CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO WINTER 2009

network

Forensic Mental Health

Pathways to Justice for the Mentally Disordered Accused

network
Winter 2009
VOL. 24 NO. 2

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CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO
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OUR MISSION
Working on behalf of, and with our branches, CMHA Ontario promotes mental health and advances excellence in the delivery of mental health services through knowledge transfer, policy development, advocacy and the inclusion of consumers and family members in decision-making.

Network magazine is published 2 times each year.

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Printed in Canada ISSN 1181-7976

Ontario

The financial support of the Ontario Ministry of Health and Long-Term Care is gratefully acknowledged.

Re: Cover

Ruth Castledine, *3:00 A.M.* (2007, oil on canvas).

Reproduced by permission. This work appeared in the Touched by Fire art exhibit at the Gladstone Hotel in Toronto.

Mad or Bad

Reflections on the Mental Health System's Responsibilities to Mentally Disordered Offenders

Steve Lurie, BA, MSW, MMgt

Canada's crime rate peaked in 1991 and has been generally falling ever since. According to the most recent annual report from the Canadian Centre for Justice Statistics, in 2007 the "national crime rate reached its lowest point in 30 years. Canadian police services reported a 7% decline in crime, the third consecutive annual decrease."

In 1992, amendments to the Criminal Code changed the insanity defense in court from "not guilty by reason of insanity" to "not criminally responsible." Before then, the term *forensic patient* generally applied to persons living with mental illness who had committed serious criminal offences; but nowadays, at least a third of forensic patients have committed non-violent offences. Psychiatric hospitals in many provinces report exponential increases in the number of mentally disordered offenders under their supervision. That being said, forensic programs serve fewer than 15 percent of people with mental illness who are before the courts.

Between 2001 and 2002, the number of clients with mental disorders who appeared before the Toronto courts rose from 1,800 to 2,361 — a 31 percent increase. In 2004, 39 percent of these cases involved Class 1 offences [crimes considered the least serious]; 42 percent, Class 2 offences; and 17 percent, Class 3. Most of these clients were therefore served primarily by the justice system and not by the mental health system.

Far too many of these clients are considered "forensic" clients by mental health service providers who then argue that they are unable to provide services because they cannot manage the risk. The justice system sees these clients as mentally disordered offenders, some of whom are difficult to manage in corrections settings. Those offenders who cannot be managed in the general jail population are sent to special-needs units in Ontario jails, which are designed for people with medical rather than psychiatric problems. Officials with the Ontario Ministry of Community Safety and Correctional Services estimate that on any given day there are 300–400 people in Toronto-area jails with mental health problems — enough to fill a psychiatric hospital.

What is happening? Why is it that while the crime rate appears to be declining, the need to provide services to mentally ill offenders in the mental health and justice systems is increasing? Some argue that these problems are a result of deinstitutionalization. This may be one of those public-policy myths that gain currency despite facts to the contrary. In Canada, a majority of psychiatric beds were closed between 1959 and 1969. Why would it take 40 years for us to notice the problem?

A more plausible explanation would be that despite the rhetoric of mental health reform we have failed to develop a sufficient supply of community mental health services, in combination with changes to the Criminal Code that have resulted in higher numbers of low-risk mentally ill offenders being directed to mental health services for assessment and treatment by the justice system.

Data from studies and clinical experience here in the Toronto area would seem to support this explanation. In 2002, the Health Systems Research and Consulting Unit at the Centre for Addiction and Mental Health (CAMH) conducted a study of in-patients and outpatients receiving mental health services in Toronto and Peel regions, including clients in the Toronto court support programs. Their study showed that 47 percent of court-support clients needed contact with community mental health services at least weekly — and only 2 percent were receiving it. A study by the CAMH unit on Ontario-wide community mental health needs showed

Why is it that while the crime rate appears to be declining, the need to provide services to mentally ill offenders in the mental health and justice systems is increasing?

that more than half of clients were receiving less care than they needed. Data from CMHA Toronto's case management program, which provides services to people on community treatment orders, showed that 80 percent of clients had never before been connected to a community mental health service. One-third had previous involvement with the criminal justice system.

Data from the 2002 study on Toronto court support services showed that 70 percent of clients who required fitness assessments were found fit to stand trial. This would suggest that the justice system may have been using fitness assessments as a way to get mentally disordered offenders into treatment. Data from our Scarborough court support program shows that access to outpatient psychiatric treatment and community mental health services (which includes housing) dramatically reduces the demand for fitness assessments while increasing bail orders, diversion orders and probation orders. Data from a mental health court outcome study in St. John, New Brunswick shows that 19 of 25 clients avoided jail and a criminal record, while 14 of 22 clients in a comparison group who went through the regular court system were incarcerated and received a criminal record. Moreover, the mental health court group had more access to mental health services.

Although there are problems of access to mental health services in the community, there are also problems providing mental health services within provincial and federal corrections. In 1997 Ontario recognized that there was a need to bring government ministries and community services together and began to establish Human Service and Justice Coordinating Committees in local communities. These committees focused on points of intersection between the mental health and justice systems; guided investments by the Ministry of Health and Long-Term Care (MOHLTC); and looked at ways of improving coordination between the two systems, including information-sharing and training. Unfortunately, inter-ministerial oversight and cooperation evaporated at Queen's Park, and by 2003 many of the local groups had stopped meeting.

However, in some parts of the province police services began to look at the effects that having to deal with mentally disordered offenders was having on their communities. The London Police Service and colleagues from the mental health and justice systems reviewed their statistics from 1998 to 2001. During this period criminal charges for people with mental illness doubled, and 57 percent went to jail. Only 11 percent of people were diverted, of whom a quarter had another contact with the police within four days. These findings and others convinced people that something had to be done. When the issues were raised with Premier McGuinty, who visited London during the 2003 campaign, he promised that if elected his government would do something about this problem.

In the summer of 2004, the MOHLTC announced funding for local mental health and justice committees across the province; in January 2005, the ministers of Community Safety and Health jointly announced funding to enhance services for people living with mental illness who are involved with the justice system. This funding represents a strategic investment to help people access community mental-health services and reduce pressures on correctional services. The funding includes pre-charge diversion, crisis response, safe beds, expanded court support programs, case management and supportive housing. These programs are now being implemented across the province.

In 2005, the MOHLTC funded the Health Systems Research and Consulting Unit at CAMH to evaluate the effects of these investments. As a result, the four-year Systems Enhancement Evaluation Initiative (SEEI) project was developed. SEEI includes nine research studies from around the province and the establishment of a provincial mental health and addictions knowledge exchange network. Final results from the SEEI studies are now starting to be published.

Ontario's response marks a promising start to collaboration between the justice and mental health systems. More needs to be done: ensuring access to psychiatrists remains a challenge, and development of an evidence base to track what is working and what doesn't is necessary. Creating capacity to better meet the needs of people with mental illness who also have substance-use issues or developmental delays requires more planning and funding. The development of links with federal corrections and more mental health courts across the country are also required.

Mental health and justice issues are finally on the agenda. Let's hope this interest can be sustained while we avoid the Law of Inverse Relevance, which states that "The more we talk about something, the less we intend to do about it."

Steve Lurie is executive director of the Toronto Branch of the Canadian Mental Health Association, chair of the Toronto Human Services and Justice Coordinating Committee, and chair of the Service System Advisory Committee for the Mental Health Commission of Canada.

An earlier version of this article appeared in the Canadian Criminal Justice Association's Justice Report *20, no. 4 (Fall 2005): 7-9.*

By
Pam Lahey

JAILHOUSE Lottery

BRENT IS A FREQUENT FLYER. BUT HE DOESN'T TRADE REWARD MILES TO BOARD A PLANE TO PARIS OR MONTEGO BAY. INSTEAD, HE TRADES HIS FREEDOM TO DO "DEAD TIME" IN A CRAMPED AND STERILE CELL.

Now 37, Brent has been in and out of correctional facilities since he was 16. Although he was hospitalized with mental health issues when he was just seven years old, it took almost three decades and multiple incarcerations before his schizophrenia was diagnosed and treatment was begun. For Brent and many other offenders who have a serious mental illness, jail has become a second home — and without the appropriate mental health services during incarceration, an endless cycle of reoffending is difficult to break. Brent believes what is needed to keep repeat offenders out of jail is prompt assessment upon admission, access to a psychiatrist within the first days of incarceration, and ongoing observation and evaluation of the offender's mental health condition. "I know that sounds impossible because of the number of people offending and re-offending, but that is what I think would work."

Judging from the stories of Brent and others who struggle with mental health issues while in jail, getting this assistance while incarcerated is a bit like winning the lottery: it's one part persistence and one part luck.

Brent's vision of a responsive and universal mental health system in Ontario's correctional facilities is echoed in a 1997 policy blueprint called *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario*, developed by the Human Services and Justice Coordination Committee. The committee was a cooperative effort among the ministries of the Attorney General, Health and Long-Term Care, Community and Social Services, and what is now Community Safety and Correctional Services. The blueprint sets out a strategy to guide operational and policy initiatives for persons with mental illness who come into contact with the law — what the ministries describe as their "common forensic client." For the strategy to be successful all four ministries must work together to provide a coordinated and seamless system of care for offenders, from arrest to discharge.

According to Greg Brown, associate professor of criminal justice and sociology at Nipissing University, the goal of the strategy is "to identify offenders with serious mental health issues who keep coming back into the system and not getting the services they really need to break the cycle."

But whether or not this system of care works the way it was envisioned seems to depend on where the offender does his or her prison time.

Every inmate escorted into an Ontario correctional facility is given a mental health assessment as part of an overall health evaluation. The accused awaiting trial or the offender awaiting sentencing is transferred to a detention or remand centre, regardless of the severity of the crime. When mental health screening tools identify a problem, the person is placed in a mental health unit, if one exists in the facility.

If the centre doesn't have a special unit — and most remand centres do not — the individual is given medication and remains with the other inmates. Or sometimes a mental health problem gets missed and the inmate gets streamed into the general population. Either way, his or her chances of being victimized by other inmates are greatly increased.

This was the experience of Martin, an offender with a mental illness who is currently in the Algoma Treatment and Remand Centre. "The questions seemed like they were flying by in a blur," recalls Martin of his initial assessment. "It was hard to concentrate. The next thing I know, I was placed in a cell with 20 others. I felt so small — I thought they all knew how scared I was."

Brent shares a similar experience: "They put you on a unit with 25 other guys and if you do well, you do well, and if you don't, you don't." According to Brent, those suffering acute symptoms do the worst. "If someone is experiencing a psychotic episode and is not in the right frame of mind," he explains, "… someone beats someone's face in. The guards just take out the guy who got their face beat in and lock everyone else down."

Stuart McGetrick, senior coordinator of the Communications Branch of the Ministry of Community Safety and Correctional Services, indicates that "resources specific to mental health care vary among institutions, depending on such factors as the size of the institution and the needs of the offender population." But if the offender is lucky enough to get housed in one of only four correctional treatment centres in Ontario (such as the Vanier Centre for Women in Milton) or a detention centre that has a special mental health unit, they may just hit the jackpot.

Although "special needs" offenders (a label given to inmates with serious mental health issues) at Vanier do sometimes get misdirected to the general population — as often as a couple of times a week — it soon gets corrected. "They [special needs offenders] get found out pretty quickly because they can't function. Officers are very good at identifying them and telling us," explains Patricia, a correctional officer with the Intensive Management and Assertive Treatment (IMAT) Unit at Vanier.

