238] Piat, M. & Sabetti, J. (2012). pp. 19–28.
[239] Piat, M. & Sabetti, J. (2012). pp. 19–28
[240] Office of the Correctional Investigator of Canada. (2010). Report for the Office of the Correctional Investigator of Canada. *Under Warrant. A Review of the Implementation of the Correction Service of Canada's Mental Health Strategy*: Service. J. PhD.

MOHLTC and the LHINs continue to move forward in implementing the AGO's recommendations, and further strengthening the move toward 'recovery'-based values. There should be a future need to compare these two approaches in regards to a rights based focus that ultimately addresses question raised over just treatment, inclusion, and autonomy. From this picture it is apparent that Canada is not yet at the stage of adopting and implementing a national framework for the treatment of persons with mental illness. Furthermore, these value-based differences at the top lead to difficulties on the ground in ensuring a minimum core basket of services along with reasonable standards in practice, timely access, and freedom of choice.

Conclusion: Policy Analysis on the Horizon

Policy gaps for future analysis exist in the need to determine which kinds of policies can make social structures more inclusive for fostering faster social integration. There is also the need to make clearer to what extent federal/provincial mental health policies should reflect a shared societal and community responsibility, as opposed to exclusively individual responsibility.

Research suggests that professional and social perceptions are still leading to problems. Professional attitudes that persist with a medical or 'treatment paradigm' in mental health services disrupt continuing service delivery through the idea that if symptoms abate, the job is done.[241] In this sense, the 'recovery' model goes further in embracing a wider process than simply a cure.[242]

How to increase support among service providers for recovery, including the need to translate knowledge, and develop curricula and competency standards, were major issues for spokespeople in New Brunswick, Manitoba and Prince Edward Island.[243] In this respect, the recent Accreditation Capacity Building Toolkit project by the CHMA has compiled a number of successful internal operation polices, which intend to act as guidelines to aid in the standardization of care, accreditation of service delivery, and enhance overall capacity to account, track progress, and receive recognition for promising practices.[244] Although there is as of yet no national mandatory requirement for accreditation, pursuing this option along with the Multi-Sectorial Accountability Agreements, may be a promising step forward for enhancing capacity, outcome evaluation, and supplying more adequate funding.

At the local level, policy gaps should be closed to ensure that clients and their families have access to system navigators who will connect them with the appropriate treatment and community support services (e.g., housing, income support, employment, peer support, and recreational opportunities). This might also include better follow up care for persons who have received care in crisis beds. Hospitals, community mental health providers, and police play a large role in determining the first contact experience and success of follow up care. Important research is needed in regards to how the sharing of personal health information can increase the continuity of care between police diversion practices, crisis beds, and follow up care (for example, from a CMHA) in a way that decreases the risk of criminalization. According to a report for the Office of the Correctional Investigator a comprehensive continuum of mental health care that spans the country is an integral part of any service delivery system.[245] This connective tissue needs national standards based on best practices, and the necessary technological and human infrastructure.[246] In conjunction with these recommendations are the need to improve discharge plans

---

[241] Piat, M. & Sabetti, J. (2012). pp. 19–28

[242] Piat, M. & Sabetti, J. (2012). pp. 19–28

[243] Piat, M. & Sabetti, J. (2012). pp. 19–28

[244] Canadian Mental Health Association. Retrieved March, 2013 from: http://www.ontario.cmha.ca/capacity_building.asp?cID=1457585.

[245] Office of the Correctional Investigator of Canada. (2010). p.15

[246] Office of the Correctional Investigator of Canada. (2010). p.36

and ensure those with continuing and complex needs are supported not just through integration strategies like employment, but also through further recovery and wellness (peer supports/case workers). There is great potential for provincial and territorial governments to establish mental health policies in their jurisdictions to ensure the rights of persons living with a mental illness are respected. In this regard, values behind national and provincial policies have the power to lead the way in standardizing the use of language, and communicating about the need to standardize the quality and access mental health services.

This section has discussed the some of the biggest policy challenges that mental health and addictions services face, their fragmentation, and their spread across several ministries with shared or unclear responsibilities. In this respect, future research is needed regarding the performance differences between centralized versus decentralized service delivery. Considering the relatively recent changes regarding Alberta Health Services, greater responsibility for Ontario LHINs, and the promises of Multi-Sector Service Accountability Agreements, any stronger conclusions requires more evidence, and over more time. In light of this context steps can be taken at the local level to strengthen policy gaps in service delivery. There is the need to clarify, strengthen, and protect the use of personal health information at the national level, to ensure a delicate balance between enhancing quality care without jeopardizing privacy rights. Other ground level changes need to address the concerns that LHINs have fallen behind in their community engagement for mental health services. Furthermore, their funding structures are not as strong nor responsive as they could be, and outcome evaluation regarding the quality of care persons receive is lacking. In conclusion, the strength and cohesion mental health care service policies have directly effects, not only the risks relating to the criminalization of persons with mental illness, but to the overall quality of life for thousands of Canadians more broadly. In so far as it stands today, there continues to be the need for overlapping consensus regarding how polices relating to mental health should treat persons, the quantity of public funds available for such services, the implementation strategies for programs and service delivery, and a toolkit of standardized outcome evaluation methods that seek to ensure a feedback loop of research and reform are continual. An important insight to keep in mind, as expressed by The World Health Organization, is the fact that there can be no health without mental health.

