Towards an Integrated Network

Working Together to Avoid Criminalization of People with Mental Health Problems
Towards an Integrated Network

Working Together to Avoid Criminalization of People with Mental Health Problems

prepared by
Josée Tremblay

for
St. Leonard’s Society of Canada
and
Canadian Criminal Justice Association

with support from
Public Safety Canada
and
Law Foundation of Ontario
Towards an Integrated Network
Working Together to Avoid Criminalization of People with Mental Health Problems

© St. Leonard’s Society of Canada and Canadian Criminal Justice Association, 2008

St. Leonard’s Society of Canada
211 Bronson Ave., Suite 208
Ottawa, ON K1R 6H5
Registered Charitable Organization
#12894 6829 RR0001

Canadian Criminal Justice Association
1750 Courtwood Crescent, Suite 308
Ottawa, ON K2C 2B5
Registered Charitable Organization
#11883 0660 RR0001

ISBN 978-0-9783244-2-1

The St. Leonard’s Society of Canada and the Canadian Criminal Justice Association wish to acknowledge the generous support of Public Safety Canada and the Law Foundation of Ontario which made the production of this manual possible.

Supplements/updates will be made available at:
www.stleonards.ca

Environmentally friendly, vegetable based inks were used in the offset printing of this report.
# Table of Contents

Acknowledgments........................................................................................................................... iv  
Participants ...................................................................................................................................... v  

A Introduction  
Introduction .................................................................................................................................. A-1  
Research Report Summary ........................................................................................................... A-5  

B Challenges and Concerns for the Mental Health Service Delivery Network  
The Impact of Definitions........................................................................................................... B-2  
Social Determinants of Health ................................................................................................. B-9  
The Silo Effect .................................................................................................................. B-12  
The Image of Mental Health .............................................................................................. B-14  
Risk Management and Comprehensive Assessments .................................................. B-17  

C Towards a Model Community Mental Health Strategy  
Developing a Strategy ...................................................................................................... C-1  
Core Principles and Values .................................................................................................. C-2  

C-i: Developing a Multidisciplinary Approach to Collaboration and Partnerships  
Communication and Information-Sharing ........................................................................... C-7  
Examples of Promising and Effective Practices ......................................................... C-8  
Cross-Sectoral Relations and Horizontal Initiatives ..................................................... C-10  
Examples of Promising and Effective Practices ....................................................... C-12  
Program Development and Evaluations ........................................................................ C-15  
Examples of Promising and Effective Practices ....................................................... C-16  
Protocols and Agreements ............................................................................................... C-19  
Examples of Promising and Effective Practices ....................................................... C-20  

C-ii: Engaging the Consumer  
Providing the Consumer with Information ....................................................................... C-25  
Examples of Promising and Effective Practices ......................................................... C-26  
Self Management/Recovery-Oriented Approach ......................................................... C-29  
Examples of Promising and Effective Practices ......................................................... C-29  
Voluntary Participation: Creating Trust ........................................................................... C-32  
Examples of Promising and Effective Practices ......................................................... C-33  

C-iii: Cross-Training and Education  
Training .......................................................................................................................... C-37  
Examples of Promising and Effective Practices ......................................................... C-38  
Education ......................................................................................................................... C-41  
Examples of Promising and Effective Practices ......................................................... C-41  
Public Education and Media Relations ........................................................................... C-42  
Examples of Promising and Effective Practices ......................................................... C-44  

D Conclusion  
Conclusions and Recommendations.................................................................................. D-1  
References .................................................................................................................. D-2  
Directory of Organizations and Programmes by Province ....................................... D-6
Acknowledgments

The challenge of providing adequate services to those suffering from mental illness has been with us for many decades. It has been a much shorter period of time however, since the relationship between mental illness and criminalization has come to be recognized for the severe problem that it is. The Canadian Criminal Justice Association and the St. Leonard’s Society of Canada decided to collaborate to contribute to the resources available to assist in avoiding criminalizing persons with mental disorders.

This subject cannot be easily condensed and has far-reaching social justice implications. The aspect that we undertook to explore and disseminate was the array of promising practices in various Canadian cities that have done significant work in approaching this challenge. We are very grateful for the direction provided by our eminent advisory group, Prof. Archie Kaiser, Dr. Julio Arboleda-Flórez, Daniel MacRury, Kathy Gregory, Glenn Thompson, Camia Weaver, and Tim Veresh. Their wise counsel both shaped the project and identified key participants. As a result, we met with local experts and talked about their challenges and success in Halifax, Nova Scotia; Kingston, Ontario; Calgary, Alberta; and Vancouver, British Columbia. These fora represented but a sampling of the constructive advances being made in this field across Canada and we see the present results as a beginning upon which we hope to build future chapters.

None of this could have been undertaken without the support of Public Safety Canada and the Law Foundation of Ontario to whom we are indebted. Each forum reflected the distinct nature of its milieu. The generous contributions of our four renowned keynote speakers, Prof. Archie Kaiser, Dr. Julio Arboleda-Flórez, Dr. Patrick Baillie and Prof. Simon Verdun-Jones established an informed and cross-sectoral base for dialogue. The extent of their knowledge and willingness to share it models the collaboration that is identified as the key to resolving some of the most difficult challenges in this field.

This project demanded an extraordinary effort and talent from the lead Project Co-ordinator, Josée Tremblay. Her dedication to researching the significant factors and culling the most representative examples from the wealth of material presented during the discussions has brought this handbook to life. We are enormously appreciative of her talent and contribution throughout the whole.

It takes a strong team to support the production of this kind of work. We thank the staff and volunteers of both our organizations for their individual and collective contributions throughout: Linsey Butler, Erin Donohue, Diane Larouche, Pierrette L’Ecuyer, Susan Haines, Joanne Knox, Carole Mallows, Glenn Provick and David Whiteley.

Finally, and most importantly perhaps, the results presented are all inspired by the contributions and sharing of the wonderfully committed people that we spoke with in each forum. While initiatives and promising practices may vary from city to city, the commitment of each of the participants in each city was uniformly superb. We are heartened by their level of concern and dedication that we hope will one day lead to a significant abatement of the level of criminalization of those living with mental illness.

Elizabeth White
St. Leonard’s Society of Canada
Ottawa, March 2008
Participants

Kingston Forum, November 13 and 14, 2007
Julio Arboleda-Flórez, Queen’s University
Nancy Barkman, Frontenac Community Mental Health Services
Mary-Anne Beeby, Frontenac Community Mental Health Services
Carol Blake, Frontenac Community Mental Health Services
Laurie Bourne-MacKeigan, Brockville Mental Health Centre
Judi Burrill, Elizabeth Fry Society of Kingston
David Champagne, Correctional Service of Canada
Daryl Churney, Public Safety Canada
Dorothy Cotton, Queen’s University
Veronica Felizarado, Correctional Service of Canada
Paul Fernane, St. Leonard’s Community Services of London & Region
Lisa Finateri, John Howard Society of Kingston & District
Leonore Foster, Federation of Canadian Municipalities
Katherine Furst, Providence Continuing Care
Erik Gaudreault, Public Safety Canada
Craig Jones, John Howard Society of Canada
Linda Hahn, Elizabeth Fry Society of Kingston
Michael Magill, Providence Care Mental Health Services
Dianne McCarthy, Kingston Police Department
Diana McDonnell, Lanark County Mental Health
Edward Ormston, Ontario Court of Justice
Michael Petrunik, University of Ottawa
Vijaya Prabhu, Hotel Dieu Hospital
David Simpson, Psychiatric Patient Advocate Office
Darla Souliere, Correctional Service of Canada
Glenn Thompson, Canadian Mental Health Commission
Nancy Wills, Ministry of Community Safety & Correctional Services
Colleen Woodruff, Psychiatric Patient Advocate Office
Ivan Zinger, Office of the Correctional Investigator

Halifax Forum, November 21 and 22, 2007
Doug Campbell, Metro Community Housing Association
Crystal Grass, Dalhousie University
Norman Greenberg, Connections Clubhouse
Shannon Harvey, Correctional Service of Canada
Jean Hughes, Dalhousie University
Malcolm Jeffcock, Nova Scotia Legal Aid Service
Bob Jolotta, Lake City Employment
Archie Kaiser, Dalhousie University
Dan MacRury, Canadian Criminal Justice Association
Bill Moore, Halifax Regional Police
Christine Muir, Dalhousie University
Donald Mullins, Disabled Individuals Alliance
Melissa Phillips, Saint Leonard’s Society of Nova Scotia
Andrew Sare, Disabled Persons Commission
Shireen Singer, Correctional Service of Canada
Verona Singer, Halifax Regional Police
Don Spicer, Halifax Regional Police
Gola Taraschi, Nova Scotia Department of Justice
Scott Theriault, East Coast Forensic Hospital
Carole Tooton, Canadian Mental Health Association, Nova Scotia Division
Francine Vezina, Healthy Minds Cooperative
Sheila Wildeman, Dalhousie University

Calgary Forum, November 26 and 27, 2007
Bob Alexander, The Alberta Seventh Step Society
Patrick Baillie, Peter Lougheed Centre
Moira Brownlee, Circles of Support and Accountability
Trevor Daroux, Calgary Police Service
Kathryn Gregory, Canadian Criminal Justice Association
Jim Hayman, Correctional Service of Canada
Arlene Hunte, Peter Lougheed Centre
Dave Kotowski, Calgary Police Service
Roland LaHaye, Mount Royal College
Tom MacKay, Peter Lougheed Centre
Heather Quirico, John Howard Society of Calgary
Gord Sand, John Howard Society of Calgary
Val Villeneuve, Southern Alberta Psychiatric Centre
Melanie Weaver, Circles of Support and Accountability
Sharon Zibin, Peter Lougheed Centre

Vancouver Forum, November 29 and 30, 2007
Edward Baess, Vancouver Island Health Authority
Andrew Cochrane, Vancouver Community Court
Shelley Cook, John Howard Society – Central & South Okanagan
Lara Davidsen, Royal Canadian Mounted Police
Art Gordon, Correctional Service of Canada
Sheldon Green, Community Corrections & Corporate Programs
Nancy Hall, Canadian Mental Health Association, British Columbia Division
John Higenbottam, Canadian Mental Health Commission
Jurina Judas, Motivation, Power & Achievement Society
Jamie Marshall, Kelowna Alcohol & Drug Services
Michelle Patterson, Simon Fraser University
Sandra Robertson, Kelowna Mental Health Centre
Karen Sloat, Correctional Service of Canada
Merrikay Snelgrove, Parent of child with FASD
Simon Verduin-Jones, Simon Fraser University
Tim Veresh, John Howard Society – Lower Mainland of B.C.
Camia Weaver, Canadian Mental Health Association, British Columbia Division
Jim White, Correctional Service of Canada
SECTION A: INTRODUCTION

IN THIS SECTION…

Introduction

Research Report Summary
Towards an Integrated Network

Working Together to Avoid Criminalization of People with Mental Health Problems

Section A

Introduction

This handbook is the culmination of a literature review, research, and facilitated discussions among academics, service providers and public service officials across Canada who are concerned with the criminalization of persons with mental health problems.

In the late 1960s, 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 90% of institutional beds closed; however, the requisite community supports did not develop as anticipated. The resulting detrimental effects have surfaced gradually over the last forty years, generating substantive evidence of significant failures in meeting the needs of people with mental health problems. By the beginning of the 21st century, the extent of the problem was recognized as one requiring a comprehensive response.

Penny Marrett of the Canadian Mental Health Association informed the Standing Senate Committee on Social Affairs, Science and Technology (2006) that prisons had “… have become warehouses for the mentally ill due to funding cuts and closures in community psychiatric facilities.”¹ This opinion was echoed by many social service providers across Canada.

Recognizing this reality as evidenced through their policy and direct service activities, the Canadian Criminal Justice Association (CCJA) and St. Leonard’s Society of Canada (SLSC) designed a national initiative to identify the elements and means that can contribute to reducing the criminalization of individuals with mental health problems. Towards a Model Community Mental Health Strategy: an interactive community-based project that brought together service providers, researchers and academics to share experiences and knowledge about mental health programs and services was launched in 2006.

In addition to a research paper to be submitted to the Canadian Journal of Criminology and Criminal Justice, the project entailed four regional fora in Vancouver, Calgary, Kingston, and

Halifax in the fall of 2007. Each forum brought together concerned experts from health, mental health, law, corrections and law enforcement to meet, 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 address 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.

Given the breadth of discussions across Canada, the Advisory Committee has further been asked to submit recommendations to the Mental Health Commission of Canada as offered by the experts within the fora. By complementing in some small way the Commission’s development and implementation of demonstration projects across Canada, Towards a Model Community Mental Health Strategy will facilitate further linkages and information sharing in order to have a positive impact on the delivery of local programs and services for people suffering from mental illness.

