Diverting the Crisis Call

Report of the Crisis Call Community Development Project

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Mental Health and Criminal Justice Project
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"Thank You" to all whose hard work and dedication contributed to the success of the Thunder Bay Mental Health and Criminal Justice Project, with warmest thanks to the psychiatric Survivor participants who opened our minds to the problems they so frequently encounter in the administration of justice and to realistic solutions that hold the promise of transforming mental health and criminal justice programs and services in Ontario.

Sky Works Charitable Foundation

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TABLE OF CONTENTS

"Incarceration is costly and demands resources that would be better invested in social programs that have a more direct impact on crime prevention."
Towards Improved Corrections: A Strategic Framework http://www.icclr.law.ubc.ca

"Reform seems to connote taking what lies at hand, and making it better. Transformation seems to imply taking what exists, and making it different and even better still…If you reformed a caterpillar you would get a better caterpillar, if you transformed a caterpillar you would get a butterfly.

"For transformation of the justice system to succeed…society must no longer use the criminal justice system to handle social problems."

Legacy of Hope: An Agenda For Change Volume 1, Final Report From the Commission On First Nations and Métis Peoples and Justice Reform, June 21, 2004.
Chapter 4: Restorative Justice: Restoring Justice In Saskatchewan.
http://www.justicereformcomm.sk.ca/volumeone/09ChapterFour.pdf

1. Foreword

Desperate Times and Desperate Crimes: Abuse and Poverty

- Relentless Poverty/ Little Credibility
- Premise
- Complex Issues
- Empowerment

Human societies have been struggling with social, criminal, economic, ethical, and therapeutic issues relating to persons with mental disorders for centuries. While some individuals with a psychiatric disability knowingly break the law, people with mental health issues are more often victims of abuse, and social and economic circumstance. It is known that a great many psychiatric Survivors were victims of child abuse. Evidence from a number of studies reveals that as many as 80% of persons experiencing mental health issues have histories of abuse and a significant number of these individuals were physically and sexually abused while in psychiatric institutions.

Relentless Poverty / Little Credibility

Psychiatric Survivors not only face greater victimization than the general public, they also encounter greater barriers to accessing the justice system. Survivors often exist at the margins of society, living in poverty and homelessness. Fears and misconceptions about people with mental illness are as prevalent within the justice system as in society-at-large. Many Survivors neglect to report their victimization to police, feeling that they will be dismissed as non-credible victims or witnesses.

A crucial difference between the Thunder Bay Mental Health-Criminal Justice Committee and similar groups examining the criminalization of psychiatric Survivors is that of perspective. We believe that relentless poverty can itself induce severe depression, anxiety, interpersonal conflict, and may lead to suicidal thoughts, attempts and completed suicide. Relationship break-ups, and/or the loss of one's job, income or home may drive a person over the line between socially acceptable and unacceptable, even criminal behavior.

A person need not have a diagnosed mental illness to experience mental health problems, or to commit an offence that comes to the attention of police officers. The theft of food from a supermarket is more likely to occur because the thief is hungry than because s/he has a criminal mentality. The thief might or might not meet the criteria for a diagnosis of schizophrenia, depression or other specific disorder, but someone who has to steal in order to survive is likely to experience depression and anxiety.

Premise

The MH-CJ Project adopted the premise that *mental illness cannot be separated from poverty as the cause of unlawful behaviour*. The offences that bring people with mental health issues before a judge or justice of the peace are frequently acts referred to in the National Association of Mental Health Planning and Advisory Councils' Policy Statement[1] as *lifestyle crimes*: sleeping on park benches or in bus shelters, panhandling, and stealing

[1] "In Support of Maximum Diversion of Persons with serious Mental Illness From the Criminal Justice System", National Association of Mental Health Planning and Advisory Councils, February 19, 2003. http://www.namhpac.org

food. The Mental Health-Criminal Justice Committee views these as crimes related to economic deprivation and social exclusion. Canadian society devalues the poor and punishes behaviours inherent in living on the streets.

Readers are asked to note that the term "*Consumer/Survivor*" has been shortened to "*Survivor*", for convenience and because many members of the psychiatric survivor community refer to themselves not only as survivors of an illness, but also as people who have survived the psychiatric treatment system. The phrase *"mental health issues"* is used in place of *"mental illness"* wherever possible, and references to diagnostic categories are avoided. In this context, mental health issues are concerns that arise from traumatic events and life circumstances that could bring on emotional or psychological crises in anyone.

The distinction between the terms "*mental illness*" and "*mental health issues*" is significant.

- People can experience anxiety, depression and stress without meeting the criteria for a specific mental illness, as described in the physicians' reference text, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and
- Anxiety, depression and other psychological symptoms can be reactions to stressful circumstances, as well as signs of mental illness.

Extreme stress affects people differently and one's socio-economic status is a factor in the social impact of mental health problems. For example, in April 2004 when British Columbia MP Svend Robinson admitted to stealing a ring worth over $50,000, "friends, and even foes, were quick to express sympathy, concern, even respect for this man whose political career had come to such a sad, abrupt and dramatic halt." [2]

Robinson has been described as a "victim" of "severe stress and emotional pain", a mental state that applies to any number of inmates in Canada's correctional system. Jails are overcrowded with people suffering from severe stress who are guilty of sleeping in bus shelters because they have no home, or shoplifting bread and meat in order to have something to eat. Yet these people do not receive outpourings of sympathy.

Punishing an individual who commits an offence in response to hallucinatory commands will not rehabilitate that person or deter him/her from re-offending while in a psychotic state. Access to quality treatment and support is essential in such cases. Alternative police and judicial protocols may not help the Svend Robinsons of this country either, because they are so readily forgiven.

What the Mental Health-Criminal Justice Project did, and is continuing to do, is bring attention to the issues and needs of Canadians experiencing mental health crises brought on by social and/or economic circumstances beyond their control. For these people access to community supports, including income assistance, housing, education and employment services, can make every difference to their ability to live a full and meaningful life.

Complex Issues

Canada and other nations have a long way to go in search of an ideal system. The law is complex, and so is human nature.

[2] *Modern ritual replaces 'wrong' with 'illness',* The Vancouver Sun. http://tanadineen.com/COLUMNIST/Columns/svendrobinsonstress.htm

Psychiatric disorders are not all the same in terms of symptoms, cause or remedy. In some cases, symptoms can be controlled through use of medications, and counselling can help the person rebuild his/her interrupted life. But many Survivors believe their chances of recovery are better if they steer clear of psychotropic medications, because medication side effects can be more debilitating than the symptoms they are supposed to relieve. There is also an ongoing backlash against the medical model of psychiatry. People who don't believe their symptoms or actions are the result of a chemical imbalance or disease process may choose not to use medications to alter their behavior.

The Mental Health-Criminal Justice Working Groups have a diverse membership and a diversity of viewpoints and opinions. Some strongly believe that mental illnesses are brain diseases, and that psychiatric treatment is the first priority. For example, a person who is responding to visual or auditory hallucinations may need to be stabilized medically before other interventions can be of any benefit. Diverting that person to a supportive safe house may not be adequate to stem a crisis unless or until symptoms are controlled.

As stated, the issues surrounding mental health crises are extremely complex, often combining to create a repetitive pattern of trauma-crisis-arrest-trauma that seems to have no satisfactory solution.

Readers of *Diverting the Crisis Call* are asked to remember that persons with mental health issues often live in abject poverty and their offences reflect economic and societal circumstance. Implementing a broader and more effective social and economic safety net would make every difference in keeping a large number of people with mental health issues out of the justice system.

This task requires a great deal of cooperation among professionals, advocates and Survivors in systems that historically have been wary of one another. It requires much learning and a willingness to put aside traditional approaches to "managing the mentally ill client". But one of the greatest challenges is listening to the people directly affected by any and all changes that take place in these huge, complex systems: psychiatric Consumer/Survivors.

Empowerment

By listening we empower the speaker. Empowerment allows people to start taking back control over their own lives, and opens doors of opportunity and hope. Recovery, "*the process in which people are able to live, work, learn, and participate fully in their communities,*"[3] is built on hope, but the building blocks of hope involve more than visits to a psychiatrist and prescription medications. As persons with mental health issues struggle toward wellness, they need to be supported by Consumer-controlled services, a guaranteed income and comprehensive drug/medical benefits, housing, transportation, supportive employment initiatives and case management in least restrictive settings. Psychiatric Survivors, like other members of the community, benefit from the right to be part of the paid workforce—the right to work real jobs, earning real wages. This kind of support system comes with a substantial price tag, and funding initiatives are the responsibility of Federal and Provincial governments.

However, it is a price that must be

[3] *Integrating Consumers as Staff and Experts in Jail Diversion Programs*, September 22, 2004 http://gainscenter.samhsa.gov/html/resources/presentation_materials/ppt/Sept4NetConf.ppt

paid, because the cost of mental illness should never be a criminal record. *And,* please remember that an accused person with mental health problems has the same rights under the *Criminal Code of Canada* as any other accused person. Having a mental illness does not automatically make someone guilty as charged.

2. Introduction

- Unique Region / Unique Needs
- Pioneering Spirit
- Disability Rights
- Psychiatric Survivor Movement
- PACE
- Self-Disclosure Hard for Some to Handle

Unique Region / Unique Needs

Thunder Bay is located near the geographical centre of Canada, on the shores of Lake Superior, in a region nearly the size of Europe.

Northwestern Ontario is isolated, with limited road access to many communities. The climate and low population density of the region have a significant impact on the provision of health/mental health services. It is difficult to recruit and retain physicians, and people often must leave their home communities to obtain health and medical services.

Two thirds of the area encompassing Northwestern Ontario has no year-round road access. Residents of isolated communities must drive dangerous winter roads or rely on expensive air travel to get in and out of remote communities. The only major roadway, the Trans-Canada Highway, is frequently closed in the winter because of dangerous weather-related conditions and in the summer due to washouts.

Pioneering Spirit

Perhaps because of its geographical isolation, the people of Thunder Bay have developed a pioneering spirit of self-help and mutual support. People with disabilities in Thunder Bay actively built upon on the Canadian Consumer Movement of the 1970s to create strong community supports based on the Independent Living Philosophy. Thunder Bay led the way, establishing a supportive residential community in 1975, years ahead of other Canadian cities.

Disability Rights

Independent Living (IL) is a vision, philosophy and movement of persons with disabilities that has changed the way society views and responds to those with disabilities.[4] Independent Living is founded on the right of all people with disabilities to:

- Live with dignity in their chosen community;
- Participate in all aspects of their life; and
- Control and make decisions about their own lives.

Psychiatric Survivor Movement

While the IL Philosophy encompasses the full cross-sector of disabilities, the Psychiatric Survivor movement established itself in the city in a parallel but independent manner. In November 1989, three Canadian Mental Health Association (Thunder Bay Branch) New Foundation's Club House members attended a national conference for users of mental health services, called "Our Turn". It was the call for Psychiatric Survivors to band together and fight for their rights as oppressed and marginalized human beings. Soon after, a provincial organization called the Ontario Psychiatric Survivor Alliance (OPSA) was formed to act as a resource to Consumer/Survivor development, to

[4] *What Is IL?* Centre for Independent Living in Toronto. http://www.cilt.ca/Lists/What%20is%20IL/WhatIsIL.aspx

provide education and address systemic issues across the province. While the provincial body had representation from across Ontario, the majority came from the southern portion of the province.

PACE

In Thunder Bay, the OPSA provincial representatives and a core group of Survivors developed a terms of reference. By February 1990, Survivors in Thunder Bay formed the first OPSA Chapter. Over the following years, the membership grew and in January 1993, the organization adopted a new name. People Advocating for Change through Empowerment Inc. (PACE) became the first Consumer/Survivor organization in the province with a specific mandate to provide systemic advocacy, education, and peer support within a social/meeting club-like atmosphere. It was an organization run by and for past and current recipients of mental health services. Members would decide the future of the organization through membership meetings. The only criteria for membership in PACE was support for its philosophy and an agreement to its terms of reference.[5]

It is this same pioneering spirit that differentiates the Thunder Bay Mental Health-Criminal Justice Committee from similar projects around the country. Most readers of this report will already know that changes are desperately needed in the treatment of persons with mental health issues who come into contact with the Criminal Justice System. The administration of justice has not kept pace with the Canadian and Ontario Human Rights Codes, which legislate inclusion, respect and dignity to persons with physical and mental disabilities.

The Mental Health-Criminal Justice Committee considers Psychiatric Survivor participation vital to effecting change within the system. Many Survivors have lived the issues of discrimination, stigma and poverty daily and are uniquely qualified to point out the problems and gaps in programs and services.

Self-Disclosure Hard For Some to Handle

However, similar justice projects and committees in Canada and other nations have not invited Survivors to the table. Self-disclosure and personal stories can be difficult for "professionals" to deal with. Mental health service providers do not want to be seen to stop a Survivor in the process of self-disclosure. People who work within the justice system may feel they are being blamed for the insensitive and downright traumatic treatment persons with mental health issues have suffered at the hands of police, correctional officers and in Canada's criminal courts and psychiatric hospitals.

These personal stories are heavily laden with emotion that can stall meetings and interrupt agendas. And memories are subjective; how then do we even get past the stories?

The Mental Health-Criminal Justice Committee struggled with this dilemma. Getting beyond this impasse sometimes bogged us down. But what makes the Thunder Bay Committee different from so many others is the willingness to persevere, to listen and validate feelings, to keep coming back to the table and use the stories to identify common concerns.

The process of change has begun, and our time has been well spent.

[5] *History of PACE*. People Advocating for Change through Empowerment. http://www.pace-tbay.net/category/3

Diverting the Crisis Call

"Consumers who disclose may continue in flashbacks for several days after. Professionals can also experience distress, just hearing these stories."
--MH-CJP Participant

"Tell the person who disclosed, 'We take what you shared with us seriously and want to use your story to help prevent this from happening to others.' Have someone on hand to take the person aside for extra support if they want it, and then get on with the meeting."
--MH-CJP Participant

3. Life for People With Mental Health Issues at the End of the 20th Century

- Compulsory Powers
- Mental Illness as a Metaphor
- Anti-Psychiatry
- Mental Health Reform
- The Price of Divestment
- Charges Generally Minor

In the mid-20th Century, with the rapid development of drugs to treat the symptoms of many mental illnesses and funds available to care for large numbers of people in institutions, mental disorders came to be thought of as diseases to be treated medically and patients were hidden away from society. However, as defense forces returned from the two World Wars, Korea and Viet Nam, suffering emotional wounds nearly as grave as their physical injuries, attitudes toward mental health care began to change.

Compulsory Powers

Adult who have maladies like migraine headaches or stomach ulcers are rarely treated against their will, but treatment for a psychiatric disorder may be imposed upon a person. In many countries, including Canada, a person judged to be dangerous to self or others can be involuntarily admitted to a psychiatric facility for assessment and/or treatment. Because of these compulsory powers, psychiatry has been criticized for undermining the civil liberties of individuals who do not ascribe to the prevailing belief system and behaviors of their culture.

Mental Illness as a Metaphor

A popular view of mental disorders held in the 1960s maintained that *insanity is a sane response to an insane world.* Liberal activists like Dr. Thomas Szasz, strongly criticized these compulsory powers. Szasz argued that mental illness is a metaphor, describing undesirable behaviors, thoughts or feelings rather than a demonstrable biological pathology.

According to Szasz, the mental health system has no right to impose psychiatric treatment on anyone for "disorders" that are merely euphemisms for behaviors disapproved of by the state. Furthermore, "just as legal systems work on the presumption that a person is innocent until proven guilty, individuals accused of crimes should not be presumed incompetent simply because a doctor or psychiatrist labels them as such. Mental incompetence should be assessed like any other form of incompetence, i.e., by purely legal and judicial means with the right of representation and appeal by the accused".[6]

Szasz also argued that both the "insanity defense" and "involuntary mental hospitalization" should be abolished. "No one should be deprived of liberty unless he is found guilty of a criminal offense. Depriving a person of liberty for what is said to be his own good is immoral. Just as a person suffering from terminal cancer may refuse treatment, so should a person be able to refuse psychiatric treatment".[7]

Anti-Psychiatry

These ideas came to be associated with a movement called anti-

[6] Thomas Szasz: Information From Answers.com http://www.answers.com/main/ntquery?method=4&dsid=2222&dekey=Thomas+Szasz&qwp=8&curtab=2222_1&linktext=Dr.%20Thomas%20Szasz's

[7] Szasz: Information From Answers.

psychiatry, which opened the door to giving people with mental illness greater control over their lives. Over the past thirty years, patients and ex-patients (Consumers/Survivors) recovering from the incapacitating effects of their illness, institutionalization, and diminished self-esteem have promoted a movement toward peer support, and consumer-controlled services. Since its anti-psychiatry beginnings, the Consumer/Survivor movement has made significant gains in promoting its vision of recovery and acquiring legal rights against extended and unjustified institutionalization.[8]

At the dawn of the 21st Century, various groups with contradictory ideologies are competing to shape mental health services and treatments. New research findings regarding the biological basis of mental illness and how mental illness can affect the brain have prompted a revival of the medical model and the concept that violent or criminal behaviors are manifestations of a person's illness, not intentional wrongful acts. At the same time, the move toward closing psychiatric hospitals in Canada, and other Western nations, has been influenced by the revolt against the medical model.

But *hospital restructuring* in Ontario was also precipitated by a financial crisis in the health care system. According to the Atlas Reports[9] describing OHIP-provided core mental health services, "Between 1992/93 and 1997/98, costs for fee-for-service core mental health services rose 12.7 per cent, a rate slightly higher than the increases for total health and total OHIP costs." And, "The major contributor to the growth in core mental health care costs was an increase in the percentage of Ontario's population who used those core services."[10]

Mental Health Reform

Mental health care in Ontario is moving away from its long-time emphasis on institutionalization of people with mental health issues to a system that depends on effective and accessible services delivered in the community. This policy redirection is referred to as mental health reform.

Over the past 20 years, twenty mental health policy reports have repeated the recommendation that real investment in community-based care is necessary for mental health reform to succeed.

If one compares long-term care systems that focus on custodial care, limit individual freedoms and pay scant attention to rehabilitation, to relatively more cost-effective systems providing respectful community services, it seems self-evident that de-institutionalization improves peoples' quality of life. The transition from institutional to community care has benefited individuals who have the skills and financial resources to live independently. However, this policy shift has essentially abandoned a great many people with serious mental health issues to homelessness, struggling to survive with few services or supports.