Offenders' days at the Vanier Centre are structured around programs. IMAT nurses do three programs a week, psychologists run groups, and the social worker does one-on-one counselling. In addition, Patricia adds, "the correctional officers are very involved with their offenders."

The offender population has grown significantly since 1997, outstripping the capacity of the system to provide timely and adequate services. Because of this, offenders are spending more and more time in remand centres and not getting the treatment they need.

So, incarceration can be a double-edged sword. On the one hand, research shows that the correctional culture can aggravate a pre-existing condition, and make recovery and a successful transition back into the community more challenging. But it can also sometimes provide access to mental health services that can make a positive difference.

Lance's story illustrates this tension. Now 40, Lance has offended at least 20 times since the age of 15. "I was always quite depressed as a child," he says, "and when I was [in the system], I was sexually abused by another inmate and I got really suicidal and when I was in the segregation unit they sent me to the regional treatment centre." Lance's mental illness was finally diagnosed 18 months ago while he was serving time in a provincial treatment centre.

Unfortunately, the offender population has grown significantly since 1997, outstripping the capacity of the system to provide timely and adequate services. Because of this, offenders are spending more and more time in remand centres and not getting the treatment they need. In fact, in 2007/2008 admissions to remand centres accounted for 83 percent of all admissions to provincial correctional facilities.

Remand centres are a bit like a hotel, asserts Greg Brown, with each inmate "in and out real fast. So to get any sort of assessment done or even get a handle on the fact that this individual has difficulties is very difficult to do." Couple this with another trend that Brown has observed — the increasing number of people with mental illnesses who are ending up in the correctional system — and the result is that many inmates with mental illnesses do not get the specialized care they need. Medication is still the first, and often the only, course of treatment for special needs offenders serving time in detention centres.

As an offender with schizophrenia, Brent knows this all too well. For the majority of his time behind bars he did not receive the specialized services he needed. "There is nothing there," explains Brent, "you are just put on the unit with murderers and armed robbers and gangs. You are just thrown in. You are not assessed, you are not asked any important questions. And when you see the doctor it is because *you* want to see the doctor, not because the doctor wants to see you!" The only treatment Brent received each time he was incarcerated were half-hour visits with the doctor, medication and brief exchanges with his psychiatrist: "Is the medication working? We'll continue the medication. Hang tight."

While many offenders have symptoms of depression and anxiety, explains Greg Brown, and about 80 percent* have substance abuse issues, roughly 15 percent of offenders with serious mental illnesses experience a level of psychosis or depression that cannot be handled effectively in a correctional setting — at least not in many of the existing facilities. If detention centres continue to house people with serious mental illnesses and for longer periods of time, it becomes much more critical that short-term inmates who serve their entire sentence at a detention centre get timely access to adequate mental health services.

Sonia Dalpra, a nurse with Hamilton–Wentworth Detention Centre, explains the shortage of mental health programming: "Intensive therapy programs, defined as 15 weeks or longer, are not offered," she says, "because the average stay is not long enough and because the focus is not on rehabilitation. Providing intensive therapy programs at a remand centre is an unrealistic expectation, since offenders are going through the court process and are therefore often absent from the institution. Once their matters are decided, they are either classified to a corrections facility or released from custody. The psychiatric case management unit attempts to provide links to community services and we work very closely with CMHA to this end. Remand centres are short-term, usually."

However, she adds, "Core programming (approximately five sessions) is offered at the detention centre, and specific life skills programs are currently being offered to our special needs psychiatric population on a weekly basis by CMHA staff. The programs are short — one hour usually."

FOOTNOTE

*The 80 percent figure arises from the findings in Professor Brown's as yet unpublished prevalence study. According to Stuart McGetrick, who works in the Ministry of Community Safety and Correctional Services, Communications Branch, MCSCS figures "indicate that in 2007/2008, 34 percent of admissions to the adult institutions had an alert(s) identifying a substance abuse concern, and based on an institutional snapshot from November 8, 2008, 36 percent of the population that day had an alert(s) identifying a substance abuse concern."

fast FACTS

72.6

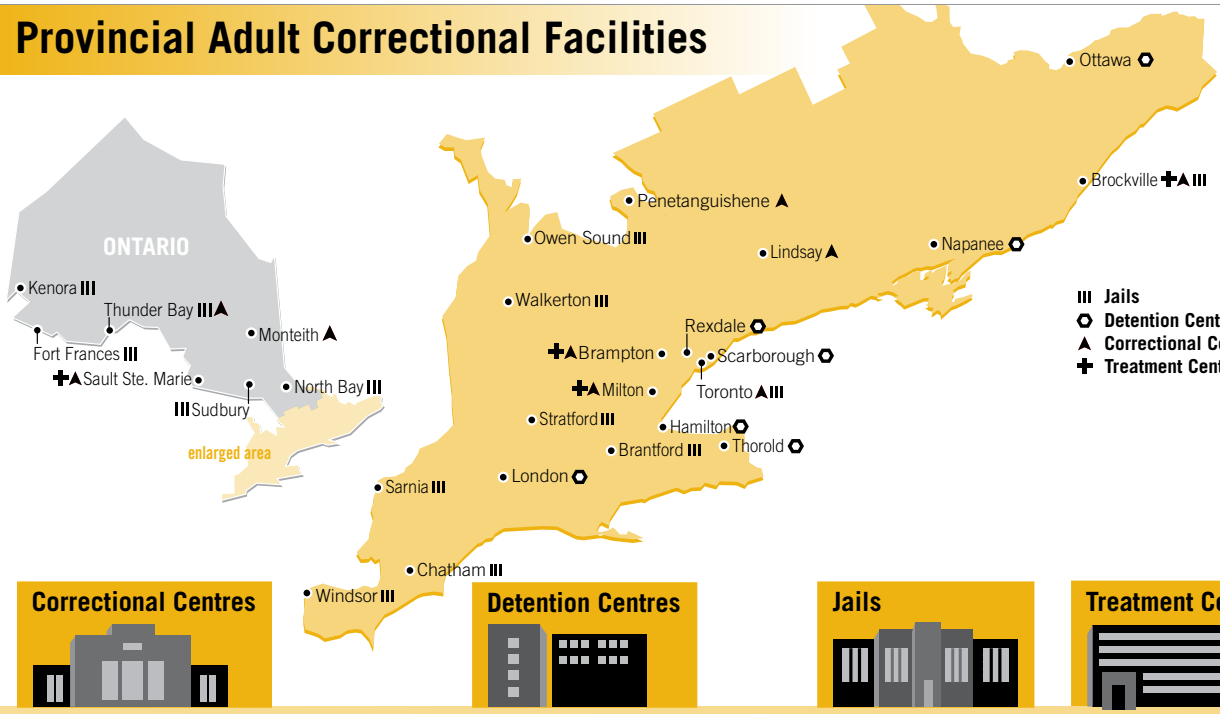
Average length, in days, of sentences under two years that were spent in provincial custody in 2000–2001 for adult men.

49.8

Average length, in days, of sentences under two years that were spent in provincial custody in 2000–2001 for adult women.

(Source: Ministry of Community Safety and Correctional Services)

Provincial Adult Correctional Facilities



Correctional Centres

- Algoma Treatment and Remand Centre, **Sault Ste. Marie** *(104 beds)*
- Central East CC, **Lindsay** *(1,184 beds)*
- Central North CC, **Penetanguishene** *(1,184 beds)*
- Maplehurst Correctional Complex, **Milton** *(1,550 beds)*
- Mimico CC, **Toronto** *(457 beds)*
- Monteith Correctional Complex, **Monteith** *(232 beds)*
- Ontario Correctional Institute, **Brampton** *(228 beds)*
- St. Lawrence Valley Correctional and Treatment Centre, **Brockville** *(494 beds)*
- Thunder Bay CC, **Thunder Bay** *(132 beds)*
- Vanier Centre for Women, **Milton** *(124 beds)*

Detention Centres

- Elgin-Middlesex DC, **London** *(450 beds)*
- Hamilton-Wentworth DC, **Hamilton** *(414 beds)*
- Niagara DC, **Thorold** *(260 beds)*
- Ottawa-Carleton DC, **Ottawa** *(326 beds)*
- Quinte DC, **Napanee** *(228 beds)*
- Toronto East DC, **Scarborough** *(453 beds)*
- Toronto West DC, **Rexdale** *(631 beds)*

Jails

- **Brantford** Jail *(90 beds)*
- **Brockville** Jail *(44 beds)*
- **Chatham** Jail *(53 beds)*
- **Fort Frances** Jail *(23 beds)*
- **Kenora** Jail *(105 beds)*
- **North Bay** Jail *(121 beds)*
- **Owen Sound** Jail *(52 beds)*
- **Sarnia** Jail *(101 beds)*
- **Stratford** Jail *(53 beds)*
- **Sudbury** Jail *(185 beds)*
- **Thunder Bay** Jail *(132 beds)*
- **Toronto** Jail *(561 beds)*
- **Walkerton** Jail *(53 beds)*
- **Windsor** Jail *(140 beds)*

Treatment Centres

- Algoma Treatment and Remand Centre, **Sault Ste. Marie** *(104 beds)*
- Ontario Correctional Institute, **Brampton** *(228 beds)*
- St. Lawrence Valley Correctional and Treatment Centre, **Brockville** *(494 beds)*
- Vanier Centre for Women, **Milton** *(124 beds)*

Source: Ministry of Community Safety and Correctional Services, www.mcscs.jus.gov.on.ca

ILLUSTRATION BY ROSE ZGODZINSKI

The fundamental tension between control and rehabilitation services is at the root of the problem. Couple this with competing mandates from various ministries and you get inmates that need mental health treatment and correctional staff whose primary role is to maintain order.

Despite the concerns from staff and inmates about overcrowding and understaffing, asserts Brown, non-existent or severely limited mental health programming is not simply an issue of capacity. The Nipissing University professor recently conducted the first and only study of prevalence rates and mental health needs of offenders with serious mental illnesses in the provincial correctional system. He echoes Dalpra when he explains that it is not the first priority of corrections to provide mental health services. "It comes down to an issue of whose responsibility it is," he says, "because corrections' primary mandate — [despite the existence of] specialized units — is not mental health."

Is it possible, then, for all special needs immates to get the mental health services they require? The answer goes back to the Human Services and Justice Coordination Committee's provincial strategy document and the need for coordination across ministries. In his report to the Ministry of Community Safety and Correctional Services, Brown recommends that what is needed is "a seamless system where corrections and the health care system work together a little bit better."

There are already some examples of this successful collaboration in the province. The St. Lawrence Valley Correctional and Treatment Centre in Brockville combines a psychiatric hospital with a correctional facility to offer a seamless system of care. The centre, a 100-bed unit within the correctional facility, is staffed by mental health professionals from the Royal Ottawa Hospital. There are no correctional officers on the floor; it is staffed by nurses, psychiatrists and social workers. The only time a correctional officer is seen is when staff on the floor request assistance to address a security issue. "It is a unique kind of facility," says Brown, "a demonstration that if corrections and health care work together, it is a better solution."