TOWARDS AN INTEGRATED NETWORK—2008 RECOMMENDATIONS

The conclusions and recommendations in TAIN remain relevant and merit reproduction at this time. The commitment to overcoming the many challenges faced by persons with mental disorders and those who work with them was demonstrated over and over again throughout the course of this project. Dedication and persistence emerged as defining attributes of the architects of the promising practices brought forward during the discussions in 2007-08. It is our hope that these may serve as groundwork and encourage others to develop their own interventions tailored to the needs of their communities and constituents. This handbook highlights examples from 2007-08, but not prescriptions, that were found to be effective. To guide the development of context appropriate interventions, we have identified the following recommendations for consideration:

WORKING TOGETHER

- ☑ Create a common reality
- ☑ Identify key players willing to actively participate in the development, planning and implementation phases
- ☑ Focus on prevention, intervention and community capacity building
- ☑ Complete and complement existing initiatives with new initiatives, rather than replacing them
- ☑ Identify what works, why it works and what the shared guiding principles values are
- ☑ Integrate non-traditional sectors (i.e. the private or commercial sector, community engagement)
- ☑ Develop an integrative and multifaceted approach to the mental health service delivery system
- ☑ Implement flexible and adaptable programs and services guided by similar principles and values
- ☑ Challenge how we talk to the community
- ☑ Work the media: Educate and provide success stories

THE INDIVIDUAL

- ☑ Accept mental health as it is rather than creating a mould into which it should fit
- ☑ Accept them as a person first, followed by someone who lives with a mental health problem
- ☑ Focus on definitions of mental health that do not impede an individual's right to appropriate services
- ☑ Address exclusions, complex cases and dual diagnoses

THE MENTAL HEALTH SERVICE DELIVERY NETWORK

- ☑ Offer a client-centered approach: Promote confidence, dignity and respect
- ☑ Build and maintain relationships through trust and communication
- ☑ Encourage use of manuals and protocols through provincial and federal support
- ☑ Encourage staff empowerment and confidence
- ☑ Campaign for mental health and corrections as a career choice

"Just do it!"

CONCLUSION

The opportunity of revisiting an issue some five years later provides the privilege to identify trends, advances, and also to highlight matters where further attention is warranted. This second edition of *Towards an Integrated Network* has afforded that window into the developing understanding in Canada of the importance of addressing the challenge of avoiding criminalizing people with mental health problems and illness. The involvement and contributions of so many who were part of *Towards an Integrated Network* particularly has been helpful by providing continuity within this framework. There is true satisfaction in reporting how their initiatives and concerns have progressed. Their commitment and leadership signals health in responding to the major challenges this group of people face.

The influence of the Mental Health Commission of Canada stands out as a significant factor in both increased awareness of the barriers confronting people with mental health illnesses and the promotion of promising practices and core values; including that of timely and equitable access to mental health care—a key factor for those at risk of conflict with law. Federal departments have designed mental health services within their mandates. Provincial governments have introduced strategies that have a clear direction to ensure that there are open doors to mental health programs and treatment. The heightened priority to provide service across Canada is encouraging and appears poised to provide tangible and positive results.

Much remains to be achieved. The twin problems caused by addictions and mental illness remain managed separately too often. Bridging that divide must continue to be a focus of all who want to see true advances in the well-being of people with mental health problems and illness. Major initiatives to fight stigma and discrimination are showing impact. However, those who are hardest to serve, most difficult to reach, and most seriously ill, often are met by barriers they cannot overcome. The increased risk of criminalization this causes is a problem for Canada to address now.

Cross-sectoral interventions, specialized courts, diversion, enhanced training for front line professionals are seen to provide positive outcomes. Resources are a constant concern, both as a result of overall economic conditions, but also because of the cross-jurisdictional nature of the issues in this field. We are confident that these can be overcome. Addressing them must not result from human tragedy. Continued and proactive efforts will yield positive results. This requires and demands an ongoing spotlight on the benefits of avoiding criminalizing people with mental health illnesses. We hope that the policies and practices in this report will support efforts to that end.

APPENDIX

In the first edition of *Towards an Integrated Network,* a Foucaultian approach was used to root the handbook within a theoretical framework. For the purposes of the second edition it was decided that a review of the literature on community mental health and criminalization would be of more use. The review establishes current evidence-based practices and suggestions for future research on the topic of avoiding the criminalization of persons living with mental health problems and illness. However, the original research report summary is made available below.

RESEARCH REPORT SUMMARY (2008)

The aim of the research report is to complement the knowledge gained from the fora by adopting a theoretical lens through which to understand the challenges and successes that were highlighted during the eight days of discussion and in this handbook. Paramount to the inclusion of a research report is the intention of bridging the gap between theory and practice, whereby those who are dealing with mental health consumers will be able to provide support in an increasingly thoughtful and innovative manner to the benefit of the community. After exploring the theoretical perspective that is being engaged in this report, we conducted an analysis of the criminalization of persons who suffer from mental health problems. This is followed by a look at the purpose of materials such as handbooks. Voices that would otherwise go unheard find a place of power, within these materials, to invoke more informed and helpful practices.

To begin, it should be noted that the analysis for this report lies within a Foucaultian approach. While it is impossible to cover all of the concepts used by this set of theorists, for the purpose of this project, we are reflecting on issues related to identity, governmentality, and resistance.

Foucaultian theorists see it as problematic to categorize individuals in a static, cookie-cutter way. Foucaultians look for a deeper than surface-level understandings of who people are and seek to uncover how they come to be understood in this way. Foucaultians look at how people are constructed through techniques of surveillance, observation, examination, self-governance etc. Foucaultians assert that people are classified in particular ways in order to establish governing techniques that allow for normalization. While Ian Hacking would not describe himself as a Foucaultian his work on the looping effect is helpful in understanding identity, which recognizes the impact an imposed identity has on an individual. He also acknowledges that the identity and the individual are mutually reinforcing. While it is often subtle, those classified can also change what an identity means.[247]

Foucaultians also work with the ideas of governmentality. Nikolas Rose defines this concept as: "rationalities and technologies underpinning a whole variety of more or less rationalized and calculated interventions that have attempted to govern the existence and experience of contemporary human beings, and to act upon human conduct to direct it to certain ends."[248] What kinds of programs and resources are provided to whom? What knowledge is being produced about the mental health service delivery network? Who has the power to produce these discourses? These are questions we can ask in an attempt to better understand the constructed mental health identity. The trend of representing the mental health identity as a criminal one is shifting towards a reconceptualization that focuses on social conditions such as problems related to housing, employment etc.[249]

---

[247] Hacking, I. (2004). Between Michel Foucault and Erving Goffman, *Economy and Society,* 33, 297-298.

[248] Rose, N. (2000). Government and Control, *British Journal of Criminology,* 40(2), 321- 322.

[249] For additional information on the mental health identity as criminal, see: Fisher, W. H., Silver, E. & Wolff, N. (2006). Beyond Criminalization: Toward a criminologically informed framework for mental health policy and services research, *Administration and Policy in Mental Health and Mental Health Services Research,* 33, 544-557.