The Price of Divestment

As psychiatric beds close, police are called upon to respond to increasing numbers of incidents involving people

[8] http://www.psychosocial.com/IJPR_8/Recovering-McLean.html

[9] Lin, Elizabeth, Goering, Paula. Fiscal Changes for Core Mental Health Services Delivered by Fee-for-service Physicians: http://www.ices.on.ca/file/Fiscal%20changes%20for%20core%20mental%20health%20services%20delivered%20by%20fee-for-service%20physicians.pdf

[10] Lin and Goering, *"Fiscal Changes"*

with mental health issues, so-called "Emotionally Disturbed Person" (EDP) calls. Oftentimes these calls originate with landlords or desperate family members who misinterpret the behaviors of people with mental ill health as indicators of criminality and violence. Persons with mental health issues often wind up incarcerated because there are no community supports that can be put in place quickly when crises arise.

Incarcerating people with mental health issues imposes substantial costs on the justice system and criminalizes an already marginalized population. Jails and prisons are not environments conducive to appropriate or humane treatment of people who are poor and sick. The filing of criminal charges against someone with mental health issues should be a last resort. Incarceration exacts a costly and dangerous toll on the ill person, their family, human service agencies and the justice system.

Offenders with mental illnesses are frequently held in custody for offences that wouldn't result in a custodial sentence even if they were convicted. As Jake Rupert, a reporter with The Ottawa Citizen, writes, "People who suffer from mental illness and are charged with crimes are, collectively, spending years in jail waiting for hospital beds to open up so they can be assessed to see if they should be in the justice system at all."[11]

Charges Generally Minor

When a person with mental health issues is arrested the charges are usually minor: loitering, begging, disturbing the peace, and other misdemeanors. When offences involve violence, the violence is generally directed towards family or friends, not strangers. Police protocol requires a no-nonsense response to the threat of violence for their own safety and that of the public. Tragically, encounters between police and persons with a mental illness sometimes result in police use of lethal force.

This was what happened on February 20, 1997, when Edmond Yu, a 35-year old homeless man diagnosed with paranoid schizophrenia, was shot dead by police in Toronto, Ontario. The circumstances surrounding his death and the revelation of Edmond's tragic struggle with mental illness and homelessness attracted intense public and media scrutiny. Yu had been a bright medical student, forced to drop out of school because he could not cope with his illness. Like many other people with mental illness, Yu lived on the streets. After an altercation at a bus stop, police isolated him on a city bus. Officers talked with him for a number of minutes but when he reached into his coat and pulled out a hammer he was shot six times at close range, and killed instantly.[12]

> The last few years of his life were spent bouncing back and forth between hospital and the streets. Eventually the cops stopped picking him up even though it was obvious that without help he would die.
>
> --MH-CJP family member's experience (Personal communication)

[11] Rupert, Jake, Mentally ill wait in jail for justice to be done; Judge fails to rule on legality for 20 months. The Ottawa Citizen, Friday, May 27, 2005. http://www.ottawamenscentre.com/news/20041110_mentally_ill.htm

[12] Open Season on the Mentally Ill. Canadian Broadcasting Corporation http://www.brsk.net/cybereye/edmyu.htm

4. What Started the Process of Change?

- Sky Works Documentary Film
- Police Officer Haunted By Shooting
- A Vision of Change
- CMHA Justice Project and Needs Assessment

Crisis Call - The Documentary Film

Incidents like the shooting of Edmond Yu occur repeatedly in Canadian cities, and other developed countries. In her documentary, *Crisis Call* (2002), filmmaker Laura Sky asks whether people with guns should ever be the ones who respond to individuals experiencing a mental health crisis. Her belief is that people need to be diverted into appropriate support systems long before they encounter police or the courts. And diversion should include an alternative to both jail and hospital.

Crisis Call was the catalyst for change in Thunder Bay, where much of the research and filming of the documentary also took place. Three important conditions existed in Thunder Bay, leading to Sky's decision to film here and to engage stakeholders in the development of a coalition advocating for systemic change: There was a police officer on the Board of Directors of the Canadian Mental Health Association, Thunder Bay Branch, who was known as a community organizer; CMHA Thunder Bay had particular credibility with the Survivor community as a good advocacy group; and Survivors in Thunder Bay were organized.

Police Officer Haunted By Shooting

Andria Cowan, a Toronto police officer who was involved in the shooting of Edmond Yu, says that society let Yu down and that she feels "haunted" by the shooting.

> "[Police] have the authority under the Mental Health Act to make an assessment and take someone's liberty away, but we don't have the authority to make an assessment to get someone the help they need." [13]

This sentiment was echoed by police and other stakeholders in Thunder Bay who agreed that the protocols governing how police interact with people experiencing mental health crises must change.

Crisis Call has been the subject of panel discussions across Canada and is being used by police services in various municipalities as a training film, including Aylmer, ON where the Ontario Police College is located.

A Vision of Change

Sky's vision was to use the film to change behavior.

> "One of my goals was to keep cops in the room when [screening] the film, to give them enough surface of identification, and give them the opportunity to think about these things in a different way than they were used to thinking about them. I wanted

[13] Cops, Courts and Compassion; Finding Justice for the Mentally Ill. Network, Canadian Mental Health Association, Ontario. Vol. 20, Number 3, Winter 2005, p. 7 – 9. http://www.ontario.cmha.ca/admin_ver2/maps/network%5Fwinter%5F2005%2Epdf

> to say to them, 'We think you're interested in positive change,' rather than just to scold them and give up."

That vision was realized in the form of the Thunder Bay Mental Health-Criminal Justice Project, a partnership between Sky Works Charitable Foundation and CMHA, Thunder Bay, which successfully brought together a 60+ stakeholder coalition to examine the problems Survivors experience, advocate for change and, where possible, implement changes to police and other criminal justice protocols and procedures at the local level.

CMHA Justice Project and Needs Assessment

Interest and concern about the difficulties persons with mental illness encounter when dealing with the criminal justice system prompted the Thunder Bay Branch of CMHA to initiate a needs assessment as part of a local justice project (Mental Illness and the Criminal Justice System, 2002) to identify areas requiring improvement and to examine possibilities for change.

The purpose of the Needs Assessment was to provide CMHA and the community with a better understanding of the concerns pertaining to individuals with mental illness who come into contact with the criminal justice system. The findings of the assessment were published in the report, Mental Illness and the Criminal Justice System: A Needs Assessment: Report to the Canadian Mental Health Association, Thunder Bay Branch, September 2003.

The Needs Assessment highlighted problems within the criminal justice system that are not likely to change without considerable efforts on the part of human services and justice system professionals, and the implementation of alternative protocols for handling mentally ill offenders.

"We have Consumer advocates and hard-nosed people within the correctional system pointing out the same problems and concerns."
--MH-CJP Participant

5. The Thunder Bay Mental Health-Criminal Justice Project

- Building a Working Group
- Inaugural Meeting
- A Framework For Change
- Moving Forward
- Steering Committee
- Sub-Committees
- Community Working Group
- Many Hours of Commitment
- Barriers to Equitable Participation
- Inclusiveness and Working With People Who Live in Long-Term Poverty
- Survivors Shouldn't Have To Pay To Volunteer Their Time
- Supporting Survivor Participation
- Spring 2005 and a Controversial Letter
- A Larger Role for Survivors
- Survivors Are Our Guides
- Disclosure Can Cause Discomfort
- A Venue for Validation
- Disclosure and Confidentiality
- Positive Learning Experience
- Betrayal of Trust
- Strategic Planning
- MH-CJP Challenged By the Introduction of a Provincial Strategy for Justice and Human Services
- Impact of Provincial Strategy on the Mental Health-Criminal Justice Committee
- Making Important Decisions
- Eligibility To Vote
- Revisiting the Decision of November 10
- Reconvening
- Ministry Preference

Building a Working Group

Several key players in the Thunder Bay MH-CJ Project participated in the filming of *Crisis Call*, including Jim Gillespie, founding member of the Consumer/Survivor organization, People Advocating for Change through Empowerment Inc. (PACE), who was hired to review the literature and media pertaining to mental health issues, criminality and the law, and to start the process of inviting psychiatric Survivors, mental health service providers and criminal justice system personnel to the table.

During the months of July, August and early September 2004, the Project Coordinator interviewed interested stakeholders in preparation for the inaugural meeting of the Project. Interview questions were geared to the individual or the agency the interviewee represented, to elicit information about the person/organization's experiences or perspectives on Mental Health-Justice issues.

Inaugural Meeting

The Inaugural Meeting of the MH-CJ Project was held on October 28, 2004, and brought together more than 50 stakeholders with the will to collaborate and create systemic changes of benefit to all. This Working Group included frontline workers, outspoken Survivor-advocates, Aboriginal groups and professionals with the authority to influence or make decisions within their organization.

Articles in the local daily newspaper and effective outreach efforts by CMHA and Mr. Gillespie brought together a diversity of participants who spoke to the need to address these issues in Thunder Bay. The number of Survivors in the room was also promising. In order to implement solutions, it was

clear that the group needed the active participation of Consumer/Survivors who use mental health services.

Stakeholders were asked to identify one or two current practices, which from their perspective, knowledge or experience work/don't work well for people with mental health problems experiencing a crisis.

Concerns raised at this first meeting included:

- The criminalization of people with mental illness exacerbates the mistreatment of this vulnerable and socially alienated group of people;
- There is a lack of funding for programs that seek to find solutions to the problems;
- Regional resources are scarce and difficult to access;
- Many of the people institutionalised in Thunder Bay constitute a socially isolated, displaced population flown in from Northern communities for treatment;
- These displaced people have become a "hard-to-serve" population;
- Professionals with expertise in complicated disorders such as Borderline Personality Disorder and Dissociative Identity Disorder, are scarce; doctors often must be brought in from Southern Ontario to provide care and consultations;
- The courts are at a loss in terms of helping/diverting people with mental health issues to appropriate resources—hospital, conditional sentences, etc;
- Few pre-sentence reports or assessments are conducted;
- Many people with mental health needs are convicted, incarcerated then released after serving short sentences without being assessed for mental health, income or housing needs;
- The closing of the Women's Shelter has led to homelessness and the victimization of vulnerable women;
- Many service providers are unfamiliar with existing resources, and don't have the time to research referral options;
- Long waiting lists for services create an atmosphere of frustration and helplessness for service providers and the people waiting for help;
- Police officers attempting to find help for a person in crisis are regularly turned away by the mental health system. Police often detain and release the same person again and again without finding help for them. This creates a cycle of frustration and resentment.
- Police response to Survivors in crisis—showing up in large numbers, using excessive force or with tactical weapons-- is seen as "overkill";
- More and more offenders with mental health issues are being detained at the District Jail, where there is a ratio of one nurse to 120 inmates;
- Aboriginal mental health needs are under-served and under-resourced. More education about Aboriginal issues is needed across all sectors and the courts, police services and correctional facilities should hire more Aboriginal workers;
- Discharge planning is the key to bridging services and sectors. Currently it is a fragmented, poorly coordinated process;
- Ineffective multi-sector planning speaks to the need for communication and collaboration among sectors,

agencies, institutions and relevant Ministries.
- A lack of awareness among professionals and public ignorance gives rise to "NIMBY" (Not-In-My-Back-Yard") stigma.

A Framework for Change

The MH-CJ Committee's priority was to prevent the criminalization of people with mental health difficulties by diverting people into appropriate community support services.

Typically, diversion is a court-based intervention that offers an alternative to criminal prosecution and incarceration of people whose mental health issues are the major contributing factor to their criminal offence. Over the course of MH-CJ meetings, a broader notion of community-based and institutional diversion emerged.

This re-defined concept of diversion includes:
- Crisis prevention as a crisis diversion model, including social and housing supports, employment training and opportunities.
- Alternatives to hospitalisation and criminal prosecution for police intervention in response to 911 calls.
- Making court diversion work.
- Diversion programs and practices within the jail system.
- Alternative practices and policies in discharge planning and follow-up support services.

Diversion practices include:
- Effective peer support systems integrated at various levels of intervention,
- Additional and re-allocated resources,
- Pilot projects and limited term alternative practices that would be tracked and evaluated.

All of these alternatives necessitated addressing priorities the group had already identified: adequate funding, lobbying and advocacy, professional and public education, cooperation and collaboration between sectors, agencies and organizations, and discharge planning. The principle guiding this framework was Survivor inclusion in the delineation, description of issues, options and strategies throughout the community development process.

Moving Forward

One of the challenges facing the broad, diverse Working Group was to organize their work in a manner that balanced the continued involvement of everyone committed to the project, with a structure that allowed work to be accomplished. To this end, five sub-committees and a Steering Committee were formed according to goals identified at the December 2004 meeting.

Steering Committee

The Steering Committee, comprising the Chairs of each sub-committee and Survivor representatives, was established to develop an overall plan based on the identified priorities; review sub-committee plans and progress; ensure a systemic approach that includes systemic priorities; oversee the actual work and direction of the project; ensure the effective participation of psychiatric Survivors; and participate in an ongoing evaluation of the group's progress, including problem-solving and re-directing the process, if necessary.

Sub-Committees

- Pre-Crisis Diversion
- Police Issues
- Court Diversion
- Incarceration
- Community Supervision & Discharge Planning

Each of the five original sub-

committees was allotted the task of developing a work plan to address key priorities within its scope. The work plan involved identifying action steps, timelines and persons taking action; ensuring the participation of psychiatric Survivors on every sub-committee; reviewing plans and progress; ensuring a systemic cross-sector approach; and documenting all activities and learning.

In the initial stages, the decision was made *not* to formulate a separate psychiatric Survivor sub-committee for fear of isolating and compartmentalizing Survivor participation. This changed when Survivor members realized that they needed to provide each other with strategic support for their effective participation in the larger group and on other sub-committees.

Community Working Group

Some stakeholders participated solely in the larger Community Working Group. This group met every month to six weeks to review action plans, ensure that these plans were consistent with identified goals, and participate in other decision-making.

In February 2005, the Project Researcher/Coordinator resigned due to health issues and work-related stress. Although considerable attention went into the formulation of an accommodation plan on the part of the project co-sponsors, the employee felt that it was in his best interests to leave the project at that time. One month later, another Survivor, with an educational background in clinical psychology and previous experience as coordinator of disability/abuse/justice-related projects in Thunder Bay, was hired to take the project to completion.

Many Hours of Commitment

Developing and maintaining a coalition of professionals and concerned citizens requires a huge time commitment from everybody involved. For people in the mental health and criminal justice systems, MH-CJ Committee participation meant fitting frequent meetings into already busy schedules.

Barriers to Equitable Participation

Many Survivor participants did not have paying jobs, and subsidized their participation through the outlay of expenses and contribution of their time. Survivors' life expertise was an essential component of the learning process, and one that opened the eyes of salaried participants to the barriers preventing full inclusion of Survivors—many of these barriers created by living on welfare or ODSP.

For example:

- Many Survivors rely on public transportation, and taking the bus means being at the stop on time, or not getting to a meeting at all. It was not unusual for Survivors to attend 2 or 3 meetings/week, and many could ill afford the round trip bus fare.
- Several Survivor participants are single/unemployed parents. Attending meetings generally means getting a babysitter and paying out-of-pocket for child-care. This is a significant expense to a low-income family.
- Fitting in with a roomful of professionals, often means using limited funds to pay for new clothing, haircuts and other personal goods that raise one's self-esteem and boost self-confidence.

Many Survivors spend countless hours in under-valued and uncompensated voluntary work. Participation on boards and committees is time-intensive for anyone, but Survivors

generally do not see the fruits of their labor reflected in consultant's fees or a paycheck.

Inclusiveness and Working With People Who Live in Long-Term Poverty

The challenge that human service organizations face is "to make volunteerism a relevant, purposeful engine for democracy and sustainable communities *today*, and by doing so, to create a vibrant, purposeful society *tomorrow*." [14]

As previously stated, many salaried participants do not fully appreciate the barriers to participation on boards and committees that arise from poverty and Survivors, whose position is strictly voluntary, may feel like token participants in the process of change.

Tokenism refers to situations where community members appear to have a voice in operating a program or making decisions, but in fact have little or no choice about what they do or how they participate.

Survivors Shouldn't Have To Pay To Volunteer Their Time

Psychiatric Survivors are the experts on what is effective in their lives, and what is not. Mental health and justice system professionals can help by providing Survivors the space to grow, and by listening and truly hearing their point of view.

Respect, understanding and appreciation of the value of Survivor participation can be communicated by publicly thanking people for their volunteer work. Committees can establish a welcoming atmosphere by remembering that the inability to introduce oneself by a professional title and agency affiliation is uncomfortable and can even feel belittling.

Supporting Survivor Participation

There are a number of ways to support Survivor participation, including:

- Taking occasional breaks. Despite the enactment of no smoking policies in public places, cigarette smoking has long been a significant part of hospital culture, and some smokers maintain that smoking calms their nerves.[15]
- Reduce, eliminate or explain professional jargon and acronyms. The way professionals talk, analyze issues and plan solutions is abstract and complex. It is important that all participants are able to understand the issues being discussed.
- Try not to reword a Survivor's ideas or statements. This habit can undermine a Survivor's belief that his or her contribution is acceptable at face value.
- Ensure that more than one Survivor participates on any given committee. As with professional colleagues, Survivors' views and opinions differ and most committees seek a range of viewpoints when making decisions. When a Survivor sits as a representative of a Peer Support agency or Consumer/Survivor initiative, s/he may need time to connect with Peer colleagues before plans or decisions are finalized.
- Ensure that clerical/ administrative support is made available to Survivor

[14] Fletcher, Adam. The Freechild Project; *Purpose, Empowerment and the Experience of Volunteerism in the Community.* http://www.freechild.org/volunteerism3.htm

[15] Psychiatric Patient Advocate Office: *Advocacy Guidelines for Restrictive Smoking Policies in Psychiatric Hospitals.* http://www.ppao.gov.on.ca/pos-smo.html

participants, or that Survivors are assisted with the cost of materials such as printer paper and ink cartridges. Make photocopiers and fax machines available for the distribution of information.

- Provide for honorarium money when budgeting for special projects and participation costs. It's one thing to ask Consumers to give freely of their time and life expertise, but nobody should have to pay to volunteer.