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

**Target Goals**

- Increase community awareness/education 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;

**Targeted Audience**

- Academics and researchers
- Mental health service providers
- Corrections front-line workers and managers
- Police officers and leaders
- Civic officials
- Consumers and consumer representatives
- Members of the justice system, the health system and the social service system
It must be underscored, however, that in order to fully realize CCJA and SLSC’s vision in Towards a Model Community Mental Health Strategy, communities must be empowered to adopt it and adapt to their own needs these promising and effective practices. 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.

Mental Health Consumer

“In the last decades, discrimination […] has become the focus of professional concern, possibly as a result of changes in the locus of service for most mental conditions.”

Individuals suffering from mental health problems are transferred to the health and justice systems to obtain support and services. The deinstitutionalisation of psychiatric services has contributed to the deterioration of social service permeating our systems.

The complexity of identifying a suitable, non-stigmatizing term to refer to people with mental health problems has been a towering challenge experienced by the mental health service delivery network. 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 who suffer from mental health problems are defined, described, and perceived. Experts working for the health, mental health and justice systems have employed interchangeably a multitude of terms when speaking of individuals with mental health problems. “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.”

The main concern in relation to the terminology being employed is to avoid any further stigmatization and violation of the human rights of this particular group. Experts have noted that many individuals are reluctant to use the word “consumer” in that it presumes the individual has a choice in requiring services and interventions. On another note, the term “survivor” has also led to much debate given that it connotes that the individual have been able to manage and deal with his/her mental health problems and is moving towards recovery – which inadvertently excludes a large group of people. Experts have also noted a return of the use of the term “patient”. This seems to be supported by those proposing that individuals who suffer from a mental health illness should be treated in the same vein as those with a physical illness.

---

In this handbook, based on all the advice that we have received, we have decided to use the term “mental health consumer”, imperfect though it may be. However, the term “client” and “patient” have also been used within the handbook. These terms were employed by experts, both during the regional fora and in additional written submissions, and are used in order to preserve the integrity of the information provided.

A more generic term has also been employed in the handbook to describe the population: “people who suffer from mental health problems/mental illness”. The terms mental illness and mental health problems are often used interchangeably; however, a distinction was noted by the experts. 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 consumers. “[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.”4 The differentiation between mental illness and mental health problems further illustrates the how definitions, terminology and language are an essential part of mental health assessment and intervention.

“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*

---

**Research Report Summary**

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 conception that by bridging the gap between theory and practice, 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 the way in which 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. He recognizes the impact an imposed identity has on an individual but 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.\(^5\)

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.”\(^6\)

What kinds of programs and resources are provided to whom, what knowledge is being produced about the mental health service delivery network and who has the power to produce these discourses are questions we can ask in an attempt to better understand the constructed mental health identity. The current trend is to represent the mental health identity as criminal, where mental illness is perceived to be directly correlated with criminal activity rather than the result of their social conditions such as problems related to housing, employment etc.\(^7\)

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\(^8\) 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

---


\(^8\) By psy-science experts, we mean those in the field of psychology, psychiatry and social work, primarily.
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.” This stigmatization discourages skilled individuals from working with this particular population and further contributes to the criminalization.

Related to the effect 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. 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 in the 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. Without appropriate resources to support this group, many will end up in the criminal justice system.

The above-mentioned factors are highlighted in the 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.

We argue that one of the most productive ways 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”. This means that the knowledge gained by those who are affected by or work directly with the target

---

10 Skerritt, 2007; see also, Arboleda-Flórez, 2005: 9.
population is not deemed “expert” knowledge. As a result, their knowledge is not perceived as powerful enough to affect 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 experts. 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. 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. 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.\textsuperscript{15} 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.

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.

SECTION B: CHALLENGES AND CONCERNS FOR THE MENTAL HEALTH SERVICE DELIVERY NETWORK

IN THIS SECTION...

The Impact of Definitions
Social Determinants of Health
The Silo Effect
The Image of Mental Health
Risk Management and Mental Health Assessments
Section B
Challenges and Concerns for the Mental Health Service Delivery Network

Factors Contributing to Criminalization

Mental health treatment services have been identified as a key issue in desperate need of reorganization. In the last forty years, empirical research has demonstrated the detrimental effect of the deinstitutionalization of mental health services in Canada (Kelly, 2004; Brink, Doherty, & Boer, 2001). 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” (Verdun-Jones, 2007: 4). 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 (Kelly, 2004).

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 (2001), the cornerstone of public concern and fear of individuals who suffer from mental illnesses comes from the misconception that they are dangerous. 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” (Verdun-Jones, 2007: 31). 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 (Kaiser, 2007). Rather than taking into account existing social inadequacies in the services available to individuals who suffer from mental health problems, 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 (Kaiser, 2007). “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” (BC Justice Review Task Force, 2005: 29). 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 individuals who suffer from mental health problems.

Central to this project 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 recurrent challenges and concerns were identified, which have been used to shape this section:

A. The Impact of Definitions
B. Social Determinants of Health
C. The Silo Effect
D. The Image of Mental Health
E. Risk Management and Comprehensive Assessments
The Impact of Definitions Assigned by the Mental Health Service Delivery Network

Definitions of Mental Illness/Disorders

The mental health service delivery system is primarily responsible for the terms and expressions used to describe an individual suffering 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” (Petrunik, 2007: 1).

For instance, the Diagnostic and Statistical Manual of Mental Disorders, fourth edition-revised (DSM-IV-TR, 2000), uses the term “mental disorder” as a general term for all the categories; however it does not include a definition for the term “disorder”. As an alternative, a “mental disorder” classification is designated when the following three components are present:

i. There must be negative consequences in the form of
   a. considerable pain, stress, discomfort, or disability for an afflicted individual
   b. or considerable pain suffering & other harm to others with whom the individual associates.

ii. There must be a dysfunction of some internal process whether biological or psychological;

iii. Deviance or conflicts between the individual & society do not qualify as a mental disorder unless the deviance is considered a symptom of internal dysfunction.

However, there are major concerns regarding these definitions of “mental disorder”. Although they are comprised of a variety of specific criteria, these definitions remain very exclusionary in nature. Specifically, individuals that do not fit the criteria proposed by the DSM-IV-TR are often neglected or perceived as less severely problematic given the expert’s inability to assign a “mentally ill” status. As indicated by Dr. P. Scott Theriault, caution must be taken before diagnosing an individual with personality disorders due to the negative image that is often associated and/or the negative consequences that occur as a result of this particular classification.

For example, it has been suggested that 75% of men in correctional settings suffer from Antisocial Personality Disorder (ASPD). Among the criteria for ASPD, the individual must demonstrate “a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, which is indicated by three (or) more specific components including a failure to conform to social norms, deceitfulness, and conning others for personal profit or pleasure and consistent irresponsibility” (DSM-IV-TR, 2000, Disorder 301.7). As a result, definitions of mental disorders as defined by the DSM-IV-TR may further impede on the services and support that are offered to this particular group given their newly assigned status. In addition, Dr. Theriault revealed that a large number of high risk offenders are more likely to re-offend as a result of their criminogenic culture (peers, criminal past, social setting).

1 M. Petrunik (2007). Mental Disorders and Justice (personal communication, University of Ottawa, Department of Criminology course notes).
Consequently, “mental disorder” categories provided by the psychiatric field have often led to significant stigmatization and discrimination of individuals who suffer from mental illnesses. “There can also be a labelling effect or self-fulfilling prophecy when the person labelled internalizes the label, acts accordingly, and makes the label, either negatively (secondary deviance) or positively (tertiary deviance) a core part of her/his identity” (Petrunik, 2007: 49). Undoubtedly, mental health professionals and service providers play a major role in how the individual is perceived by others and society. Similarly, these terms and expressions are crucial to the definitions used by mental health consumers to describe themselves. As repeatedly expressed by the experts, to reduce criminalization requires addressing the issue of mental health definitions and mental health status. Definitions of mental health and mental illness should be developed on a continuum without becoming too inclusive or too exclusive.

Two Sample Definitions of Mental Disorder Used by Service Providers within the Mental Health Service Delivery System:

**CALGARY DIVERSION PROJECT**

Mental Disorder as defined by the Mental Health Act: any individual who has a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life. These individuals experience mood, thinking and/or perception disturbances that become evident in their behaviour. A consumer’s presentation is often the first indication of the severity of mental illness and is often first noticed by friends and family members in the way the individual behaves, reacts or feels towards the world around him/her.

**Signs and Symptoms:** Focus on the individual’s appearance, mood, behaviour, speech pattern, thought processes and content and sensorium.

**CALGARY MOBILE RESPONSE TEAM**

Mental disorder ("Mental disorder", 2008): defined by psychiatry and other mental health professions as a mental condition assessed as abnormal or maladaptive and involving significant distress or disability. This can involve cognitive, emotional, behaviour or interpersonal difficulties.

However, note that within the *DSM-IV-TR* caution is noted when attempting to assign and evaluate an individual’s mental health state as a specific category/label, which could further explain why so many direct service providers are also having difficulties. The *DSM-IV-TR* also indicates that public safety must always be a priority over the individual while acknowledging the complex nature regarding this question and in providing an answer that is appropriate and that best works.

The challenge remains difficult: 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. According to Dave Champagne⁵, his concerns regarding the use of the term “forensics” relates to how differently people have come to

---

³ F. Barnes, Calgary Diversion Project, (personal communication from D. Kotowski, December, 2007).
⁴ M. Brager, Calgary Mobile Response Team, (personal communication from D. Kotowski, December, 2007).
⁵ D. Champagne, RSW, RTC-ON, (personal communication, Kingston Forum, November, 2007).
define and make use of this particular term. 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.

However, this term more accurately 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 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 (i.e. the
Atlantic Region). Consequently, the use of the term “forensic services” has become too loose to include
all mental health services that apply for individuals who come into conflict with the law, whether or not
they have been found fit to stand trial or found criminally responsible.

“For instance, in Toronto when the Forensic ACTT teams were first established, I
attempted to refer cases to these specialized teams but was advised that federal
offenders with mental disorders did not meet the criteria because they were not
true forensic cases.”

The inconsistent use of the term “forensics” has ultimately contributed to a decrease in much needed
services to offenders suffering from a mental disorder coming from federal corrections. It has become
very difficult to manage and provide services to this offender population, released back into the
community, given the faulty perception that there are a wide range of services that will be available to
them. Therefore, a differentiation must be made between mental health services to individuals who
have or have not been in contact with the law and services that are offered for NCR assessment and
application in order for service providers to identify the appropriate services and support that are
available to the individual.

Another major issue related to the implementation of forensic services concerns the increasing funds
directed towards “forensic services”, which are limited to a specific population. This increase does not
provide any further assistance in dealing with the lack of mental health services or difficulty in accessing
mental health services for consumers who have had encounters with the criminal justice system. An
important question to also be investigated should be: How to reduce “forensicization” of mental health
services and develop more effective and appropriate means of diversion? How should we define
mental health services offered to offenders released back into the community? Should they be any
different from the services offered to mental health consumers residing within the community?

Unquestionably, attention must be paid to researching and evaluating effective means of providing
mental health services for the various groups within the mental health community. Despite this
challenge, the mental health service delivery network can contribute to changing the use of the term
and how it is defined by recognizing this issue and paying it the attention it deserves.

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. As
revealed by the experts, the complexity in nature of some individuals’ lives given the added social and
health problems such as housing and poverty has placed on service providers a larger responsibility in

---

6 D. Champagne, RSW, RTC-ON, (personal communication, December, 2007).
improving the quality of life of mental health consumers. Services and support must address a large number of social problems that impede on the individual’s ability to recover. As a consequence, many consumers 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 dealing with individuals who suffer from severe addictions and mental illnesses. 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).

Similarly to the challenges concerning the term “forensics”, further attention must also be paid to the definition assigned to individuals who suffer from severe mental disorders in order to avoid minimizing the individual’s situation, which in turn may reduce the services and support that are available. According to Dr. Theriault, definitions of mental disorders should not attempt to create similarities between an individual suffering from a mental illness and one suffering from 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.

A great deal of interest and support has developed around homelessness and severe addictions and/or mental illness (SAMI) in BC; it is time to build on these first steps. We know what works. It is time to take action. The population of street homeless adults with SAMI can be used as a starting point for describing the need for new units and services.