The criminalized identity that exists within the mental health service delivery network has been constructed with the use of a number of governing techniques. The exclusive language used by psy-science[250] experts to define who has access to the mental health service delivery network has gained momentum. Their discourses have come to be recognized as "truth claims" rather than as subjective concepts worth questioning. This exclusive use of terminology has stigmatized those who suffer from mental health problems. This stigmatization further criminalizes these individuals as there are limited options available outside of the criminal justice system to assist with the mental health service delivery network. The "mentally ill" identity has become wrapped up in negative discourses that defines them as "lazy, free-loaders, and a burden to the system, hence the symbolic threat to social values of self-reliance and social obligation to contribute to the general good."[251] This stigmatization discourages skilled individuals from working with this particular population and further contributes to the criminalization.

Related to the effects of stigmatization, there are significant differences between the characterization of physical health and mental health. The mental health identity has become more closely associated with criminality than as a component of an illness. The priority given to physical health over mental health is visible in a number of sectors, including: federal and provincial funding for resources, accessing insurance and/or disability claims, and a lack of programming. This latter issue in particular adds to the discourses that label the person suffering from mental health problems as criminal, in that in many cases the programs and services are primarily accessible if one has had encounters with the criminal justice system.[252] The lack of resources available to mental health consumers is a major consequence of the imposed identity. There is an obvious need for training, funding and information-sharing to improve the resources that are currently available. This has been proven to be difficult given that the voluntary sector has been obligated to reduce its advocacy work and focus almost exclusively on project-based initiatives that fit into the narrow mandates set out by the state.[253] Without appropriate resources to support this group, many will end up in the criminal justice system.

The above-mentioned factors are highlighted within this research report as some of the most pressing concerns related to the mental health identity. At its core, this report is arguing that the way the mental health service delivery network has come to understand the consumer as criminal is not a "truth", but one of many ways of socially constructed representations of this population. With new and markedly different ways of thinking about the mental health identity, positive changes can be made.

One productive way to allow for new discourses to emerge and have an impact on mental health is through promising and best practice handbooks and protocols. Sharing this knowledge in a public domain is a form of resistance that is essential to changing the way the mental health identity is constituted. We see this type of institutional, ground level knowledge as powerful and innovative information that can shape our understanding of "what works". This information also contributes to strengthening the voices that are not often heard; we call this subjugated knowledge. Subjugated knowledge is "a whole set of knowledges that have been disqualified as inadequate [...] or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity".[254] This means that the knowledge gained by those who are affected by or work directly with the target population is not deemed "expert" knowledge. As a result, their knowledge is not perceived as powerful enough to affect

---

[250] By psy-science experts, we mean those in the field of psychology, psychiatry and social work, primarily.
[251] Arboleda-Flórez, J. (2005). Stigma and discrimination: An overview, *World Psychiatry,* 4, p. 9.
[252] Skerritt, (2007); see also, Arboleda-Flórez, J. (2005). p. 9.
[253] Ilcan, S. & Basok, T. (2004). Community Government: Voluntary agencies, social justice, and the responsibilization of citizens, *Citizenship Studies,* 8, p.129-144.
[254] Allen, B. (2005). Foucault's Nominalism in *Shelley Tremain, (Ed.) Foucault and the Government of Disability.* Ann Arbor: University of Michigan Press, p. 101.

the way the mental health identity is understood. Given this, we recognize the creation of handbooks such as this one as a form of resistance against the exclusivity of expert knowledge. Promising and best practice handbooks offer the opportunity to disseminate the information gathered by those who work with this particular group to a larger audience. It can also play a role in re-defining the mental health identity. Handbooks and protocols are a form of resistance in that they provide an outlet for new ways of thinking that could potentially be contradictory to the dominant knowledge produced by the specialists in the field. We argue that the best way to produce this new knowledge is through collaboration between research and practice.

Producing this new knowledge about the mental health service delivery network as a partnership between academics and service providers can only be accomplished if we move away from solely deconstructing the social science arena and look at reconstruction. By this we mean that much of critical criminology has become committed almost exclusively to highlighting problems with the criminal justice system. While this is in fact important information, and we ourselves are attempting to deconstruct how mental health is understood, there is in fact a need for re-construction.[255] Without this step, programming and services for the most marginalized of populations are left without hope and stifled in their ability to help those in need. By working in partnership with those who have the skills in critically analyzing a setting by engaging with multiple barriers and those in the community who strive to provide the best service possible, best practices can be implemented.

An important use for promising and best practice handbooks is describing what works in a format that allows those who work with consumers to provide knowledge about the social environment in which individuals live, rather than focus only on individual responsibility. This also acts as knowledge that resists the current mental health identity that perceives those with mental health problems as somehow responsible for their illnesses. Best practice handbooks allow support personnel to share their knowledge on programs that are both specific to individual needs while at the same time recognizing the larger context in which they live. In other words, taking into account specific concerns an individual might have, such as a learning disability, is important but needs to be understood alongside the environment outside of community support with which this individual will engage.[256] Promising and best practice handbooks are a way to pursue individual needs within the context of their social environment.

Fundamental to being able to sincerely look at "what works" is a renewed interest in finding common ground between academia and practice. Reducing the gap between research and the implementation of programs, services etc. can be seen as a positive step forward for both groups. For academics, information concerning the direct impact of particular governing techniques on those who experience them can be made much more accessible. This type of research can focus on improving the quality of life for this population. For direct service providers, research can offer a new perspective on how to approach the systems and offers insight into the broader social and political context in which initiatives are implemented. The goals of addressing social injustice and providing meaningful services can be one and the same through a more open minded approach to collaboration.[257] Those who work directly with the mental health service delivery system can provide unique knowledge in the field of research while academics have the potential to remove this knowledge from a place of suppression in influencing the classification of mental health; we need to advance for a shared power.

---

[255] Cullen, F. T. & Gendreau, P. (2001). From Nothing Works to What Works: Changing Professional Ideology in the 21st Century, *The Prison Journal, 81(3)*, 313-338.
[256] Cullen, F. T. & Gendreau, P. (2000). Assessing Correctional Rehabilitation: Policy, Practice and Prospects. *Criminal Justice* 3 *(Policies, Processes, and Decisions of the Criminal Justice System),* p. 150.
[257] Cullen & Gendreau (2001). p. 333.