Spring 2005 and a Controversial Letter

March 2005 was a new beginning, of sorts. The new Project Coordinator was fortunate to step in to a well-established coalition that was already working towards realizing the goals and objectives it had identified.

In April, the structure and process of the Community Working Group was inadvertently tested when the Steering Committee approved a letter written to introduce the nature and purpose of the MH-CJ Project to the Members of Parliament and Provincial Parliament representing Thunder Bay and Region.

The letter was sent to the membership asking whether people wanted their names included in the MH-CJ Stakeholder list that was to be enclosed with the letter. Reaction took the Steering Committee by surprise. Many people felt that, if such a letter was needed, the CWG should have been consulted beforehand. Some of these individuals, given their jobs and their working relationships, could not have their names associated with political lobbying and/or advocacy. Others questioned the wisdom of introducing the MH-CJ Committee's work to local politicians at a stage in the process when we were not ready to ask for any specific political action.

The controversy was an eye-opener for the Steering Committee, but one that demonstrated participants were alert and valued the egalitarian decision-making process that gives equal status to all participants.

A Larger Role For Survivors

By necessity, a small number of Survivors found themselves shouldering the task of speaking for many who could not participate with any regularity. It was not only a huge responsibility, it was often difficult and uncomfortable for Survivors to sit across the table from police and/or correctional officers who represent everything Survivors had come to mistrust.

Systemic issues became personalized. In order to communicate experiences, Survivors had to "tell their stories". Emotionally laden disclosures tended to derail agendas or halt meetings entirely. Survivors sometimes left meetings angry or in tears.

Emotional support was inconsistent. Some Survivors complained that even the mental health professionals at the table seemed impatient. The stories made many participants uncomfortable.

But, as one Survivor stated, "The issues and the stories are supposed to make us uncomfortable. We're talking about serious issues that make us angry and affect peoples' quality of life."

> "Listening to other peoples' stories was a strange experience at first. Just listening to each other, thinking about the mental health system, and how it could be different. It was really powerful because in the 10 years since I was first in hospital I never met people who would sit and listen to my personal experiences in the system. Mostly people get upset and angry, or play it down, or tell me to forget it. But here is a place where people can share intimate secrets and were prepared to listen to me

with encouragement."
--Survivor

"Yeah, I'm angry, but having raged at the injustice of it all in the safety of our working group, I don't have to lose it in a meeting, even when I'm triggered. I can use my anger to argue for the changes I believe are necessary."
--Survivor

Survivors Are Our Guides

Near the end of April 2005, psychiatric Survivors formed their own work group—the Consumer/Survivor Issues Sub-Committee. Initially this committee was conceived as a forum for discussing personal/systemic issues and obstacles to full participation in the MH-CJ Project. It took on the additional role of an oversight committee that June to monitor the activities of the other five sub-committees, to maximize Survivors' voices in the process of identifying problems/solutions, and to ensure that Survivor input was valued, respected and incorporated into the community development process.

Facing barriers to recovery and inclusion in the community on an almost daily basis, members of the Consumer/Survivor Issues Sub-Committee have a unique opportunity to influence change through their participation in the MH-CJ Project. Survivors are our guides, taking participants who do not have psychiatric histories through the alleyways of poverty, discrimination and stigma, and the map we use is drawn from their life stories.

The MH-CJ Project has become known across Ontario, and perhaps elsewhere in the country, for its determination to include Consumer/Survivors and to learn from their experiences. We have re-defined "normal working relationships" by integrating Survivors' views, experiences and ideas. Meetings include attention, space and time for Survivors' voices. The experiences and the knowledge base of Survivor members inform our discussions and our strategies.

This has taken a great deal of learning and change that wasn't always easy. We had to look closely at what we thought, believed and felt about the lives of psychiatric Survivors. Survivors expressed frustration--even anger--at what the rest of us didn't know or understand.

Disclosure Can Cause Discomfort

Similar groups have been heard to talk about the Thunder Bay MH-CJ Committee with curiosity and wonder. At an out-of-town conference attended by several MH-CJ Steering Committee members, a Southern Ontario professional stated that his group had tried talking with Survivors, but found it too hard, "*because they always need to tell their stories, and that makes us uncomfortable*."

From the podium, another presenter admitted that the work being done in his community does not include Survivors. He was admiring but perplexed that psychiatric Survivors are active in Thunder Bay.

There are compelling reasons why Consumers should be involved in all areas of mental health and forensic services. Consumers can speak on most issues from personal experience, and offer innovative ways of looking at barriers, gaps and other problems of service delivery. Consumer involvement renders policies and processes more relevant to their lives, and it is in keeping with Federal and Provincial Governments' principles that all persons with disabilities speak for themselves.

In **"Kia Mauri Tau!"**: *Narratives of Recovery from Disabling Mental Health Problems,* the authors write:

> "Stories play a key role in our interactions with professionals and agencies. We narrate a series of events to a lawyer, we give a doctor an account of how our symptoms arose, and in order to obtain a welfare benefit, we are expected to tell stories about events impacting on our health, family or employment situation. In mental health settings, the stories patients and family members tell about what has been happening are part of the process leading towards diagnosis and treatment…
>
> Psychotherapy and counselling rely on people's ability to relive their experiences emotionally as they talk about them… Therapeutic conversations provide a setting for the emergence of stories which we may not wish to tell elsewhere – stories of guilt, shame, loss, failure, disability, deep hurt, betrayal and abuse."[16]

A Venue For Validation

"Talk" is a well-accepted psychotherapeutic tool used by many counselors and therapists. It is a way to externalize trauma, confront painful memories and work towards healing the wounds of horrific experiences.

In the context of the MH-CJ Project, disclosure was a way of seeking validation of personal traumatic experiences. Disclosures reveal kernels of truth, which are useful in identifying practices that must be changed, despite the fact that any person's perceptions and recollection of events is subjective.

Consumer/Survivor Issues Sub-Committee meetings became venues for validation, support and the identification of crucial issues and obstacles, and Survivors' stories reflect experiences, good and bad. We cannot afford to shut the stories out.

Disclosure and Confidentiality

In any group where personal information is disclosed, confidentiality and trust among members are essential. But problems arise when these principles are not clearly defined or understood. Many of the personal stories disclosed in Consumer/Survivor Issues meetings had educational potential for the larger Committee. The problem became how to communicate these stories when recording details could betray the identity of the teller.

The CWG was small enough for regular participants to get to know one another. The decision to publicly state, *"I have mental health issues that have led to law enforcement/justice system contact"* cannot be made lightly. Although audiences across the country learned from the disclosure of Survivors appearing in the documentary *Crisis Call*, some of the Survivors who told their stories experienced backlash from family and friends. While one of the positive aspects of disclosure can be opening others' eyes to one's quality of care/quality of life, people with mental health issues are vulnerable, and the risks include losing those closest to you and having doors of opportunity shut in your face because we have yet to overcome stigma.

[16] **"Kia Mauri Tau!"** Report of the University Of Waikato Mental Health Narratives Project 2002. Narratives of Recovery from Disabling Mental Health Problems. Hilary Lapsley, Linda Waimarie Nikora and Roseanne Black. http://ccamhr.ca/resources/Narratives_of_Recovery_From_Disabing_Mental_Health_Problems_2002_KiaMauriTaureport.pdf

Unfortunately, many of the stories told around the Consumer/Survivor Issues table cannot be told until or unless those risks are reduced considerably.

Positive Learning Experience

The meetings and activities of the C/S Issues Sub-Committee provided positive learning experiences for participants. The sharing of personal experiences--good and bad—led to a strong sense of belonging and the affirmation that the status of psychiatric Survivor can actually be empowering. The sum of a Survivor's life experience gives him/her unique qualifications that can be used to help others. One Survivor participant said that acknowledging his psychiatric history is like "coming out of the closet". It might take a while longer to tell work colleagues he is a Survivor, but being open with clients has led to improved relationships and clients approaching him to talk about their problems.

Betrayal of Trust

C/S Committee members made every effort to be welcoming, inclusive and patient with personal disclosure. But betrayal of confidentiality and trust within its own ranks was unexpected. In the summer of 2005, the C/S Issues Sub-Committee Chair asked the Steering Committee for help dealing with a member who had interfered in the medical-legal affairs of other participants, without their knowledge or permission.

Neither the Steering Committee, nor the CWG, or any of the smaller work groups had foreseen the need for ethical guidelines regulating the behaviour of project participants. Steering Committee members hesitated to take disciplinary action against the person, but eventually asked the person to withdraw from participation in the Project as a whole.

The decision to exclude this individual was based on a working document of Guiding Principles for Participation in the Consumer/Survivor Issues Sub-Committee, which states that the C/S Sub-Committee *must be a safe, non-judgmental forum for sharing personal stories…Each person has the right to leave meetings feeling safe and unharmed. Our stories may be shared but our names may not…Confidentiality is essential to the safety of all*.

This situation took its toll on everyone, but drove home the realization that inclusiveness does not rule out excluding individuals whose actions are potentially harmful to other participants and detrimental to the building of trust in the larger group.

Strategic Planning

The Crisis Call Community Development Project received a grant from the *National Crime Prevention Strategy, Community Mobilization Program* for one year, which was supplemented by funds from Sky Works and CMHA to sustain the project for several additional months. From the start, the focus was on turning talk into action, and everyone acknowledged that further funding would be required to realize specific goals.

A Strategic Planning meeting was held in late June 2005, guided by Dr. Neil Nelson, Coordinator of the Thunder Bay Multicultural Association *Diversity in Policing Project*.

Like other CWG meetings, the Strategic Planning day was interrupted by emotional disclosures and personal agendas. The consequence of these disruptions was lack of time to address the topic of future project planning and funding. This omission opened the door later in the summer to a suggestion by the Consultant from the Ministry of Health and Long Term Care that a provincial government justice

committee carry on the work started by the MH-CJ Project.

MH-CJ Project Challenged by the Introduction of a Provincial Strategy for Justice and Human Services

The Thunder Bay MH-CJ Project owes both its strength and its fragility to its grassroots origin and its cross-sector diversity. It has enjoyed the autonomy to work toward implementing change according to its own assessment of community needs. Its focus has been on empowering Survivors to participate and take back control over their lives. Participants grew comfortable enough with one another to share their wounds and their dreams. Survivor participants worked long and hard to persevere, to work through their frustrations over the misconceptions about mental illness held by non-Survivor committee members. They generated a lot of learning and change within the group as a whole through their commitment to the process and to group members.

At the same time, across Ontario, the Ministry of Health and Long-Term Care was re-instituting provincial government committees first established in the 1990s to *'introduce a policy framework that brings service providers together in a cooperative search for solutions to the criminalization of people with special needs and to develop 'models of shared responsibility and answerability' in dealing with this group of offenders within the justice system'.*

According to their Terms of Reference, Human Services and Justice Coordinating Committees (HSJCC) will oversee *'service enhancements'* to keep a target population of offenders, including *'people with a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addictions, and/or fetal alcohol syndrome'* out of the Criminal Justice system*.*

Impact of the Provincial Strategy on the Mental Health and Criminal Justice Committee

The news that the MOHLTC planned to establish a Thunder Bay District Human Services and Justice Coordinating Committee, and their proposal that the MH-CJ Project move ahead under a provincial government umbrella, with its Steering Committee "becoming" the mental health/justice core of the new HSJCC deeply divided MH-CJ Project participants. This announcement was made to the Steering Committee of the MH-CJ by the MOH consultant in August 2005, after almost a year of building the organization. The "fallout" lingered through the final months of the funded project.

Some participants liked the idea of a merger because it held promise that the work begun by the MH-CJ Committee could continue, given that further funding for the MH-CJ Project was not assured and without funding it could no longer maintain a paid Coordinator. Although funding for the local HSJCC would be extremely limited, and none of the money was earmarked for support staff salary, a framework to continue would exist. The bottom line for many became continuing the good work under whichever governance facilitated the accomplishment of MH-CJ goals. The main proponents of merger were people who worked for government agencies or programs funded by government ministries. Many of those members were expected to sit on the Thunder Bay District and/or Northwest Regional HSJCC as part of their work responsibilities. For some of those members it didn't matter what organization facilitated the process.

The people most opposed to the Ministry's proposal were Survivors and

those who did not want to see the Group's autonomy and grassroots nature destroyed. They argued that a governmental framework threatened the strong sense of *ownership of process and independence* built up over the year. This group was also very concerned that the Ministry might place a much lower priority on Survivor inclusion/involvement.

Ownership and self-confidence took Survivors most of the year to build. The idea of having to discuss distressing issues with a new group of authority figures, in a forum where full Survivor participation was not assured, led to key Survivors talking about walking away from the entire process. Over the past 20 years Consumer/Survivors have heard many promises from many different governments and responded cynically to assurances that the HSJCC wanted and valued Consumer participation. The HSJCC guidelines did not reassure Survivors about the value of their participation within this new powerful committee structure.

Making Important Decisions

Decision-making within the CWG and sub-committees had always been achieved through friendly consensus. When consensus was not possible on a given issue, members "agreed to disagree", and the matter would be addressed again at a later time.

The question of whether to become part of the HSJCC or remain independent was presented to the membership at the September 2005 CWG meeting following a status report on the Strategic Plan. This was the first announcement of the Provincial Government Justice Committee many CWG members had heard.
The Steering Committee presented participants with 3 options: 1) merge fully with the HSJCC, 2) run parallel to it, or 3) remain an entirely separate organization, following its own independent course of action. They anticipated that a decision on the matter would be reached at the September meeting and were somewhat surprised by the Community Working Group's resolve to see the Strategic Plan before making any crucial decision. The vote was rescheduled for November.

The November meeting was the first occasion the MH-CJ Committee had to call a formal vote on any concern. A question and answer period preceded the vote during which the options, and their pros and cons, were presented for discussion. At the last minute a group member made a comment that confused the meaning/implications of the options in the minds of some participants. The options were reframed and boiled down to two possibilities: Become the Thunder Bay HSJCC or run parallel to it. A vote by show of hands was called.

Before proceeding to a vote, the issues of poverty, income, recovery and compensation for Survivor participants, which had emerged as priority concerns for the C/S Sub-Committee, were discussed to inform the pre-vote dialogue and provide a context for continuing to work as an autonomous organization.

Again, the vote was accomplished by show of hands. Of the 26 voting members who signed the attendance sheets, 11 voted to *become the HSJCC* and 10 voted for the option of *working parallel*. Emotion ran high in a group suddenly divided down the middle.

In retrospect it was evident that something went wrong with the discussion and/or voting process that day. The MOHLTC Mental Health Consultant could not provide certainty about the role of the HSJCC, and/or the interface between both groups. That information was not available to her—or to our organization—at that

time. The mistaken notion that the entire CWG might be able to advise the provincial government committee as equal participants on the local HSJCC was raised in the discussion. It was even suggested that our organization could join forces with the Ministry Committee, but walk away to revitalize the MH-CJ Project if the merger didn't work out. Inadequate and inconsistent information led to a great deal of confusion.

Eligibility to Vote

There were fewer regular participants at the November CWG meeting and several new faces. The Steering Committee, accustomed to easy-going collaboration, did not anticipate the need to define eligibility to vote, whether quorum would be needed to hold a vote, or what constitutes a majority. Neither did they formulate exact wording of the options.

The decision reached that day, to become one with the HSJCC, led to divisive frustration. No one expected the newcomers, and thus no policy existed to limit voting rights to people who knew and understood the issues, the history of the MH-CJ Project or why we were voting at all.

The new people in the room *did vote*, but how their choices affected the result is unrecorded and lost to analysis.

Revisiting the Decision of November 10

Because of the intense frustration over the decision to join forces with the local HSJCC, the Steering Committee resolved to disregard the November vote, though doing so was not universally popular. Not everyone felt confused or let down by the process. Some people questioned the reasoning behind revisiting the options, believing that it was only an attempt to sway the vote toward Option 2. But others were grateful for a second chance, asserting that they felt misled by a few very outspoken individuals.

Reconvening

The CWG met December 8, 2005 for a final deliberation of the options. In contrast to the previous meetings, the afternoon was exhaustively pre-planned. The Steering Committee worked out an exact wording of the options, votes were to be cast by secret ballot, everyone, including new members, could vote and a simple majority (51%) would decide the winning option. The ballots would be collected and counted by two neutral overseers who were not voting members of the MH-CJ Community Working Group, and thus would not cast ballots.

Orderliness and preparation do not guarantee that everything will play out as planned. In the end, the Chair abstained from voting, as did the Mental Health Consultant for the MOHLTC, who was also a long-time Steering Committee member.

Ministry Preference

Ultimately, the MOHLTC provided the most compelling reason to revisit the vote. The MH-CJ Community Working Group is large, and attendance/ participation inconsistent. Shortly before the December meeting, the MOHLTC Consultant informed the Steering Committee that, in fact, the Ministry would not be able to accommodate participation by all MH-CJ CWG members. The Ministry's preference was that only the MH-CJ Steering Committee would become the mental health-criminal justice core of the Thunder Bay District HSJCC, ensuring a more dedicated and manageable government committee.

The wording of Option One at the November meeting had seemed to imply that the HSJCC would embrace the entire membership of the CWG. The whole divisive debate had been

predicated on inadequate information.

This time, the Options were articulated as follows:

> OPTION ONE: The MH-CJP Steering Committee will **become** the Mental Health/ Criminal Justice core of the Thunder Bay District HSJCC, while also continuing to function as the MH-CJP Steering Committee and working toward fulfilling the goals and objectives expressed in the MH-CJP Strategic Plan. This means that the Steering Committee will have two roles: The MH-CJP Steering Committee will work under the direction of the MH-CJP Community Working Group **and** under the direction of the MOHLTC.
>
> OPTION TWO: The MH-CJP Steering Committee will **not** become the local HSJCC. Instead, MH-CJP committees will remain independent and continue working on the goals and objectives expressed in its Strategic Plan **without any formal relationship with the Ministry Committee.** The MH-CJP Steering Committee, in concert with the Community Working Group, may work cooperatively with the Thunder Bay District HSJCC, if it so chooses.

The votes were tallied and the decision to adopt Option One was announced without reference to actual numbers.