The Systems

In addition to the challenges experienced by service providers in attempting to identify suitable definitions of mental health/mental illnesses, there have also been an increasing number of incidents of criminalization of mental health consumers by service providers. Many service providers have little or no mental health training, yet they are left to take on the responsibility of ensuring that these individuals receive appropriate and immediate services. This has drastically affected the role of service providers in

---

8 Ibid, p. 27.
9 Ibid, p. 90.
Towards an Integrated Network

that, in many cases, they are unable to provide adequate services or access to services that are best suited because of their own limited understanding of the medical and psychiatric fields. The challenges and incidents experienced by the mental health service delivery network in their inability to provide adequate services have led many to turn to the criminal justice system as a means to provide support and services to this particularly vulnerable population.10

Accordingly, the status/label that is assigned to an individual when he/she enters the system will ultimately define him/her and the services and support that will follow. How he/she enters a system and as a result of what conditions will also contribute to defining the person.11 A mental health status as defined by the mental health courts, for example, may affect the perceptions and treatment offered by the hospital assigned to his/her care. The individual may become stigmatized or feared by the hospital staff given his encounter 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 SPECIAL NEEDS PROGRAM12

A major concern of the social worker was her inability to refer many of the clients to mental health agencies due to a lack of a formal mental health diagnosis. This was in spite of the fact that 33 (91.7%) of the clients identified that they suffered from a serious mental illness and nine (25%) of the clients also identified a moderate mental illness. This self-identification was confirmed for 20 (55.5%) clients who were admitted to the crisis support beds with mental health medications only prescribed for individuals suffering serious and/or moderate mental illnesses. This identification was deemed insufficient for community mental health agencies that required a confirmed medical diagnosis to accept clients into their programs. As with many new programs, time and diligence can often result in resolving issues.

ALBERTA SEVENTH STEP SOCIETY13

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.

Consistent with the above mentioned, Ivan Zinger14 revealed that 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. 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 as offenders with mental illnesses continue to be segregated in response to displaying symptoms of their illnesses, and released later in their sentence.”

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 the consumer, on how he/she is perceived, on what he/she is 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 harm to himself or herself or to another person and that, in some cases, the least-restrictive environment could be his/her community if the individual is appropriately monitored and supported. By statute, a CTO is put in place to ensure that the individual, when in the community, will take appropriate medications, follow through with other forms of treatment, or access necessary supports and 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.

“The reality of CTO legislation, however, has proven to be very different.”

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, certainly under Alberta’s new provisions, be put in place only 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 or that passed in 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.

---

15 Ibid, slide 12.
16 Dr. P. Baillie, Psychologist, Peter Lougheed Hospital, (personal communication, February, 2008). *Community Treatment Order Submission.*
17 Ibid.
designated. Finally, there exists a problem in the legislation regarding what happens if an individual
breaches 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 in a busy emergency
department finds that the individual, at that moment, does not pose a danger to himself, herself, 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.”

There continues to be opposition to the mechanism of CTOs, from a political and moral perspective, as
they are seen as coercive, not consensual, and designed to medicate the homeless, for example, while
avoiding the need to expand hospital-based mental health programs.

The Individual

The next step in addressing this challenge 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 within the “Towards a Community
Model Mental Health Strategy” chapter, there exist a large variety of promising and effective practices
providing services and support to mental health consumers. Although these service agencies/programs
are largely contributing to reducing criminalization, their main priority remains the delivery of services
that assist the individual in improving his/her 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. The individual has come to be
defined by their mental health state, their addiction 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, when dealing 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?

18 Ibid.
Social Determinants of Health

Housing and Homelessness

Present research and policy-related initiatives have recognized the necessity to address homelessness in Canada. Research findings have revealed an increasing number of Canadians living in poverty, contrary to popular belief. Among the initiatives, the Institute for the Prevention of Crime\textsuperscript{20} attended to this issue through consultations across Canada. “In an Ottawa study of people experiencing homelessness and staying in emergency shelters, 31\% of the sample reported having been diagnosed by a health care professional with depression, 10\% with bipolar disorder, and 5\% had been diagnosed with schizophrenia or multiple conditions (Aubry et al., 2003). Regardless of the exact numbers, homeless persons suffer from high rates of mental illness (Hwang, 2000).”\textsuperscript{21} As conveyed among the experts, this report urges a commitment to addressing the social components that contribute to homelessness, incarceration and victimization.

Suitable housing, notably for those with dual diagnoses and comorbid disorders, has been quite a challenge. According to David Simpson\textsuperscript{22}, many communities are unable to offer safe and supportive housing to individuals who suffer from mental health problems. Strikingly, shelters have become the new warehouse for the mentally ill. Consumers requiring the assistance of shelters are relocated from the health, mental health and correctional systems. In Halifax, for instance, Pendleton Place\textsuperscript{23} has become a predominant diversionary tactic to deal with crisis response situations.

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:

“In September 2007 a man attempted to kill his six-year-old daughter as she lay sleeping on a couch in the family home. Police were called and the suspect was arrested and taken to jail. It became apparent based on collateral information from family and in speaking to the suspect that he was suffering from a significant mental illness. Relying on details from the investigating members, Crown Counsel requested that the accused be remanded in custody pending a psychiatric evaluation. The judge agreed and ordered an assessment to determine if he was fit to stand trial on the attempt murder charge. He was transported to North Fraser Regional Correction Centre where he sat waiting for a bed at the forensic psychiatric facility. When he went back into court a month later his lawyer, frustrated at the time his client spent in jail, requested that the judge order that the next evaluation take place in a designated psychiatric facility. The presiding judge stated that he was apprehensive to get involved in what was essentially a provincial resource issue. The accused went back to prison to await room at a designated facility.

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, January 2008


\textsuperscript{21} Ibid, p. 21.

\textsuperscript{22} D. Simpson, Program Manager, Patient Psychiatric Advocate Office, (personal communication, Kingston Forum, November, 2007).

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-risk populations, followed by concurrent disorders and, less frequently, mental illness alone.²⁴

Principally, housing options should take on a different approach to mental health. A different look must be taken on 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. Moving towards an integrated network, starting with adequate housing, is a crucial component to successful recovery and as a mean to improve the quality of life for mental health consumers.

**Health and Social Systems**

Health services have encountered many challenges in dealing with this particular population. The shortage of mental health professionals has led many consumers to turn to their physicians to receive treatment, referrals and support. Many are provided with drug prescriptions without any additional support or services. The limited number of mental health professional staff has resulted in over-prescription to compensate for the limited availability of resources and interventions. Another major problem is that many 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 services providers. As a result, misusing or the lack of taking any medications 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. There is a remarkable gap in programs and services within those areas.

Experts have also noted the existence of an undisclosed two-tier system of health and social services which operates to the detriment of the vulnerable population who, in most cases, do not have the financial support to access these services (i.e. private sector). Noteworthy concern regarding the effect of family systems on an individual’s mental health and mental health recovery has equally received increased attention. There is a huge failure in serving children of parents with mental health problems who become responsible for their own well-being and social condition. 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 Burill²⁵, many women prefer to remain at a halfway house as it assures a certain level of services and support that they are unable to access in the community. 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 their criminal justice system-related status. Challenges experienced by the individual returning to the community include difficulties in accessing medication and treatment. Most experts have indicated 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. Individuals are often placed on waiting lists or restricted from housing options given their status. 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 difficult. Certainly, offering limited support is extremely problematic when dealing with high risk individuals.

The struggle in providing continuous mental health services to the individual once returned in the community have been exceptionally detrimental for federal offenders. Upon entry to an institution, federal offenders 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 offenders without health cards and medical coverage, which as a consequence restricts many from obtaining medication previously prescribed and monitored within the institution. The development of an integrated strategy should account for this challenge 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 assure 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.26

The Silo Effect

The term *silo effect* has been widely used 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 mental health consumers because of lengthy waiting lists. Countless individuals are waiting for services provided by the selected few, which is heightened by agencies that are unwilling to work collaboratively to assure 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. 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. Subsequently, communication challenges pose a great dilemma as many service providers are acquainted with the service agencies in their surroundings. Consumers often deal with agencies that have provided services to them prior to their contact with the criminal justice system. Information management strategies to reduce criminalization have been perceived as too great of 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.

According to Constable Dianne McCarthy, 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. Police officers are guided by the Mental Health Act from the transportation process to arresting the individual. As a result, many will regulate the release of information in order to avoid any criticism 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 non-forensic mental health professionals of getting involved with the courts and in dealing with the judges 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 role of the court is to punish and deter through restrictions and surveillance. Consequently, therapists and clinicians are required to opt for social 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.”

A large number of “forensic patients” return to this particular setting for services and support, being that there are limited community services available; by adopting a “forensic patient” label they have somewhat secured adequate services. This is a major downfall of the lack of communication and understanding among competing disciplines working with individuals who suffer from mental health problems. The social disengagement between the service systems to assist others and work together has led many to struggle when returning to the mental health system outside the forensic setting.

On another note, there are challenges experienced within hospitals, especially psychiatric units, in dealing with this particular population. Individuals are, more often than not, 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. Following this short-term arrangement, the hospital is under the obligation to release the individual unless there is reason to believe that he/she must be hospitalized for a longer period of time. As noted by Dr. Theriault, 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 support that are best suited.

An important consequence of the silo effect is that little attention has been paid to evaluate the effectiveness of practices. The lack of communication and collaboration may have contributed to the increase in human rights violations towards this particular population. 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. Experts 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 to part of 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 only encourages collaborations.

Working with police has improved access to police information that can impact a clinical approach. Pairing mental health clinicians with police raises the level of education for police officers related to mental health assessment/referral and helps to promote a consistent and efficient approach to addressing Mental Health Act provisions. The IMCRT police officer’s established rapport with other police officers increases the willingness of other officers to learn about mental health issues and available treatment provisions.

---

31 V. Villeneuve, Director of Southern Alberta Forensic Psychiatric Centre, Calgary Health Region, (personal communication, Calgary Forum, November, 2007).
The Image of Mental Health

Public Opinion

As above, the definitions used to describe a person who suffers from mental health problems have played a major role in the services and support that have been offered to this particular group. For instance, the DSM-IV-TR has been employed to classify individuals into specific categories of mental illness. The criteria set by the psychiatric field have restricted many from obtaining services given their inability to meet all 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. As indicated by Dr. Arboleda-Flórez (2005), stigma and discrimination have entered the realm of mental illness and have affected the experience of all those implicated (i.e. consumer, family member, service providers). “Mental 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.” The negative images and perceptions that have been associated with mental illness have further contributed to the increased perception that those who suffer from mental illnesses are a threat to public safety.

Professor Simon Verdun-Jones referred to the existence of a particular relationship between violence and mental illness. He exposed the stereotypical perception that all 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.” 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.

Figure 1: Public Perception by Country

Beliefs that persons with schizophrenia or a non-specific mental illness are violent, aggressive, or dangerous.

---

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.\textsuperscript{36} 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.\textsuperscript{37} 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.

\textbf{How can we focus on changing the image of mental illness if mental health consumers continue to be incarcerated, discriminated and neglected within our institutions?}

\textit{Media}

The media have also played an important role in preserving a negative image of people with mental health problems. Excluding the social aspect of mental health, current images create the perception that these individuals do not socialize and that they isolate themselves deliberately. The 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, from Jekyll/Hyde to Hannibal Lecter; a persistent image of mental illness has been associated with violence and irrational behaviours. The characteristics that are 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. As stated by Patrick Bateman in American\textit{ Psycho} (2001) to describe himself:

\begin{quote}
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.\textsuperscript{38}
\end{quote}

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. Extensive research (Surette 1998, Reiner, 1997) has demonstrated how the public relies on the media as a source of information and entertainment. “The media and criminal justice systems are penetrating each other increasingly, making a distinction between ‘factual’ and ‘fictional’ programming ever more tenuous.”\textsuperscript{39} For this reason, the

\begin{itemize}
\item \textsuperscript{36} S. Verdun-Jones (2007). \textit{The Mentally Disordered and the Criminal Justice System}. Presented at SLSC & CCJA Towards a Community Mental Health Fora, Vancouver, British Colombia.
\item \textsuperscript{37} Ibid, slide 58.
\end{itemize}
media must be included in public education and awareness campaigns that target the reduction of stigma and discrimination that has been directed towards individuals who suffer from mental health problems. Their impact on public perceptions suggests that they should play a significant role in the initiative for change. Positive 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 Prabhu⁴⁰, stigma is also present within hospitals and universities; not only do consumers 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. 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 provided to service providers has led many to integrate perceptions and attitudes similar to those expressed by public opinion 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.”⁴¹ 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 particular 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 suffering from mental health problems.

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

How do we better our relationship with the media?

How do we demonstrate the importance, even necessity, to address these issues to politicians and funders?

How can we make such professions more attractive?

⁴⁰ Dr. V. Prabhu, Associate Professor, Departments of Psychiatry and Family Medicine, Queen’s University, (personal communication, Kingston Forum, November, 2007).
Risk Management and Comprehensive Assessments

The move towards risk assessment and management as a priority has had a direct impact on the relation between individuals with mental health problems and police officers. Many 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 support that has been provided to mental health consumers. 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 who suffer from mental health problems.

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 illnesses. 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).

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. Personal directives have posed a challenge to direct service providers and psychiatric hospitals. How to ensure that an individual recognizes that he/she is signing over his/her right to make choices regarding his health and mental health? How are we to monitor the agents to avoid any violations?

There is also concern regarding the use of Section 810 of the Criminal Code (CC). According to the CC, 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 to 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 approximately 35-40 appearances a day in Vancouver courts. They are most frequently

---

The lack of adequate mental health and social services, especially for individuals who have had encounters with the criminal justice system, has contributed to 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.