As well, the Ministry of Community Safety and Correctional Services is working in collaboration with the Ministry of Health and Long-Term Care to continue to implement and monitor the service enhancement strategy announced in 2005, "Keeping Persons with Mental Illness Out of the Criminal Justice and Correctional System."

Lance credits the attention he received in the treatment centre at the Brockville institution for his improved mental health. "I would see the psychiatrist once a week," he says, "and I did all kinds of

groups from anger management and stress management to yoga and life skills groups. In the regular jails you have to wait a month or two to see the psychiatrist and you have the guards down your throat."

Martin's experience is different. He has been in the Algoma Treatment and Remand Centre for the past five and a half months, and lacks access to the range of mental health services that Lance has. The centre has medical services but no unit specifically providing treatment for inmates with mental illnesses, which reinforces McGetrick's admission that mental health resources vary a great deal from institution to institution.

Compassionate and timely mental health services are essential in a system that, by its very nature, can aggravate a mental illness. Based on his experience, Martin would like to see a system of care like the one proposed in the provincial strategy, including a better way to keep track of inmates with mental illnesses, in order to provide continuity of care from the moment they step inside a correctional facility. "When people with mental illness are identified and [their illness] diagnosed, they should keep a file indefinitely," Martin says, "and when they are admitted and everything is punched into the computer, they would know this guy has a mental illness and then he could be dealt with more appropriately. This should be something that is available to everyone who has a mental illness and is in and out of jail frequently."

But for those mentally ill offenders that win the jailhouse lottery by serving time in a correctional facility with a mental health unit, their chances of exiting a life of crime are greatly improved. "I am trying to take advantage of the mental health resources that are available to me," Lance says, showing a determination and hope not felt in a long time. "It is not easy, but I'm going to make it."

Pam Lahey is a community mental health analyst at CMHA Ontario.

Q&A

Network interviewed Stuart McGetrick, Senior Coordinator, Communications Branch, Ministry of Community Safety and Correctional Services.

Q: Does the Ministry of Community Safety and Correctional Services have a mental health strategy?
A: Correctional services is committed to the fair and compassionate treatment of all those in our custody, including those with signs or a diagnosis of mental illness.

The ministry works closely with its community partners and community mental health resources to provide care during incarceration and to provide a safe transition to the community.

Q: Are mental health assessments a mandatory procedure in all offender admissions?
A: A comprehensive health-care assessment is completed upon inmate admission by MCSCS nursing staff. The individual's mental status and mental health history is explored during this assessment. Additionally, there are mandatory suicide screening procedures in place for all newly admitted persons.

Q: Are these assessments adequate?
A: In most cases, the assessment completed during intake is adequate. However, if the nurse completing the initial health-care assessment is alerted to the need for further assessment, appropriate referral is made to the physician, psychologist, psychiatrist or mental health nurse.

Q: Do all Ontario correctional facilities have a mental health team?
A: All facilities are staffed with registered nurses and contract the services of a physician. Institutions also have access to specialist mental health professionals, including psychologists and psychiatrists. As well, some facilities have a special needs unit designated for the placement of offenders with mental health needs. Resources specific to mental health care vary among institutions depending on such factors as the size of the institution and the needs of the offender population.

Q: Are special needs offenders housed with the general prison population?
A: Some special needs offenders may be housed in the general population if they are stable and demonstrate the ability to function within the designated unit.

Q: What percentage of offenders identify at intake with a mental health disorder?
A: These statistics are not available.

Q: How does treatment by mental health services benefit the offender while they are incarcerated?
A: Frequently, offenders with mental illness may be experiencing an exacerbation of their illness. Incarceration offers access to health care and appropriate therapeutic intervention (e.g., access to psychiatric services, medication, etc.), which may help the individual stabilize.

Q: Does involvement in mental health services get counted in an earned remission program?
A: No, it does not.

Q: Does the overcrowding and lack of mental health staff result in delays in making proper assessments, diagnoses, or treatment plans?
A: Correctional Services is committed to the fair and compassionate treatment of inmates in our institutions, including those with signs or a diagnosis of mental illness. To that end, all of our inmates have access to appropriate health care.

As well, the Ontario government has invested $50 million since 2004/2005 in service enhancements to keep people with mental illness out of the criminal justice system.

This investment has expanded the continuum of services such as crisis teams, safe beds, mental health court workers, case managers and supportive housing to prevent, when possible, people with mental illness from being charged with criminal offences and/or supporting their diversion to other services whenever possible.

By Elizabeth Lines, with files from Jennifer McVittie

Striking a Fine BALANCE

In our province, the interface between the mental health and criminal justice systems is the Ontario Review Board. The ORB system was established under the Criminal Code of Canada as the government's attempt to strike a balance between society's need for safety and the liberty rights and rehabilitation needs of the individual.

This role comes into play when a person with a serious mental illness is charged with committing a criminal offence but is found by the court to be either not criminally responsible (NCR) or unfit to stand trial (Unfit) on account of their mental disorder. A finding of NCR is based on the legal principle that people cannot be held accountable or punished for a criminal offence if, at the time, they could not appreciate the nature, quality or wrongness of their actions. A finding of Unfit means they are considered unable to participate in their own legal defence at trial. Simply having a mental disorder, however, does not make a person unfit to stand trial.

If a doctor assessing someone's Unfit status decides that treatment could, within 60 days or so, bring this person to a condition of fitness to stand trial, the court will order the treatment to take place. Mental disorders serious enough to render someone Unfit generally do not respond to treatment so quickly; make fit orders (also known as treatment orders) are therefore unusual events. If the follow-up assessment confirms the doctor's prediction, this individual goes on to trial; if not, the person under arrest — termed the accused — is referred to the ORB. But in most cases, whenever an assessment determines an arrested person to be NCR or Unfit, the case goes into the ORB system more directly.

The ORB operates across the province in five-member panels composed of judges, lawyers, psychiatrists, psychologists and public members appointed by an order-in-council. Ultimately, like the courts, the ORB is responsible for decisions that govern the individual's freedom of movement and related personal liberties. But unlike the criminal justice system, the ORB's decisions are oriented toward rehabilitation and reintegration rather than punishment. And unlike court-imposed sentences, under the ORB system there is no set date for release. A person generally remains under ORB authority until they are either found fit to stand trial or,

in the case of someone ruled NCR, are granted an absolute discharge. Any appeals of ORB decisions go directly to the Ontario Court of Appeal.

The types of crimes committed by those who come under ORB jurisdiction span the whole spectrum, but according to Dr. Derek Pallandi, a forensic psychiatrist at the Centre for Addiction and Mental Health (CAMH) and a member of the ORB, most of the crimes committed are either property offences or involve low-grade violence. "Counter to some common misperceptions, there is only a small percentage of accused who are charged with more serious crimes like manslaughter or sexual offences. By and large, most of the offences are simple assaults or relatively lower grades of assault with a weapon."

It is often at the first assessment by a psychiatrist or clinical psychologist, prior to referral to the ORB, that a person can enlist the help of an advocate from the Psychiatric Patient Advocate Office. The PPAO has an office at 11 psychiatric hospitals in the province. "The advocate might make sure they [accused persons with a mental illness] have a lawyer, make sure they apply for legal aid," says Linda Carey, PPAO's manager of rights advice services. "Also, sometimes [advocates] need to explain what's going on, because it's often a very scary process and the person may not have received a very good explanation as to what's happening."

Once someone is referred to the ORB, there is an initial hearing within 90 days. (If the court has left the decision to the ORB as to where the accused should go in the longer term, the initial hearing will take place within 45 days of the referral.) As for evidence, Pallandi explains, "Often, for that initial hearing where the person has been found NCR, they will have the report written by the psychiatrist, they might have some other hospital records, a person's criminal record, all the documentation that relates to their arrest and conviction, and maybe a court transcript. And the Board will make an initial disposition [a binding decision] based on that information alone, without really any verbal evidence from anybody."

In the case of a person found NCR, the ORB has three disposition options: an absolute discharge, a conditional discharge, or a detention order. For those found Unfit, there are only two disposition options: a detention order or a conditional discharge. A person found unfit to stand trial cannot receive an absolute discharge. Rather, they remain under ORB jurisdiction until they are found fit to stand trial and then are returned to the court system. All persons under the jurisdiction of the ORB are entitled to an annual hearing to review their case. All ORB hearings are open to the public, although the ORB has the option to exclude people if greater privacy is thought to be in the best interest of the accused.

According to Dr. Gary Chaimowitz, head of forensic psychiatry services at St. Joseph's Healthcare in Hamilton and also an ORB member, "The first issue in considering a disposition is to determine whether the person is a significant risk to the safety of the public. The ORB considers that, every time. And if the person is NCR and is not a significant risk to the safety of the public, they are granted an absolute discharge, which is like being found not guilty in the courtroom. The patient is able to essentially walk away, free from any legal encumbrances that the Board could have imposed. So even at initial hearings, people sometimes are not considered significant risks to the safety of the public and are released."

But just what constitutes a significant risk or threat to the public's safety? The concept was clarified in 1999 through a legal decision of the Supreme Court known as the Winko decision. It defines a "significant threat" as a foreseeable likelihood of further criminal acts that may do physical or psychological harm to anyone; moreover, the potential harm has to be too serious to be overlooked. As a result of the Winko decision, the rate of absolute discharges has increased; since that time, if the ORB has doubts about threat significance, it must now grant the accused person an absolute discharge rather than opt for uncertainty leading to prolonged ORB involvement.

> "One of the common things I hear is, 'Why don't we send this person to the forensic system?' But it's not like checking into a hotel! A person enters the system for a very particular reason, based on a finding in a criminal court."
>
> Dr. Derek Pallandi, Centre for Addiction and Mental Health

However, where the person *is* seen to pose a significant threat to the community, the ORB has two options: to grant a conditional discharge, or to issue a detention order. The latter usually means full-time detention under a specified level of security (minimum, medium or maximum security) in a hospital setting at one of the forensic mental health units in the province. "The Board has to balance any potential risk to the community or the public and the rehabilitative needs of the patients," says Chaimowitz, "but when there are options, it's always the least restrictive one that will be chosen" by the ORB.

"So the initial hearing essentially sets the frame for the patient and, if it's a detention order, gives us a sense of whether they are going to be in a maximum, minimum or medium secure environment for the following year," he explains. "It also guides the determination of privileges that might be granted." Privileges generally represent opportunities for greater freedom of movement, such as an increased opportunity to leave the hospital building or grounds. They pave the way for reintegration into the community.

It is also possible that the disposition might stipulate that certain privileges be granted only in the company of an "approved person." Pallandi explains

that family, friends and others can apply to be designated as such, and stresses that this unique element of the ORB system can aid in a person's rehabilitation and reintegration. "As the person gains privileges to enter the community and even has passes or lives in the community, the thing that family members, or friends, or anyone who's involved can do is step forward and become an approved person. This can be a big part of building a support network in the community."

Privileges and the role of approved persons also apply in the context of conditional discharges. A conditional discharge is generally granted in a situation where the person does not need to be hospitalized. "So these are people who can live in the community and their residence does not need to be approved. Basically, their choice of residence is not viewed as a risk issue," says Chaimowitz. "But," adds Carey, "almost all of the community-located clients are still tied to a hospital. So, for example, their annual review would still be held at the hospital. And they would still access our PPAO services. So if someone has community-living privileges and has a hearing coming up, they may see us to get a legal aid application done, contact a lawyer, or seek other assistance, because they're still technically tied to the hospital — even though they're living in the community."