The December meeting permitted a solution that brought with it renewed optimism and a spirit of cooperation among all members. Before the meeting adjourned, several people recommended that member agencies should step in to sponsor meetings of the Consumer/Survivor Issues Sub-Committee, including providing the lunches that help draw people out to those meetings. This motion was passed favourably and another recommendation made—that agencies contribute funds, which could be pooled to provide honoraria for Survivors.

6. Thunder Bay Issues

Mental Health and Criminal Justice Project Sub-Committees, Goals and Achievements

6.1 Preventing Problems From Becoming Crises: Pre-Crisis Diversion Sub-Committee

- Membership
- What Is Pre-Crisis Diversion?
- Issues and Local Focus
- Long Waits in ER
- No Vacancy at Hospital
- Sensitivity, Awareness and Acceptance
- Successes Achieved

Membership

Membership of the Pre-Crisis Diversion Sub-Committee included mental health professionals and educators from several organizations, including St. Joseph's Care Group, the Psychiatric Patient Advocate Office, Ministry of Health and Long Term Care, as well as representatives from Consumer/ Survivor advocacy organizations including PACE and Patients' Council.

What is Pre-Crisis Diversion?

Pre-crisis diversion involves community-based interventions, which enable individuals to stabilize and manage their mental health issues, develop life skills and build social and family support systems, thus reducing the occurrence of behaviors that put them at risk of involvement in the criminal justice system. Pre-crisis intervention includes supports in areas such as housing, jobs, education, social services, transportation, and medical and nursing care.

The goals of the MH-CJ Pre-Crisis Sub-Committee included:

- Education, specifically early warning signs/symptoms and providing assistance prior to police intervention, and
- Prevention of police contact
- For all adults, regardless of age, and
- Inclusive of the geriatric population.

The strategy to accomplish these goals included the following options:

- Develop a training/education program targeting specific audiences (e.g., landlords, health workers, teachers) that includes an evaluative component to ensure that the information is helpful and relevant. Topics include discrimination, anti-stigma, and client rights.
- Parent support group for individuals with a mental illness.

> "The overriding goal of mental health reform is for people who need care to have access to high-quality, tailored mental health services and supports in their communities, in least restrictive settings, designed to foster recovery, community integration and economic self-sufficiency."
>
> (Bazelon Center for Mental Health Law, An Act Providing a Right to Mental Health Services and Supports: A Model Law. (Washington, D.C., U.S.A.) http://www.bazelon.org/issues/general/publications/newvision/index.htm

Issues and Local Focus

The introduction of case management, peer support, telephone and mobile crisis response and other components of mental health reform make it possible for a number of individuals with mental health issues to manage

their illness and thereby avoid contact with the criminal justice system. In reality however, such services are so scarce as to be unavailable to the people who need help the most. There continues to be a large group of individuals at risk of involvement in the criminal justice system due to mental health-related issues.

In cases where the community mental health supports available in Thunder Bay are not sufficient to prevent an individual from experiencing a crisis, or the person does not have access to those services when s/he needs them, the police may be called to intervene. When confronted with a person exhibiting mental illness, Thunder Bay Police/OPP officers have limited options at this time. They may:

- Leave the person in the community,
- Arrest the person, or
- Take him/her to the Thunder Bay Regional Health Sciences Centre Emergency Room for a mental health assessment.

Long Waits in ER

Police often wait with the ill person for hours in the City's only ER before a physician can see them, and police protocol dictates that individuals in custody must be handcuffed, and remain so until custody is assumed by hospital staff. To sit, restrained like a criminal, in a waiting room among scores of other people also awaiting medical attention, is an indignity that can only worsen the mental state of the person in crisis and perpetuates the myth that people with a mental illness are violent and dangerous.

No Vacancy at Hospital

To complicate matters, inpatient psychiatric beds are scarce and only patients assessed to have a serious mental illness—those who pose a danger to themselves or others--are likely to be admitted. After spending many idle hours with the ill person, police may have to arrest or release him/her for want of alternative crisis or safe house beds.

The problems and service gaps affecting psychiatric Consumer/ Survivors in Thunder Bay include the need for:

- Individuals to be triaged promptly,
- Expanded crisis services & safe house, so that the ER is no longer the only option,
- Sensitive ER staff who are knowledgeable about Mental Health issues,
- Physicians who are knowledgeable about locally available services & refer appropriately,
- Services that are culturally sensitive and aware,
- Family/loved ones as full partners in developing individualized care and treatment plans,
- Beds (in-hospital or safe house) available when Consumers need them,
- Appropriate recognition of severity of illness,
- An increase in the number of physicians and psychiatrists,
- Respectful, dignified, prompt care in a healing, restorative setting,
- Clients discharged when ready (not sooner) and with treatment plans and referrals to community programs,
- Supports that are effectively integrated with all other mental health/criminal justice systems.

Sensitivity & Awareness

If the Mental Health System could approach an ideal state with a snap of our fingers, many important changes would occur. People would talk about mental health and mental illness openly and without shame. There would be greater awareness of the

social and economic issues that people with mental health problems encounter day after day, and broad public education campaigns would teach that recovery is not only possible, but also that many people do get their lives back on track and resume interrupted educations, careers and family lives. Awareness would reduce the fear associated with unusual behaviors and diminish the stigma of mental illness, while a decrease in prejudice and discrimination would facilitate recovery.

Awareness would make early response to mental health needs possible. There would be greater, improved treatment options and accessible programs and services. Persons with mental health issues would have access to the right service at the right time in a non-restrictive, therapeutic setting that doesn't close its doors to people in need.

Individuals who now end up in jail for want of food, shelter and an income would have access to essential support services, and Hope would no longer be only a dream.

Successes Achieved By Pre-Crisis Diversion Sub-Committee

1. Developed an educational program/speakers' bureau, *"Hear Us"* (Hope, Education, Awareness, Recovery + Understanding Stigma); work is proceeding well.
2. Identified existing resources, both formal and informal.
3. Made and kept commitment to full Consumer/Survivor participation.

"I needed a safe place away from my family to get stabilized and the Regional Hospital is the only place to go. I went late at night and the doctor in ER admitted me, but I spent 3 days sleeping on a bed in the hallway in Emergency because there weren't any beds on the psych unit. I hid my head under a blanket the whole time. It was the worst 3 days of my life."
--Survivor

"Couldn't the cops have taken the handcuffs off me? I wasn't going to bolt on them. I know I need help."
--Survivor

"The patrol guide, by definition, cannot be specific enough to address every situation. It's not a tactical manual."

"Officers say there are two basic types of situations: the guy in the house, off his medications and the guy out on the street, disturbing the peace. The vast majority of these contacts end without incident, and no one hears anything more."

Michael Wilson, The Intersection of Troubled People and Armed Police, December 28, 2003
http://www.nytimes.com/2003/12/28/nyregion/28EDP.html?ei=5070&en=9ac46308e02b0bd2&ex=1121918400&pagewanted=print&position

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6.2 First Point of Contact: Police Issues Sub-Committee

- Membership
- Police Role in Crisis Intervention
- A Question of Responsibility
- Systemic Issues and Local Focus
- Few Options
- Call Details Not Fully Captured
- ER Workload
- Responding to Problems and Needs
- Crisis Response Team
- MHAT
- More Resources Needed
- What Needs to Happen to Improve the System or Process
- Shifting Societal Attitudes
- If the System Were Perfect
- Successes Achieved

Membership

The membership of the Police Issues Sub-Committee included representatives from Thunder Bay Police Services, Ontario Provincial Police, Thunder Bay and Area Victim Services, Multicultural Association *Diversity in Policing Project*, Thunder Bay Regional Health Sciences Centre, including Adult Mental Health & Forensic Programs, Emergency/Trauma, Canadian Mental Health Association and Consumer/Survivor representatives.

The Role Police Play in Mental Health Crises

Police in Canadian society have two primary duties: to ensure safety and to provide protection to the public. Circumstances under which the police come into contact with mentally ill persons include:[17]

- Apprehensions under the Mental Health Act
- Disturbances in which a person appears to be mentally ill
- Situations in which a mentally ill person is the victim of a crime
- For purposes of assessment of threats
- For purposes of assessment of risk
- Apprehensions in conjunction with Community Treatment Orders

> "Police officers have to make a quick assessment of whether a person poses a danger to self or others. When we do detain a person looking for mental health support for them, we're frequently frustrated by long waiting lists or the person doesn't fit a service provider's criteria, and we end up letting the person go."
>
> --MH-CJ Project Participant

A Question of Responsibility

Most Police Officers have little formal training in how to respond to individuals experiencing a mental health crisis and are ambivalent about responding to situations that should be the responsibility of mental health service providers. But most community-based mental health services are overburdened, limited in scope, and poorly integrated with other human services programs. All too often, police respond to crisis calls because there is no one else to step in when crises arise.

The problems police in Thunder Bay and Northwestern Ontario encounter in their interactions with persons with mental health issues are echoed in municipalities across North America. Priority issues identified at initial

[17] *Serving and Protecting…The role of the police in the care of people with mental health problems.* Presentation to the Standing Senate Committee on Social Issues, Science and Technology In Response to Mental Health, Mental Illness and Addiction: Issues and Options for Canada, February 16, 2005. Canadian National Committee for Police/Mental Health Liaison. http://www.pmhl.ca

meetings of the MH-CJ Police Issues Sub-Committee included:

- Intervention is needed prior to police involvement
- Determine who police can call if the situation is not a crisis
- Quick assessments are needed to free police to respond to public needs and prevent further deterioration to the person's mental state
- Intervention after assessment if the person is not admitted to hospital
- A Safe House for those in need

Systemic Issues/Local Focus

While Police Services are the first point of contact with the criminal justice system, and police are increasingly the first responders to mental health crises, blaming police for the problems of mentally ill offenders or targeting them for the first order of change is unwarranted. Persons with mental health issues do face discrimination and stigma from professionals in the legal and justice systems, as they do from the general public, but the most significant challenges psychiatric Survivors face result from changes and failures within the mental health system, the Ontario Disability Support Program and Ontario Works.

Few Options

Police officers are not trained to be mental health workers, nor do police in Thunder Bay and Northwestern Ontario have many options when responding to a person experiencing a mental health crisis. As stated previously, the only options are jail, hospital or immediate release back into the community.

Thunder Bay Police statistics indicate that between January 15/05 and February 4/05, Officers responded to at least 41 incidents relating to mental health issues, including:

- Medication overdoses
- Wrist cuts
- Threats of self-harm with various weapons
- Hangings and
- Persons standing in traffic

Call Details Not Fully Captured

The Police Records Management and Dispatch Systems do not capture full details of Mental Health calls. In order to identify which calls involve mental health issues it is necessary to scan call logs line by line under Police Assistance, Sudden Death, Mischief, and Assaults. This does not cover crisis situations where individuals in lock-up attempt suicide; these people are generally sent to appear in court with only a flag on the police computer indicating they pose a *suicide risk.*

The Ontario Provincial Police experience a similar difficulty identifying Mental Health calls through their computer system. However, limited statistics reveal the following information:

Police/Crisis Response MH Calls in Thunder Bay and Region

Mental Health Related Calls in Region (2004)	700 (271 Attempted Suicides) (22 Completed Suicides)
Thunder Bay Police Mental Health Calls January 1/05 to June 8/05 Note: Some calls reclassified upon final disposition	• Total = 295 calls (Approx 56/month) • 32% reports of attempted suicide • Police took person to ER 61 times • 420.32 man hours spent waiting in

	ER for person to be assessed • This represents $13,450.24 in wages for 2 police officers • Patrol Units operating at 2 officers below strength at these times
CMHA Mobile Crisis Response Unit Calls (2004)	• 17 contacts with OPP (Approx 1.4/mo) • 94 contacts with Thunder Bay Police (Approx 7.8/mo) • 60% admitted to hospital after assessment

ER Workload

Another difficulty preventing accurate assessment of police response to mental health crises is a lack of statistics on Mental Health intakes in Emergency/Trauma at Thunder Bay Regional Health Sciences Centre. This reflects both a heavy workload in the ER and the ER intake procedure.

Responding to Problems and Needs

The logical point to divert Survivor involvement away from the criminal justice system is at the initial point of contact: at or prior to arrest. This necessitates coordination between police and the mental health system, so that police can arrange for psychiatric assessment and treatment rather than arresting and detaining a person for a minor offence.

Crisis Response Team

Locally, police can and do call on the Canadian Mental Health Association's Crisis Response team for assistance. The Crisis Response Service is a community-based crisis support program for individuals experiencing acute psychological distress from any number of life crises, trauma, or psychosocial problems and/or mental illness. The goal is to assist people in distress to overcome their crisis in the community. Crisis Response workers provide immediate crisis assessment and intervention, referrals and follow-up for individuals, their families and friends.[18]

MHAT

Another local hospital-based resource is the Mental Health Assessment Team (MHAT). MHAT is not a stand-alone program, but an assessment and consultation resource for ER staff, available from 8 a.m. to 11:30 p.m., to assess patients who present with mental health problems. The Team includes staff from Psychology, Social Work, Occupational Therapy, and a Chaplain, and provides a Medication Clinic, psychiatric follow-up (as needed) and multidisciplinary follow-up after hospital discharge, for a limited time.*

More Resources Needed

More community resources are needed to support police interventions with individuals experiencing mental health crises. The problems and service gaps that frustrate police officers attempting to intervene in Survivors' crises include:

- The public image of police as being aggressive and abusers of authority. To some, a police uniform symbolizes authority,

[18] Canadian Mental Health Association, Thunder Bay Branch. Programs and Services: Crisis Response Service. http://www.cmha-tb.on.ca/crisis.htm

* Since the initial publication of this report, MHAT has increased its hours of service to 24/7—a significant success for the MH-CJP.

honor and comfort. To a person panicking in the throes of a mental health crisis, any authority figure can inspire panic.

- Inconsistent education in mental health issues. Police services vary greatly from one jurisdiction to another in the amount and nature of training officers receive in responding to people coping with mental health issues.
- There is a perception of "police overkill" when responding to some mental health calls. Examples of such apparent excess might include the use of the Thunder Bay Tactical Unit responding to a person in emotional crisis.
- Frustration at long waits in the ER is exacerbated when physicians decide the person does not need to be hospitalized and the person is released. Police may pick up these individuals again and again because their crisis has not been addressed or resolved adequately.
- Individuals with a mental illness who are arrested and taken to the police station do not have access to their medication. Even temporary stoppage of medications can result in worsening of symptoms and deterioration of behavior.
- Media sensationalism of mental illness contributes to myths and misconceptions that perpetuate the problems people with a mental illness face day in and day out.
- Police often have very little information when they are dispatched to a call. Lack of information combined with fear can escalate the tension, leading to excessive use of force, injuries and/or death of the "subject" or officers.

What Needs To Happen To Improve The System Or Process

- Effective pre-crisis intervention and crisis response services to reduce police involvement in nuisance or minor offence situations;
- Development of a crisis plan in cooperation with mental health agencies and service providers to identify situations that would benefit from clinical intervention and reduce or prevent harm to the person in crisis and to first responders;
- Police training to recognize and appropriately manage behaviors indicative of a person facing a mental health crisis, and to respond to the person with greater sensitivity and awareness;
- Conflict might de-escalate if police officers had greater knowledge of existing mental health services & options;
- Crisis & incarceration might be avoided if more intervention and treatment options were available;
- Consumer/Survivor participation in Police training;
- Regular meetings between police and Consumer/Survivors to share experiences and concerns;
- Reduction in media sensationalism of news stories involving Consumer/ Survivors, and similar reduction in the entertainment media;
- Early identification and awareness of persons at risk or in need of assistance;
- Suicide interventions by teams including police and mental health workers;
- Swift identification and interventions in attempted "suicide by cop";
- Mutual understanding and awareness: People in crisis no

longer see police as the enemy or threatening.

Shifting Societal Attitudes

To paraphrase Jeremy Travis, Director of the National Institute of Justice (USA) in a speech to the National Association of State Forensic Mental Health Directors, September 3, 1997[19], police stand on the front lines of shifting societal attitudes toward crime and justice. The issues police deal with daily represent cutting edge issues in criminal justice: increasing numbers of mentally ill defendants coming through the criminal justice system; hardening of public attitudes toward people who violate the law, including those who violate minor, quality of life edicts; decreases in public resources for treatment, training and health services; the public attitude that the criminal law should be used to solve social problems that are perhaps better defined as public health or mental health problems. These are difficult and challenging issues.

If The System Were Perfect

In an ideal system, people with mental health issues who commit lifestyle offences would not come into contact with the police because our social and health care systems would provide for more than the basic necessities of survival. Thunder Bay and Northwestern Ontario would offer safe houses, with peer-supported interventions to avert crises, or to simply provide breathing room for people on the verge of crisis to pull themselves together in the supportive company of their peers.

Police and Survivors would work together to understand the issues and develop mutually respectful solutions. We don't live in a perfect world, but we are sitting at the same discussion table, and that is a good beginning.

Successes Achieved By Police Issues Sub-Committee

1. Police have gathered incidence data including average time spent on mental health calls and shared these with group.
2. Police have identified need for training of members of the force, specific content not yet determined.
3. Linkage has already improved coordination between Police and Hospitals.
4. Group has identified current and desirable role of Police.
5. Group agrees that compensation for time and travel costs of Consumer/Survivor members must be provided.
6. Consumer/Survivor members report feeling honestly included and listened to.

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[19] *The Mentally Ill Offender: Viewing Crime and Justice Through a Different Lens*, Jeremy Travis, Director of the National Institute of Justice, Speech to the National Association of State Forensic Mental Health Directors, September 3, 1997. http://www.ojp.usdoj.gov/nij/speeches/menill.htm

6.3 Going To Court: Court Diversion Sub-Committee

- Membership
- Systemic Issues
- An Additional Alternative
- Diversion is Cost-Effective
- Community-Based Safety Nets Failed
- Prompt Identification
- Client Cooperation
- Defining Successful Diversion
- Availability of Community Resources
- Assessment of Health and Needs
- Diversion Criteria
- Local Concerns
- Conflicting Public Attitudes
- Successes Achieved

"They wouldn't give me my meds in jail. When I had to go to court I was shaking, crying. I have manic depression and I was a mess."
--Survivor

"I told the judge I could pay the $300 if I get the job I'm training for, but I might not get it now because of the judgment against me. ODSP is going to cut me off my benefits because I can work part-time. I'm trying to explain all this and the [court clerk/court reporter] right beside the judge start mouthing something to each other and laughing. Then I see the judge trying not to laugh, too. What's so funny about being poor and depressed all the time? Let them change places with me for a week and see if they still think it's funny."
--Survivor

"In my job I have the ability to make small changes in the lives of accused persons with mental health issues. I listen more carefully [now] when I work with people. It's a little thing. I think I'm more sensitive to the issues and believe my colleagues are more sensitive too, because we're more aware of people's needs. Most people get caught up in the demands of their own lives, and it's an eye-opening experience to become aware that the clients we serve have lives outside of the Courthouse. If you really listen, you begin to put things into perspective. You begin to think of people with mental illnesses as 'more real'."
--Legal Aid Ontario Duty Counsel Supervisor/ MH-CJP Participant

Membership

The Court Diversion Sub-Committee comprised a membership of Survivors, police, lawyers, court outreach and mental health court support workers, corrections and probation/parole personnel, and others with knowledge pertaining to relevant services.