Handbooks such as this one provide a forum in which to display the unique knowledge of direct service providers. This, in conjunction with research that can support their voice, has the potential to allow for a new way of conceiving the mental health identity. Currently, the mental health identity is a criminalized one, where mental health and the criminal justice system have become interwoven by such powerful discourses that re-classification seems impossible. Through the work of Foucaultian theorists, we learn that this power relationship is not static and that different knowledges, even those which are subjugated, can gain power and re-shape an identity. The information found in best practice handbooks can be thought of as subjugated knowledge, but when put in this format and used as a knowledge-sharing device, has the potential to have a significant impact on the kinds of support, programs, research and funding available within the mental health service delivery network. The research report from which this summary is taken and this handbook are important steps towards these goals.

WORKS CITED

Across U-Hub: http://www.acrossuhub.com/acrossuhub/Default.asp.

Adelman, J. (2003). *Study in Blue and Grey. Police Interventions with People with Mental Illness: A Review of Challenges and Responses.* Vancouver, BC: CMHA BC. http://www.cmha.bc.ca/files/policereport.pdf.

Alexander, B., Executive Director, Alberta Seventh Step Society, (personal communication, Calgary Forum, November, 2007).

Allen, B. (2005). *Foucault's Nominalism* in Shelley Tremain, (ed*.) Foucault and the Government of Disability.* Ann Arbor: University of Michigan Press.

American Psychiatric Association. (2000). *(DSM-IV-TR) Diagnostic and Statistical Manual of Mental Disorders*, (4th ed) Text Revision. Washington, DC: American Psychiatric Press, Inc.

Anthony, W. Rogers, E.S. & Farkas, M. (2003*).* Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*. 39, 101-114.

Arboleda-Florez, J. (2004). Mental health systems and forensic psychiatric services. *Current Opinion in Psychiatry*. 17(5), 377-380.

Arboleda-Florez, J. (2004). On the evolution of mental health systems. *Current Opinion in Psychiatry*, 17, 337-380.

Arboleda-Florez, J. (2005). Stigma and discrimination: An overview. *World Psychiatry*, 4(1), 8-10.

Arboleda-Florez, J. (2007). *Dispossessed and Disposable*. Presented at SLSC & *CCJA Towards a Community Mental Health Strategy* Forum, Kingston, Ontario.

Baillie, P., M.D. Psychologist, Peter Lougheed Hospital, (personal communication, February, 2008). *Community Treatment Order Submission.*

Baess, E.P. (2005). Review of Pairing Police with Mental Health Outreach Services*. Integrated Mobile Crisis Response Team (IMCRT).*Vancouver Island Health Authority. http://www.pmhl.ca/webpages/reports/Pairing-report.pdf.

Barton, R. (1999). Psychosocial rehabilitation services in community support systems: A review of outcomes and policy recommendations. *Psychiatric Services*, 50(4), 525-534

Baun, K. (2009). Stigma Matters: The Media's Impact on Public Perceptions of Mental Illness. *OttawaLife Magazine* (*Mental Health Series: A Friend, A Home, A Job*), February 2009.

BC Justice Review Task Force, (2005). http://www.bcjusticereview.org/.

Binnema, D., R.N., B.N., (personal communication, Calgary Forum, November, 2007).

Blackburn, D. (2004). "What Works" with Mentally Disordered Offenders. *Psychology, Crime & Law,* 10(3).

Bourne-MacKeigan, L. Outpatient/Crisis Outreach Team Coordinator, Brockville Mental Health Centre (personal communication, Kingston Forum, November, 2007).

Brager, M., M.S.W (personal communication, Calgary Forum, November, 2007).

Braidwood, T. R. (2009). *Restoring Public Confidence: Restricting the Use of Conducted Energy Weapons in British Columbia*. Victoria, BC: Braidwood Commission on Conducted Energy Weapon Use. http://www.braidwoodinquiry.ca/report/P1Report.php.

Brink, J.H., D. Doherty, D., & A. Boer. (2001). Mental Disorder in Federal Offenders: A Canadian Prevalence Study. *International Journal of Law and Psychiatry,* 24(4-5), 339-356.

British Columbia. Ministry of Justice. (2013). *BC Policing Community Safety Plan for Consultation*. http://www.pssg.gov.bc.ca/policeservices/publications-index/docs/BCPolicingPlan.pdf.

Burill, J. Elizabeth-Fry Society of Kingston, (personal communication, Kingston Forum, November, 2007).

Callender, H., Executive Director, St. Leonard's Community Services London and Region, (personal communication, March 2013).

Canada. Standing Senate Committee on Social Affairs, Science and Technology. (2006). *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions Services in Canada*. http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/pdf/rep02may06part1-e.pdf.

Canadian Mental Health Association. (2011). *Project IN4M: Integrating Needs for Mental Well-Being into Human Resource Planning. Final Report*. http://www.cmha.ca/public_policy/project-in4m-integrating-needs-for-mental-well-being-into-human-resource-planning/#.UVRh8Byfj3l.

Canadian Mental Health Association. (2008). Retrieved March 4, 2008 from www.cmha.ca.

Canadian Mental Health Association, British Columbia Division. (2005). *Hallucinations and Delusions: How to Respond.* http://www.cmha.bc.ca/files/6-hallucinations_delusions.pdf.

Canadian Mental Health Association British Columbia Division. (2007). http://www.cmha.bc.ca/.

Canadian Mental Health Association New Brunswick Division. (2008). http://www.nb.cmha.ca/bins/site.asp?cid=284-1007&lang=1.

Canadian Mental Health Association Newfoundland and Labrador Division. (2007) *Changing Minds.* http://www.cmhanl.ca/minds.asp#changingminds.

Canadian Mental Health Association Ontario. http://www.ontario.cmha.ca/.

Canadian Mental Health Association Ontario. *Accreditation Building Capacity Building Toolkit*. http://www.ontario.cmha.ca/capacity_building.asp?cID=1457585.

Canadian Mental Health Association Toronto Division (2008). http://www.toronto.cmha.ca/.

Cancer Care Ontario. (2013). https://www.cancercare.on.ca/about/who/vision/.

Caplan, D. (2009). *Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy, a Discussion Paper*. http://health.gov.on.ca/en/public/programs/mentalhealth/advisorygroup/docs/rep_everydoor.pdf.