CSC is legislatively mandated to provide health care to offenders through the Corrections and Conditional Release Act (CCRA). Federal offenders 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 federal offenders, including those residing in Community Correctional Centres (CCC). There has been much talk about the implementation of a more comprehensive mental health assessment within institutional programs and services. Much concern focuses on the need to address the institutional structure of penitentiaries, which often poses difficulties when attempting to develop effective services and programs.

According to the OCI, “the actual number of offenders with significant Mental Health issues is likely underestimated as CSC’s mental health screening and assessment on admission is currently inadequate. Improving outcomes in this area is critical as offenders with mental illnesses continue to be segregated in response to displaying symptoms of their illnesses, and released later in their sentence.” In many cases, offenders 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 of or deterioration of an individual’s mental health within correctional settings. The correctional onset of mental health problems should also be the focus of research in order to identify whether correctional settings are apt to deal with the institutional onset of specific disorders. Findings have revealed that this challenge stems 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. The issue of criminalization 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.

The participation of the correctional system is crucial to the instigation of change.

---

SECTION C: TOWARDS A MODEL COMMUNITY MENTAL HEALTH STRATEGY

IN THIS SECTION...

Developing a Strategy
  Core Principles and Values

C-i: Developing a Multidisciplinary Approach to Collaboration and Partnerships

C-ii: Engaging the Consumer

C-iii: Training and Education

(Also, see tabs for Sections C-i, C-ii and C-iii)
Section C
Towards a Model Community Mental Health Strategy

Developing a Strategy

Towards a Model Community Mental Health Strategy sets out 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 to the population. Many direct service providers are dealing with individuals who suffer from multiple health and social problems and who have experienced great difficulties in meeting their basic needs. Unfortunately, a large number of service providers have judged themselves ill-equipped to deal with this specific group, especially for those consumers who have been in contact with the criminal justice system.

The Institute for the Prevention of Crime recently released a report entitled Homelessness, Victimization and Crime: Knowledge and Actionable Recommendations, which further demonstrates the criminalization of vulnerable populations as a result of existing inadequacies in our systems. 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” (IPC, 2008, p.19). The lack of effective collaboration and partnerships between systems has had a huge impact on the services that are available. As a result, the relationship between the health, social and justice systems cannot be overlooked. Canada must take on a holistic approach to mental health services.

Stigma and discrimination on the part of the community at large and direct service providers has also had an impact on the social support and service networks. “Many people living with a mental illness report that the stigmatization of mental illness causes them more suffering than the disease itself” (MHCC, 2007). The media have also played an important role in preserving a negative image of people with mental health problems. This particular group has been labeled as “dangerous”, “sick”, “crazy” and “irrational”. Movies have reinforced this image by suggesting that there exists a causal relation between criminal behavior and mental disorder.

Despite present systemic barriers, the evidence supporting the success of leading cities, agencies and organizations has underlined 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. Related to core values, such as “respect the dignity of individuals, the rights of all members of society, and the potential for human growth and development” (CSC, 2007), CSC has engaged in improving mental health services within their institutions and in developing a community mental health strategy. 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

- 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

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

Outlining the Parameters

This chapter outlines the means and 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 experts who took part in this project’s workshops, a community mental health strategy should

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

Each of these components is supported by building blocks that assist in the development of effective community practices and protocols. These are presented within the contents of this chapter, and include examples of existing community practices that illustrate them. Each section also includes recommendations provided by the experts on how to improve current practices.

Sample Protocols and Programs

Considering the diversity of the Canadian population, this project recognizes that existing practices may require adjustments if designed to be 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 that exist within Canada. 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. The cities, 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 have been involved in leading initiatives in several cities across Canada. For example, Dr. Arboleda-Flórez, Chair of Queen’s University Department of Psychiatry and expert in the field, is also familiar with the challenges faced by Alberta and British Columbia. He originally took part in the implementation of Tele-Mental 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 dealing with individuals with mental health problems 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.

References


Section C-i: Developing a Multidisciplinary Approach to Collaboration and Partnerships

IN THIS SECTION…

Background

Communication and Information-Sharing
   Examples of Promising and Effective Practices

Cross-Sectoral Relations and Horizontal Initiatives
   Examples of Promising and Effective Practices

Programme Development and Evaluations
   Examples of Promising and Effective Practices

Protocols and Agreements
   Examples of Promising and Effective Practices
Section C-i

Developing a Multidisciplinary Approach to Collaboration and Partnerships

Background

Deinstitutionalization has had a great impact on the number of individuals who are homeless, a population that moves between the streets, the correctional system, and the health care and social service systems. “Since 1995 there has been a 27% increase in the number of people with a mental disorder who have been admitted to correctional facilities in Ontario. The increased prevalence of people with a mental disorder coming into contact with the criminal justice system has raised concerns about policing and court resources, institutional capacity, availability and adequacy of resources and access to treatment and assessments”. (MOHLTC, 2006, p.4) A client’s positive or negative experience with the system depends upon their point of access. Many clients feel isolated and neglected. They require a social support network to turn to for assistance.¹

In 2001/2002, the British Columbia courts estimated that among the mentally disordered accused:

- 3% were certifiable (severe psychotic illness);
- 15% had clear signs of mental illness and were seriously disturbed;
- 50% were dysfunctional but not seriously mentally ill;
- 30% had situational or short-term disorders; and
- 2% were mentally challenged.²

Yet, attorneys have a minimal understanding of mental illness 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. “These cases are diverted and the charges are withdrawn or the crown attorney might stay the charges. This involves a suspension of the court proceedings for one year. The crown attorney can reactivate the charge(s) within the one year suspension period. After this one year period the charges are automatically withdrawn [emphasis in original]”.³ However, access to this program is only possible through referrals and must be approved by the provincial crown attorney. As a result, 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 our systems.

In addition, access to a client’s information has become a major challenge. 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. The divisions between direct service providers and across sectors have had 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 some have gone undiagnosed or are simply neglected as a result of their mental health. Therefore, taking a look at how and why services and agencies are disengaged from each other may assist the development of more effective communications and collaboration.

Many different activities were suggested for implementing the strategy, but there was clear agreement that a variety of methods is needed, with interpersonal contact a strongly recurring theme.

Mental Health Commission of Canada, October 2007

Relevance

Identifying the elements to community mental health strategies are necessary to improve inadequate social responses and to develop more effective means of serving this clientele. A multidisciplinary approach to collaboration and partnerships would comprise of 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 to 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.” Consequently, this handbook does not intend to provide an ideal model community mental health strategy but rather it aims to present guidelines for developing strategies that best suit the needs of organizations and communities.

Working Towards a Multidisciplinary Approach

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

References


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 both the individual’s health and mental health but also his/her social environment, social network and system of support.

According to the experts, such practices have contributed to reducing social isolation experienced by mental health consumers. 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/agencies 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 to learn about practices implemented in their own region, which could be beneficial to the consumer’s recovery process. Effective 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 safety of the consumer. Such practices should take into account these issues when developing protocols and agreements in order to minimize any risk. There must be 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 (i.e. offenders as mental health consumers).

How do we coordinate effective collaborative strategies?
How do we ensure continuous and positive communications among service providers and across sectors?

Recommendations

- Work from a common language that focuses on a multidisciplinary approach to mental health service delivery
- Language must focus on a recovery-oriented approach to service delivery
Identify and agree upon the type of information that is disclosed and how one should proceed to provide and obtain information from community partners.

Address and work with competing mandates and legislation, which requires creativity, flexibility and compromises.

Illustrate how each contribute 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 takes part in achieving the Commission’s key initiatives (anti-stigma campaign, knowledge exchange centre and development of a national strategy on mental health).

COAST Hamilton’s crisis line, 905-972-8338 is answered 24 hours a day, 7 days a week.

The COAST mobile team, consisting of a mental health worker, and a police officer, will respond to crisis calls between the hours of 8 a.m. and 1 a.m. daily.

COAST Halton’s crisis line, 1-877-825-9011, is answered 24 hours a day, 7 days a week.

From midnight until 8:00 am, Halton crisis calls are answered by the COAST program in Hamilton. During the night time hours, COAST Hamilton Mental Health Workers have access to the COAST Halton data base to support individuals comprehensively.

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 (Brockville Mental Health Centre), COAST and other similar partnerships have reduced the waiting time for police officers in emergency rooms.

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.

---

4 COAST Hamilton, see website for information: http://www.coasthamilton.ca/index.html.

5 L. Bourne-MacKeigan, Outpatient/Crisis Outreach Team Coordinator, Brockville Mental Health Centre (personal communication, Kingston Forum, November, 2007).
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-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.⁶

---

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). According to Constable Lara Davidsen, trained officers proceed to their regular duties and in the event of a mental health-related crisis will be dispatched as first responders.

The incidents are either resolved on site, require the consumer 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 (i.e. persons brought in are seen within 15 minutes, and none are refused medical and/or psychiatric attention).

The RCMP also intends to set up this initiative across the Lower Mainland (fifteen detachments/communities) and, in partnerships with the CSC, would like to provide mental health training for emergency response nurses. This initiative is an excellent example of a cross-sectoral-holistic approach to mental health service delivery.

---

Additional Projects⁷

- **Building Capacity: Mental Health and Police Project**
  - Canadian Mental Health Association, British Columbia Branch
  - Camia Weaver, Justice Coordinator
  - 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
  - Shelley Cook, Executive Director
  - Significant partners: BC Housing, Interior Health, and City of Kelowna

- **Beyond the Revolving Door: A New Response to Chronic Offenders**
  - Significant Partners: Provincial Court of BC, Vancouver Police Department, and Community Corrections, Ministry for Public Safety and Solicitor General

---


⁷ See program directory for website and contact information.
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. Experts indicate that although small, local, initiatives have been most successful in reducing the criminalization of mental health consumers; 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. Specifically, experts 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\(^8\) (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 Albertan rural population with services and support and to provide a comprehensive forensic assessment and treatment services for people legally mandated in remote areas of Alberta via satellite clinics and by traveling to rural areas and Treaty Seven First Nation Communities.\(^9\)

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 7 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

---

\(^8\) Southern and Northern Alberta Forensic Psychiatric Services, see website for information: http://www.calgaryhealthregion.ca/mh/sites/programs/programsindex.htm.

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.\textsuperscript{10}

As for assuring federal support, horizontal initiatives developed in collaboration with the Correctional Service of Canada would be advantageous. It has been suggested that CSC regional projects funded through CSC national should be presented to its community partners as a means of ensuring accountability, and also, for community agencies/organizations to be part of the intervention/reintegration development plan. The majority of participants also indicated the need for CSC to take part in the \textit{Initiative for Change} given their central role in serving and supporting offenders with mental health/addiction problems.

\textbf{How can we produce changes if mental health consumers continue to be incarcerated, discriminated and neglected within our institutions?}

An important issue is the lack of services or access to services for offenders released at \textbf{Warrant Expiry Date (WED)}, particularly with respect to providing housing and a continuity of care. Many offenders 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, experts recommend that CSC examine this problematic issue and its impact on the offender’s reintegration process. They also suggested that discharge and transitional planning should occur earlier on in the offender’s incarceration period and insists on developing a collaborative planning initiative that assures immediate and short-term support.

\textbf{Pharma-care support} is an excellent example of the need for adequate discharge planning. Discussions are necessary to best integrate and use Pharma-care even when an individual is looking for employment. Standards and outcomes measurements must be developed in order to reduce the number of individuals that fall through the cracks of the system.

\textbf{What is the starting point to establishing a national standard of care?}

\textbf{What are the benefits of horizontal initiatives and cross-sectoral relations?}

\textbf{How do we reduce the gap between policies and research/practices?}

\textbf{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
- Working together requires common goals, objectives and shared outcomes: A focus on change and \textit{recovery}
- Policies must be elaborated using evidence provided both by direct service providers and academics in the field of


\begin{tcolorbox}[breakable,amsblock]
\textbf{Toronto Branch - CMHA}

\textbf{Intake Contact Information:}

\textbf{East of Yonge Street}
Tel: 416-289-6285 ext. 243
Markham Road Site
1200 Markham Rd.,
Suite 500
Toronto, ON M1H 3C3

\textbf{West of Yonge Street}
Tel: 416-789-6880
Fax: 416-789-6895
Lawrence Ave., West Site
700 Lawrence Ave., West
Suite 480
Toronto, ON M6A 3B4

\textbf{Email Contact:}
tmckay@cmha-toronto.net
\end{tcolorbox}
mental health and corrections

- Acknowledge the need for each other; we must involve other sectors and organizations in order to best serve the client
- Leadership: Identify key individuals that are willing to actively participate and become the voice for the project/initiative
- 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, benefits and education

Examples of Promising and Effective Practices

The Toronto Mental Health Court was developed 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. 11

The Mental Health Court Support and Diversion Program offered by CMHA-Toronto assists court referred mental health consumers in locating the 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 case management to clients.12 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.13

---

13 CRCT also offers an online manual to help mental health consumers navigate the Toronto mental health system (see reference section). Also see website for information: http://www.crct.org/services/mhcss.cfm.
The St. Lawrence Valley Correctional and Treatment Centre also has a Case Management Unit for special needs offenders at the Hamilton-Wentworth Detention Centre and the Elgin Middlesex Detention Centre has recently opened special needs units. There is also the Adult Special Needs Contingency Fund and a Release from Custody initiative, which is part of the overall Ministry of Health and Long Term Care Service Enhancement Strategy. This initiative provides Mental Health Case Managers (MHCM) to facilitate the transition of offenders with mental health needs/illness into the community (note: this initiative is in various stages of implementation across the province).\(^\text{14}\)

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.\(^\text{15}\)

John Howard Society Kamloops developed a housing project, The Victory Inn, which takes 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 project has been very effective due to the partnerships that have been created; the partners include BC Housing, the Real Estate Foundation, the Forensic Psychiatric Service Commission, BC Corrections and Interior Health Authority.