Annual review hearings are typically held at the hospital where the person is detained or required to report. Again, in its review of the current disposition, the ORB takes into consideration the "need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused" (ORB Annual Report 2005/2006). But unlike an initial hearing, these subsequent reviews are less restricted and able to draw upon a more extensive base of evidence.

Pallandi offers a description of the types of evidence presented. "If the person has been treated by a team or a psychiatrist for the year, then there will be a report of that information as part of an annual report, as well as 'live' evidence from the attending psychiatrist. There may be a formal risk assessment process to help determine degree of risk to the community, along with social-work reports, psychology reports — any host of formal information. There can also be information gathered from the community, such as letters of reference from people who provide employment or housing to our people who live in the community. So in the end you try to synthesize all of the information to create a reasonably comprehensive report that you present to the Board on an annual basis.

"We've had some fairly good experiences because we've been able to treat and to improve the mental health of many of the people who are coming to [the Ontario Review Board]. So families who've been more watchful from the sidelines have been able to re-engage with their loved ones. Dr. Gary Chaimowitz, St. Joseph's Healthcare

"Then," he continues, "in terms of hearing process, the attending psychiatrist provides an overall update regarding the person's progress since they were last reviewed, and most importantly, answers questions of the Board, of the accused person's lawyer, and of the Attorney General's representative (the Crown Attorney). The Board has independent powers of inquiry, and they can put questions to the person, as well as to the psychiatrist, about how the person is doing or what accounts for different findings of progress, or lack of progress for that matter."

Also, revisions to the Criminal Code in 2006 now invite victim impact statements to be submitted from any person adversely affected by the offence at any ORB hearing where discharge is a possibility. Carey has concerns about this. "The ORB is supposed to be deciding if a person is a risk to society now and whether or not a person's illness is under control or has abated. But it shouldn't be deciding punishment. And victim impact statements are more related to punishment than anything else."

With rehabilitation and reintegration as key objectives of the ORB system, access to comprehensive treatment is an integral component of the system. "It is a system where you get a platinum card for accessing mental health care," says Chaimowitz. "Once you are in the forensic system, you're pretty much guaranteed to get full-service psychiatric treatment. And the forensic system has the ability to stay involved with a patient through thick and thin, no matter what. So a patient can't fire the forensic service; the only way to get out of the system is by an absolute discharge."

Although the court can issue a make fit order, the ORB cannot order mandatory treatment as long as a person is deemed capable of making their own treatment decisions. It can, however, use compliance with treatment as a requirement for keeping or increasing freedom privileges if treatment compliance is seen as necessary for managing a person's assessed risk to the community.

"We can compel a person to submit a sample of their blood or urine to ensure they're taking their treatment. We can keep them in the hospital for as long as we think is necessary to manage and attenuate their risk," explains Pallandi. "We have the power to tell them where they can live, whether they can consume substances or not, who they might be able to associate with. From a liberties point of view,

these measures are quite intrusive. But from our perspective, we see the outcomes are good. The rates of recidivism [re-offending] are low, and people tend to do well. Sometimes they will be on treatment uninterrupted, steadily, and off substances for the longest period of time in their adult life. We're giving them the first opportunity to be well. And that's different. A lot of times the civil system just doesn't have the teeth to be able to do that."

And it is the apparent limits of the civil system, which operates under the Mental Health Act rather than the Criminal Code, that lead some in the community, particularly family members, to sometimes view the forensic mental health system as a preferred place to seek treatment for loved ones — both for its access to services and the sense that treatment compliance can be enforced.

In reality, too, by the time a person reaches the forensic system they are often estranged from their families and friends. Yet, if they can become engaged, friends and family can provide essential supports through the process. "We've had some fairly good experiences," offers Chaimowitz, "because we've been able to treat and to improve the mental health of many of the people who are coming to us. So families who've been more watchful from the sidelines have been able to re-engage with their loved ones. It's often reassuring that there's a system that's not going to abandon them — the forensic system. And because of that they are more willing to engage with their loved ones."

But the bottom line is that the forensic system and the ORB operate in specific circumstances, under rules governed by the Criminal Code — a fact that the public and service providers don't always appreciate. As Pallandi describes it, "One of the common things I hear is, 'Why don't we send this person to the forensic system?' But it's not like checking into a hotel! A person enters the system for a very particular reason, based on a finding in a criminal court. But even still, despite the amount of education we've done, I still get calls from people who say, 'Well, I think he's getting unmanageable. I think we should send him to a forensic facility.' But it just doesn't work that way. So I think that both the public and even people who work within the system should know that. This is a particular system, and the entry and exit points are very clearly defined.

"Also," adds Carey, "people sometimes think that when a person ends up not criminally responsible by reason of mental disorder it's just an easy walk. People have to realize that many are under the ORB much longer than they would be if they had pleaded guilty and gone to jail. So it's not an easy way out for the person at all. I would say a large proportion of people spend more time under the ORB than they would if they were found guilty in court."

Still, Carey suggests, "The criminal justice system is the newest arm of the mental health system. I think people are so frustrated that they call us and say, 'How can I get my person arrested and into a system where they'll get treatment?' They're so frustrated, because they can't get treatment, they can't get doctors, they can't get anything." But from Pallandi's perspective, "It is really a tragedy if people think it is desirable to enter the forensic mental health system. For the most part, we do have the resources in the community to look after a person's mental health needs before they ever get to the point of needing forensic services."

Of course, in the end, most people eventually leave the forensic system and return to the community. What then? "People have to move on," observes Pallandi. "And in fact, once discharged there's no requirement for a person to be involved with forensic mental health services. So we need to develop good reciprocal relationships between the forensic system and the civil system in order to allow for a seamless transition between systems.

"As a recent example of how things can work, there's a fellow who has been involved with an ACT [Assertive Community Treatment] team in Toronto for about six years now. He was ultimately arrested for one of the assaults upon his mother and found not criminally responsible, ending up in my minimum secure unit. He's done very, very well. And much to my delight, as soon as he came into our system, the first call I got was from the ACT team, who said 'We're wondering how he's doing, what's going on, because our goal is to stay fully involved with him throughout his time there. And when he gets his absolute discharge, we'd like to resume our contact and follow up with him.' This is absolutely ideal. So I'm in touch with them regularly. We give updates back and forth. He's been discharged back into the community and the ACT team is following up with him. I see him quarterly, just to see how he's doing — and it has worked absolutely flawlessly."

Elizabeth Lines is a researcher/writer in the areas of health and social issues.
Jennifer McVittie is the e-content developer at CMHA Ontario.

*fast*FACTS

144
Number of Ontario Review Board members across the province in 2008

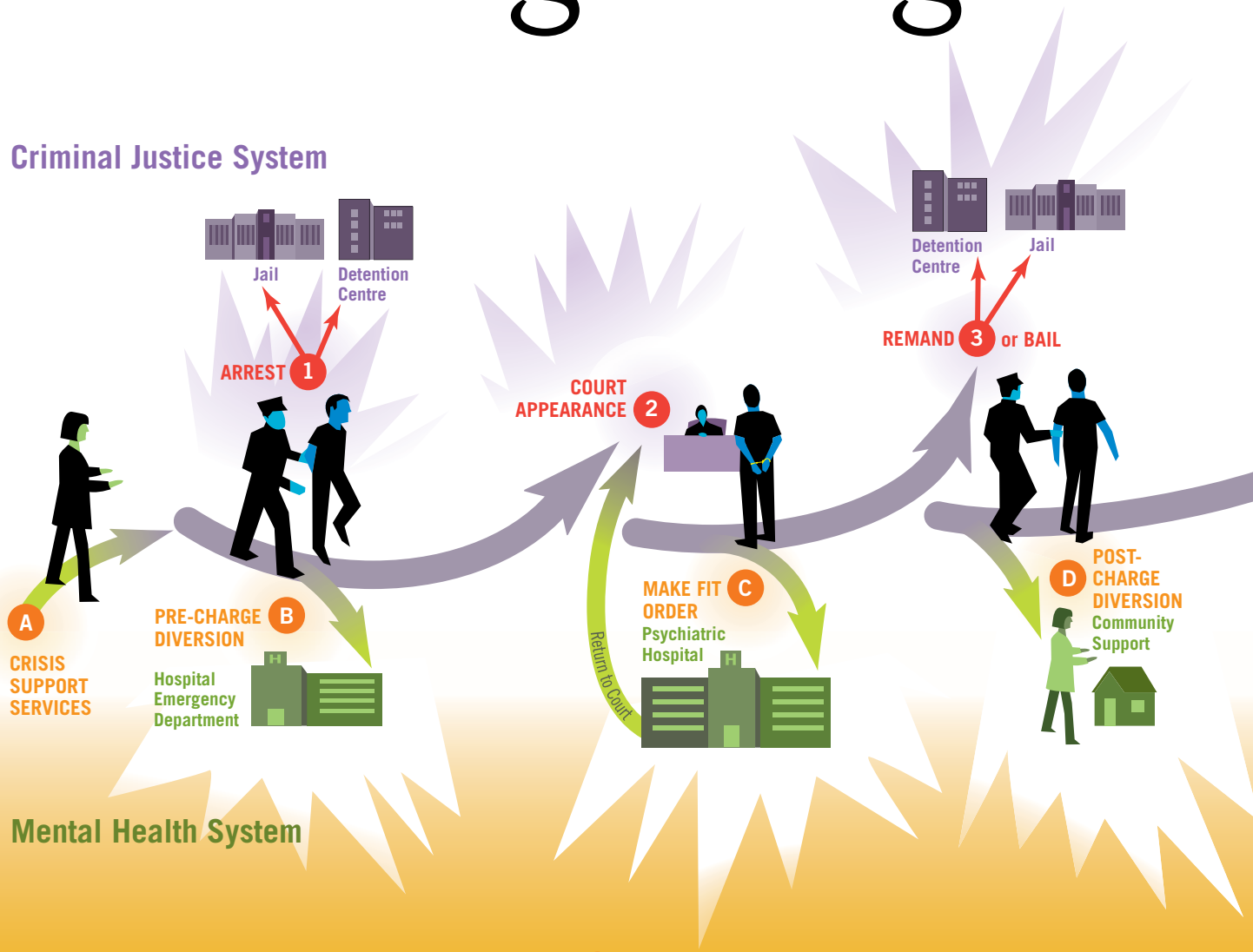
1,805
Total number of ORB hearings during the year 2007/2008

115%
Increase in numbers of new accused from 2003/2004 to 2007/2008 (four years), in percent

88
Number of absolute discharges in 2007/2008 (peak: 135 in 2003/2004)

(Source: Ontario Review Board)

Navigating *the*



The diagram above represents a simplified map of the various pathways through a complex system, illustrating the points of intersection between criminal justice and mental health care. It is important to remember that each person's case is very different, and some journeys through the system will not be reflected here. This map is meant only as a general overview.

Ontario's forensic mental health system is based on Part XX.1/Mental Disorder in the Criminal Code of Canada. Those provisions spell out a range of options for dealing with an accused person appearing before a court who has (or is thought to have) a mental disorder. The provincial forensic mental health system consists of a broad continuum of mental health services, ranging from secure in-patient settings to integrated mental health programs and community services and supports.