The Committee sought to develop a plan to stimulate positive system change, increase collaboration and understanding of the roles of each stakeholder in the system, improve the quality of life for persons with mental health issues, reduce professional and agency crises and be a forum to review and discuss operational issues of a local nature.

Specific projects included increasing Survivor participation, charting available services, improving the access and availability of education to accused people and the public, investigating the scope/ambit of current mental health diversion, and meeting individual needs of accused persons, including identifying gaps in services.

Systemic Issues

Until recently, mentally ill offenders deemed responsible for their criminal act were sent to prison; those found "not guilty by reason of insanity", a now archaic verdict, might spend the remainder of their lives in an asylum.

But laws regarding the mentally ill have changed greatly in recent years. In Canadian criminal law, there is no longer such a thing as the defense of insanity; rather, a person today may be found "not criminally responsible on account of mental disorder".

An Additional Alternative

According to the Rt. Hon. Beverley McLachlin, Chief Justice of Canada, "We are no longer faced with a stark choice between acquittal and conviction of mentally ill persons…The law now offers a third alternative, under which mentally ill offenders are diverted into a special stream where the twin goals of protecting the public and treating the ill offender fairly and appropriately are pursued."[20]

When people with mental health issues get into trouble with the law, it's not because they're innately bad, untrustworthy or don't have a conscience. It's generally because they are poor and/or their psychological issues have not been recognized and treated, or the medication prescribed for them is not effective.

Diversion Is Cost-Effective

Mental Health Court Diversion programs provide cost-effective alternatives to court proceedings for non-violent offenders with mental health issues who commit relatively minor crimes related to poverty and homelessness, such as shoplifting, vagrancy, panhandling, use of street drugs, sleeping on park benches or in bus shelters. These programs seek not to punish offenders, but to secure and monitor treatment for the health issues and behaviors that brought the person into the criminal justice system.

Instead of proceeding with a criminal charge through formal court proceedings, diversion programs provide a community-based alternative for adult, non-violent offenders. Should the individual choose to participate in a diversion program, by admitting responsibility for the offense, the client is expected to satisfy specific program requirements before the Court withdraws the charge.

Community-Based Safety Nets Failed

The need for mental health diversion is directly related to the fact that community-based safety nets for people with mental health issues have failed. People enter the justice system having committed nuisance and lifestyle offences such as repeatedly loitering in a shop, restaurant or hotel lobby or stealing from a store. Many have serious alcohol, drug addiction, housing, employment and physical health problems that have not been addressed, in addition to a mental disorder. In many cases, the person has come before a judge because s/he has been unable to connect or stay with community-based mental health services.

Mental Health Courts, and other judicial strategies that address critical problems faced by people with mental health concerns, raise significant issues.
These include:

- Prompt identification of diversion candidates;
- Voluntary vs. coerced treatment;
- Defining success of treatment/intervention;
- Sanctions for "poor performance" by clients; and
- The availability of community treatment/support services.

[20] Rt. Hon. Beverley McLachlin, Chief Justice of Canada: *"Medicine and Law: The Challenges of Mental Illness" at the University of Alberta and the University of Calgary in the framework of the 2005 Honourable Mr. Justice Michael O'Byrne/AHFMR Lecture on Law, Medicine and Ethics.* http://www.ahfmr.ab.ca/publications/newsletter/Spring05/www.files/inside/views.feat.htm

Prompt Identification

Fair and effective mental health screening of potential diversion candidates must be performed as early as possible in criminal processing to allow the person to stabilize and to begin the placement/referral process. But the need to assess a person quickly conflicts with the need to conduct a thorough assessment. In Thunder Bay, forensic assessments are generally performed on an inpatient basis by clinical teams at the Thunder Bay Regional Health Sciences Centre. However, many mental health clients in Thunder Bay, across Ontario and other parts of Canada are still held in jail awaiting assessment—a practice repeatedly denounced the Ontario Superior Court. Some of these people, like Martine Ann Ladouceur, an Aboriginal woman who committed suicide while in custody at the Thunder Bay District Jail waiting for her bail hearing, slip through cracks in the system before problem-solving judicial strategies can intervene.

Client Cooperation

Most court ordered diversion programs rely on the voluntary participation of clients, because treatment is seldom effective if it is "unwanted". Courts that require guilty pleas from clients before clients are diverted to community-based treatment programs must of course demonstrate that the plea was made knowingly and willingly. Voluntary participation increases the likelihood of successful treatment outcomes.

But the very nature of mental health diversion raises questions about an individual's competency to stand trial and their ability to understand the proceedings, the options being presented to them and the consequences of those options (e.g., going to trial on a criminal charge, or participating in mental health treatment).

In the U.S. Bureau of Justice Assistance monograph, *Emerging Judicial strategies for the Mentally Ill in the Criminal Caseload*, the authors discuss conflicts in values and goals "inherent in criminal justice and treatment orientations."

> "While the criminal process might need to proceed expeditiously to adjudicate criminal charges, mental health professionals require time to diagnose the mentally ill defendant's condition, take immediate steps to stabilize the defendant and then to place the defendant in appropriate supportive services for treatment. From the perspective of mental health treatment, potentially the worst experience for many mentally ill persons would be arrest, jail and formal proceedings in the criminal court…These conflicts in method, aims, values and style pose a particular challenge in the emerging mental health court initiatives to produce a hybrid model that attends to the basic requirements of each.[21]"

Defining Successful Diversion

The variety of symptoms, types of mental health disorders, and the potentially lengthy process of stabilizing clients and finding living conditions that will maximize their effective functioning in the community, makes evaluating the success of Mental Health Diversion programs difficult. Successful completion of an

[21] Goldkamp, J.S., Irons-Guynn, C. *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage*. Bureau of Justice Assistance, U.S.A., April 2000, p. xii. http://www.ncjrs.org/pdffiles1/bja/182504.pdf

alternative sentence is based on a client's degree of compliance with treatment orders. Non-compliance with any diversion conditions may be dealt with by such means as "returning participants to earlier and restrictive treatment stages or, even, making use of jail in selective instances."[22]

The use of court-imposed sanctions to promote mental health treatment goals raises serious questions. For example, is it ethical for a court to sanction a client who does not take his or her medication? Can court-imposed sanctions be effective at all in the case of a low-functioning client who may not truly understand his/her circumstances or what the court/service provider expects of him?

Some diversion programs deal only with people facing misdemeanour charges; other programs go by the criteria of diagnosis with a serious mental illness, e.g., schizophrenia, bipolar disorder or chronic major depression. Too strict criteria can leave out a lot of people to face incarceration and perpetuate the criminalization of people with mental health issues, including undiagnosed persons committing an offence during their "first significant crisis".

Availability of Community Resources

The MHCJ Project came about in large part because psychiatric institutions are being closed down and people with mental health issues have few treatment options other than under-funded and over-burdened community-based programs and services. The success of mental health court diversion depends on getting a person assessed quickly yet thoroughly and appropriately linked to community mental health supports. There is a great deal of irony involved in devising strategies that use the justice system to place offenders with mental health issues into the hands of a system that has already failed them.

Even when community services are available to assist diverted offenders, the need to identify appropriate candidates among the general population of offenders, risks placing even greater demands on overtaxed treatment resources.

Assessment of Health and Needs

A Mental Health Court Worker (MHCW) typically meets with the person to assess his or her situation and needs. Assessment includes an evaluation of the person's mental health status, their current living situation, a determination of appropriate supports and referrals to psychiatric and other services.

Based upon assessment findings, the MHCW makes recommendations to the person about services that might be appropriate for the development of a diversion plan, and obtains the approval of the Provincial Crown Attorney. The plan might include psychiatric assessment and treatment, securing resources for shelter, food and clothing and finding short or long-term community supports. The MHCW and the client will agree to a plan, which is also acceptable to the Crown Attorney. Mental Health Court Workers then assist the person to access and use the identified services and supports.

Diversion Criteria

Mental Health Diversion is appropriate for persons:

- Who have a serious mental health problem/mental illness;
- Who have been charged with committing a low risk offense;

[22] Goldkamp and Irons-Guynn, p. xiii.

- Who accept mental health diversion; and
- Whom the provincial Crown Attorney approves for diversion.

Ideally, Mental Health Diversion programs would also provide consultation to people who are not deemed suitable for diversion; link people to short and long-term services and supports; provide support and information to family members and significant others; offer education about Consumer/Survivor issues, mental illness, mental health services and the mental health system and be available for consultation and advice to the judiciary on cases referred for disposition.

<u>Local Concerns</u>

The issues and concerns identified by the Court Diversion Sub-Committee included:

- The legal system needs to make better use of its present resources and collaborate with other sectors of the mental health and justice systems to prevent "Revolving Door Syndrome"/additional charges from accumulating
- Access to addiction treatment programs necessary while person serving time
- There are no community-based alternatives to incarceration in a correctional facility or detention in a psychiatric facility
- Some accused persons experiencing a mental health crisis will plead guilty because they do not understand court proceedings and/or their rights
- There is a lack of advocacy and support for people going through the criminal justice system
- Establish ways to better meet the needs of both victims and offenders with mental health issues
- More and better training required for those working with mentally ill persons within the criminal justice system to ensure recognition & awareness of mental health issues by court and legal staff
- More Mental Health Diversion workers are needed to provide support
- Mental Health support must be available in the courtroom
- Continuity of medications/medical support needs to be provided
- Need alternatives to custody/ appropriate use of Diversion programs
- Dedicated Mental Health Court
- Language used in court proceedings is not "user-friendly"

<u>Conflicting Public Attitudes</u>

We live in a world where there is a crying need for a broader, more sensitive understanding of the issues and barriers experienced by marginalized people. Yet attitudes are hardening towards anyone who violates the law, and our legal and penal systems, never designed to be therapeutic, are being called upon to

resolve complex social issues. While some legal analysts argue that, "psychiatry ought not to attempt to change the legal system into a therapeutic system anymore than the law should attempt to change the psychiatric system into law enforcement and incarceration"[23], concepts of right and wrong must be re-evaluated under the lens of ethics and a right to non-restrictive community treatment for special needs offenders.

By redirecting scarce resources into community treatment programs for persons who bear the burdens of poverty, homelessness, mental illness and drug/alcohol dependence, rather than arresting and incarcerating them for violating the law, we are taking visible steps towards building a system that protects public safety while alleviating social problems.

Successes Achieved by the Court Diversion Sub-Committee

1. Developed and implemented an outreach recruiting program resulting in good representation from the Consumer/Survivor community.

Education

2. Developed terms of reference to provide structure and focus.
3. Identified three main areas of concern:
    - Education
    - Scope of diversion
    - Meeting individual needs
4. Informed ten duty counsels of new options for persons with a mental health history.
5. Provided information session to local Criminal Justice Coordinating Committee. Followed up with summary letter.
6. Mental Health Support Worker attended international conference in Ottawa September 2005.
7. Have begun writing a pamphlet for accused persons with mental health concerns re the Criminal Justice system.

Scope of Diversion Criteria

8. Gathered information from Mental Health Court Support Coordinator and specialized crown at Old City Hall in Toronto.
9. Working on revised Crown Attorney Manual to aid in future diversion discussions.
10. The number of formal Mental Health diversions has more than doubled since January 2005.

Meeting Individual Needs

11. Developed Flow Chart to track passage through the system
12. Identified gaps in service using that chart.
13. Two new jobs created and filled by CMHA: court outreach worker and short-term case management worker. Helps persons with Mental Health concerns at entry to the system and exit points.
14. The two workers above were well trained and had "apprenticeships" here and in other cities.
15. Working on getting court outreach worker to spend time at the jail.

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[23] Clements, Colleen, *ETHICS: Psychiatry Ought Not To Change The Legal System*. The Medical Post, June 08, 2000 Volume 36 Issue 21. http://www.medicalpost.com/mpcontent/article.jsp?content=/content/EXTRACT/RAWART/3621/13a.html

6.4 Going To Jail: Incarceration Sub-Committee

- Membership
- Systemic Issues
- Disruptive Behavior
- In Jail Awaiting Assessment
- Mental Health Deteriorates
- Local Issues and Potential Responses
- Victimized By Other Inmates
- Alternatives To Imprisonment
- Successes Achieved

"Offenders are sent to prison as punishment, not for punishment, and therefore prison environments must be safe and humane and as close as possible to conditions in the community." --Towards Improved Corrections: A Strategic Framework. http://www.icclr.law.ubc.ca	"When you go before a state legislature and advocate for better mental health services as a psychiatrist, it seems self-serving. But when you go before them as a warden or a sheriff or a police officer, folks listen." --Fred Osher, M.D., Director of the Center for Behavioral Health, Justice and Public Policy at the University of Maryland (In: *Kanapaux, William*, Guilty of Mental Illness. *Psychiatric Times,* January 2004, Vol. XXI, Issue 1 http://www.psychiatrictimes.com/p040101a.html)

Membership

The Incarceration Sub-Committee membership included representatives from Correctional services and community agencies, including the Deputy Superintendent--Programs, Thunder Bay District Jail/Correctional Centre (DJ/CC); DJ/CC Nursing/ Recreational staff/ Classification Officer, Schizophrenia Society of Ontario; Elizabeth Fry Society; Alpha Court Rapid Response Program as well as members of the Consumer/Survivor community.

The Incarceration Sub-Committee was formed to examine issues facing individuals with mental health problems in the Thunder Bay District Jail and Correctional Centre. The District Jail is presently working towards the eventual implementation of an adult case management model and Core Rehabilitative programming for inmates geared toward addressing the behavioral issues that lead to incarceration. Equally important are the links to expertise in the community in order to strengthen internal service provision.

Systemic Issues

The factors that contribute to persons with mental health issues being arrested, tried, convicted and incarcerated relate to inadequate access to effective mental health services. Without these supports, people with mental health issues may engage in acts that lead to arrest and detention.

Many of the people with mental health issues in the criminal justice system are there for misdemeanors and crimes of poverty. People with mental health and substance abuse problems generally live on the margins of society, and are almost always poor and disabled by their illness. As reiterated frequently throughout this report, people with serious mental illness should not be incarcerated at all. It is a "lose-lose" situation that fails both prisoners and correctional facilities.

"For seven months at the District Jail, I was in segregation or isolation, 23 and 24-hour lockups…Often, I didn't have a shower for five days. At one point, I didn't get outside for three weeks. In isolation, I slept on a steel plate without a mattress. My arm turned blue from lack of circulation. I wasn't allowed clothing or meals that required utensils. The conditions compounded my fragile mental state. I rapidly deteriorated to self-destruction…I cut myself with anything I could get my hands on. Nobody cared, some even antagonized me and encouraged me."

--Glenn Rothenburger, Mental Illness and the Criminal Justice System: *One Man's Story.* CMHA Thunder Bay. http://www.cmha-tb.on.ca/articles-justicesystem.htm

Disruptive Behavior

Prisoners with mental health issues may be disruptive, refuse to obey orders, and engage in acts of self-mutilation and/or attempted suicide. Behaviors of this kind can result in prisoners being locked in segregation without any therapeutic intervention.

When such individuals are released from jail or prison, they often cannot access community mental health services, or find safe, affordable housing due to their criminal record and/or history of violent behavior. People get stuck in the criminal justice system, arrested and imprisoned again and again because too little is done to deal with their underlying problems.

In Jail Awaiting Assessment

Not everyone who is incarcerated has been convicted of the charges against him or her. If the police decide not to release an individual they have arrested, the accused is "on remand" in detention at least until their bail hearing.

Federal and provincial criminal law encourages release of prisoners prior to trial unless convincing evidence indicates that an accused is unlikely to show up for trial or presents a danger to the public. However, because employment status and residential stability are used as criteria for assessing risk, accused persons can be denied bail because they are homeless and/or unemployed. This practice affects the poor and groups that are economically disadvantaged (First Nations, blacks, women, people with mental health issues) more than other population groups.

"In Toronto, it is common knowledge in legal circles that persons detained while awaiting trial are [often] forced to live in cells designed for two persons but occupied by three or four. That means that many inmates including persons awaiting trial must sleep on the floor of an overcrowded, smelly cell within inches of an open toilet. They have virtually no privacy. Everything that they do, including using the toilet, is open to the view of the guards and inmates. They must appease inmates who try to intimidate them or risk physical harm."
--Ted Matlow, Superior Court Judge, Ontario

Fact Sheet #17: *Doing "Dead Time": Custody before trial,* John Howard Society of Ontario, January 2002
http://www.johnhoward.on.ca/Library/Fctsheet/17/fctsh-17.pdf

A coroner's jury in Ottawa, looking into the November 2003 death of a 59-year old inmate diagnosed with schizo-affective disorder, recommended that jails should not be used to house mentally ill people charged with crimes as they wait for in-hospital assessments on criminal responsibility and fitness to stand trial. The Ontario Superior Court has declared the practice a breach of peoples' Charter of Rights guarantees not to be detained arbitrarily.

Mental Health Deteriorates

The media report case after case of persons with mental health issues jailed for lengthy periods over minor offences that would not result in

custodial sentences, even if the person were convicted. The mental health of these inmates deteriorates rapidly, in part because of discontinuity in prescribed medications.