Excerpt from Creating Housing for Homeless People: A Case Study (October 2006)

---

\(^\text{14}\) Ontario Ministry of Community Safety and Correctional Services, (personal communication, January 2008).

\(^\text{15}\) ROHCG, see website for information: http://www.rohcg.on.ca/index-e.cfm.
each would be publicly stating in order to assure consistency among their approach. A case study (2006) 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.

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 a supportive housing unit for men and women who are at risk of homelessness and who also have mental health and/or addiction problems. This housing initiative, Cardington Apartments, is currently underway and is expected to take in residents as of fall 2008.

---

18 John Howard Society Central and South Okanagan, see website for more information: http://www.jhscso.bc.ca.
**Program Development and Evaluations**

According to Glenn Thompson,\(^{19}\) we should not restrict ourselves to assessing and recognizing best-practices; promising practices should also be considered. 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 suit the individual. Given the lack of and the 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 focus 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 (NGO’s) how to evaluate their own work with the help and empirical support of academics. This could assure a more generic service delivery system and also provide support to NGO’s in understanding how to integrate research into their practice.\(^{20}\)

Research and evaluation should avoid attempting to identify a model strategy for reducing criminalization, and focus on identify what works, why it works and what are the shared guiding principles and values from which these programs/services originate.

The standardization of practices/programs was also revealed to be a vital problem to the issue of criminalization. There is a need to ensure that all is accredited and completed in a manner that respects the client. 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.

---

\(^{19}\) G. Thompson, Interim President, Mental Health Commission of Canada (personal communication, Kingston Forum, November, 2007).

**Towards an Integrated Network**

**Recommendations**

- A definition of mental health/mental illness should not hinder or impede on an individual’s right to appropriate services and should be explained and understood by services providers.

- Address exclusions, complex cases and dual diagnoses: 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 mental health consumers.

- Build a community development advisory group: Focus on communication between ministries but also with and within the community.

**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 *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.21

**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*, 2001.

---

Health (CAMH). 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.

A promising practice includes the development of a roundtable of invested stakeholders that are proactively investing in public and governmental awareness of evidence-informed options for system transformation. This initiative will contribute to developing the capacity of Nova Scotian communities to improve the mental health of Nova Scotians and reduce involvements with the criminal justice system. Current research taken on by Crystal Grass focuses on two related areas: 1) identifying the existing capacity of Nova Scotian communities for supporting people with mental illness who have been in conflict with the law, and 2) developing a means of evaluating the efficacy of system level initiatives for building community capacity to prevent initial and/or additional conflicts with the law for people with mental illness.

SPECIAL NEEDS PROGRAM

St. Leonard’s Community Services – London and Region currently offers various programs and services within the residential division in order to address mental health issues. It provides residential beds to male and female federal offenders on conditional release at Cody Centre, Gallagher Centre and Maison Louise Arbour. It also has 3 male and 3 female crisis beds for persons with mental health issues who are involved or at risk of becoming involved in the criminal justice system. These short term “safe beds” allow an opportunity for individuals to stabilize and put into place discharge plans that will assist them in avoiding incarceration or hospitalization.

The Special Needs Program offered by St. Leonard’s Community Services London and Region’s Gallagher Centre receives referrals from a number of mental health, social services and criminal justice agencies. According to their recent evaluation report, referral agencies are not assuming responsibility for the individual while he is in the Special Needs Program. Agencies offer limited commitment to support the individual once the program has been completed, nor do they provide any assistance in establishing

---

22 CAMH – TAMI, (community guide also available) download from website http://www.camh.net/education/Resources_teachers_schools/TAMI/tami_teachersresource.html.
23 C. Grass Dalhousie University, Occupational Therapy (personal communication, February, 2008).
24 Ibid.
contacts with the community while the individual is participating in this program. Consequently, it was recommended that

A reintegration program has also been developed to assist men and women with mental health issues who are incarcerated at our local detention centre, to connect with a social worker, and to assist in the transition back to the community. This program has assisted in doing so with persons on bail, provincial probation and federal parole.

**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 offenders with multiple psychiatric diagnoses and addictions for periods of 6 or 12 months depending on their needs. These individuals are served beyond end of court order. **Program entry requirements are the following:**

- The individual has willingness to participate;
- He/she is currently under court ordered disposition;
- He/she 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.

---

Protocols and Agreements

Protocols and agreements are an integral part of information-sharing by allowing 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 assuring 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 on 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 to develop protocols 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, although this 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 will be addressing this as one of its key priorities.

Recommendations

- Develop strategies and practices that are adaptable to others
- 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
- Make a social commitment: 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 manual and protocols (i.e. Encourage the Ontario Police College (OPC) to implement “Not just another call” within their training)
Implement policies that focus on the continuity of care: Ensure immediate, short-term and long-term assistance

The community and continuity care initiatives along with integrating the correctional system both in prevention and community capacity building strategies

**Examples of Promising and Effective Practices**

**Canadian Association of Chiefs of Police**

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. These guidelines comprise 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.”

**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”.

The Calgary Mobile Response Team (MRT) 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,

---

28 Dr. Dorothy Cotton, Clinical Neuropsychologist, Co-chair to Police/Mental Health Sub Committee, Kingston forum (personal communication).
30 Ibid.

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 resources. We also assess a client’s capacity to accept responsibility for themselves and their situations; a major factor in 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.\textsuperscript{32}

\textbf{SERVICE SYSTEMS ADVISORY COMMITTEE OF THE MENTAL HEALTH COMMISSION OF CANADA}\textsuperscript{33}

The Commission’s Service Systems Advisory Committee has a specific mission of addressing mental health service systems issues to facilitate the development of accessible, accountable, effective services which support the recovery of people living with mental illness. There is a substantial body of knowledge which has identified promising practices which support mental health recovery. Where these practices have been implemented, people living with serious mental illness recover and live successfully in the community without repeated psychiatric re-hospitalization.

The Service Systems Advisory Committee has placed priority on supporting the implementation of these promising practices with particular emphasis on the community mental health services which support recovery. Accordingly, priority initiatives of the Committee include proposing a major national study of housing and the steps which are necessary to develop an adequate supply of housing in the provinces and territories. Other priority projects will focus on such issues as diversity, primary care and peer support. The projects proposed by the Committee will provide opportunities for stakeholders to share perspectives on promising practices and lessons learned on the route to provision of effective services and supports for people living with mental illness.

\textsuperscript{32} Ibid.
\textsuperscript{33} J. Higenbottam, Member of the Service Systems Advisory Committee (personal communication, January, 2008).
Section C-ii: Engaging the Consumer

IN THIS SECTION…

Background

Providing the Consumer with Information
  Examples of Promising and Effective Practices

Self Management/Recovery-Oriented Approach
  Examples of Promising and Effective Practices

Voluntary Participation: Creating Trust
  Examples of Promising and Effective Practices
Section C-ii

Engaging the Consumer

“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.”

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

Merrikay Snelgrove

Background

Over the last few decades, there has been major support towards an initiative for change on behalf of the mental health delivery system. Researcher/academics and the social service system have endorsed this approach. More recently, the Senate report, entitled Out of the Shadows at Last, documented the inadequacies present within the Canadian mental health system. As a result of this report, the Canadian government implemented the Mental Health Commission of Canada, which focuses on three key priorities: developing an anti-stigma campaign, assuring knowledge exchange and the development of a national mental health strategy by 2010.

The Canadian Mental Health Association (CMHA) has also been working towards and endorsing the initiative for change. A third edition of its “A Framework for Support” policy project is available. This project focuses on three essential components for implementing effective mental health policies and service delivery; these components are known as the Knowledge resource base, the Personal resource base and the Community resource base. Among these components the community resource base and personal resource base particularly centers on the individual and how he/she is included and takes part in the recovery process in order to improve the quality of life. Specifically, this framework takes on a recovery-oriented approach to mental health/mental illness.

This approach has led to a new way of understanding mental health and mental illness and the challenges that impede an individual’s capacity to cope. “The focus on community serves to anchor our thinking in the real process of consumers’ lives in society. It balances the service-focused bias of older policies by calling for full partnerships with consumers and families, and by recognizing the complex


35 For more information on these components and the approach taken by CMHA regarding mental health services in Canada, see the website: www.cmha.ca.
range of factors that shape the lives of consumers in the community. The focus on personal resources redefines the inner landscape of consumers from a repository of illness and symptoms to a dynamic mixture of skills and capacities that can successfully confront illness. Taken together, these focal points and other elements of the Framework model describe a process for moving ahead”. (2004:3)

Relevance

Consequently, mental health professionals and direct service providers are pushing for policies and legislation that are more suited to the needs of the consumer as opposed to restricting the individual. David Simpson, Program Manager for the Patient Psychiatric Advocate Office, affirmed that there is a serious need to improve the quality of life of mental health consumers.

He has also indicated that further attention should be placed on the protection of human rights, especially given the vulnerability of this particular population. Both the service system and the legislation should focus on reducing the human rights violations that are the result of an inadequate mental health delivery system. A focus on human rights and client-centered programs/services should further assist consumers experiencing difficulties with the mental health delivery system.

Guidelines to Engage the Consumer

In order to engage the mental health consumer in his/her own recovery the following building blocks should be explored:

- Providing information to the consumer regarding his/her mental health/mental illness
- Self-Management/Recovery-Oriented Approach
- Voluntary Participation: Creating Trust

References

M. Snelgrove (personal communication, February 2008). What I learned through Fostering Children and Youth Diagnosed with Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorder.


Providing the Consumer with Information Regarding His/Her Mental Health/Mental Illness

The way in which individuals talk about their condition, their problems and situation may hinder their recovery. Comprehensive knowledge of mental health/mental illness provided to a consumer can only be beneficial to his/her quality of life. He/she may become better at identifying and describing his/her needs, at identifying and making links between social situations and mental health states, etc. It is important to emphasize and ensure that consumers 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 the consumer.

Engaging the client in a discussion about his/her mental health and how he/she comes to define himself/herself and talks about his/her problems provides additional assistance to service providers attempting to ensure the completion of 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 consumer’s voice must 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, consumers 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.

**Recommendations**

- To better educate individuals about their mental health and other-related health and social problems
- Accept mental health as it is rather than attempting to create a mold to which it should all fit in
- A mental health consumer is a person first, followed by someone who suffers from a mental health problem
- Improve the quality of life and protection of human rights
- Experts and professionals should use similar terms that are comprehensive to mental health consumers
- Make use of motivational interviewing
- Encourage discussion between consumers and their families, direct service providers and civic officials
- Encourage consumers to publicly discuss their stories as a tool for reducing stigma and discrimination
- Mental health consumers as champions! Acknowledge and promote success stories
- Focus on and recognize individual differences and diversity

**Consumer Initiative:**

“Clubhouse Connections 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
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”:

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

Use concrete examples

BUILDING CAPACITY: MENTAL HEALTH AND POLICE PROJECT

Excerpt from Fact Sheet “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 him or herself, 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.

---

86 Canadian Association of Mental Health, British Columbia Division (2005). See website for information: www.cmha.bc.ca.
**PSYCHOSOCIAL REHABILITATION**

*Connections Clubhouse* is based on the **psychosocial rehabilitation approach** to mental health and 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”\(^{37}\) This model strives for a long term transformation of the client into a self sufficient member of society.

*Connections Clubhouse* accepts as **members 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 themselves.\(^{38}\)

**MOTIVATIONAL INTERVIEWING (MI)**

MI 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.\(^{39}\)*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**\(^{40}\)

Women offenders on conditional release both in community residential facilities and 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 offenders 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.

---


\(^{40}\) T. Crawford, Executive Director, Elizabeth Fry Kingston (personal communication, Kingston Forum, November 2007).
The Elizabeth Fry Society of Kingston proposes a comprehensive women-centred model of service delivery. This approach integrates the woman into the planning and decision making process as a means to ensure 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.