Centre for Addiction and Mental Health. (2001). *Teachers Guide. Talking about Mental Illness: A Guide for Developing an Awareness Program for Youth.* Canada: CAMH. http://www.camh.net/education/Resources_teachers_schools/TAMI/tami_teachersresource.html.

Centre for Addiction and Mental Health. (2001). *Community Guide. Talking about Addictions and Mental Illness: A Guide for Developing an Awareness Program for Youth.* Canada: CAMH. http://www.camh.net/education/Resources_communities_organizations/TAMI_community/index.html.

Centre for Addiction and Mental Health. (2001). *Teachers Guide. Talking About Mental Illness: A guide for developing an awareness program for youth.* http://www.camh.ca/en/education/teachers_school_programs/resources_for_teachers_and_schools/talking_about_mental_illness/Pages/talking_about_mental_illness.aspx.

Chaimowitz, G. (2012). The Criminalization of People with Mental Illness. *The Canadian Journal of Psychiatry, 57*(2), 1-6.

Champagne, D. RSW, RTC-ON, (personal communication, Kingston Forum, November, 2007).

Circles of Support & Accountability. (2008*). A Reintegration Program that Works* [pamphlet] http://www.stjohnsottawa.ca/pages/cosa.html.

Clark Institute of Psychiatry Health Systems Research Unit. (1997). *Best Practices in Mental Health Reform: Discussion Paper*. Canada: Minister of Public Works and Government Services Canada. http://www.phac-aspc.gc.ca/mh-sm/pubs/disc_paper/index-eng.php.

COAST Hamilton. http://www.coasthamilton.ca/index.html.

Coleman, T. G. and D. Cotton. (2010). *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing*, prepared on behalf of the Police/Mental Health Subcommittee of the Canadian Association of Chiefs of Police and the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada.

Community Resource Connection of Toronto. (May 2008). *Navigating Mental Health Services in Toronto: A Guide for Newcomer Communities*. Toronto: The Ontario Trillium Foundation.

Community Resource Connection of Toronto. (2008). *Our Services: Mental Health Court Support Services in Toronto.* http://www.crct.org/services/mhcss.cfm.

Community Resource Connection of Toronto. (2007). *Navigating Mental Health Services in Toronto: A Guide for Newcomer Communities*. The Ontario Trillium Foundation.

Connections Clubhouse, Situational Analysis. http://www.phac-aspc.gc.ca/mh-sm/pdf/sit_analysis_e/e_sasec1-4.pdf.

Correctional Service of Canada. (2007). *Sustainable Development Strategy 2007-2010.* http://www.csc-scc.gc.ca/text/pblct/environmentRpt/5-eng.shtml.

Canada. Parliament. Corrections and Conditional Release Act, c.20. (1992). http://laws.justice.gc.ca/en/showtdm/cs/C-44.6///en.

Coleman, T.G. and D. Cotton. (2010). *Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing*. Prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada. http://www.mentalhealthcommission.ca/SiteCollectionDocuments/PoliceProject/Police%20Learning%20Model_Jul%2023%20(4).pdf.

Cotton, D. and T. Coleman. (2008). *A Study of Police Academy Training and Education for New Police Officers Related to Working with People with Mental Illness.* Prepared on behalf of The Police/Mental Health Subcommittee of the Canadian Association of Chiefs of Police and the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada.

http://www.mentalhealthcommission.ca/SiteCollectionDocuments/PoliceProject/aa%20academy%20report-MHCC_FINAL.pdf.

Cotton, D., Clinical Neuropsychologist, Co-chair to Police/Mental Health Sub Committee, (personal communication, Kingston Forum, 2007).

Crawford, T. Executive Director, Elizabeth Fry Kingston (personal communication, Kingston Forum, November 2007).

Crisis Outreach and Support Team. (2007). *About COAST.* http://www.coasthamilton.ca/index.html.

Cullen, F. T. and P. Gendreau. (2001). From Nothing Works to What Works: Changing Professional Ideology in the 21st Century. *The Prison Journal,* 81(3), 313-338.

Cullen, F. T. and P. Gendreau. (2000). Assessing Correctional Rehabilitation: Policy, Practice and Prospects. *Criminal Justice,* 3 (*Policies, Processes, and Decisions of the Criminal Justice System*), 109-175.

Davidson, L., Drake, R.E., Schmutte, T., Dinzeo, T., & Andres-Hyman, R. (2009). *Oil and Water or Oil and Vinegar? Evidence-based Medicine Meets Recovery. Community Mental Health Journal*, 45, 323-332.

Davidsen, L., Cst., CIT Trainer, RCMP Lower Mainland Division (personal communication, Vancouver Forum, November, 2007).

Dieleman, C., Dalhousie University. (personal communication, Halifax Forum, 2007).

Do it for Daron. http://www.difd.com/.

Durbin, J.; E. Lin and N. Zaslavska. (2012). Police-Citizen Encounters that Involve Mental Health Concerns: Results of an Ontario Police Services Survey. *Canadian Journal of Community Mental Health* 29, Suppl. 5, p. 55.

Felizardo, V., CSC-RTC(O) (personal communication, Kingston Forum, 2007).

Felizardo, V., Senior Project Officer, Federal/Provincial/Territorial and Mental Health Partnerships. (personal communication, March 2013).

Fisher, W. H., Silver, E., and Wolff, N. (2006). Beyond Criminalization: Toward a criminologically informed framework for mental health policy and services research, *Administration and Policy in Mental Health and Mental Health Services Research,* 33*,* 544-557.

Gaetz, S. (2008). Why are we still struggling with homelessness in Canada? *Canadian Housing*, 24, Special Edition. 27-31.

Gaetz, S. (2012). *The Real Cost of Homelessness: Can We Save Money by Doing the Right Thing?*

Toronto: Canadian Homelessness Research Network Press.

Gaetz, S. and O'Grady, B. (2009). Homelessness, Incarceration, and the Challenge of Effective Discharge Planning: A Canadian Case. In: Hulchanski, J. D.; P. Campsie; S. Chau; S. Hwang and E. Paradis (eds.) *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 7.3. Toronto: Cities Centre, University of Toronto. http://www.homelesshub.ca/FindingHome.

Green, S., Program Analyst, Government of British Columbia (personal communication, Vancouver Forum, November, 2007).

Hacking I. (2004). Between Michel Foucault and Erving Goffman. *Economy and Society*, 33, 277-302.