A When the police are called, the decision to arrest or charge someone is based on the seriousness of the offence as well as on public interest. Some police services have agreements with their local mental health crisis teams that allow the crisis team to be called in to assist.

B Under Ontario's *Mental Health Act*, the police have the power to take a person with a suspected mental illness who is deemed to be a risk to themselves or others to be seen by a doctor, usually at the local hospital emergency department. In some cases, the doctor will issue a Form 1: Application for Psychiatric Assessment, which allows the hospital to hold the person for up to 72 hours to complete a more extensive psychiatric assessment.

Forensic *System*

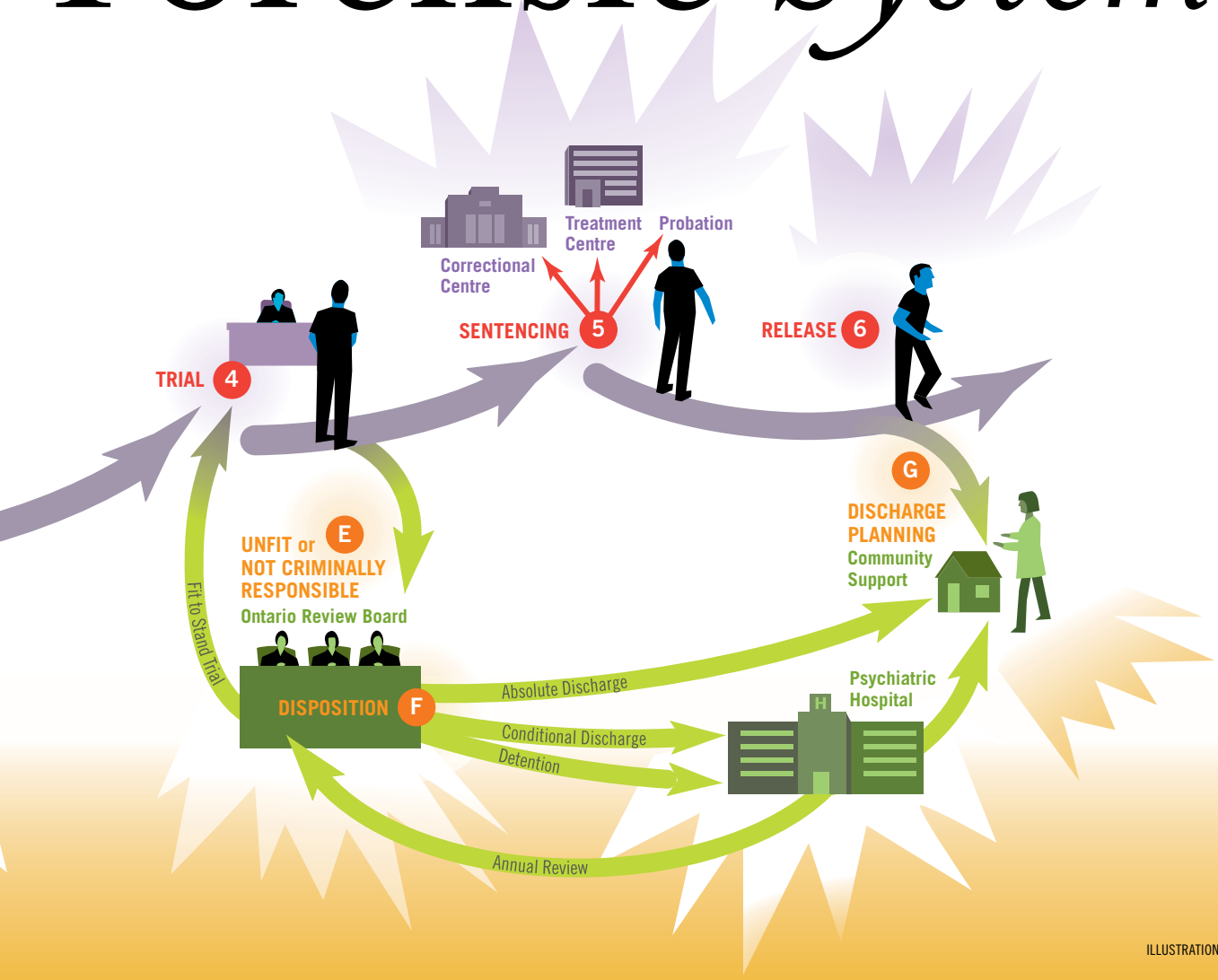


ILLUSTRATION BY ROSE ZGODZINSKI

C At any time in the court process, either side can raise the issue of "fitness to stand trial." A person is unfit to stand trial if they have a mental illness that prevents them from understanding the nature or object of what happens in court, understanding the possible consequences of what happens in court, or communicating with and instructing their lawyer. The court will typically require a psychiatric or fitness assessment. If the person is found unfit, the judge may order them to receive treatment for up to 60 days in order to return them to a "fit" state. This is called a "make fit" order (or treatment order).

D After charges have been laid, Crown attorneys have the option not to prosecute and to divert the person into mental health treatment and support instead. This is referred to as post-charge diversion (or pre-trial diversion or court diversion). Diversion can take place at any stage of the proceedings. If the accused is eligible for diversion, a mental health court support worker will work with the person to develop a program that may include community support, supervision and/or treatment.

E If the person is found unfit to stand trial and remains unfit even after treatment, a formal finding of unfit to stand trial is made and the case is transferred to the Ontario Review Board (ORB). The accused may also be transferred to the ORB if they are found to be not criminally responsible (NCR), which means that at the time of the act they were incapable of knowing what they were doing and that it was wrong.

F The Ontario Review Board will make a decision, called a disposition, about whether to release the accused person or detain them in a psychiatric hospital based on whether they believe the person is a danger to the public. (See "Striking a Fine Balance," pp. 10-13.)

G When someone with a mental illness is released from hospital or a correctional institution, a discharge plan is created. Community mental health service providers will work with the person to help them follow the plan and reintegrate into the community. (See "Bridge over Troubled Water," pp. 25-27.)

MARK BELVEDERE, *RESOLUTION* (PHOTOGRAPH, 16.5" X 16.5"), DETAIL. THIS WORK APPEARED IN THE BEING SCENE 2007 ART EXHIBIT AT THE CENTRE FOR ADDICTION AND MENTAL HEALTH IN TORONTO.

By Susan Gow

Justice* Served

"I don't want fear running my life," says Faithful, a former inmate of the Grand Valley Institution for Women, the federal penitentiary operated by Correctional Services Canada (CSC) in Kitchener, Ontario. Faithful [not her real name] has been incarcerated three times during the past 15 years for drug trafficking. Now, at the age of 40, she has no intention of ever again returning to prison. Faithful says her resolve to not go back was reinforced the last time she was discharged from the Grand Valley Institution, when she decided to stay in Kitchener.

After

deliberately choosing to relocate away from her former home, Faithful feels she is fortunate to be living in a transition house with five other former inmates. She also immediately attended a community drug treatment program and attends Twelve Step meetings twice a day. With her two previous discharges, Faithful opted for the parole system in the hometown where her drug addiction began, but found both times that she picked up where she left off. Her good intentions each time, she confesses, lasted about a month.

One thing that made it easier this time for Faithful to continue to reach for help was the presence of Stride Night at the Grand Valley Institution. Stride Night is a weekly social gathering organized by Kitchener's Community Justice Initiatives (CJI) and attended by community volunteers who join for recreational activities with inmates. CJI is a leader in offering restorative practices. Stride Night gatherings also serve as an effective way of bringing the community existing outside the prison to the inmates. Inmates connect to the volunteers on an emotional and social basis; in the various stages of their association, inmates find healthier examples of how to be in relationship, and can give voice to parts of themselves that perhaps have been closed to them in the past.

Restorative justice is a tool to foster healthy communities. Use of this tool promotes the mental health of people in the community, including those who are marginalized. Restorative justice is a process to acknowledge, mend and re-establish relationships when conflict, violence and injury result in damage and harm. The process of restorative justice requires the victims of an offence or crime to meet with their offenders to find means to right the wrongs to those injured and to restore harmony to the community affected.

The purpose of restorative justice is to understand the causes that prompt the offence and its resulting effects. With the learned awareness, together participants identify consequences and agree on appropriate ways to make amends, heal and recover.

The final outcome is change that has been respectfully encouraged and willingly provided. For those involved in the process, there are changes in attitude about the injuries and offences. Feelings are altered, and behaviour is adjusted because participants themselves have control and determine their recovery from the injuries suffered. All these changes are key components in reacquiring and sustaining mental health. Additionally, future offences are reduced and crimes prevented.

Finding a home, a job and a friend are other components to sustaining mental health. To be included or to believe they belong in their community, people need to feel safe to be themselves and contribute to community life in a way that is meaningful as *they* define it. To feel so included, people need access to available and concrete resources and support.

When members from community agencies and community volunteers engage with incarcerated women, the inmates' capacity to make positive changes in their lives is greatly enhanced, while at the same time the communities become much more likely to receive them more positively upon their release. This interaction reflects one of the core values and principles of a process called restorative justice. Offenders, victims and community members shift from their original perceptions of a damaging experience, and make these changes within the context of a relationship with each other.

The community representatives visiting women in prison through Stride Night are informed about the justice system and the issues of crime, incarceration and reintegration, to help them assist inmates to connect more realistically with their future communities and resources. Having already practised shared respect, dignity in common and some autonomy, paths for healing behaviour are much better maintained.

LOCATED IN KITCHENER, ONTARIO, COMMUNITY JUSTICE INITIATIVES IS A NON-PROFIT ORGANIZATION KNOWN WORLDWIDE AS HAVING STARTED THE FIRST RESTORATIVE JUSTICE PROGRAM. FOR MORE INFORMATION, VISIT **WWW.CJIWR.COM.**

Stride Circles, which are facilitated through Stride Night activities, consist of a CJI facilitator and two to four CJI volunteers who are matched with a woman wanting a Circle to support her in her reintegration into a new community. Members help an inmate reframe her options and recognize her achievements. A woman works with her Circle members to find housing, employment, education and community groups, and to face the many other challenges, both practical and emotional, in becoming self-sufficient.

Starting first inside the prison at Stride Nights and then within the Circle, Heartfelt [also a pseudonym] knew she was accepted and not judged. She felt encouraged, therefore, to find different ways to manage her daily stresses and adjustments. For example, when Heartfelt first arrived at the same transition house where Faithful lives, she had been provided a small room, smaller than the one she had while in the Grand Valley Institution for Women. Heartfelt learned later it was nicknamed "The Closet," and although it was intended only as a temporary room for her until another was ready, she panicked.

Heartfelt felt very claustrophobic in The Closet and was greatly upset, but she didn't think she should say anything. Her Circle people responded to her distress and together with the house manager moved quickly to get the other room ready. Heartfelt also received new bedding from her Circle friends, which added to her feeling comforted and comfortable. This act of human kindness in the face of a challenge set the tone for Heartfelt to feel more confident to make changes for herself.

One of the goals for volunteers and inmates is open and honest communication. Volunteers need to have an understanding of the real fears, dilemmas and challenges that inmates experience when becoming a part of their new-found community once released from prison. Inmates gain respect for Circle volunteers when, after sharing their genuine needs for recovery and adjustment in the integration process, they are offered meaningful and sensitive support in response. Every participant, inmate and volunteer alike, is accountable for the impact of their suggestions, their ambitions, their heartfelt words and deeds, and the extent to which they share feelings and thoughts.