1. Skill teaching and support services to women offenders with significant functional disabilities, both in the C.R.F. and the community with a special focus towards long term, stable housing with supports;
2. Assistance in accessing and maintaining appropriate mental health counseling and support in conjunction with CSC mental health nursing, social worker and agency personal support workers; and
3. Coordination of wrap-around services within the agency, community, and institutional setting and assist in education and training in conjunction with CSC support services.

David Champagne41 has suggested a promising practice advocating for the appropriate use of the term “forensics”. As indicated in the challenge section, the use of the term forensic has been widely misinterpreted and has had a devastating effect on those who do not fit this legal/psychiatric requirement. Additional research should identify the challenges that funding oriented towards the forensic population has had on offenders with mental disorders, especially for complex cases that are released from provincial/federal corrections given the limited services and support. Simultaneously, there is a need to work together to develop a series of definitions that can be used to the advantage and benefit of the consumer as opposed to current practices.

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”.42 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 consumer’s voice and include him/her in the identifying what are the changes needed to address issues of advocacy, peer support, transition and discharge planning.

### Priorities
- Better access to mental health services
- Public education regarding 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

**Healthy Minds Cooperative: A Blue Horse Initiative**

---

Self-Management/Recovery-Oriented Approach

The individual must be included in the decision making process, which involves providing the consumer with the necessary tools and knowledge available to make the best informed decision. The consumer 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 planning, which consists of a 5 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 his/her following successes and failures. This practice has been implemented so as to assure the individual’s continuity of care is in line with his/her needs and contributes to improving his/her 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 mental health consumers; they assist the individual attempting to complete daily tasks, to obtain employment services, to create a social network.

Recommendations

- Encourage consumers to be aware of their rights
- Empower the consumer to take on a significant role in planning the community management strategy: Take part in the decision making process
- Provide the consumer with the means to identify and use the tools and practices that are available
- Encourage improving their quality of life and focus on a recovery-oriented approach
- A positive sense of self: Create purpose and meaning
- Educate consumers regarding the importance of connecting with all community social networks
- Focus on the individual by promoting self-management
- Key component: Communication

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 the opportunity to accompany offenders 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.

---

LAKE CITY EMPLOYMENT SERVICES ASSOCIATION

Lake City 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 on an on-going basis provide support to assure a more comprehensive understanding of their situation and what is required of them if they desire to hold down a job.

SUPPORTED INDEPENDENT LIVING PROGRAM (SIL)

Provides services to adult male offenders with a developmental disability and/or a concurrent psychiatric condition. These offenders are often, but not always pedophiles. They are generally well-known to the police and 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 has two components, a three bed residential program and a one intensive community support program. As part of the Relapse Prevention 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 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.

MOTIVATION, POWER AND ACHIEVEMENT SOCIETY (MPA)

The MPA assists mental health consumers 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.

---

45 Lake City Employment Services, see website for information:  http://www.lakecityemployment.com/.
47 Ibid. p. 6
**Patient Psychiatric 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, publishing reports and media releases. The services/programs offered by PPAO originate from the following vision, values and principles:

- Consumers be actively involved in all decisions affecting their life, care and treatment
- All consumers of mental health services be treated with dignity and respect
- Consumer directs the advocacy process, using the advocate as a resource
- All advocates respect each client’s personal choices, providing advocacy from the client’s point of view

Among the services offered by the PPAO, mental health consumers 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 mental health consumers 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 mental health consumers how to define a problem, to develop an action plan, to carry out the action plan and to evaluate the results. An explanation is provided with each of the four steps, including a series of questions for consumers to ask themselves while completing the step.

**Developing a Personal Resource Base**

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

![Diagram of a Personal Resource Base (PRB)]

“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.”

---

40 Patient Psychiatric Advocate Office, see website for information: http://www.ppaio.gov.on.ca/.


Voluntary Participation: Creating Trust

Maintaining good relationships between service providers and consumers is not easy. A variety of challenges have 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 the systems and its service agencies as a result of the pervasive stigma and discrimination that exists. They have become very cautious when dealing with others. Another major consequence of ongoing discrimination and stigmatization is that many professionals perceive the consumer’s personal situation as a risk factor for criminality rather than as a point of intervention for recovery. Therefore, many consumers will limit the information that is shared with professionals in order to avoid the potential of being subjected to additional restrictions.

As a result, a trusting relationship requires service agencies to set into place a number of important conditions, such as consistent personnel, clearly defined relationships with psychological boundaries, the use of discretion and the creation of a respectful social environment. Personnel stability assures that a consumer is provided with an intervention plan that is best tailored to his/her needs rather than being tailored to the knowledge of the direct service provider regarding available services and prior experience. In addition, service agencies must take on a client centered approach that focuses on dignity and respect. Their role includes promoting self-confidence in one’s ability to actively participate in improving the quality of life. Therefore, service agencies should endorse staff empowerment and self-confidence in their decision-making abilities. Service agencies should 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 not adequate.

Conversely, service providers must be careful when establishing a relationship. They should define concrete and visible boundaries to the relationship, including what is acceptable and what is not. Many consumers 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 must establish a clear definition of their relationships. They also need to have psychological boundaries. Consumers need to connect to the real world outside of support groups in order to gain greater self-confidence and independence. The individual must focus on the self, on his/her independence and on how to live among the community and share with others.

Recommendations

- Encourage consumers to be aware of their rights
- Encourage and work towards personnel stability 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 period” at the start of the relationship: Consumers must prepare from the beginning the ending of the relationship in order to best deal with it

Create psychological boundaries: Consumer 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 including group homes, supportive housing and independent living opportunities. A direct service provider is also available to visit or reside within housing units (24/7 to weekly visits, etc.). The consumer is involved in the planning and decision making process from the moment he/she has made 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 consumer and living option. The staff takes on a team approach to offering support and supervision. They also assist clients in taking advantage of resources in the community so that they can set up their own networks.

**CIRCLES OF SUPPORT AND ACCOUNTABILITY (COSA)**

Offenders are frequently released WED without an adequate supportive network or housing in the community. Although CSC integrates such concerns within the correctional plan, their continued support has been limited both by mandate and resources. As a result, programs such as COSA may take on an individual released at WED. COSA is a reintegration program for federally sentenced sex offenders but has also begun taking on individuals with addictions. A COSA involves a group of four to six trained volunteers who commit themselves to support and hold accountable a former sex offender returning to the community with little or no support. The core member's participation is voluntary. The individual is directly involved in his own reintegration with the support from the volunteers that also assist him to have access to a support network and services within the community. The key component to an effective relationship between the volunteers and the core member is communication. Together they must clearly define the parameters of their relationships in order to identify and recognize what is accepted and what is not. Volunteers are trained to support the core member and assist him in his attempt to create or re-create his social network.

“We are not trained to be their friends. Our role consists of providing support and assistance to individuals trying to reintegrate in the community”.

---

52 Metro Community Housing Association, see website for more information: www.mcha.ns.ca.
53 Ibid.
**Supported Independent Living Program - Gallagher Centre**

The majority of consumers either have no contact with their family or very infrequent contact, and for some establishing and maintaining a relationship with their family is of great importance. As a result, consumers and staff must create a relationship based on trust and respect in order to be most effective and for the consumer to willingly share his fears and needs with the service provider. As pointed out by a case worker of the Gallagher Centre, consumers want “someone in their lives who is not paid to care”. This is not easily achieved as many of the consumers’ families are also extremely dysfunctional. However, as indicated by the SIL evaluation report, both the social worker and the case workers were incredibly diligent in their efforts to ensure they could identify family members that were able to provide positive and appropriate support to the consumer. The consumers that were able to establish or re-establish a relationship with their family commented on how positively they viewed this aspect of the SIL Program.  

**The Success of Connections Clubhouse**

Principles and values that contribute to the success of the Clubhouse, which at its core requires ensuring a trusting relationship between Clubhouse members and staff:

<table>
<thead>
<tr>
<th>Diverse life experience</th>
<th>An eclectic array of social, philosophical, spiritual, political and vocational life experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialized training</td>
<td>Staff are multi-disciplinary and include occupational therapists, social workers, psychologists, nurses, psychiatrists</td>
</tr>
<tr>
<td>Personal style</td>
<td>Staff are extroverted/introverted; process/task oriented; directive/non-directive; hospital-based/community-based experience; and closed/open-ended. This variety enables members to choose which staff might best be able to meet their needs in any given circumstance</td>
</tr>
<tr>
<td>Staff as role models</td>
<td>Staff model self care, healthy living, competence, self worth, flexibility, accommodation, values of trust and hope. They have insight and awareness into their own strengths and limitations. They also work closely with each other to solve problems</td>
</tr>
<tr>
<td>Relationship to other services and supports in the system</td>
<td>Staff liaises with a large number of community agencies in order for members to access services and programs present in community</td>
</tr>
</tbody>
</table>

---


Section C-iii: Cross-Training and Education

IN THIS SECTION…

Background

Training
Examples of Promising and Effective Practices

Education
Examples of Promising and Effective Practices

Public Education and Media Relations
Examples of Promising and Effective Practices
Section C-iii

Cross-Training and Education

Background

A recent report produced by the BC Street Crime Working Group (2005), entitled “Beyond the revolving door: A new response to chronic offenders”, revealed many of the challenges faced by service providers and law enforcement professionals within the Vancouver area. Among their findings, the report discussed problems related to communication and collaboration among the service system, the influence of public opinion and the limited or lack of cross-training and education. “The particular observations on this problem are revealing. For example, the Street Crime Working Group heard from Crown Counsel that justice system personnel become numbed by the sheer volume of addicted offenders and the complexity of their underlying problems. They don’t have the expertise or resources to perform the “social worker” role that is often required in these cases” (2005: 36).

Following discussions with significant stakeholders, the Working Group attempted to identify solutions to counter the increasing number of chronic offenders entering the criminal justice network. Their recommendations coincide with those provided by the experts who attended the four fora. A major challenge for service providers dealing with individuals with mental health problems has been the limited or lack of (cross)-training, their perception of mental health, the influence of public opinion, and the reluctance to take responsibility for such a vulnerable and complex population. As a result, the initiative for change focuses on assuring that service providers are better equipped to deal with this particular population, but also requires the active participation of the community.

As expressed by a community stakeholder to the BC Street Crime Working Group, “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” (2005: 40). Consequently, and in conjunction with the views of the Mental Health Commission Canada (MHCC), the initiative for change must becomes a social concern, a social problem towards which all are integrated; there must be a national consensus endorsing changes within the mental health delivery system in order for change to occur.
Relevance

According to Malcolm Jeffcock positive shifts have taken place within the system; most notably the use of alternative solutions to housing by the Nova Scotia courts (i.e. group homes as a housing solution). However, he noted that many challenges, especially regarding housing persist. Melissa Philips further indicated that most shelters and community-based agencies do not have on-site psychiatric staff to provide immediate services. Many consumers are wait-listed and left without adequate support or limited services.

Consequently, the 2008 federal budget announcement of $110 million towards the MHCC for research to gain a better understanding on the issue of mental health and homelessness has been long-awaited. “Very little is known about the most effective ways of providing services to people living with mental illness who are homeless,” said Mr. Kirby (2008). “What they require is a complex basket of services including supportive housing, access to primary health care and a wide range of other supports.”

Among the required services, fora experts recommended developing more comprehensive training regarding mental health and the consequences of criminalization, the development of a strategic campaign for corrections and mental health careers, and encouraging research targeting the many challenges faced by mental health consumers (i.e. mental health and homelessness, mental health in youth).

Guidelines for Cross-Training and Education

In order to reduce stigma and discrimination and ensure a more mental health delivery system, the following building blocks should be explored:

- Training
- Education
- Public Education and Media Relations

References


“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, Crisis Intervention Team Trainer, RCMP-Lower Mainland Division.
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 have been 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 within this handbook.

The lack of appropriate (cross-) 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, etc.

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, current programs offer 3-4 months (twice a week) of mental health training. 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 include 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. Nursing programs should include additional knowledge and training in working with difficult and complex clients – especially with involuntary patients – such as correctional patients, institutional work etc.

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 services 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.

**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 consumers and awareness of the different practices and strategies to be used
- 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)**

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

---

Vancouver’s Integrated Mobile Crisis Response Team (IMCRT) aims to effectively address crisis situations for every individual in need. By integrating police, child and youth health services, mental health and addiction services, IMCRT facilitates 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 leading to more appropriate service dispositions.\(^5^9\)

**COMMUNITY MENTAL HEALTH INITIATIVE\(^6^0\)**

CSC has implemented a Community Mental Health two-day training session for CSC and non-CSC community staff and Community Residential Facility (CRF) staff working with women. The following table contains the number of trained service providers as of November 26, 2007:

<table>
<thead>
<tr>
<th>Train the Trainer Attendees</th>
<th>Women’s Training Attendees</th>
<th>2 Day Mental Health Training - Community</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Region</strong></td>
<td><strong>Staff Trained</strong></td>
<td><strong>Total Staff Trained</strong></td>
</tr>
<tr>
<td>ATL</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>QUE</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>ONT</td>
<td>4</td>
<td>43</td>
</tr>
<tr>
<td>PRA</td>
<td>13</td>
<td>43</td>
</tr>
<tr>
<td>PAC</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>NHQ</td>
<td>1</td>
<td>Total 33</td>
</tr>
<tr>
<td>Non-CSC</td>
<td>2</td>
<td>Total 156</td>
</tr>
</tbody>
</table>

**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 would like to

\(^{59}\) Ibid.