Halifax Mobile Crisis Response Team http://www.cdha.nshealth.ca/mental-health-program/programs-services/mental-health-mobile-crisis-team.

Health Systems Research Unit of the Clarke Institute of Psychiatry. (1997). *Best Practices in Mental Health Reform: Discussion Paper.* Canada: Minister of Public Works and Government Services Canada.

Healthy Minds Cooperative. (2007). *A Blue Horse Initiative*. www.cdha.nshealth.ca/.../healthy-minds-cooperative-brouchure.pdf.

Hiday, V.A. and H.W. Wales (2011). The Criminalization of Mental Illness. In, C.S. Anesthensel; S. Carol and C. Jo (eds.) *Handbook of the Sociology of Mental Health.* 2nd edition. Dordrecht, Germany: Springer Science + Business.

Higenbottam, J., Member of the Service Systems Advisory Committee (personal communication, January, 2008); Update provided by Marr, K. MHCC, March 2013.

Higgins, C. Team Lead, Forensic Mental Health. Ministry of Health and Long Term Care Ontario. (personal communication, March 2013).

Hughes, J. and C. Dieleman (personal communication, Halifax Forum, November 2007).

Hulchanski, J. D., Campsie, P., Chau, S., Hwang, S., and Paradis, E. (eds.) *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 7.3. Toronto: Cities Centre, University of Toronto. www.homelesshub.ca/FindingHome.

Human Services and Justice Coordinating Committee. http://www.hsjcc.on.ca/Default.aspx.

Ilcan, S. and Basok, T. (2004). Community Government: Voluntary Agencies, Social Justice, and the Responsibilization of Citizens. *Citizenship Studies*, 8(2), p.129-144.

Institute for the Prevention of Crime. (2008). *Homelessness Victimization and Crime: Knowledgeable and Actionable Recommendations.* University of Ottawa. http://www.socialsciences.uottawa.ca/ipc/pdf/IPC-Homelessness%20report.pdf.

InterRAI. (2012). http://www.interrai.org/index.php?id=98.

Internet Movie Database. (2008). *Memorable quotes for American Psycho.* http://www.imdb.com/title/tt0144084/quotes.

Jabbar, A.M. and J. Abelson. (2011). Development of a Framework for Effective Community Engagement in Ontario, Canada. *Journal of Health Policy*, 101(1), 59-69.

John Howard Society of Central and South Okanagan. (2007). http://www.jhscso.bc.ca/.

Judas, J., Motivation Power and Achievement Society (personal communication, Vancouver Forum, November, 2007).

Kaiser, A. K. (2010). Commentary: Too Good To Be True: Second Thoughts on the Proliferation on Mental Health Courts, in *Canadian Journal of Community Mental Health*, 29(2), Fall, 19-25.

Kaiser, A. (2007). *Towards a Model Community Mental Health Strategy.* Presented at SLSC & CCJA Towards a Community Mental Health Forum, Halifax, Nova Scotia.

Kellen, A. et al. (2010). *Homeless and Jailed: Jailed and Homeless.* John Howard Society of Toronto.

Kelly, C. A. (2003). *Challenges in the Management of Mentally Disturbed offenders on psychotropic medication.* Presented at St. Leonard's Society of Canada's *Bolton Day* conference, 2003.

Krauss Whitbourne, S. (2012). Psychology's Best Movies: and the Oscar goes to…which psychological disorder? *Psychology Today: Fulfillment at Any Age.* January 14.

Lake City Employment Services Association. (2008). http://www.lakecityemployment.com/.

Love, S., Program Coordinator, (personal communication, COSA-Ottawa, NAACJ-CSC Consultation Meeting, February 2008).

Lynn, D. Program Coordinator, VI Access & Integrated Mobile Crisis Response Team (IMCRT), Vancouver Island Health Authority. (personal communication, March 2013).

MacPhail, A. and S. Verdun-Jones. (2013). *Mental Illness and the Criminal Justice System*. Vancouver: International Centre for Criminal Law Reform and Criminal Justice Policy.

Marr, K., Mental Health Commission of Canada, (personal communication, March 2013).

Marrett, P. (2005). Sub-Standard Treatment of Mentally Ill Inmates is Criminal: Experts**.** *News Release*. Toronto: Canadian Mental Health Association.

Marshall, J. Supervisor, Kelowna Alcohol and Drug Services, Interior Health, (personal communication, Vancouver Forum, November, 2007).

McCarthy, D., Det. Kingston Police Department, (personal communication, Kingston Forum, November, 2007).

McDonnell, D. Supervisor, Lanark County Mental Health (personal communication, February, 2008).

Mental Health Commission of Canada. *At Home*. http://www.mentalhealthcommission.ca/English/Pages/homelessness.aspx.

Mental Health Commission of Canada. (2009). *Toward Recovery and Well-being: A Framework for a Mental Health Strategy for Canada*. http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Mental_Health_ENG.pdf.

Mental Health Commission of Canada. *Knowledge Exchange Centre.* http://www.mentalhealthcommission.ca/English/Pages/KnowledgeExchangeCentre.aspx.

Mental Health Commission of Canada. (2012). *Changing Directions, Changing Lives: The Mental Health Strategy for Canada.* http://strategy.mentalhealthcommission.ca/.

Mental Health Police Records Check Coalition Statement. 2008. CMHAO, PPAO, OAPC. http://www.sse.gov.on.ca/mohltc/ppao/en/Documents/PRCC%20Mission%20Statement.pdf.

Miller, W.R. and S. Rollnick. (2002). *Motivational Interviewing: Preparing People for Change*. 2nd edition, New York: Guilford.

Mental Health and Addictions Services. (2007). *Year End Service Summary April 1, 2006 – March 31, 2007.* Alberta: Calgary Health Region.

Mental Health Commission of Canada. (2012). *Changing Directions, Changing Lives: The Mental Health Strategy of Canada*. Calgary: Mental Health Commission of Canada. http://strategy.mentalhealthcommission.ca/pdf/strategy-summary-en.pdf.

Mental Health Commission of Canada. (2008). *Status Report to January 26-28, 2008 Board Meeting*. Retrieved, March 2008 from www.mentalhealthcommission.ca.