Being a part of a Circle was another reason Faithful decided to remain in Kitchener once she was released. She finds the women in her Circle "caring and compassionate" and they never judge her for her crimes against society or for her addictions. She knows she can turn to them for help — and she wants to.

Julie Thompson, program director at CJI for Stride and for the Family Group Decision Making program, is grateful for the recent three-year funding commitment that allows a vital aspect of Stride to be revived. Stride was started in March 1998 and Stride Night was introduced in 1999. Stride Circles — that vital aspect to the CJI programming — was closed for a little over two years in 2005 and re-started in mid-2007.

"Institutionalized systems teach marginalized people to define themselves by what is wrong with them rather than by what is right with them. We at CJI believe in working with the 'well parts' of inmates."

Julie Thompson, Community Justice Initiatives

"Institutionalized systems teach marginalized people to define themselves by what is wrong with them rather than by what is right with them. We at CJI believe in working with the 'well parts' of inmates," Ms. Thompson states. "[We] create an activity, a get-together, to reframe what [healthy] relationships are about and to support them in the redefining of themselves with community." Inmates like Faithful and Heartfelt are thankful for Stride.

Faithful participated in most of the CSC programs available to inmates during her three sentences. With her last incarceration, she discovered that because of cutbacks, previous workshops offering cognitive skills development, anger management, alternatives to violence, and parenting skills have been combined to form the CSC program called the Women Offender Substance Abuse Program (WOSAP).

"CSC has an intense drug program," acknowledges Faithful, "but confidentiality is not always protected. There are no trained therapists, only correctional staff who have been parole officers and trained for a week or two. [In a WOSAP meeting once,] I said I wanted a 'joint' [a drug to smoke] and their focus was on who I'd get it from and not why I wanted to do drugs."

Faithful and Heartfelt explain they had similar experiences with WOSAP where they did not dare to be "a hundred percent honest" for fear their sharing would be spread around the compound, that they would be criticized and talked about outside the group, and that they would be "looked

PHOTOS: SUSAN GOW

The purpose of restorative justice is to understand the causes that prompt the offence and its resulting effects. With the learned awareness, together participants identify consequences and agree on appropriate ways to make amends, heal and recover.

down on" by both staff and fellow inmates. They even felt they ran the risk of receiving "wrong feedback" or information they believed was driven by the facilitators' agenda and not in response to their own self-discovery for healing. Both Faithful and Heartfelt know from their involvement with drug rehabilitation programs that honesty and staying in the present are critical to continuing their recovery and their survival for health.

Training and orientation for CJI's Stride volunteers takes place over three months. It starts with the submission of an application, an interview, and a criminal-records check. Nine hours of training sessions cover risk management, the sensitive use of language in conversations and interactions with inmates, prison visitor protocols, and a tour of the Grand Valley Institution for Women. Discussions are held about trust and respect, good judgment, and how to notice and recover when boundaries are overstepped. Focus is given to mentoring, not counselling: volunteers are encouraged to bring their humanity to their involvement, as are all staff and volunteers at CJI's four programs. Volunteers are asked to set aside assumptions and preconceived notions about those who are incarcerated at Grand Valley Institution for Women.

Once volunteers complete the screening, training, and orientation process, they attend and participate in weekly Stride Nights. Should they choose to participate in a Circle, they receive an additional 18 hours of training to prepare them to give effective support. Community volunteers in Circles hear about the women's stories and personal struggles, and share their enthusiasm as they approach their release. They share in the disappointment, too, when some women return to former ways and to prison.

This is the social support that Faithful and Heartfelt treasure and that has made the difference this time in their release and recovery. "I'm on a path to reality," says Faithful. "I love my little life today … a lot. I have hope, faith, and a lot of People in Heaven to help me." Faithful is not religious but practises a different form of spirituality that is very meaningful to her.

Ms. Thompson through CJI is trying to help build the Circles model in other communities.

This time, Heartfelt and Faithful chose not to be paroled but rather to spend their full sentence in prison, accessing Circle support while there. With the parole system, the women felt they were constantly being tested — tested for drugs and tested for their obedience to rules and regulations. The parole system appears to lack an identifiable focus on getting well.

Ms. Thompson identifies some of the problems with education and retraining for inmates. "If women are [not] able to pay for their own university and college courses — which most aren't — they have to take them by correspondence." Most distance education courses have to be done online, which further limits access to courses: inmates don't have Internet access. All forms of communication in and out of penitentiaries are monitored for security reasons, and that includes the Internet.

Ms. Thompson knows that many at the CSC recognize that funding reintegration and restorative justice is a good idea, but currently there is no specifically defined budget for this essential part of an inmate's recovery. And because Stride serves federally sentenced women, there is no funding from other levels of government. The current federal funding for mental health is only for specific clinical services, so funders within the community must contribute substantially to keep Stride going.

All voices in the restorative justice process speak to sharing the tools for human decency, to recover with reconnection, and to move forward with new ways. Inmates ask for opportunities and help to prove they can contribute, ask that labels such as "Meth Mom" and "Crack Head" be dropped, and advise that "it takes longer to get back on track than to lose it." They want patience from community members as much as they are learning to extend patience to themselves, without losing sight of their goals for improvement. They want to be empowered to make healthy decisions.

Faithful requests that people "not be so quick to judge us," meaning recovering addicts and former inmates. Judgment, she adds, "leads to barriers," which for her prevents her from becoming a more confident and contributing community member. She loves it when her Circle gathers on the porch at the transition house. "These are people who are accomplished and they enjoy my company. We laugh, have a good time, and they don't expect nothing from me — except my honesty."

Everyone involved with restorative justice wants for both Faithful and Heartfelt what they want for themselves: to accept the consequences of their actions, to change former decisions that were self-defeating and injurious to the community, and permit physical, mental and spiritual healing. That way, safer communities exist — and with greater community involvement, true justice results.

The two former inmates chose the pseudonyms for each other. They were delighted at how each name suits them.

Susan Gow is a freelance journalist and communications consultant from Waterloo, Ontario.

Q&A

Interview with Cinnamon Tousignant by Paula Bude Bingham

BRIDGE OVER TROUBLED WATER

IN EARLY 2006, THE MINISTRY OF HEALTH AND LONG-TERM CARE ANNOUNCED A NEW "RELEASE FROM CUSTODY" PROGRAM TO FACILITATE THE TRANSITION OF PEOPLE WITH MENTAL ILLNESS RELEASED FROM CORRECTIONAL CUSTODY BACK TO THE COMMUNITY.

Short-term case managers were funded to provide outreach and client identification, conduct comprehensive assessment and discharge planning, coordinate a continuum of services based on client choice and need, and advocate not only for individual clients but also for coordinated services and supports across the mental health and justice systems.

The Canadian Mental Health Association, Kawartha Lakes Branch, located in Lindsay, Ontario, is one of 33 community mental health agencies across the province (including 16 CMHA branches) who provide Release from Custody services. *Network* interviewed Cinnamon Tousignant, team leader of Justice Services at CMHA Kawartha Lakes.

Q: I'm interested to know what community needs and gaps your Release from Custody program addresses in the Kawartha Lakes region?

A: The main focus is smooth integration from the correctional centre to the community. The correctional centre discharge planners work quite hard to set up a plan that works for individuals in their communities. Unfortunately, there are a lot of barriers that can prevent someone from following through with their plan. So our program has really become a bridge. We work in partnership with the discharge planner and the individual, encouraging them to fulfill these plans that have been developed on their behalf. The program also has the goal of reducing the recidivism rate.

Q: Speaking of barriers, a concurrent substance use disorder is a strong predictor of recidivism for mentally disordered offenders. How does your program target such needs?

A: We have a well-established relationship with the hospitals and addiction services here in town. We've also developed a really good partnership with the addiction counsellors in the correctional centre. As a resource to our regional team, we have a concurrent disorder worker, who will meet with individuals from any of our justice service programs and complete the assessment forms they need to be able to access rehabilitative treatment or residential treatment. We also have two addiction counsellors on staff who are able to identify the signs and symptoms if people start using again, and they've taught the team how to recognize signs of substance abuse.

I really have to give a lot of credit to my staff, for in a very short period of time, with a population that has a lot of trust issues, they have been able to build therapeutic relationships with them. We let our clients know that we realize that people make mistakes, so it's not uncommon for an individual that we're supporting to step off the wagon and spend a weekend using and drinking, and then immediately call us and share his problems. They know that we don't stop services for them. If anything, we activate additional long-term supports.

Q: Can you tell me more about the challenges and barriers that mentally disordered offenders experience as they try to reintegrate into the community?

A: It's about learning a new lifestyle, learning new habits. A lot of people don't recognize the multiple barriers that individuals face. I've been looking at the statistical data we collect and I'm surprised by the number of people who have experienced abuse and trauma in their life. Significant abuse — in some cases, after an individual has disclosed the abuse, my staff has had to come for debriefing. It's not uncommon for us to be talking to individuals about when they experienced their first delusion or hallucination, or when they first started to feel depressed, or manic, and they would tell us that it happened when they were 9 or 10. That's quite an early onset for these symptoms. And they often cope with these symptoms by self-medicating with drugs or alcohol. So then the cycle continues to perpetuate itself. They don't have a lot of good social skills and communication skills, they have trust issues from the abuse, and they've developed survival skills to cope with the abusive situation.

Even when they're out of that [negative] situation, they are still using those survival mechanisms although they are no longer appropriate. It's a really hard cycle to break, and it's very, very difficult to coordinate all of the services that need to be available at the same time. It's not uncommon for [a service provider] to say, "Well, the trauma needs to be dealt with first, before we can deal with the substance abuse." And then the substance abuse [treatment provider] will say that the mental health needs should be taken care of first, and so on. Sometimes you get stuck in that cycle. But the individual needs to start somewhere, with someone, and nobody has the availability to deal with the number of barriers that these mentally disordered offenders are facing.

> "The important thing is to understand that there is a need out there, and that we as a society are responsible for the health and wellness of everyone in our community. It is important to advocate and speak for those who can't."
>
> Cinnamon Tousignant, CMHA Kawartha Lakes Branch

It's very important to emphasize that Release from Custody is a voluntary program that supports offenders to achieve their community reintegration goals. We do not close doors. There is no "three-strikes and you're out" mentality. We had an individual who needed to go through our program seven times in less than a two-year period in order to make a change in his outcome. We were frustrated at one point, but we took him back and it was worth it.

This was an extreme case where the individual had to deal with a number of barriers. For example, with regard to housing, the only place he was allowed to go to was with a family member who perpetuated the abuse and problems he had struggled with. He also had many addiction issues, a developmental issue, a physical disability issue ... he had barrier after barrier to deal with. So whenever he was released, he found the process set in place for him — the resources he needed to access, etc. — so anxiety-provoking that he would purposely re-offend within a 12- to 48-hour period so that he could return to the correctional facility. He explained that in prison he at least got fed, received his meds, had friends, was away from abuse, had structure, etc. He went through the Release from Custody program seven times. We of course wondered about the value of our services to him, but finally after lots of encouragement he agreed to relocate to a different area with more resources. So during round seven, he was out in the community for two full months before he re-offended. Our staff was ecstatic.