\(^{60}\) V. Felizardo, CSC Community Mental Health Trainer (personal communication, Kingston Forum, November, 2007). Community Mental Health Initiative Table.
provide a refresher course once a year that would allow trained officers to address challenges and concerns they been encountered over the year.61

The CMHA- BC Branch62 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 screened to make sure that they exercise good judgment and maturity. Skill testing and structured interviews are suggested as reliable screening tools.

“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.”63

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

The 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 (but are not exclusive to) the findings in support of this type of intervention within correctional settings64:

- 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

63 Ibid.
64 Ibid.
**Education**

According to Professor Michael Petrunik, 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.

Educational courses should go beyond prevention and changing public opinion, but also focus 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 would also benefit from more extensive mental health training as they are in many cases responsible for referring consumers to programs and services that target mental health problems. They should have a more comprehensive understanding of mental health-related issues. 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). Developing a wider social service network could allow for partnerships that focus on developing strategies in dealing with homelessness and mental health.

Educational 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.

Educational courses should also cover, and include, family-related issues and challenges in dealing with individuals who suffer from mental health problems (i.e. children of parents who suffer from mental illnesses). Educating family may differ from the education program that are 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 situation and more apt to describe and explain their concerns and challenges with the mental health delivery system.

---

65 M. Petrunik, Professor, University of Ottawa, Department of Criminology, (personal communication, Kingston Forum, November 2007).
Towards an Integrated Network

**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
- Educational courses should address separately addictions issues and mental health issues
- Allow courses offered by agencies/organizations to be included in degree requirement
- Education on cultural diversity and ethnic differences among those who suffer from mental health problems
- Educational courses should also cover, and include, family-related issues and challenges in dealing with individuals who suffer from mental health problems

**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 concurrent diagnoses if any, and arrange for appropriate interventions/referral to be taken. It also intends to provide GPs with an alternative tool to prescription medication.

Two psychiatrists and two Vancouver Interior Health Authority (VIHA) therapists deliver a manual based, on site Enhanced Skills Training module to GPs. The goal is to enhance their skills in diagnosing, doing differential diagnosis and becoming familiar with Cognitive Interpersonal Behavioral (CIB) Skills Made Easy manual, thus enhancing their skills and treatment choices. Cognitive 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.

---

66 Dr. R. Weinerman, VIHA (personal communication, February, 2008). *Model for General Practitioners Regarding Mental Health Assessment and Intervention.*
Objectives

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 taking part working with Depression and Anxiety around diagnosis, differential diagnosis and the use of CIB skills Made Easy tools

Rivian Weinerman, Vancouver Interior Health Authority

CHANGING MINDS

This training program originated from CHMA -Newfoundland/Labrador and, since has been implemented in various other provincial CMHA’s (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 2 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.”

Sample: Module 7 – Understanding Complex Mental Health Problems

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

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 consumer survivors willing to tell their story, their experiences and why they feel that they were able to overcome such challenges as opposed to so many who continue to struggle. It needs to emphasize the importance of the community as part of problem and part of solution. Regular meetings and continuous education should also be viewed a significant factors to ensure continued discussions among the various groups and advocacy towards mental health services.

We need to challenge how we talk 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 our resistance to openly addressing mental health needs, which simply aggravates the situation. A common reality must be created.

Tim Veresh\(^69\) asserted that stronger media relations are a key concern. While the media have had a huge impact on public perception, 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 turns 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 the media 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.\(^70\)

Recommendations

- Working 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

\(^{69}\) T. Veresh, Executive Director, John Howard Society of Lower Mainland of British Columbia (personal communication, Vancouver Forum, November, 2007).

\(^{70}\) Dr. P. Baillie (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 implemented, which focuses on mental health 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.”71 However, Quebec was not one of the provinces visited for this project and therefore requires its own research into how they are dealing with inadequacies in the mental health delivery system, in developing practice and strategies and in moving towards an initiative for change.

TALKING ABOUT MENTAL ILLNESS (TAMI):
A GUIDE FOR DEVELOPING AN AWARENESS PROGRAM FOR YOUTH

Experts suggest that such educational programs should target younger children, as young as grade 4, given the growing prevalence of depression and suicide within this particular group. 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 and dual diagnosis (mental health and addictions) due to a lack of early intervention.

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:

- Which course the program is being incorporated into;
- How much time the teachers have available; and
- Where they are in the course outline when they take part in the program.”72

STAND UP FOR MENTAL HEALTH73

David Granirer, mental health consumer, Counselor and stand-up comic, offers a mental health course where mental health consumers turn their stories into performing acts that are presented at conferences, treatment centres, and various mental health organizations.

---

73 Stand up for Mental Health, see website for information: http://standupformentalhealth.com/.
SECTION D: CONCLUSION

IN THIS SECTION...

Conclusions and Recommendations

References

Directory of Organizations and Programmes by Province
Section D

Conclusion

Conclusions and Recommendations

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 through the course of this project. Dedication and persistence emerged as defining attributes of the architects of the promising practices brought forward during the discussions. 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, but not prescriptions, that were found to be effective. To guide the development of context appropriate interventions, we have identified the following key principles:

Recommendations to Remember:

**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 are the shared guiding principles and values as opposed to fashioning a model strategy
- Integrate nontraditional sectors (i.e. the private sector, the commercial sector, community engagement)
- Develop an integrative and multifaceted approach to the mental health service delivery system
- Implement flexible and adaptable programs and services that are 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 a mental health consumer as a person first, followed by someone who suffers from a mental health problem
- Focus on definitions of mental health/mental illness 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!”
References


**Figure**

**Figure 1**

# Directory of Organizations and Programmes by Province

## NOVA SCOTIA

<table>
<thead>
<tr>
<th>Agency/Organization</th>
<th>Specific Program identified</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connections Club House</td>
<td>For more information on their programs and services, please visit the website at: <a href="http://www.connectionsclubhouse.com">www.connectionsclubhouse.com</a></td>
<td>Norman Greenberg, Psychologist 1221 Barrington Street Halifax, NS B3J 1Y2 Phone: (902) 473-8692 Fax: (902) 473-6259 <a href="mailto:clubhouse@navnet.net">clubhouse@navnet.net</a></td>
</tr>
<tr>
<td>LakeCity Employment Services Association</td>
<td>For information regarding their LakeCity Woodworkers retail operation and other services, please visit the website at: <a href="http://www.lakecityemployment.com">www.lakecityemployment.com</a></td>
<td>Bob Jollota, Employment Coordinator 386 Windmill Road Dartmouth, NS B3A 1J5 Phone: (902) 465-5000 Fax: (902) 465-5009</td>
</tr>
<tr>
<td>Metro Community Housing Association</td>
<td>For more information regarding their Support and Residential Services, please visit the website at: <a href="http://www.mcha.ns.ca">www.mcha.ns.ca</a></td>
<td>Doug Campbell Client Support worker 7001 Mumford Rd Tower 1 Suite 215 Halifax, NS B3L 4N9 Phone: (902) 453-6444 <a href="mailto:info@mcha.ns.ca">info@mcha.ns.ca</a></td>
</tr>
<tr>
<td>Canadian Mental Health Association – NS Branch</td>
<td>Training Program: Changing Minds Originated in NFLD/Labrador and is now being offered in various CMHA across Canada Website: <a href="http://www.novascotia.cmha.ca">www.novascotia.cmha.ca</a></td>
<td>Carole Tooton, Executive Director 63 King Street Dartmouth, Nova Scotia B2Y 2R7 Phone: (902) 466-6600 Toll Free: 1-877-466-6606 Fax: (902) 466-3300 <a href="mailto:cmhans@eastlink.ca">cmhans@eastlink.ca</a></td>
</tr>
<tr>
<td>Disabled Individuals Alliance</td>
<td></td>
<td>Donald Mullins 1278 Tower Road Bethune Building, Suite 262 Halifax, NS B3H 2Y9 Phone: (902) 422-6888 Fax: (902) 425-0766</td>
</tr>
<tr>
<td>Agency/Organization</td>
<td>Specific Program identified</td>
<td>Contact Information</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Correctional Service</td>
<td>Community Mental Health Nurse</td>
<td>Shannon Harvey</td>
</tr>
<tr>
<td>Canada Community Mental Health Initiative</td>
<td>Clinical Social Worker</td>
<td>Shireen Singer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Halifax Parole Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MacDonald Building, Suite 200</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (902) 426-9865</td>
</tr>
<tr>
<td>Justice Department</td>
<td>Court Services Division</td>
<td>Gola Taraschi, Manager, Special Projects</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="http://www.gov.ns.ca">www.gov.ns.ca</a></td>
<td>5151 Terminal Road, PO Box 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone (902) 424-7404</td>
</tr>
<tr>
<td>Nova Scotia Legal Aid Service</td>
<td></td>
<td>Malcolm Jeffcock</td>
</tr>
<tr>
<td>St. Leonard’s Society of Nova Scotia</td>
<td><a href="http://www.saintleonards.com">www.saintleonards.com</a></td>
<td>Melissa Phillips, Operations Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>603-45 Alderney Dr.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(902)237-6818</td>
</tr>
<tr>
<td>Healthy Minds Cooperative</td>
<td><a href="http://www.healthyminds.ca">www.healthyminds.ca</a></td>
<td>Francine Vezina, Executive Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7071 Bayers Rd. #112</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (902) 404-3504</td>
</tr>
</tbody>
</table>

**ONTARIO**

<table>
<thead>
<tr>
<th>Agency/Organization</th>
<th>Specific Program identified</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Psychiatric advocate Office</td>
<td>For more information or to locate Regional Psychiatric Offices, please visit the website at: <a href="http://www.ppaogov.on.ca">www.ppaogov.on.ca</a></td>
<td>David Simpson, Program Manager Colleen Woodruff, Patient Advocate Head Office: 55 St. Clair Avenue West Suite 802, Box 28 Toronto, Ontario M4V 2Y7 Phone: (416) 327-7000 or 1-800-578-2343 Fax: (416) 327-7008</td>
</tr>
</tbody>
</table>
| Community Resource Connection of Toronto | Toronto Court Support Services, Mental Health Court Diversion Program  
Also available the following handbook: *Navigating Mental Health Services in Toronto: A Guide for Newcomer Communities*  
To download the handbook or obtain additional information, please visit their website at: www.crct.org | 230-366 Adelaide St. E  
Toronto, ON M5A 3X9  
Phone: (416) – 482-4103  
Fax: (416) 482-5237  
crct@crct.org |
| --- | --- | --- |
| Hamilton/ Halton Crisis Outreach and Support Team (COAST) | Crisis Line & Mobile Response Team  
Website: [www.coasthamilton.ca](http://www.coasthamilton.ca) | Hamilton Crisis Line (905)972-8338  
Halton Crisis Line 1-877-825-901  
*Midnight until 8:00 am, Halton crisis calls are answered by Hamilton COAST* |
| Lanark County Police Services and Lanark County Mental Health, Emergency Department, Ambulance Services, Diversion (L.E.A.D) | L.E.A.D. Team or Community Patrol Branch involvement is initiated by calling the Emergency Communications Centre  
Lanark County Mental Health: Will provide advice or mobile response to local hospital Emergency Department | Diana McDonnell,  
Supervisor, Crisis Team Lanark Mental Health  
911 for emergency or (888) 310-1122 for Non-emergency. Perth Police (613) 267-3131 for Non-emergency. Smiths Falls Police (613) 283-0357 for Non-emergency. Lanark Ontario Provincial Police (613) 267-2626 for Non-emergency. During business hours 8 a.m. - 8 p.m. Monday - Thursday, Friday 8 a.m. to 5 p.m.  
Call (613) 283-2170 or Fax Referral (613) 283-9018  
After Hours: 8:00 p.m. - 8:00 a.m. and weekends telephone consultation: Call (613) 284-1410 and request the On-Call Mental Health Worker. |
<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Mental Health Association, Toronto Division</td>
<td></td>
<td>Website: <a href="http://www.toronto.cmha.ca">www.toronto.cmha.ca</a></td>
</tr>
<tr>
<td>Brockville Mental Health Centre</td>
<td></td>
<td>Assertive Community Team for Persons Dually Diagnosed (ACT-DD)</td>
</tr>
<tr>
<td>Leeds, Grenville, and Lanark Mental Health Crisis Response</td>
<td></td>
<td>Mental Health Crisis Line Supported by Brockville Psychiatric Hospital, a division of ROHCG, and Lanark County Mental Health</td>
</tr>
<tr>
<td>St. Leonard's Community Services of London and Region</td>
<td></td>
<td>Special Needs Program (Gallagher Centre &amp; Maison Louise Arbour) Supported Independent Living Program Relapse Prevention Program</td>
</tr>
</tbody>
</table>