Jake Rupert, a reporter for The Ottawa Citizen writes, Ontario Superior Court Justice Robert Desmarais "noted that in jail, these people 'often' suffer threats of violence, actual assaults, stress, fear, confusion, uncertainty and improper treatment and care, all of which increase the severity of their psychiatric problems."[24]

Local Issues and Potential Responses

Concerns identified by the Incarceration Sub-Committee included:

- There is a lack of timely assessment and too few treatment services for inmates
- Access to medications/ continuity of medications is a problem
- The environment of a jail or prison is not conducive to improving or maintaining mental health. Instead it often creates and/or amplifies mental health problems
- There are inadequate numbers of legal aid workers
- There is a lack of education/ expertise and a need for better-trained professionals
- There are inadequate numbers of front line workers (e.g. social workers, nurses, psychiatrists) for inmates. Inmates experiencing emotional difficulties need access to support services, such as the Crisis Response Service
- The women's dorm at the District Jail is overcrowded
- There is a need for culturally appropriate programs to meet the needs of Aboriginal women who are "over-represented" in the District Jail
- The devastating effects of segregation/isolation for Consumer/Survivors must be recognized and addressed, and "Post Incarceration Trauma" needs to be dealt with
- Outreach workers are needed to visit with/advocate for incarcerated people who have psychiatric histories
- Incarcerated individuals who reside outside of Thunder Bay often cannot afford to stay connected with family and friends due to the cost of long distance, collect phone calls
- There is a need for transitional services prior to and following release to show the positive impact of a service continuum, and to avoid the argument of "our hands are tied"
- Avoid the practice of releasing individuals from custody on Saturday and Sunday (when services are generally closed)
- Telephone access/collect calls: Although most collect calls are accepted, it would help to have an accessible phone with a direct line vs. calling collect. For example, a phone to which Correctional Officers can connect direct calls when individuals need to make urgent calls (i.e. to a lawyer) to avoid scenarios such as 5 different outgoing calls required to connect with one lawyer

Victimized By Other Inmates

Prisoners with mental health problems and serious mental illnesses may face victimization by other inmates, punishment by prison staff for illness-related behaviors, and may be placed

[24] Rupert, J., *Mentally ill jailed despite judge's order. Province misses deadline to fix problem identified in landmark ruling.* The Ottawa Citizen, Friday May 17, 2005. http://www.cfact.ca/Ottawa%20Citizen%20Article%20May27.asp

in highly restrictive settings that exacerbate their symptoms. Jail and prison overcrowding issues are high on the priority lists of police departments across North America, and corrections officials are crying out for improved community mental health treatment. The high rates of people with serious mental illness in the criminal justice system and the difficulties they create in terms of service utilization and jail management compel mental health service providers to partner with law enforcement, the courts and correctional services.

Alternatives To Imprisonment

Alternatives to incarceration for persons with mental health issues include dedicated mental health courts, in-jail treatment and support, transitional services and vocational training. However, it would be counterproductive to build up mental health services in jails and prisons without also putting funds into fortifying community-based services that help keep people out of the criminal justice system in the first place. Mental health care systems need to bolster programs and services that take a team approach to providing person-centred supports. While funding forensic services helps deal with the immediate problem of handling a prisoner who is actively mentally ill (e.g., psychotic) it only puts a Band-Aid on systemic problems.

In an ideal system, people with mental health issues would be diverted into appropriate support systems that keep them out of the criminal justice system entirely. The danger of pouring more money into forensic services than into preventative community programs is that judges may be encouraged to incarcerate people in order to get them diagnosed and treated. Jails and prisons are punitive environments and a criminal record will haunt a person for the rest of his/her life.

Successes Achieved by the Incarceration Sub-Committee

1. Having a CMHA Mental Health Court Worker attend the DJ five days per week to assist inmates with mental health issues with the video court process;
2. Having the Elizabeth Fry Society of Northwestern Ontario attend the DJ on a weekly basis.
3. Maintaining a commitment to achieve the mandate to treat inmates as clients;
4. Maintaining a commitment to focus on the needs of Aboriginal clients;
5. Commitment to involve leaders from all sectors in the planning process;
6. Holding the September 30/05 Open House at the DJ and use of a *Hear Us* presentation;
7. Maintaining linkages with other agencies/sectors dealing with Mental Health;
8. Continued information sharing across the board.

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6.5 Getting Out: Community Supervision & Discharge Planning Sub-Committee

- Membership
- Systemic Issues and Local Needs
- Fear of Violence
- Gaps and Barriers
- Planning Starts on Day One
- In an Ideal System
- Active Partners in Planning Process
- Support Upon Release
- Successes Achieved

Membership

The membership of the Community Supervision & Discharge Planning (CS-DP) Sub-Committee consisted of social service providers within the community, including Alpha Court Rapid Response Program; Ontario Multifaith Council Reintegration Program; Brain Injury Services of NOW Community Housing and Outreach Services; Elizabeth Fry Society, CMHA Homelessness Outreach Program; Thunder Bay Probation and Parole, Thunder Bay Indian Friendship Centre Aboriginal Community Council Program (Court Diversion).

The primary focus of this committee was to research and review community programs that provide discharge planning/reintegration services and supports for inmates leaving the forensic unit of the Thunder Bay Regional Health Sciences Centre, the District Jail or Correctional Centre. These programs were looked at in terms of the nature of the support, i.e., transitional housing, employment, assistance getting to appointments after release; who they provide services to, i.e., men, women, Aboriginal offenders, youth; and what seems to be working well and what needs improvement.

"Released inmates need safe, appropriate housing. For many detainees with mental health issues, sending them back to their home communities is like sending people from a drug treatment program to live in a crack house."

--Community Supervision & Discharge Planning Sub-Committee Member

Systemic Issues/Local Needs

As other sub-committees also found, systemic issues and the concerns of released offenders in Thunder Bay and Northwestern Ontario are very much alike. The vast majority of offenders with mental health issues serve time for minor transgressions, and most are eventually released back into the community. Unfortunately, going home sometimes means returning to environments and/or dysfunctional relationships established prior to incarceration, which promote recidivism. Many inmates receive no treatment for mental health or addiction issues while in detention.

Where treatment is available, it is generally limited to the meting out of medications to manage symptoms and subdue disorderly behavior. Inmates receiving even this minimal treatment generally leave jail or prison with only a small supply of medication, and without a prescription—or physician—to continue treatment. Successful re-entry into community and/or family life requires linkages to continued treatment, housing, employment and income supports, at the very least.

The inability to provide therapeutic supports, which can reduce the likelihood of individuals re-offending and returning to the criminal justice system as if through a revolving door,

is frustrating for all concerned. Offenders with mental health issues and/or addiction may not be aware of the behaviors that get them into trouble. Confused clients, or those who lack introspection, may be unable to follow through with a discharge plan on their own, failing to schedule appointments or forgetting about them.

Fear of Violence

Service providers may fear criminalized clients, and thus refuse them service, whether or not a particular individual has a history of violence. Our perceptions of other people tend to be based more on appearances and outward behaviors than on factors that cannot be as readily seen, such as the person's pre-illness personality or their value system.

In Thunder Bay and Northwestern Ontario, community reintegration services are offered to inmates leaving the TBRHSC Forensic Unit and District Jail/Correctional Complex in order to help them reintegrate into the community as they leave incarceration and reduce the risk of re-offending.

These programs and their respective objectives are listed below:

Thunder Bay Correctional Complex	• Provide discharge planning • Provide community liaison • Complete Parole Board assessment • Assess for propensity to re-offend • Enhance skills and education	• Criminogenic factors addressed • Skills for independent living enhanced • Community safety is ensured • Person accesses mental health and addiction treatment at discharge • Person is linked to and accesses community resources as needed
Probation and Parole	• Supervision of adult offenders on probation/conditional sentence/parole • Participate in re-integration planning • Comprehensive offender assessments • Monitor adherence to court orders/conditions • Initiate referral process to services from a variety of providers	• Interventions target criminogenic factors/conditions of supervision • Motivating offender to change offending behaviors • Enhance public safety • Person accesses mental health and addiction services as needed • Person successfully completes probation /parole
Ontario Multifaith Council Reintegration Program	• Participate in discharge planning • Assesses needs and matches with volunteer • Helps ex offender access services, resources in the community • Assists client with developing a discharge plan prior to release	• Person is helped to find housing, education and employment to aid successful return to the community (housing, job, education, treatment)
Howard House [John Howard Society]	• Provide short term housing • Provide skills development programs	• People access Detox, treatment programs • People learn marketable skills

	• Provide alcohol and drugs awareness program • AA groups • Assist with discharge planning from institution • Provide anger management program • Through volunteer program, provide an opportunity to work • Provide breakfast • Provide emotional support	• People learn basic life-skills • People are helped to return to their home communities • People gain control over their anger through skills development • Individual is provided stable, clean and affordable housing • Individual has needed resources (income/medical treatment etc)
Elizabeth Fry Society	• Volunteers provide support and advocacy • Help women plan discharge in the community • Aboriginal women helped to access traditional resources.	• Women access services and supports in the community in a timely fashion • Women are successful in reentering the community and reuniting with their families • Communities are able to support the reintegration of women who have been in conflict with the law
Alpha Court Rapid Response Program	• Provide short term case management to those with a mental illness and or addiction problem • Help access housing • Connect to needed resources in the community • People access treatment/ mental health care as needed • People reentering society are housed • Aboriginal people access traditional healing resources • People access financial and vocational supports	
CMHA Homelessness Outreach /Discharge Planning Service	• Aid individuals leaving institution with discharge planning • Assist client to access appropriate community resources	• Promote coordination of services focused on individual need • People will be housed and resourced as needed as they leave the institution • Resources providing service to the individual will do so in a coordinated fashion to ensure maximal effectiveness while minimizing duplication of effort

Community Housing Outreach Service Brain Injury Services Northern Ontario (BISNO)	• Provide support, life skills training and advocacy to individuals in conflict with the law who have a traumatic brain injury • Provide/access stable and affordable housing • Provide crisis management • Provide opportunities for peer support • Coordinate services to be maximally effective	• People will be housed in affordable safe environment • People will learn skills and have the support necessary for independent living in the community • People will engage their community and access resources as needed

Gaps and Barriers

The following list outlines the gaps, barriers and/or issues relating to discharge planning and community reintegration issues in Thunder Bay and Region, and provides a baseline by which to assess changes that may take place over time:

1. Needs
   - Follow up in the community after discharge
   - Continuity of service provision
   - Continuity of medications
   - Prompt access to financial support/ immediate cash-in-hand
   - Transportation, e.g., bus tickets
   - Food vouchers
   - Employment services
   - Transitional & emergency housing for men and women
2. What Works?
   - Howard House has open door with few restrictions
   - Food banks
   - Thunder Bay Coalition Against Poverty (T-CAP)
   - Ontario Works provides emergency Drug Benefit Card on day of release
3. Services/Supports that Need Improvement
   - Access to addiction treatment: an onerous process especially while incarcerated
   - Access to education and training
   - Access to financial supports
   - Access to safe and affordable housing
   - Continuity of financial supports
   - Coordination of mental health and addiction services
   - Employment
   - Financial assistance for travel back to home community outside of Thunder Bay
   - Lack of resources for remanded individuals
   - Obtaining/replacing ID—need money and a guarantor
   - Very limited services for women
   - Violent offenders have difficulty accessing many services such as addiction treatment, mental health case management
4. Partnering Opportunities
   - With police
   - Family Services
   - Strengthening connections between community service

providers and corrections facilities
- Probation and Parole & Institutions—continuity of care/seamless reintegration
- Medical system
- Housing providers

A review of community reintegration programs also revealed:

- In 2004/05, approximately one-third of individuals admitted to the Thunder Bay Correctional Centre had been linked to community supervision, i.e., an active probation order and/or had a probation/conditional sentence order to follow.
- Recidivism rates remain high amongst the offender population and
- Client waiting lists are very long.

Numerous needs were also revealed, including the need for:

- A Safe House for 10 to 15 people that offers one-stop shopping for services, and a No-Refusal policy,
- After-hours, non-psychiatric crisis response,
- Gender-specific services,
- Court Diversion, where appropriate, for those with an already diagnosed mental illness,
- Communication and cooperation between service providers serving the same client,
- Implementation of a local case management model involving community (probation) and institutions (Thunder Bay Correctional Complex/District Jail) with the goal of establishing individual case management plans and meaningful discharge planning,
- Prevention/harm reduction programs,
- Half-Way House that provides education, support, food and clothing,
- Increased cultural awareness and supports for Native offenders, particularly women.

Planning Starts On Day One

Discharge planning is a process that needs to begin during the first days in custody and constructively utilizes the ties an individual already has established in the community, such as family, friends, spiritual supports and service providers. Discharge planning is evolving into a collaborative partnership among an individual's support networks, promoting a more effective and holistic approach. Looking at innovative ways to build partnerships is integral to effective planning.

In An Ideal System

An ideal system is one that is truly client-focused and responds to the requirements of offenders with special needs, provides these supports throughout contact with the criminal justice system and links inmates to community supports before their release, helping them gain new skills and coping strategies, thus reducing recidivism.

In that perfect world, people with mental health issues would receive treatment and support services tailored to their specific needs and would not wind up behind bars at all. But for those who do slip through the narrowed cracks, support workers would be knowledgeable about mental health issues and the variability in presentation of mental illness symptoms.

Active Partners In Planning Process

A person-centred Case Management approach would ensure that inmates receive consistent support across the continuum of junctures within the system, and the person, his or her family and close friends would be involved as active partners in the planning of treatment and care.

Strong community linkages/supports would be in place before the individual is released from custody, including timely access to appropriate mental health services to prevent re-offending and facilitate successful community re-entry.

On the day of discharge, the individual would leave the correctional facility or hospital with a discharge plan that includes information in a suitable format according to his/her culture, spoken and/or written language, or in an alternative format such as Braille or audiocassette to reduce confusion, miscommunication and forgetfulness. The day of release would not be a Saturday, Sunday or holiday when provider agencies might be closed.

Support Upon Release

A mental health or peer support worker would meet with the inmate before s/he leaves the correctional facility to offer practical and emotional reintegration support. If that were not possible, reliable, accessible transportation would be available to take the person to pre-scheduled appointments and to safe transitional housing, preventing even brief homelessness. Food vouchers, gift certificates, bus tickets and cash or a debit card for necessary and immediate purchases would be included in the discharge package.

Mental health service providers and peer support workers would continue the treatments and supports initiated during incarceration, and work closely with other service providers, including Probation and Parole, should the client be on a probation/parole/conditional sentence order.

Successes Achieved by the Community Supervision & Discharge Planning Sub-Committee

1. Working very seriously to follow Deputy Minister's intent in developing case management model.
2. Generally improve the "Discharge Planning" function.
3. Seek seamless fit with other services, especially probation and parole.
4. Focus on persons not on P&P will increase after that.
5. Bringing additional programming on board in several areas:

- Substance abuse
- Anti-criminal Thinking
- Anger management
- Programs for PTSD and other survivors

6. Turning Full Circle: A twelve-month healing group, Native only, covers all the previous and more including family violence and parenting. Uses Native spirituality, sweats, smudging and more as both context and foundation.
7. The "Native Sons" program is on hold. It used to allow non-Natives in and that was also very helpful to some of the latter.

7. Stakeholders With The Most At Stake

CONSUMER/SURVIVOR ISSUES SUB-COMMITTEE

- Unique Perspective
- Barriers
- How Poverty Affects Lives
- Survival on ODSP
- Homelessness "Normalized"
- Poverty Breeds Depression
- A Personal Perspective:
  - Lonely, Isolated People
  - Alone and On the Streets
  - Inclusion Isn't the Same Thing to All People
- Goals and Terms of Reference
- Successes Achieved

A Unique Perspective

Fifteen people turned out for the first Consumer/Survivor Issues meeting in April 2005. Most had personal or family experience with law enforcement and the criminal justice system. Some were well along in their recovery, while others were taking their first steps. Some were employed in the mental health field; others were volunteers on Consumer advocacy and/or mental health boards and committees. Some were still struggling with the side effects of psychotropic medications that leave one numb and feeling aimless.

All knew what it is like to try to pay rent and feed themselves/their families on monthly social assistance pensions that are frequently depleted a few days after checks are received. All knew how risky it is to say, *I am a psychiatric Consumer/Survivor* because of the social stigma and discrimination.

Barriers

Survivors face numerous barriers as they move through the criminal justice system. The following list, which breaks information down according to the relevant MH-CJP sub-committee highlights some of the things Survivors need to better adjust to the situations they face.

Pre-Crisis Diversion:

- There is a general lack of Support Groups where C/S can receive treatment or support, including professionally guided and peer supported groups
- Lack of safe, non-institutional options for support, including Safe Houses and/or Emergency Shelters
- There is a general lack of knowledge among service providers/professionals re *where else* to go for help

Police Issues:

- Police lack knowledge of mental health services / supports and service providers' names and contact information
- Police need education about mental health issues
- Sensitivity and awareness training needed for police officers and police communication centre staffs
- Survivors lack trust in police/may fear going to police for help when victimized
- Survivors need to be taken seriously by police
- Respect for psychiatric Survivors is lacking.

Court Diversion:

- Lack of education/understanding of mental health issues
- More court support workers needed
- Better explanations of court proceedings for Survivors
- Mental health sensitivity and awareness training for lawyers

Incarceration:

- Access to, and continuity of prescribed medications
- Supportive person to talk to who can explain what is going on and what else is likely to happen during incarceration
- Emotional safety: Jail is not a safe place and suicide watch over Survivor cannot ensure psychological or physical safety
- Mental Health sensitivity and awareness training for Correctional Officers
- COs trained to competently assist inmate in crisis
- Outside agency contact

Re-Integration & Discharge Planning:

- Detailed, easy to understand discharge plans so that inmates do not leave jail feeling confused, lost and not sure of where to go
- C/S leave jail lacking money, safe housing

How Poverty Affects Lives

Access to an adequate income is generally thought of as a social and economic issue, but poverty is an all too common condition of people with mental health issues, and is itself a state that breeds serious psychological problems—and sometimes crime.