It took a year and a half to get there, but the time after that he was out for four months. In a couple of years, he could easily be out for two or three years between his offences. It is a huge success. Some people may have difficulty understanding how so, but the barriers this individual deals with on a daily basis are something that the majority of us would not be exposed to during a lifetime. So I consider him to have a lot of strength as a survivor.

Q: Tell me about the history and structure of your program.
A: Our Release from Custody program is quite new. It started in 2006 with funding from the Ministry of Health and Long-Term Care. Based on need, we started a pilot program in the women's pod [at the Cental East Correctional Centre in Lindsey, Ontario]. We already had a pre-established relationship with the jail before the funding option became available. And so, even before the money came, we piloted the release from custody, to work out the bugs in partnership with the women's pod, and they were very, very supportive. In a very short period of time, word got around to the male units, because there were some successes: women were getting hooked up in the community, they were getting some access back to their children, and so on.

I had to set parameters around what we could do effectively. It's not about doing a whole bunch of things, but rather it's about focusing on what we can do really well. We're great with intensive case management, we're excellent with advocacy for individuals, we can network and partner with community resources, and those are the things that are most effective. Those were also the things that the individuals themselves were lacking in regard to follow-through. So we focused on the strengths of the staff and on the needs of the offenders.

I also wanted to maintain staff safety; that was very important to me. So we developed quite a comprehensive risk assessment, which we review continuously. This is not only for the staff, but also for the benefit of clients accessing the program. Because if the staff are feeling unsafe in a situation, then they are not going to be available to provide services to those individuals. Predatory sex offenders, for example, are a very specialized population and we recognized that we can't operate in this area of service. We refuse services to such individuals because we cannot provide the services that they really need. So we draw the line at very violent offenders.

Because we get a lot of feedback from our clients and the services are highly individualized, we really don't have a hard structure. We address basic things such as housing, psychiatric support, medical support (such as a family doctor), long-term support if the individual desires it, but how we go about obtaining those resources can vary quite a bit based on the person's diagnosis, behaviour, criminal history, etc. There is a lot of flexibility in the program. We believe in the self-determination of the individuals, too. It's a highly client-centred, empowerment-based approach. Each plan should be individualized. You're not going to get results with a cookie-cutter service.

Q: How many case managers do you have, and do they each provide unique services?
A: I have three identified case managers for the Release from Custody program. One of them does the majority of the intake and risk assessment. She has a master's in psychology, and she also had some experience working with mentally ill offenders. So her input into the program, at its conception, was quite valuable. She really helped bring the risk assessment tool to a point where I was quite satisfied that we were really having staff and client safety.

I have another individual who provides case management, and he also does some backup when my intake worker gets overwhelmed. He is trained to go into the jail and do risk assessments and treatment, but he also goes into the jail to make a first, face-to-face contact with the individuals. We find that there is a much higher rate of follow-up if we make contact with them in the jail first, before they get released, so that they at least have a face to attach to the case worker.

We also provide funding to Durham Mental Health Services for a case manager in another area that we are obligated to serve. She does follow-up and risk assessment based on overflow, as appropriate for her area. She too is trained to meet individuals in the jail before release and to establish face-to-face contact with them. She is a great resource and a phenomenal worker.

Q: Could you please outline the referral process, from jail or initiation, to the goal of community reintegration.
A: We wanted to make the program available to everyone, and we wanted to make it pretty straightforward. The referral is a phone call, and from there, our intake worker prioritizes who they meet and when they see them, based on their status. So if the individual is sentenced, obviously they do get priority because that is our mandate. And then, once we've met with the sentence referrals from the previous week, we start with the remand referrals. I'll stick to the referrals for sentenced individuals because they are much more straightforward. Ninety-five percent of the time they come from within the jail itself — from a social worker, a discharge planner, a health team member [nurse, psychologist, etc.].

Q: Can anyone refer an inmate to you?
A: Yes. Individuals can even refer themselves, and the correctional officers are very supportive with allowing them to make self-referrals. They would deliver those referrals to our mailbox in the correctional centre. So it really is a team effort.

From there we meet with the individual and complete an intake assessment, and proceed with a needs analysis and risk assessment. We explain that it's a voluntary process and that it's largely driven by the individual's needs in the community. Often there are several needs that have to be addressed at once, so we focus on their top five immediate goals: housing, getting to their social services appointment, getting in contact with their children ... it can be a variety of things, depending on the individual.

And then, through our partnerships and networking in the community, we'll start making appointments on their behalf, based on their release date. For example, if their release date is February 12, we'll work in partnership with the discharge planner to have an Ontario Works appointment confirmed on February 14 for an emergency cheque. So we make contact with them within 24 to 48 hours after release.

"Release from Custody is a voluntary program that supports offenders to achieve their community reintegration goals. We do not close doors. There is no 'three-strikes and you're out' mentality."

Cinnamon Tousignant, CMHA Kawartha Lakes Branch

After getting the cheque, we'll take them to the emergency department or a walk-in clinic to get their meds. We've worked with the health departments, so the offenders can actually get released with a few days' worth of medication so that there's a bit of a bridge. From there, we'll proceed with the safe, suitable and appropriate housing appointments. Often we'll take them around to peer support groups if they're willing, and we'll even attend their first meeting, and so on.

We are short-term and geared toward a 12-week intervention. However, based on the wait lists, the individual's needs, and where they are in regard to success and strength and confidence, we'll extend that on a case-by-case basis. After the 12 weeks, they don't get weekly service, but we will do weekly call-ins if they can access a phone. We also continue to advocate and network for them. So we can be the go-between when they feel like they want to use [drugs] — they call us for help and we get them somewhere safe like the Pinewood Centre [in Oshawa] for the weekend.

My staff are incredibly resourceful. They find resources in the community that we did not know existed. We have developed amazing relationships with a lot of informal services such as church groups, and we've learned that informal services may become a lifelong support for these individuals. We've also developed great partnerships with other agencies in the community that provide us with office space for assessments. Institutions like Legal Aid have helped us, and such institutions often fast-track the help that these offenders need.

Q: What sort of resources and community programs for mentally disordered offenders would help your program's success rate?

A: More access to transitional housing with a safe environment and support staff for individuals who are released from jail. We had a woman who desperately wanted to make changes in her life and was working so hard on it, yet she was limited in terms of housing options. Upon release, she ended up back at a place with drug use, and actually overdosed about three days later. She was petrified about being released because she knew that she did not have a safe housing option to return to.

Another need would be access to long-term trauma counselling and services. Everything is so short-term nowadays. Private practice often provides more long-term care, but there's a huge cost factor. Also, access to medications is a big need. Some offenders have been charged with fraud, and in terms of social services they don't qualify. Trying to access reasonably priced meds on their behalf is very difficult, because psychiatric medications are quite expensive. Many of these individuals are not healthy: they grew up in unstable, unsafe environments and have not been taught to practice healthy habits. So they often have health complications on top of the psychiatric problems. Frequently, there are a number of different medications that they need to stay healthy.

Many people don't realize that often the motivation exists. It's very strong even after numerous failures to reintegrate in the community. The resources are limited and difficult to access. There's a lot of jumping through hoops that one needs to do. A good example is not having a family doctor. An individual with a lot of psychiatric trauma and physical problems trying to get referrals to specialists, such as a counsellor or psychiatrist, without a family doctor has a very, very difficult time.

Q: What are some of your needs and challenges as a rural Release from Custody program?

A: One of our biggest challenges is a lack of transportation, because in a rural area, it can really impact the amount of service we can provide. If there was public transit, we would be able to provide more services on a timely basis. Instead, a large amount of staff time is dedicated to travel, and I consider it to be a successful day if a staff member meets with four people, or three in a more northern area. It may take an hour and a half to get to some of the areas that we provide services to. We have to do more with less because we're all funded based on population ratios. They don't factor in how geographically spread out people are.

Q: Is there anything you would like to add?

A: The important thing is to understand that there is a need out there, and that we as a society are responsible for the health and wellness of everyone in our community. It is important to advocate and speak for those who can't. It's easy to not want to speak about offenders because they are a population that people may get nervous about. Criminal activity and jails can be quite intimidating things. Jails are not fun places to spend time in. Even driving by a jail can be quite ominous. But we need more focus on community education and on really caring about and accepting who lives in our communities.

I think if communities were to hold each other accountable for the welfare of individual members, you would see a lot more formal and informal resources available to people who are vulnerable. The "neighbours taking care of neighbours" approach is a very grass-roots kind of thinking, but it can be very effective if everybody's committed to it.

Paula Bude Bingham is a mental health researcher and writer in Toronto.

RESEARCH SNAPSHOT

By Scott Mitchell

seei
systems enhancement evaluation initiative

SEEI Court Support Studies

In January 2005, Ontario's Ministry of Health and Long-Term Care (MOHLTC) injected $27.5 million into the community mental health sector for court support programs, intensive case management, crisis intervention, supportive housing and safe beds. A second investment followed in May 2006, bringing the total to $50 million. This new Service Enhancement Initiative was the result of an inter-ministerial partnership to keep people with mental illness out of the criminal justice and corrections system.

To evaluate and communicate the effects of this significant investment, the ministry also funded, through the Ontario Mental Health Foundation, a group of nine studies called the Systems Enhancement Evaluation Initiative (SEEI). The initiative is led by members of the Health Systems Research and Consulting Unit at the Centre for Addiction and Mental Health (CAMH) with the support of an executive advisory committee composed of stakeholder groups, including the Canadian Mental Health Association (CMHA), Ontario.

Final results are expected in the spring of 2009. In the meantime, interim reports have been published at several stages during the project and are now being shared across the province and discussed through a series of knowledge exchange forums.

Two studies — one system-wide and one local — looked at court support programs. Several key findings have emerged.

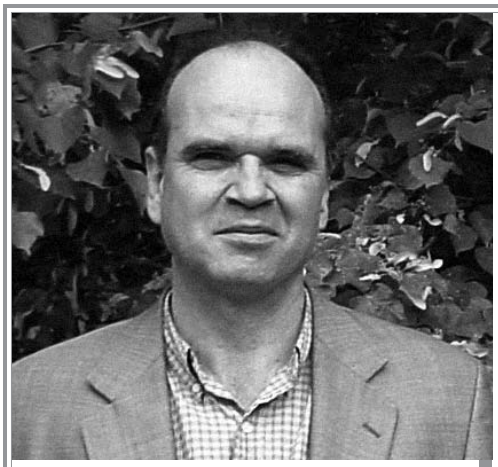
Many stakeholders predicted that court support programs would reduce the burden on the justice system by helping to divert people with mental illness out of the court system and into mental health services. Although many clients now served by court support programs are being connected with mental health supports, the SEEI studies have shown that a significant proportion are *not* being diverted from the court system.

"The [MOHLTC] guidelines for court diversion put the emphasis on people who have Class 1 or minor offences, whereas we're finding that most of the people who are being served [by court support programs] have Class 2 or Class 3 charges, so they can't be diverted because they're not minor offences," observes Carolyn Dewa, principal investigator for the Matryoskha Project, one of the studies within SEEI. The Matryoskha Project evaluated seven court support programs across Ontario.

"Because the service enhancements were a mental health and justice cooperative initiative, justice was wanting to see a significant reduction in the burden on their system. That would have been true if most of the people were being diverted. But where they're getting the benefit isn't really where they were looking, or expecting. One of the things that court support is not always recognized for is that the services they provide are consultation services within the court, where they're supporting the lawyers and the people in the justice system. That's where the added value is, I think."