**Markham Road Site**
1200 Markham Road, Suite 500
Scarborough, ON M1H 3C3
Phone: 416-289-6285
Fax: 416-289-6843
cmha.scar@bellnet.ca

**Lawrence Avenue West Site**
700 Lawrence Avenue West, Suite 480
Toronto, ON M6A 3B4
Phone: 416-789-7957
Fax: 416-789-9079
cmha.toronto@sympatico.ca

**Brockville Mental Health Centre**
1804 Hwy 2 East, P.O. Box 1050
Brockville, ON K6V 5W7
(613) 498-1492, ext. 1500 or 1501

**Leeds, Grenville, and Lanark Mental Health Crisis Response**
1-866-281-2911 (Toll-Free) or (613) 345-4600

**Centre for Addictions and Mental Health**
CAMH operates central clinical and research facilities in Toronto and 26 locations throughout the province
www.camh.net/about_camh/contact_us/index.html

**General Mental Health Assessment**
250 College Street
Phone: (416) 535-8501 ext. 6878
3170 Lake Shore Blvd West, Suite 201
Phone: (416) 535-8501 ext. 7233

**Dr. Dorothy Cotton**
Co-Chair, Police and Mental Health Subcommittee
www.cacp.ca/index/main

**St. Leonard's Community Services of London and Region**
Paul Fernane, Clinical Director
405 Dundas Street
London, ON N6B 1V9
Phone: (519) 850-3777
www.slcs.ca
<table>
<thead>
<tr>
<th>Organization</th>
<th>Program/Support</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circles of Support and Accountability (COSA), Ottawa</td>
<td>Reintegration Program</td>
<td>Susan Love, Program Coordinator 154 Somerset St. W. Ottawa ON K2P 0H8 (613) 232-4500</td>
</tr>
<tr>
<td>Elizabeth Fry Society, Kingston</td>
<td>For more information, please visit the website at: <a href="http://www.stjohnottawa.ca/pages/cosa.html">www.stjohnottawa.ca/pages/cosa.html</a></td>
<td>Trish Crawford, Executive Director 127 Charles Street Kingston, Ont. K7K 1V8 Phone: (613) 544-1744 Fax: (613) 544-0676 <a href="http://www.cefso.ca/kingston.html">www.cefso.ca/kingston.html</a></td>
</tr>
<tr>
<td>Correctional Service Canada Regional Treatment Centre - Ontario</td>
<td>Accompaniment Support Program</td>
<td>David Champagne, RSW Veronica Felizardo, RSW</td>
</tr>
<tr>
<td>The John Howard Society of Canada</td>
<td>For more information, please visit their website at: <a href="http://www.johnhoward.ca">www.johnhoward.ca</a></td>
<td>Craig Jones, Executive Director 809 Blackburn Mews Kingston, Ontario, K7P 2N6 Phone: (613) 384.6272 Fax: (613) 384.1847</td>
</tr>
<tr>
<td>St. Lawrence Valley Correctional and Treatment Centre (494 beds)</td>
<td>Secure Treatment Unit located on site the Brockville Psychiatric Hospital Case Management Unit at the Hamilton-Wentworth Detention Centre &amp; Elgin Middlesex Detention Centre (special needs units)</td>
<td>1804 Highway 2 East Brockville, Ont. K6V 5T1 General Inquiry Phone: (613) 341-2870 Fax: (613) 341-3956 Social Worker Dept. Fax: (613) 341-2891</td>
</tr>
</tbody>
</table>
## ALBERTA

<table>
<thead>
<tr>
<th>Agency/Organization</th>
<th>Specific Program identified</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Calgary Mobile Response Team | Calgary Health Region Crisis Team Program website: www.calgaryhealthregion.ca/mh/mr t.htm | Michael Brager, Therapy Specialist Distress Crisis Line (403) 266-1605  
(Central Team) Hours 9 a.m. until 11 p.m. (Monday-Friday)  
11a.m-11p.m (Weekends/Holidays)  
Fax: (403) 297-2784  
(South Team) Hours 9:30 a.m.-9:30 p.m. (Closed Weekends/Holidays)  
Fax: (403) 943-9364  
(North Team) Hours 9:30 a.m.-9:30 p.m. (Closed Weekends/Holidays)  
Fax: (403) 944-9787 |
| Calgary Health Region Southern Alberta Forensic and Psychiatric Services | Forensic Assessment and Outpatient Service (FAOS)  
Forensic Adolescent Program (FAP)  
Community and Correctional Outreach Service  
Community Geographic Team Resources (CGT)  
Telemental-Health  
Calgary Diversion Services | For information on any of the services listed call Access Mental Health at:  
(403) 943-1500  
Director: Val Villeneuve  
Phone: (403) 944-6807  
Clinical Medical Director: Dr. Ken Hashman  
Phone: (403) 944-6810  
Location: Southern Alberta Forensic Psychiatry Centre (SAFPC)  
11333 - 85th Street NW  
www.calgaryhealthregion.ca |
| Capital Health Northern Alberta Forensic and Psychiatric Services | Acute Assessment and Treatment Centerpoint Program  
The Community Geographic Team (CGT)  
Forensic Assessment and Community Services  
Phoenix Program  
Turningpoint Program | Alberta Hospital Edmonton (Location)  
17480 - Fort Road  
Edmonton, Alberta T5J 2J7  
Phone: 780-472-5391  
Fax: 780-472-5595  
www.capitalhealth.ca |
| Mennonite Central Committee | COSA Reintegration Program  
For more information, please visit the website at: mcc.org/alberta | Phone: 403-275-6935  
Toll Free: 1-888-622-6337  
#210, 2946 - 32 Street NE  
Calgary, Alberta T1Y 6J7  
office@mccab.org |
<table>
<thead>
<tr>
<th>Agency/Organization</th>
<th>Specific Program identified</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Alberta Seventh Step Society</td>
<td><a href="http://www.albertaseventhstep.com">www.albertaseventhstep.com</a></td>
<td>Bob Alexander, Executive Director&lt;br&gt;1820 - 27th Avenue SW, Calgary, Alberta, Canada T2T 1H1&lt;br&gt;Phone: (403) 228-7778&lt;br&gt;Fax: (403) 228-7773</td>
</tr>
<tr>
<td>Calgary John Howard Society</td>
<td></td>
<td>Gord Sand, Executive Director&lt;br&gt;917 - 9th Ave SE, Calgary AB, T2G 0S5&lt;br&gt;Phone: (403) 266-4566&lt;br&gt;Fax: (403) 265-2458&lt;br&gt;www.johnhoward.calgary.ab.ca</td>
</tr>
<tr>
<td><strong>BRITISH COLOMBIA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vancouver Island Health Authority</td>
<td>Integrated Mobile Crisis Response Team (IMCRT)</td>
<td>Dr. Edward Baess, Psychologist, Emergency Mental Health Services&lt;br&gt;2334 Trent St.&lt;br&gt;Victoria BC, V8R 4Z3&lt;br&gt;Phone: (250) 370-8111 ext. 3833</td>
</tr>
<tr>
<td>VIHA Head Office</td>
<td></td>
<td>Camia Weaver, Provincial Justice Coordinator&lt;br&gt;Suite 1200 - 1111 Melville Street&lt;br&gt;Vancouver, BC V6E 3V6&lt;br&gt;Phone: (604) 688-3234&lt;br&gt;Toll Free: 1-800-555-8222&lt;br&gt;Fax: (604) 688-3236</td>
</tr>
<tr>
<td>1952 Bay Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victoria BC V8R 1J8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(250) 370-8699</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian Mental Health Association, British Columbia Division</td>
<td>Building Capacity: Mental Health and Police Project&lt;br&gt;www.cmha.bc.ca/advocacy/police</td>
<td></td>
</tr>
<tr>
<td>John Howard Society Central and South Okanagan (Kelowna)</td>
<td>Doorways – Wrap Around Service&lt;br&gt;Cardington Apartments , Fall 2008 Bedford Place, accepting referrals&lt;br&gt;www.jhscso.bc.ca/index.html</td>
<td>Jennifer L. Ingraham, Program Coordinator&lt;br&gt;Shelley Cook, Executive Director&lt;br&gt;Jennifer Hamilton, Team Leader&lt;br&gt;Bedford Place&lt;br&gt;211-1433 St. Paul St.&lt;br&gt;Kelowna BC V1Y 2E4&lt;br&gt;Phone: (250) 763-1331&lt;br&gt;<a href="mailto:jhscso@uniserve.com">jhscso@uniserve.com</a></td>
</tr>
</tbody>
</table>
John Howard Society-Thompson Region (Kamloops)

Victory Inn

Dawn Hrycun, Executive Director
312-141 Victoria Street
Kamloops, BC V2C 1Z5
Phone: (250) 374-3844
Fax: (250) 374-3842

Motivation, Power and Achievement Society

Court and In-reach Workers

www.mpa-society.org

Administration Offices for Licensed Care/Supported Housing/Independent Living/Court Advocacy
122 Powell Street
Vancouver, BC V6A 1G1
Phone: (604) 482-3700
info@mpa-society.org

Mental Health Empowerment Advocate Program
1733 West 4th Avenue
Vancouver, BC V6J 1M2
Phone: (604) 482-3700
mheap@mpa-society.org

Community Resource Centre
1731 West 4th Avenue
Vancouver, BC V6J 1M2
Phone: (604) 482-3700
mheap@mpa-society.org

RCMP, Lower Mainland Division

Crisis Intervention Team (CIT)

Constable Lara Davidsen
Crisis Intervention Team Trainer
Lower Mainland District Office
12992 76 Avenue
Surrey BC V3W 2V6

Correctional Service Canada
Community Mental Health Initiative, Pacific Region

www.csc-scc.gc.ca

Ms. Karen Sloat, Regional Coordinator
Vancouver BC V6B 1K9

St. Leonard's Society of North Vancouver

Vancouver Interior Health Authority

Enhanced skills training approach

Rivian Weinerman, MD FRCPC
Site Chief Psychiatry, Victoria
641-2334 Trent Street
Victoria BC, V8R 4Z3
<table>
<thead>
<tr>
<th>Organization</th>
<th>Website/Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government of British Columbia</td>
<td>Community Courts Initiative, Downtown Community Court, Allan Shoom, Manager (604) 660-3060, Fax (604) 660-3066, Suite 300 - 21 Water Street, Vancouver BC V8W 1A1</td>
</tr>
<tr>
<td>John Howard Society – Lower Mainland of BC</td>
<td><a href="http://www.jhslmbc.ca">www.jhslmbc.ca</a>, Tim Veresh, Executive Director (604) 872-5651, Fax (604) 872-8737, 763 Kingsway, Vancouver, BC V5V 3C2</td>
</tr>
<tr>
<td>Interior Health, Kelowna Alcohol and Drug Services</td>
<td>Mon 8:30am-4:30pm, Jamie Marshall, Supervisor, 540 Groves Ave, #100, Kelowna, BC V1Y 4N7, Phone: (250) 870-5777, Fax: (250) 870-5774</td>
</tr>
<tr>
<td>Minister of Public Safety and Solicitor General, British Columbia Corrections Branch</td>
<td>Vancouver Intensive Supervision Unit (VSU), 391 Powell Street, Vancouver BC V6A 1G5, Phone: (604) 660-1946, Fax: (604) 660-1973, Mailing Address: 275 E. Cordova Street, Vancouver, British Columbia V6A 3W3</td>
</tr>
<tr>
<td>Stand up for Mental Health, Vancouver, British Columbia</td>
<td><a href="http://www.standupformentalhealth.com">www.standupformentalhealth.com</a>, David Granirer, Founder, Counsellor, Stand Up Comic, Phone: (604) 205-9242, <a href="mailto:david@standupformentalhealth.com">david@standupformentalhealth.com</a></td>
</tr>
<tr>
<td>In Toronto, Stand Up For Mental Health is given through the Mood Disorders Association of Ontario</td>
<td>36 Eglinton Ave. West, Suite 602, Toronto, ON M4R 1A1, Phone: (416) 486-8046 or 1-888-486-8236, Fax: (416) 486-8127</td>
</tr>
<tr>
<td>In Ottawa, Stand Up For Mental Health is partnered with Psychiatric Survivors of Ottawa</td>
<td>211 Bronson Ave., Suite 313, Ottawa, ON K1R 6H5, Phone: (613) 567-4379, Fax: (613) 567-4495</td>
</tr>
</tbody>
</table>