Mental Health Commission of Canada. (2008). *Mental Health Commission of Canada Promised $110 Million for Research to Help the Homeless Living with Mental Illness.* http://www.mentalhealthcommission.ca/newsevents.html.

Mental Health Commission of Canada. (2007). *Key Initiatives: Anti-Stigma Campaign.* http://www.mentalhealthcommission.ca/keyinitiatives.html.

Metro Community Housing Association, see website for more information: www.mcha.ns.ca.

Nandlal, J.; N. I. Palarchio and C.S. Dewa. (2010). Continuity of Care in Early Intervention Programs and Court Support Programs: Giving Voice to Service Recipients and Their Families. *Canadian Journal of Community Mental Health*, 29, Suppl. Special Issue, 42.

Northern Alberta Forensic Psychiatric Services. http://www.albertahealthservices.ca/services.asp?pid=service&rid=1003858.

Office of Housing and Construction Standards: Housing Policy Branch. (2006). *Creating Housing for Homeless People: A Case Study. Featured Project: Victory Inn, Kamloops, The John Howard Society.* www.housing.gov.bc.ca.

Office of the Auditor General of Ontario. (2008). *Annual Report*. http://www.auditor.on.ca/en/reports_en/en08/ar_en08.pdf.

Office of the Correctional Investigator of Canada. (2010). *Under Warrant: A Review of the Implementation of the Correctional Service of Canada's 'Mental Health Strategy'* prepared by John Service. http://www.oci-bec.gc.ca/rpt/pdf/oth-aut/oth-aut20100923-eng.pdf.

Ontario. Legislative Assembly. (2004). Personal Health Information Protection Act. http://www.health.gov.on.ca/en/public/programs/mentalhealth/advisorygroup/docs/rep_everydoor.pdf.

Ontario. Local Health Integration Network. http://www.lhins.on.ca/home.aspx?LangType=4105.

Ontario. Local Health Integration Network. (2007). *Ministry-LHIN Accountability Agreements.* http://www.lhins.on.ca.

Ontario. Ministry of Health and Long-Term Care. (2006). *A Program Framework for: Mental Health Diversion/Court Support Services,* Government of Ontario: Queens Printer for Ontario.

Ontario. Ministry of Health and Long-Term Care. (2008). *Community Mental Health Follow-up on VFM, Section 3.06, 2008 Annual Report.* Chapter 4, sect. 4.06. http://www.auditor.on.ca/en/reports_en/en10/406en10.pdf.

Ontario. Select Committee on Mental Health and Addictions. 2010. *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians*. http://www.pspc.on.ca/pdf/InfoNote_New_Wellness.pdf.

Ontario. (2011). Open Minds, Healthy Minds. Ontario's Comprehensive Mental Health and Addictions Strategy. http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf.

Ormston, E. F. (2010). Commentary: The Criminalization of the Mentally Ill. *Canadian Journal of Community Mental Health*, 29(2), Fall, 5-10.

Honorable Justice E. Ormston, (personal communication, Kingston Forum, November, 2007)

Patient Psychiatric Advocate Office. (2008). Retrieved March 6, 2008 from: http://www.ppao.gov.on.ca/.

Patterson, M.; J. Somers; K. McIntosh; A. Shiell and C.J. Frankish. (2008). *Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia*. British Columbia: Centre for Applied Research in Mental Health and Addiction (CARMHA). http://www.health.gov.bc.ca/library/publications/year/2007/Housing_Support_for_MHA_Adults.pdf

Petrunik, M. (2007). *Mental Disorders and Justice* (University of Ottawa, Department of Criminology course notes).

Piat, M. and J. Sabetti. (2012). Recovery in Canada: Toward Social Equality. *International Review of Psychiatry,* February, 24(1), 19–28.

Police/Mental Health Subcommittee of the Canadian Association of Chiefs of Police (CACP) Human Resource Committee. (2006). *Contemporary Policing Guidelines for Working with the Mental Health System*. http://www.pmhl.ca/webpages/reports/Guidelines%20for%20Police.pdf.

Pollack, S. (2009). 'Circuits of Exclusion': Criminalized Women's Negotiation of Community. *Canadian Journal of Community Mental Health*, 28(1), Spring, 83-95.

Prabhu, V., Associate Professor, Departments of Psychiatry and Family Medicine, Queen's University, (personal communication, Kingston Forum, November, 2007).

Psychiatric Patient Advocate Office. (January, 2009). *Info-guide: Four Steps to Successful Self Advocacy.* http://www.sse.gov.on.ca/mohltc/PPAO/en/Pages/InfoGuides/1Advocacy_B.aspx?openMenu=smenu_Advocacy.

Québec. Institut universitaire en santé mentale de Québec. (2011). *Plan stratégique 2011-2015.* Québec: IUSMQ. http://www.institutsmq.qc.ca/publications/documents-institutionnels/planification-strategique/index.html.

Quebec. Santé et services sociaux. *Plan d'action en santé mentale, 2005 – 2010 : La force des liens*. http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05-914-01.pdf.

Rachlis, M.M. (2004). *What are LIHNs and What Will They Mean to Toronto Health Organizations?* www.michaelrachlis.com.

Radley, P. (2007). *St. Leonard's Community Services London and Region: Evaluation of Residential Crisis Support Beds: Gallagher Centre Program.* Canada: Public Partner Inc.

Reiner, R. (1997). Media Made Criminality: The Representation of Crime in the Mass Media. In, Maguire, M.; R. Morgan, and R. Reiner (eds.), *The Oxford Handbook of Criminology*. Oxford: Oxford University Press, 376-416.

Resilience Research Centre. http://resilienceresearch.org/.

Resilience Research Centre. Pathways to Resilience Project. http://resilienceresearch.org/.

Rose N. (2000). Government and Control, *British Journal of Criminology*, 40(2*),* 321- 339.

Royal Canadian Mounted Police. (2012). *Surrey RCMP: Car 67 Program.* http://surrey.rcmp-grc.gc.ca/ViewPage.action?siteNodeId=73&languageId=1&contentId=713.

Royal Ottawa Health Care Group. (2008). http://www.rohcg.on.ca/index-e.cfm.

Royal Ottawa Health Care Group (2008). *Assertive Community Treatment Teams for Persons Dually Diagnosed.* http://www.rohcg.on.ca/programs-and-services/factsheets/assertive-community-treatment-dually-diagnosed-e.cfm.