Evidence that court support programs provide a service to the community beyond their immediate clients is

> "Court support programs are having difficulty finding partners to link with. Front-line workers are having trouble finding psychiatrists who are willing to serve people in their program, and some service providers won't accept a client unless they're through with the court system."
>
> Carolyn Dewa, Centre for Addiction and Mental Health



"Court support workers are developing an expertise in and around the legal process, and that's value added to the system."

Tim Aubry, University of Ottawa

another of the studies' key findings. Dewa reports that about 22 percent of case managers' time is *not* spent in direct client contact, but rather in consultations about basic living supports, providing assistance with bail planning, and liaising with lawyers and the Crown.

University of Ottawa researcher Tim Aubry, who evaluated the court outreach program run by CMHA Ottawa Branch, also observed collateral benefits for the broader community. "In addition to providing direct services to the clients and providing consultation to the legal people at the courthouse, this group of workers in the court outreach program is also providing consultation on a fairly regular basis to other workers at CMHA who have clients that end up running into legal issues. They're developing an expertise in and around the legal process, and that's value added to the system."

While many of the court support programs that Dewa studied are relatively new, CMHA Ottawa's court outreach program started more than a decade ago, in 1995. It was one of the first in Ontario. "There was a crown prosecutor, Andrejs Berzin, who was very progressive," recalls Aubry. "He had some involvement in mental health — in fact, he spent a number of years on the board of CMHA Ottawa — and he could see the need. There wasn't enough community support to start with, but here was an area where people were visible: they were legally involved, and the court system wasn't doing a good job.

"But you have to be humble about what a program like [CMHA Ottawa's] has accomplished," continues Aubry. "They're now assisting 90 to 120 people in a year, but that's just a drop in the bucket of who might benefit from their help.

"There's a bottleneck issue. There are more people who could use the service than are being served. The intake worker is put in a very difficult situation of trying to determine eligibility for the program, when the demands are always greater than the program can accommodate. It pushes the program to serve those with the highest need: It's not just severe and persistent mental illness, it's people who are really isolated, who have no connection at this point to any services. A lot of them are homeless, or they're very precariously housed, and there's nobody in their life to speak of. That's consistent with how CMHA has approached the entry to a lot of their programs over the last 10 years."

To help ease the intake process, Aubry recommends that additional assessment tools — not to mention additional resources — be considered.

Another key message arising from the research is that reducing recidivism rates is difficult when court support clients "constantly face the prospect of a dismal quality of life," as Dewa puts it in her most recent report. A majority of clients in the Matryoshka study had no post-secondary schooling and lived in low-income households. In fact, a third did not complete high school. The average monthly income reported was $928.

"I must say, the people we interviewed weren't surprised by the recidivism rates," comments Aubry. "This program is designed to help people through the court process and to get to the other side, to get past it. When you do have recidivism, it's an indication that people haven't engaged as much as you'd like them to. People are still slipping through the cracks."

Aubry recommends that cases be reviewed when clients of the program are re-arrested. "You can learn from that. It's a bit like the cases in mental health where there's deterioration. You ask, 'What could we have done differently?' So I think that's worthwhile for court outreach programs to periodically do reviews and reflect on what they might do differently."

He also recommends that when court support clients leave the program, agencies should facilitate referrals to address educational and vocational issues and substance abuse problems. "This program was conceptualized as short-term support, for nine months to a year. It helps a group of people who've been disconnected to engage and get hooked up with some basic supports and hopefully work on some of their basic needs, like housing. But then the question comes up: 'Well, what next? How can we now start working on some of those other needs?' Like doing something constructive and meaningful with people's time, something that's satisfying, like school, work, social relationships.

"We're not there yet in Ontario. All the data I've seen suggests we've started building a community mental health system and it's helping people — not everybody, but a group of people — subsist in the community, but they're still pretty isolated. They're not doing anything terribly constructive in their lives and they'll tell you that.

"The client group that mental health service providers are seeing through the courthouse is very similar to the client group they're meeting in shelters and in hospitals," notes Aubry. "It's the same profile, the same client set of characteristics: severe and persistent mental illness, high prevalence of concurrent disorders, people very socially isolated. They struggle with poverty and especially housing problems. There's not

anything qualitatively different in the client group, they're just meeting them in a different place."

When clients receive the appropriate services, the outcomes can be surprisingly positive. In the Ottawa study, Aubry observed a "significant jump in community ability." Using the Multnomah Community Ability Scale, Aubry was able to measure improvements in functioning. "Whether it's social skills, daily skills, or a reduction of symptoms," explains Aubry, "the MCAS captures someone's ability to live independently in the community.

"When I put together all the studies in which I've been involved — the Community Mental Health Evaluation Initiative, the evaluation of CMHA's hospital outreach, an evaluation of their concurrent disorders program — that jump in community ability is consistent across all the different programs. And it's a big effect. People who are really isolated, who are disconnected from everything and struggling with housing problems, they start at a very similar spot on these scales — and they have a dramatic improvement within the first year."

Increasing access to mental health services for a marginalized population is one of the identified strengths of court support programs. However, the Matryoshka Project found that barriers to care are steeper for clients involved with the justice system.

"They're getting services from the court support programs," explains Dewa, "but the court support programs are having difficulty finding partners to link with. Front-line workers are having trouble finding psychiatrists who are willing to serve people in their program, and some service providers won't accept a client unless they're through with the court system. People aren't familiar with how the justice system works and there's a fear that it will tie up their time, which isn't necessarily the case. There is more openness once the client has been released.

"I think education would make people feel more comfortable with how to handle clients who are maybe at higher risk — education that clients are not violent necessarily, and it won't necessarily take their entire day to sit in court. If you give people skills, they're more likely to be willing to provide services," says Dewa.

Indeed, the long-term presence of CMHA Ottawa's court outreach program has had a positive effect on others in the community. It has contributed to the development of parallel and relevant programs, including mobile crisis services and Ottawa's new mental health court. "I think it helped develop an awareness that this kind of specialty court would be worthwhile doing," says Aubry. "It really helped to raise consciousness outside of the mental health system. These specialty courts are kind of in vogue right now, but I really believe from everything I've heard that the history of the outreach program here and the people who were involved in it — the judges who were interested in it, the lawyers — all of this has increased awareness. It's demonstrated that if you have certain services that are tied to the court system, it really does make a difference."

For more information about the Systems Enhancement Evaluation Initiative, visit www.ontario.cmha.ca/seei.

Scott Mitchell is the director of knowledge transfer at CMHA Ontario.

CALENDAR

March 27-28, 2009
"Are We Mad? Critical Perspectives on the Canadian Mental Health System." Presented by members of the University of Alberta Faculty of Law and the Legal Activist Collective. Edmonton, Alberta. www.arewemad.com.

April 23-24, 2009
"In Relation." 4th International Conference on Spirituality and Mental Health. Ottawa, Ontario. www.omc.ca/smhconference.

April 27-28, 2009
Third Annual Risk and Recovery Forensic Conference. Organized by St. Joseph's Healthcare and McMaster University. Hamilton, Ontario. 905-522-1155 ext. 36493.

May 2-9, 2009
Children's Mental Health Week. Organized by Children's Mental Health Ontario. www.kidsmentalhealth.ca.

May 4-10, 2009
"Now More Than Ever: Invest in Yourself." Mental Health Week 2009. Canadian Mental Health Association. 613-745-7750, akeay@cmha.ca, www.cmha.ca.

May 28, 2009
Diversity and Equity in Mental Health/Addiction: From Policy to Practice to Policy Conference. Hong Fook Mental Health Association. 416-493-4242 ext. 2243, mho@hongfook.ca, www.hongfook.ca.

For complete calendar listings, visit www.ontario.cmha.ca/events

May 28-30, 2009
"The Next 10 Years: Advancing the Vision and Voices of Collaboration." 10th National Conference on Collaborative Mental Health Care. Hamilton, Ontario. www.shared-care.ca.

June 22-24, 2009
"Grounding Trauma." CAST Canada conference on trauma, post-traumatic stress disorder, loss and grief. London, Ontario. 905-877-6547, www.cast-canada.ca.

September 22-25, 2009
"Recovery: Practicing in Partnership." Psychosocial Rehabilitation Canada 2009 Conference. Thunder Bay, Ontario. www.psrrpscanada.ca.

October 21-23, 2009
"Hope, Health and Healing: Mental Health Nursing around the Corner and around the World." Presented by the Canadian Federation of Mental Health Nurses. Halifax, Nova Scotia. www.cfmhn.ca/conference.html.

October 28-31, 2009
"Problem Solving Justice." 32nd Canadian Congress on Criminal Justice. Halifax, Nova Scotia. www.ccja-acjp.ca.

November 2-4, 2009
"Making Gains in Mental Health and Addictions: The Future Is Now." Conference hosted by Addictions Ontario, CMHA Ontario, Centre for Addiction and Mental Health, Ontario Association of Patient Councils, Ontario Federation of Community Mental Health and Addiction Programs and Ontario Peer Development Initiative. Toronto, Ontario. www.makinggains.com.

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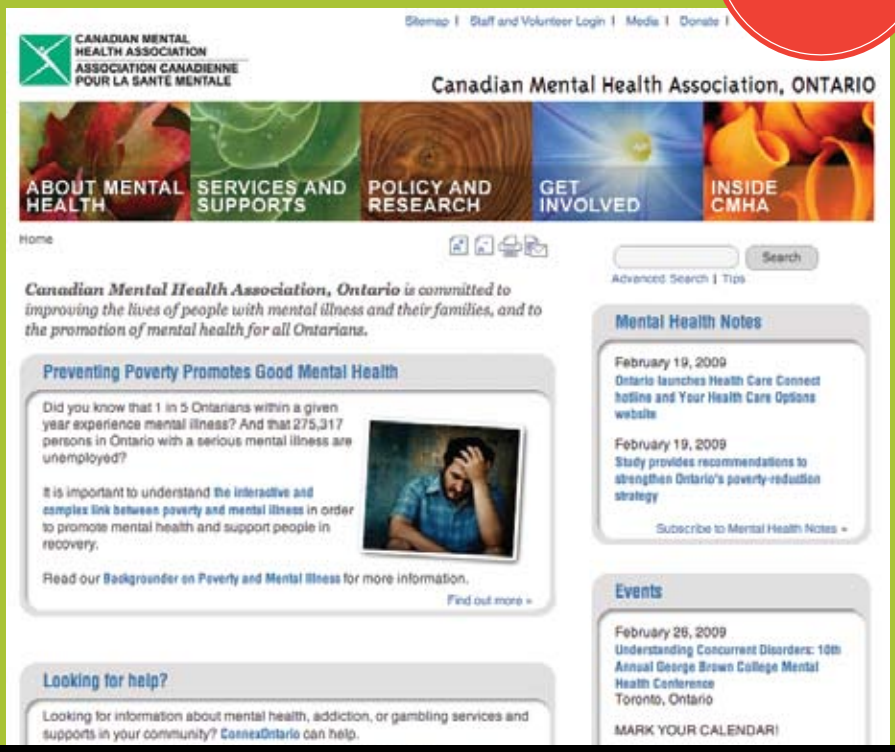

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