If an individual with mental health issues is not poor to begin with, s/he is likely to become poor through a lack of opportunities for social and financial stability. Poverty may result in almost anyone:

- Becoming severely depressed, anxious and frustrated;
- Lacking energy through the sedating effects of medication;
- Having a poor diet and lacking exercise;
- Not being able to afford a social life or holidays;
- Not being able to engage in creative opportunities through not being able to afford materials;
- Not being able to progress towards paid work because they cannot afford suitable clothing or child care;
- Not being able to provide for themselves for the future because they cannot afford to save money;
- Not being able to afford insurance;
- Living in poor accommodation;
- Struggling to make it through each day;
- Relying on others, including their families, to subsidize them;
- Being stigmatized through mental illness and poverty;
- Problems with severe mental illness being compounded, particularly as regards social isolation and motivation.[25]

Survival on ODSP

In December 2002, there were 273,652 Ontarians in receipt of income assistance through the Ontario Disability Support Program (ODSP). The annual income of a single person on ODSP was $7,500 *below the poverty line*. The majority of social assistance recipients have difficulty

[25] Rethink Policy Statement 57: Poverty and Severe Mental Illness. http://www.rethink.org/news+campaigns/policies/57-poverty.htm

making their income last for one week.[26]

In Canada, it is the people who live in poverty who are most likely to be picked up and charged by police. The poor are also the most likely to be denied bail, to appear in court without adequate legal advice or representation, and to end up serving time in jail or prison.

> "It's really threatening when your [ODSP] worker does a review. I always worry that I'll get cut off and lose everything if I'm honest and tell them my family helps me out. My mom used to give me money, but that's counted as income and gets deducted from what ODSP gives at a rate of something like 75%. Now she just buys me food and stuff rather than giving me money. I'm not sure, but I think accepting her help without reporting it is a crime I could go to jail for. Welfare fraud or something. But what am I supposed to do?"
>
> --Survivor

Homelessness "Normalized"

Governments loudly denounce crime, but government cutbacks to health, income assistance and employment services throw more and more people with mental health problems onto the streets. In some large North American cities, homeless people are becoming a normalized part of urban life. So much so in fact, that some more privileged individuals seem to believe that a life spent rooting in garbage bins for food and sleeping on park benches or in alleyways is "okay for the mentally ill" because "they're used to it". (*Personal communication*)

Street people, especially those with a serious mental illness, have a significantly higher death rate due to heart attacks, diabetes, strokes and seizures, accidents, drug overdoses, sexual assault, suicide and murder.[27]

Poverty Breeds Depression

Examining the consequences of poverty from a different angle, unemployed persons are far more likely to suffer from depression and anxiety, and visit their family physicians for physical ailments than do people who work and have a secure income.

A 1999 survey from the U.K.[28] found that people with mental health issues lacked the following:

- Fresh fruits and vegetables
- A warm waterproof coat
- Two pairs of all-weather shoes
- A special outfit
- Money to spend on self
- Money to keep home decorated
- Money to replace broken electrical goods
- Home insurance

Another British study, also cited on the "Rethink" website, found that welfare recipients who received extra benefits showed improved emotional and mental health.

People with mental health issues have life goals and dreams very similar to those of people without emotional or mental disorders. But until the foundations of mental health and social assistance programs are compassionately restructured, people with mental health issues will likely remain impoverished and relegated to leading lives of hopelessness and despair.

Lonely, Isolated People

The closure of psychiatric hospitals

[26] *ODSP Fact Sheet;* DAWN Ontario: Disabled Women's Network Ontario http://dawn.thot.net/odsp5.html

[27] Fact Sheet: *Homelessness: Tragic Side Effect of Non-Treatment*. Treatment Advocacy Center. http://www.psychlaws.org

[28] Rethink Policy Statement 57

resulted in discharge of many people with mental illness and addiction disorders, who had lived in institutions for most of their lives, to community services that don't have the resources to help so many people. The hospital was the only home many of them ever knew or remembered. Many of these people wound up living alone and isolated from their families and from the people who had become companions and friends on the ward. Being hospitalised might have been better for some of them from a social standpoint. In psychiatric units there were people around, whether or not you wanted to be around them.

Community living is the wrong term to describe the living conditions of these lonesome, friendless people. In hospital, things are done for patients. The seriously mentally ill did not, and still don't, learn social skills: how to meet and interact with others because in hospital you don't have to seek people out.

Alone and On the Streets

Putting people out onto the streets, especially survivors of child abuse who don't have the social skills to find companionship, love or have families of their own can't hope for a normal life. It's very hard, sometimes impossible, for survivors of physical and sexual abuse in childhood to trust other people or be intimate. Without help to begin recovery, life on your own comes to mean an existence without support or loving connection to other people. Lonely people often go to bars, hoping to make a connection with another person, drowning their mental pain in alcohol or drugs or both. Many of them wind up in trouble with the law, their lives out of control, and facing a grim future.

Inclusion Isn't The Same Thing To All People

For Consumers who have close family or friends, inclusion might mean having the opportunity to use their skills and life experience to find meaningful employment, to live independently and blend in to a neighbourhood, or workplace.

To someone who doesn't have love and support, inclusion is more likely to mean finding a niche somewhere so they can at least be around other people in a safe environment.

Inclusion also means being listened to and heard when a Consumer/Survivor expresses a need. For most of the Survivor participants on Mental Health and Criminal Justice Project committees, that need is for service providers to let go of their hands. Empowerment occurs in circumstances where people can try new things, take risks, succeed and even fail. That's what learning is about, and it's never too late to give someone the chance to live a rewarding life.

--Stella Montour (As told to MH-CJ Project Coordinator)

Goals and Terms of Reference

By January 2006, the Consumer/Survivor Issues Sub-Committee was progressing well toward identifying a number of strategic goals to guide the work of the original sub-committees, goals that also define the Consumer/Survivor role in the change process.

These goals/priorities include:

1. **Public Education,** including working with the media, presentations, focus groups and awareness/sensitivity training
2. **Peer Support,** including developing funding proposals for a pilot project whereby qualified Survivors are educated and eventually employed at competitive salaries in the mainstream MH system supporting other C/S
3. **Partnerships/Networking,** including outreach to other similar committees
4. **Advocacy and Advisory,** including systemic and individual advocacy
5. **Alternative Services,** including seeking a sponsor agency affiliation and funding through that sponsor for alternative, Consumer-directed services

At the Ministry of Health Human Services and Justice Coordinating Committee table, the C/S Issues Sub-Committee foresees its advocacy and advisory role to involve monitoring the governmental process of service enhancement to ensure development of a regulatory mechanism providing an accessible, visible and transparent accountability process, as well as avenues for registering complaints.

The C/S Issues Sub-Committee will also seek active involvement in the Ministry's process of implementing alternative protocols and processes with police, courts, crown offices and correctional services to help keep persons with mental health issues out of the criminal justice system.

Successes Achieved by the Consumer/Survivor Issues Sub-Committee

1. Consumers have a better understanding of how the system works, which has helped produce a more positive relationship with other stakeholders.
2. Identified need for Certified Peer Specialist training/employment.
3. Consumer/Survivor Sub-Committee has established themselves as a credible and respected Advisory Group in the eyes of other Project participants, Steering Committee and relevant Provincial Government Ministries.
4. Gained a Voice in the process of effecting change.
5. Life expertise recognized/validated.
6. Demonstrated adaptability.
7. Learned about group processes/dynamics.
8. Learning to speak in public/risking the stigma of being publicly identified as psychiatric Survivor.
9. Coming together as Consumer/ Survivors to establish a core group of people devoted to the cause.
10. Learning how to handle conflict/ difficult people.
11. Learning to trust & bond/ develop sense of unity.
12. Supporting each other while sharing.
13. Maintaining Confidentiality.
14. Finishing tasks delegated.
15. Growing in Self-Determination.

8. Aboriginal Mental Health Issues

- **Being a Native Consumer/Survivor**
- **Address Aboriginal Mental Health Issues Independently**
- **Culture Stress**
- **Aboriginal People In the Correctional System**
- **Women Prisoners with Mental and Developmental Disabilities**
- **MH-CJ Project Responsibility**

"The chaotic conditions that exist within many First Nations communities are commonly traced back to colonization and the residential school experience, which are both known to have actively and intentionally suppressed Aboriginal knowledge and cultural values. In particular, residential schooling interfered with the Aboriginal family structure and its cultural foundation. The experience has been both highly disruptive and responsible for creating a generation of individuals who, having been removed from their families, often no longer understood what it meant to be part of their family of origin, let alone how to create a healthy family of their own…

The problems associated with colonization in First Nations…include disintegration of the social fabric of Aboriginal communities; destruction of self-respect and self-esteem; disruption of family life resulting in problems related to alcohol, drug and solvent use, as well as physical, sexual and emotional abuse; and suicide."

--The Mental Health and Well-Being of Aboriginal Children and Youth: Guidance for New Approaches and Services. Sal'i'shan Institute, 2004, p. 15-16. http://www.crpnm.mb.ca/library/Mental%20Health%20of%20Aboriginal%20Children.pdf

"Mental health services vary considerably between what is available on First Nation communities and what services are available off-reserve…On-reserve Aboriginal clients access mental health services through the [MOHLTC] Non-Insured Health Benefits Program [N.I.H.B] of Medical Services Branch [M.S.B.]. M.S.B. funds community-based mental health services that have been made available through the "Building Healthy Communities/Brighter Futures" Initiatives. These include grief counselling, and suicide intervention.
However, the following services are NOT available through M.S.B.:

- Alcohol, drug and solvent abuse counselling
- Psychiatric services and psycho-analysis
- Parenting and life skills training
- Marriage counselling
- Early intervention programs for infants with delayed development
- Sex therapy
- Services used for legal action
- Court-mandated therapy (i.e., anger management)
- Children in the care of the Children's Aid Society
- Incarcerated persons
- Motor vehicle accidents (MVA)"

--Ontario Aboriginal Health Advocacy Initiative (OAHAI) Manual, October 1999. *Aboriginal Mental Health*, p. 2. http://www.ofifc.org/oahai/Acrobatfiles/Mhlthrev.pdf

Being a Native Consumer/Survivor

Few Canadians of European heritage show much empathy for First Nations people. The majority still view Native people according to the media image of the uncivilized and drunken Indian. It's a stereotype that contains some historical and present day truth, but only because, on and off reserves, Aboriginal Canadians are poorly equipped to compete socially or

economically in Canadian society. They are a lonely, frustrated and often unemployed group of people, living in rundown accommodations, drinking and getting into trouble with a system of laws that is alien to traditional values and Native ways of life. In fact, the Canadian Criminal Justice System fails Aboriginal people, with and without identifiable mental health issues, at virtually every point in the justice process.

Native communities today exhibit enormous emotional pain and damage. Native youth are killing themselves at rates 6 to 8 times the national average. Native men no longer treat their own women with the respect once bestowed upon them. Rates of sexual abuse and domestic violence are incredibly high; social and psychological problems are epidemic and alcohol is the cheapest drug to dull the pain.

Deinstitutionalization of psychiatric services has lead to widespread homelessness. The homeless, especially those who have an alcohol/drug addiction, may be denied access to community mental health supports available to persons with a residential address. Many street people are displaced Native Canadians. Flown into urban centres like Thunder Bay to await appointments for mental health assessment or treatment, many fill in idle, lonely hours in bars looking for someone to love who will also care about them, but finding instead companionship with trouble. Police are called to deal with the intoxicated and/or those who are simply bothering others, and Officers sometimes shuttle these individuals around like taxi drivers, trying to find some agency to take charge of them. If they can't find such help, they may resort to arresting the person to get him/her off the street.

But a person whose mental illness is a result of deep-seated societal problems cannot be rehabilitated through either hospitalisation or incarceration. Upon discharge or release, the person is often returned to an environment that is as bad or worse than the one they left. No one gets well under such circumstances.

A small glimmer of hope comes from in-jail programs based on traditional Native culture and ceremonies. Some Native men and women who break free from a criminal lifestyle do so because they learn about their culture while incarcerated.

Incarceration is a Euro-Canadian sanction, which conflicts with the Aboriginal belief that justice involves accountability, the healing of both the victim and the offender and restoration of people to the community. It is an ironic, untenable situation, but an emerging reality that people have to go to jail to learn about who they are.

Address Aboriginal Mental Health Issues Independently

Aboriginal mental health issues need to be addressed equally, but somewhat independently of the needs of other psychiatric Survivors due to historical social and economic injustices as well as distinct cultural differences between mainstream Canadian society and traditional Native communities.

Data collected by numerous researchers indicates that mental illnesses, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), are less common among registered or status Indians, Inuit and Métis populations than non-Aboriginal Canadians. However the suicide rate among Aboriginal adolescents and young adults is at least three to six times higher than that of other Canadians. In *Suicide Among Aboriginal People: Royal*

Commission Report (MR131e)[29] it is stated that factors contributing to this tragic trend include:

- Higher rates of serious diseases such as diabetes and tuberculosis,
- Disruptions of family life resulting from enforced attendance at residential schools,
- Adoption of Native children by non-Native families,
- An increasing use of alcohol and drugs to relieve distress, and
- Culture stress.

To paraphrase the author of the Royal Commission Report, socio-economic factors such as high rates of poverty, low levels of education, limited employment opportunities and inadequate housing are issues that affect many psychiatric Survivors, but Aboriginal Consumers in isolated communities and on reserves may be additionally affected by deficiencies in sanitation and water quality. Conditions such as these are likely to create feelings of helplessness and hopelessness that can lead to suicide and other serious mental health problems.

Culture Stress

The last point in the above list, *culture stress*:

> "Is a term used to refer to the loss of confidence in the ways of understanding life and living that have been taught within a particular culture. It comes about when the complex of relationships, knowledge, languages, social institutions, beliefs, values, and ethical rules that bind a people and give them a collective sense of who they are and where they belong is subjected to change. For aboriginal people, such things as loss of land and control over living conditions, suppression of belief systems and spirituality, weakening of social and political institutions, and racial discrimination have seriously damaged their confidence and thus predisposed them to suicide, self-injury and other self-destructive behaviours." [30]

According to the Northwest Mental Health Implementation Task Force Report (Northwest MHITF 2002), *A Regional Mental Health System for Northwestern Ontario 2002*[31], 'the Aboriginal population of Northwestern Ontario is expected to increase so that by 2010, 50% of the population will be Aboriginal'. The needs of Aboriginal consumers of mental health services must be addressed now, and it is logical that the MH-CJP Committee should add Aboriginal issues to its agenda.

Aboriginal mental health concerns, as outlined in the Northwest MHITF 2002, include:

- There is a lack of aftercare/follow-up services for First Nation people returning home from treatment in urban areas such as Thunder Bay, Kenora or Winnipeg
- There are no culturally appropriate diagnostic tools, and lack of access to culturally

[29] Chenier, Nancy M., Parliamentary Research Branch, Library of Parliament, Political and Social Affairs Division, *Suicide Among Aboriginal People: Royal Commission Report* (MR131e), Ottawa, ON, February 23, 1995. http://www.parl.gc/information/library/PRBpubs/mr131-e.htm

[30] *Suicide Among Aboriginal People*.

[31] North West Mental Health Implementation Task Force Report 2002, Ontario Ministry of Health and Long-Term Care, "Aboriginal Issues", p. 109-113, http://www.health.gov.on.ca/english/providers/pub/mhitf/north_west/northwestern_ontario.pdf

appropriate psychiatric consultation and clinical supports in home communities
- The suicide crisis overshadows the needs of Aboriginal clients with other mental health issues, and available MH resources are being used to respond to/provide support for suicide prevention to the exclusion of other MH concerns
- Community mental health workers [in NWO] have no formalized linkages with outside supports
- No case management resources to monitor client between points of service, e.g., hospital to band nurses, community MH workers, band council)
- No supportive housing, family support available in communities. Family caregivers not provided with supports, education or information
- Physician support in First Nation communities is limited and inconsistent
- There is a high turnover of mental health workers because of the inconsistent support Many workers leave the community after receiving formal education/training
- Training/education is needed in communities to increase the capacity of overloaded mental health workers, and to address the lack of formal training for workers dealing with seriously ill clients
- Wait time for supports is long, and help may not be available at all until a client is in crisis
- Linkages and protocols for referral/treatment between hospitals/physicians and community workers unclear or non-existent
- Moderately suicidal persons with addiction problems may have to stay in unsupervised setting, e.g. a hotel, with access to alcohol while awaiting appointment with service provider
- Confidentiality is a major issue in small communities. People are unwilling to seek treatment when everyone knows one another
- When family member or other appropriate escort to treatment/appointments is unavailable, police end up being the only resource and the client may wind up in jail;
- Federal/Provincial jurisdiction issues are unclear in many communities and among service providers
- No reliable data available on incidence of Fetal Alcohol Syndrome/Fetal Alcohol Effect, concurrent disorders, and associated issues that affect treatment
- Post-Traumatic Stress Disorder is common, especially in the wake of suicide epidemic
- Police are often called in to deal with individuals with serious mental health issues if hospital will not admit person
- Professional staff may have difficulty with language and translation. Ability to provide appropriate treatment or other services is impaired when health professionals do not understand cultural context

Aboriginal People In the Correctional System

Equal access to justice for all Canadians demands cultural sensitivity in the provision of justice-related services and in the very administration of justice. It is evident, however, from the over-representation of First Nation People (and other consumers of MH services) in the justice system that not all persons are treated with dignity,

respect and fairness.

Justice statistics, which are readily available on numerous websites, indicate that, provincially, First Nation people are incarcerated at rates that are 6 to 7 times the overall rate, depending on which Province one looks at. Manitoba, Saskatchewan, and Alberta have the highest rates of incarceration of Native men, women and youth.

Over-representation of Aboriginal people in the justice system reflects a complex interplay of factors, including racism, language barriers, cultural differences and socio-economic problems, which result in:

- Higher rates of police contact and arrest
- A greater likelihood of being charged and sent to court after arrest
- A greater likelihood of receiving an unfair hearing and/or being persuaded by defence attorneys to plead guilty, even when the person is innocent of the charge
- Facing harassment in prison by Correctional Officers and other inmates
- Punishment for speaking their own language with other inmates, and
- Barriers to continuing their ceremonial and spiritual practices while incarcerated

Furthermore, data cited in *Racism in the Justice System*[32] indicate, "only 18% of First Nations inmates are released on full parole, compared with 42% of the general inmate population."

According to the Native Women's Association of Canada (NWAC), "Discrimination against Aboriginal women is rampant in Canada's federal prisons." [33]

Aboriginal women in prison:

- Often go into federal facilities on lesser charges, and
- Commit infractions in prison that lead to longer sentences.
- Those federally sentenced women classified as 'maximum security' have no access to core programs and services designed for women under federal law, and
- Are denied specific programs designed for Aboriginal prisoners.
- Many of these female Aboriginal prisoners have been serving time involuntarily in men's prisons and psychiatric wards.