Circles of Support and Accountability (CoSA). (2008). *Circles of Support and Accountability Ottawa: A Reintegration Program That Works.* http://www.stjohnsottawa.ca/pages/cosa.html.

St. Leonard's Community Services London and Region. (2008). http://www.slcs.ca/.

St. Leonard's Society of Canada. (2012). *Homes for the Hard to House: A Model for Effective Second Stage Housing.* http://www.stleonards.ca/sitefiles/H2H%20MODEL%20Homes%20for%20the%20Hard%20to%20House_SLSC%202012.pdf.

St. Leonard's Society of Canada. (2010). *Community Connections: The Key to Community Corrections for Individuals with Mental Health Disorders.* Ottawa: St. Leonard's Society of Canada.

The Salvation Army. (2012). *Canada Speaks 2012: Mental Health, Addictions, and the Roots of Poverty*. http://salvationarmy.ca/DPresources/CanadaSpeaks2012_report.pdf.

Schneider, R. (2010). Mental Health Courts and Diversion Programs: A Global Survey. *International Journal of Law and Psychiatry*, 33(4), 201-206.

Silver, E. (2002). Mental disorder and violent victimization: The mediating role of involvement in conflicted social relationships. *Criminology, 40(1),* p.191-212.

Simpson, D. Program Manager, Psychiatric Patient Advocate Office, (personal communication, Kingston Forum, November, 2007).

Skerritt, J. (2007). Help Needed for Adults Living with Disorder: Experts. *Winnipeg Free Press*. http://www.winnipegfreepress.com/local/story/4039332p-4648245c.html.

Slinger, E. and R. Roesch. (2010). Problem-solving Courts in Canada: A Review and a Call for Empirically-Based Evaluation Methods. *International Journal of Law and Psychiatry*, 33(4), Sep-Oct. 258-64.

Snelgrove, M. (2008).*What I learned through Fostering Children and Youth Diagnosed with Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder*.

Southern Alberta Forensic Psychiatric Services, Community Geographic Team Resources. Calgary Health Region, Mental Health and Addictions Services, *Year End Service Summary 2006-2007.*

Stand up for Mental Health. (2008). http://standupformentalhealth.com/.

Stapleton, J. et al. (2011). *Making Toronto Safer: A Cost-Benefit Analysis of Transitional Housing Supports for Men Leaving Incarceration.* John Howard Society of Toronto.

Stefan, S. and B. J. Winick. (2005). Foreword: Dialogue on Mental Health Courts. *Public Policy and the Law*, 11(4), 507-526.

Stewart, L. A.; G. Wilton and A. Malek. (2011). *Validation of the Computerised Mental Health Screening System (CoMHISS) in a Federal Male Offender Population*. Prepared for Correctional Service Canada. http://www.csc-scc.gc.ca/text/rsrch/smmrs/rg/rg-r244/rg-r244-eng.shtml.

Street Crime Working Group. (2005). *Beyond the Revolving Door: A New Response to Chronic Offenders.* http://www.bcjusticereview.org/working_groups/street_crime/street_crime.asp.

Stuart, H. and J.E. Arboleda-Flórez. (2001). A Public Health Perspective on Violent Offenses Among Persons with Mental Illness. *Psychiatric Services,* 52, 654-659.

Surette, R. (1998), *Media, Crime and Criminal Justice: Images and Realities.* 2nd ed., Belmont: Wadsworth.

Tanenbaum, S.J. (2006). The role of 'evidence' in recovery from mental illness. *Health Care Analysis*. 14, 195-201.

Theriault, S. (2007). *From the Street to the Street.* Presented at SLSC & CCJA

Towards a Community Mental Health Forum, Halifax, Nova Scotia.

Thompson, G., Past President, Mental Health Commission of Canada (personal communication, Kingston Forum, 2007).

Trainor, J.; E. Pomeroy, and B. Pape. (2004). *A Framework for Support*. 3rd ed. Toronto: Canadian Mental Health Association.

Vancouver Island Health Authority. 2009. *Cognitive Behavioural Interpersonal Skills Manual*. http://www.gpscbc.ca/system/files/MH_CBIS_manual.pdf.

Vancouver Police Department. *Police and Community Response Unit: Car 87 Mental Health Car*. http://vancouver.ca/police/organization/investigation/investigative-support-services/youth-services/community-response.html.

Verdun-Jones, S. (2007). *The Mentally Disordered and the Criminal Justice System*. Presented at SLSC & CCJA Towards a Community Mental Health Strategy Forum, Vancouver, British Columbia.

Veresh, T., Executive Director, John Howard Society of Lower Mainland of British Columbia (personal communication, Vancouver Forum, 2007).

Villeneuve, V., Dir. Southern Alberta Forensic Psychiatric Centre, Calgary Health Region, (personal communication, Calgary Forum, 2007).

Weinerman, R., M.D., VIHA. *Model for General Practitioners Regarding Mental Health Assessment and Intervention.* (personal communication, 2008).

Wilson-Bates, F. (2008). *Lost In Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources*. Vancouver Police Department http://vancouver.ca/police/assets/pdf/reports-policies/vpd-lost-in-transition-part-2-draft.pdf.

Wright, D. (1997). Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century. *Social History of Medicine*, 10(1), 137-155.

Zinger, I. (2012). Mental Health in Federal Corrections: Reflections and Future Directions. *Health Law Review*, 20(2), 24.

Zinger, I (2007). *Towards a Model Community Mental Health Strategy.* Presented at SLSC & CCJA Towards a Community Mental Health Forum, Kingston, Ontario.

Zorzi, R., et al. (2007). *Housing Options upon Discharge from Correctional Facilities*. Ottawa: Canada Mortgage and Housing Corporation (CMHC).

Figures

Figure 1: Stigma and Misperceptions of Mental Illness. The Salvation Army. (2012). *Canada Speaks 2012: Mental Health, Addictions, and the Roots of Poverty*. http://salvationarmy.ca/DPresources/CanadaSpeaks2012_report.pdf.

Figure 2: Canadian Public Opinion Poll on Mental Illness. The Salvation Army. (2012). *Canada Speaks 2012: Mental Health, Addictions, and the Roots of Poverty*. http://salvationarmy.ca/DPresources/CanadaSpeaks2012_report.pdf.