Serving time in a men's prison not only puts these women at risk to male violence, but also denies them equal access to the programs and services that the men receive.

"Kim Pate, the Executive Director of the Canadian Association of Elizabeth Fry Societies, draws attention to the fact that Aboriginal women and women with disabilities are particularly discriminated against:

> 'Being Aboriginal means you are seen as higher risk; being poor means you are seen as higher risk; and being disabled means you are seen as higher risk. All of this results in women receiving a higher security classification, so if you are a poor, Aboriginal woman with a

[32] Racism in the Justice System, http://www.amachi.biz/divers-files/en/pub/faSh/ePubFaShRacJusSys.pdf

[33] Prisons Are A Failed Experiment (Especially For Women), PRISONJUSTICE.CA http://www.prisonjustice.ca/politics/1012_failed exp.html

disability, they literally throw away the key.'"[34]

Women Prisoners with Mental and Developmental Disabilities

Also cited in the electronic document, *Prisons Are a Failed Experiment*, is a statement from the Disabled Women's Network Canada, indicating that:

- Federally sentenced women with mental and developmental disabilities are being discriminated against under Section 17 of the Corrections and Conditional Release Regulation, which equates mental disability with a security risk.
- This legislation applies higher security classifications to these women, and perpetuates negative stereotypes and assumptions, which characterize mental disability as dangerous.
- Because of their higher security classifications based on disability, women who are suicidal or have mental or cognitive disabilities, are often isolated, deprived of clothing, and placed in stripped or barren cells.

"Prisons have become a substitute for community-based mental health services. With the increased cutbacks to healthcare and social programs, the law is increasingly coming into conflict with women's lives, as they are relegated into prisons instead of receiving appropriate services within the community".[35]

[34] Prisons Are A Failed Experiment http://www.prisonjustice.ca/politics/1012_failed exp.html

Racism, and the consequent over-representation of Aboriginal people within the justice system, perpetuates stereotypes and misconceptions about Aboriginal people in the same way that jailing persons--of any race--with mental health issues perpetuates the myth that people with mental illnesses are violent and dangerous.

Part of the solution lies in culturally appropriate services and supports across the mental health-criminal justice continuum, with the understanding that some Aboriginal mental health consumers will benefit from programs and services that reflect traditional culture and values, while others may be more comfortable with mainstream services.

Remedies to the problems in the justice system must also consist of wide-ranging social action, which addresses the socio-economic conditions that lead to and perpetuate mental health problems, and alternatives to incarceration that build on peoples' strengths and aspects of their lives that encourage lawful behaviour.

MH-CJ Project Responsibility

Mental Health and Criminal Justice Project records indicate an outreach was made to local Aboriginal organizations, but participation was nominal. One lone woman Survivor bore the burden of speaking for many Native Consumer/Survivors and this responsibility exacted a great physical and psychological toll.

Listening to this individual's frustration over not being heard or validated reflects the experiences of psychiatric Survivors in general, but whereas there were 10 to 15 non-Native Survivors who formed the Consumer/Survivor Issues Sub-Committee for mutual support around inclusion and equality of participation, there was no Aboriginal Issues Sub-

Committee. Being a lone soft voice is discouraging and difficult to sustain.

The soft voices of Aboriginal people, especially women, go unheard when opinions and suggestions for change are expressed. Those of us, whose forefathers were European, tend to nod our heads whenever someone courageously stands up for the neglected needs of a misunderstood People. "*Yes*", we say; "*we have programs for Natives in our jails and prisons. We go to workshops and learn all about Native culture*."

Unfortunately, most of what we pay is lip service to the unique needs of Aboriginal people. We need someone to continually remind us that not enough Aboriginal people are at our table, and that it requires much more than the occasional workshop to understand the fundamental differences between Native concepts of justice and the European notions upon which the Canadian Justice System is based. It is the gulf between a paradigm of healing and one of punishment. Carrying the torch gets to be a wearying burden.

We owe it to all Aboriginal people to listen more closely, but with a stipulation. While the mental health concerns of Aboriginal people reflect unique geographical and social conditions, they are also *human* and *human rights* issues. The chasm between psychiatric Survivors and service providers/professionals is one that MH-CJ Project participants are trying to bridge. Let us not fall back on the artificial "them vs. us" mentality when examining the needs of Native Canadians. We are a coalition that looks at people as people.

9. Unfinished Business

- Strengths to Grow On
- *Hear Us* & with an OPEN mind
- More Than Police Training
- Respect Enables Healing
- One Size Doesn't Fit All
- Healing From Traumatic Abuse
- Self-Destructive Behavior Patterns
- No PTSD Support Groups
- Healing From Cultural Self-Loathing
- Healing Requires Validation

"The challenge is to make education into something that will make a difference. Start with a strength and build on it, rather than pointing at a problem and saying how you are going to fix it."

--MH-CJ Strategic Planning Day

Strengths to Grow On

A fundamental need identified by every Mental Health and Criminal Justice Project Sub-Committee is that of education. A great deal of progress can and will be made through initiatives that raise awareness of the needs of people with mental health issues. In an ideal world, awareness and sensitivity training would begin in the preschool years, with youngsters being exposed to and accepting of people with all types of differences, disabilities and impairments.

The entertainment and news media could play a large role in building awareness by presenting persons with mental health issues as people first and foremost, and by *not* sensationalizing news coverage of tragic incidents involving mentally ill offenders. It is a challenge for organizations like the Mental Health and Criminal Justice Committee to make systemic progress when headlines scream: *Schizophrenic Mother Throws Three Young Sons into San Francisco Bay*, or *Accused Murderer has Psychiatric History.*

"*Hear Us*" & "with an OPEN mind"

Several MH-CJ Project community partners, St. Joseph's Care Group, PACE and CMHA have been meeting to develop public awareness campaigns that seek to counter stigma and discrimination against persons with mental health issues by demonstrating that recovery is both possible and widespread. The *Hear Us* (Hope, Education, Awareness, Recovery + Understanding Stigma) Speakers' Bureau presentation at the District Jail Open House in September 2005 was well received, and *Hear Us* speakers are bringing the anti-stigma message into Thunder Bay businesses, schools and interested community groups.

"*With an OPEN mind*", is a 5-year educational initiative of St. Joseph's Care Group and partners in the Thunder Bay Region, which will enlist the assistance of the media and community and business leaders who have lived with mental illness to increase awareness and understanding of issues surrounding mental illness and addiction; advocate for reduction of the associated stigma and discrimination; provide education, skills and resources to promote mental health; and raise awareness of mental health services and resources in the community. The anticipated "soft" launch date of "*with an OPEN mind*" is March or April 2006.

More Than Police Training

Education in the context of

implementing change in the forensic mental health system is much broader than training police officers to recognize and respond appropriately to people experiencing mental health crises. Persons with mental illness need a greater awareness of police crisis intervention powers and procedures, the language and process of criminal trials and hearings, and information about what to expect if they find themselves arrested and incarcerated.

Service providers, patients and their family members would benefit from education about Emergency Room protocols and triage. ER and other hospital staff, as well as police, paramedics, the judiciary, correctional and probation and parole officers would profit from insight into the cognitive and emotional impact of delusional thinking and hallucinations. Survivors and front line workers need to be aware of alternative supports and services available in the community--those services that would provide options beyond jails and hospitals.

Models for police awareness training in mental health have been developed in Canada, the U.S. and abroad. The Police Issues Sub-Committee has looked at various programs, including resources from the American *National Alliance on Mental Illness* (NAMI), the *Memphis Police Crisis Intervention Team,* the *Canadian National Committee for Police/Mental Health Liaison*[36]*,* and the police training manual*, Not Just Another Call . . . Police Response to Persons with Mental Illnesses*.[37]

Education does not have to take the form of classroom learning and some training programs utilize Consumer/Survivors in role-play. Any and all media, as well as direct, personal experience and the willingness to approach other people with empathy, can build the foundations of awareness.

> "It doesn't cost money to start treating people like people."
>
> --MH-CJP Participant

Respect Enables Healing

Education can go a long way toward healing systemic and individual wounds. Education that is accompanied by respect for the diversity of human experience and the uniqueness of individuals can help survivors of abuse and trauma accept them selves and grow in self-esteem.

One Size Doesn't Fit All

The stigma surrounding mental disorders leads many people to devalue themselves and one another. There is no homogeneous group of "Consumer/Survivors", despite the common usage of the term. Self-loathing can lead to isolation and jealousy of others who seem to have drawn a better lot in life, even if the other is also a person with mental health issues.

Healing from Traumatic Abuse

Women and men who have survived assault, emotional, physical, or sexual abuse, or witnessed violence perpetrated upon others, especially during childhood, may experience the mentally disabling syndrome known as Post-Traumatic Stress Disorder (PTSD). PTSD can interfere with self-esteem, interpersonal relationships and the natural sense of control over one's own life.

Individuals who have endured long-

[36] Canadian National Committee for Police/Mental Health Liaison. http://www.pmhl.ca

[37] Hoffman, R., Putnam, L., *Not Just Another Call…Police Response to Persons With Mental illness.* Ontario Association of Chiefs of Police (OACP), Sault Ste Marie, ON, 2004. http://www.equalopportunity.on.ca/eng_g/subject/index.asp?action=search_7&file_id=25617

term abuse may feel worthless, guilty, ashamed, and responsible for the abuse. Consequences of childhood physical, emotional and sexual abuse include alcoholism, drug addiction, and self-harming behaviors such as wrist cutting and overdosing on medications, prostitution, promiscuity and sexual dysfunction.[38]

Food, sex, alcohol and/or drugs deaden painful memories of abuse and help to temporarily block out reality. Emotional problems that may emerge from the experience of abuse include perfectionism, phobias, an inability to trust, and avoidance of intimacy and emotional bonding.

Self-Destructive Behavior Patterns

Abuse survivors may struggle with parenting problems. Abused people often distrust their own perceptions, leading to second-guessing parenting decisions, avoiding parenting altogether, trying to be a perfect parent or perpetuating the abuse onto the next generation.

NO PTSD Support Groups

Survivors often regard authority figures with anxiety, and when the self-destructive behavior patterns Survivors may develop lead to crises involving police, the results can be explosive and tragic. Unfortunately, Thunder Bay has no Post-Traumatic Stress Disorder support groups, and members of the Consumer/Survivor Issues Sub-Committee have identified this as a barrier to healing and a significant gap in mental health services.

Not everyone with mental health issues is a survivor of childhood abuse, but research findings regarding the prevalence of PTSD are sobering. If we regard the real crime of mental illness as a societal failure to deal with the consequences of poverty, perhaps more people will view the offender with mental health needs as a person who deserves the protection of the law, not punishment.

Healing From Cultural Self-Loathing

The injustices inflicted on Aboriginal people have led to a broad denial of cultural self-worth. To succeed in Canadian society, Native youth must compete with both white students and other Native children, while success, competition and independence are values not commonly taught in traditional Native homes.

Native youth who must leave their communities to seek a higher education or a career, risk rejection by the white majority culture *and* by the people they left behind, who come to see them as outsiders who think they're better than everybody else. These young adults suffer stigma in both worlds.

Healing Requires Validation

Healing from discrimination and stigma requires validation of one's experiences and emotions, and the presence of supportive, caring people willing to listen to our joys, fears, accomplishments and mistakes. The best mental health support systems utilize the experience of peers who have resolved their own traumas and can teach those still in recovery the skills necessary to face the barriers and prejudices they will encounter on the road of life.

The Consumer/Survivor Issues Sub-Committee is committed to developing Peer-supported programs and services that make possible healing at both the individual and community level. Educating and *employing* qualified Survivors within the mainstream

[38] *Healing After Traumatic Events*. http://www3.bc.sympatico.ca/trauma/

mental health system is a priority goal. A successful Survivor-driven model of mental health care will incorporate the values and defining principles that spurred the Mental Health and Criminal Justice Project: That service providers not only change how treatment is provided, but that Consumers become the leaders in developing their own treatment and recovery plans.

Empowerment grows from granting competent psychiatric Survivors the right and the responsibility to identify which treatment or support plans are helpful to them and which are not. Empowerment also requires attitudinal restructuring on the part of service providers to understand the fact that a person's dignity, integrity and financial status are as important to the recovery process as are clinical supports.

The Ontario government is investing large sums of money in Forensic Mental Health services, which amounts to a reformation of the *status quo.* Would it not be more responsible and less expensive to *transform care and support systems* by investing in programs and services that preserve the mental health of Canadians by reducing the social and economic conditions that create anxiety, depression and despair?

"Sometimes criminal acts are manifestations of anger at a world that fears and shuns people with mental health issues and shuts the door to the basic element of human dignity--Hope."

--MH-CJP Participant

Addendum 1

Membership in the Mental Health and Criminal Justice Project

The MHCJP Community Working Group had a membership of 60+ individuals and agency/organization/Ministry representatives from the following groups:

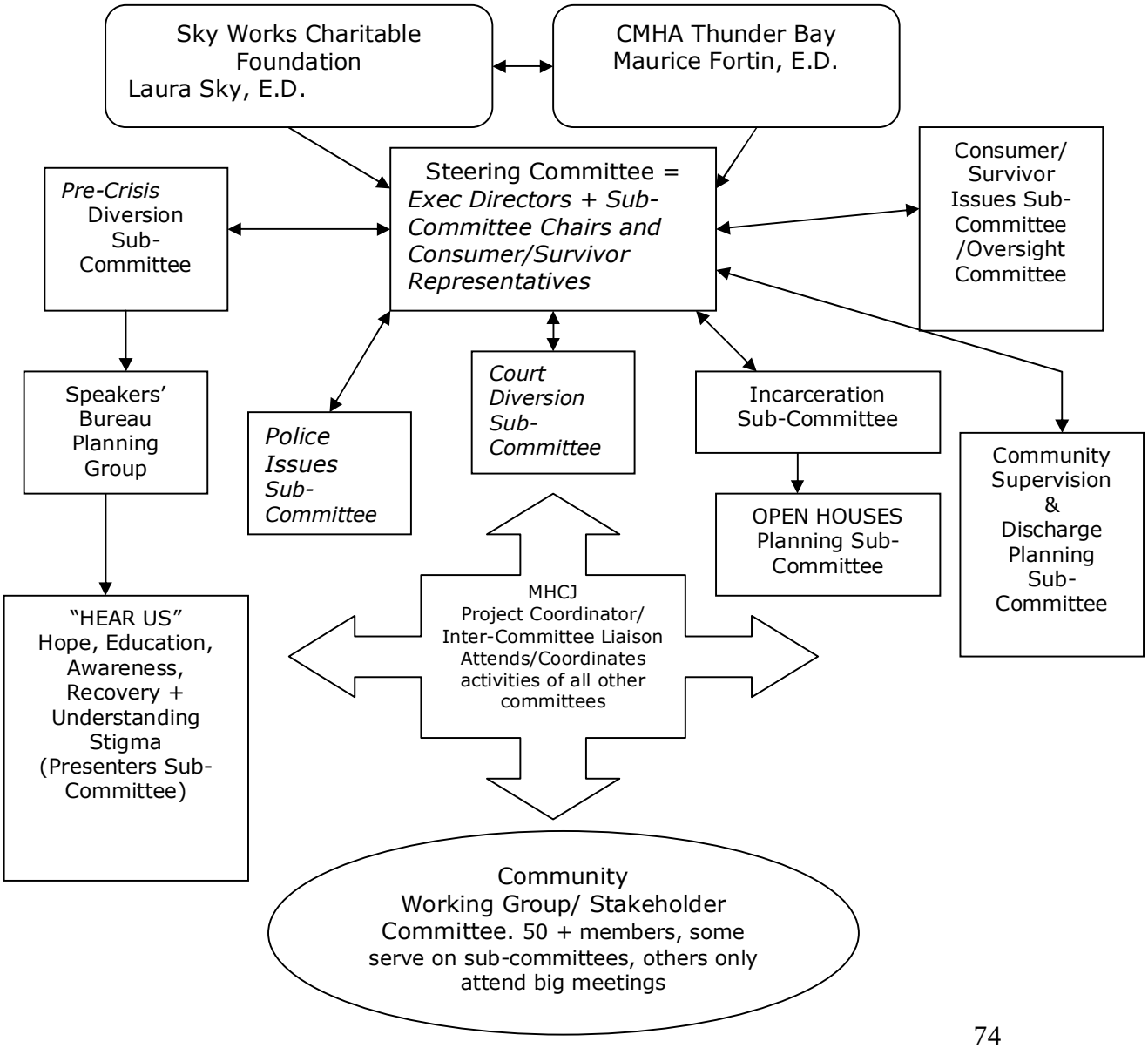
- Psychiatric Survivors
- Family members
- Sky Works Charitable Foundation
- Canadian Mental Health Association
- Thunder Bay Police
- Ontario Provincial Police
- Thunder Bay District Jail
- Thunder Bay Correctional Centre
- Probation and Parole
- William W. Creighton Youth Services
- Ministry of Health and Long-Term Care
- Ministry of Community and Social services
- Ontario Disability Support Program
- Thunder Bay Indian Friendship Centre
- Thunder Bay Multicultural Association
- City of Thunder Bay
- Superior North Emergency Medical Services
- Brain Injury Association of Northwestern Ontario
- Thunder Bay Crisis Response Service
- Alpha Court
- People Advocating for Change through Empowerment
- Psychiatric Patient Advocate Office, Thunder Bay
- Psychiatric Patient Council
- Victim Crisis Assistance and Referral Service/ Thunder Bay and Area Victim Services
- Thunder Bay Regional Health Sciences Centre
- St. Joseph's Care Group
- Children's Centre Thunder Bay (formerly Lakehead Regional Family Centre)
- John Howard Society
- Elizabeth Fry Society
- Ontario Multifaith Council
- Kinna-Aweya Legal Clinic
- Legal Aid Ontario
- Schizophrenia Society of Ontario, Thunder Bay Chapter
- Catholic Family Development Centre
- Ontario Works
- Shelter House
- Thunder Bay Sexual Assault/Sexual Abuse Counselling and Crisis Centre
- The Salvation Army
- Nishnawbe-Aski Legal Corporation
- Dilico Ojibway Child and Family Services
- 2 Judges
- 5 Lawyers/Attorneys
- 1 Doctor

Addendum 2

Flow Charts

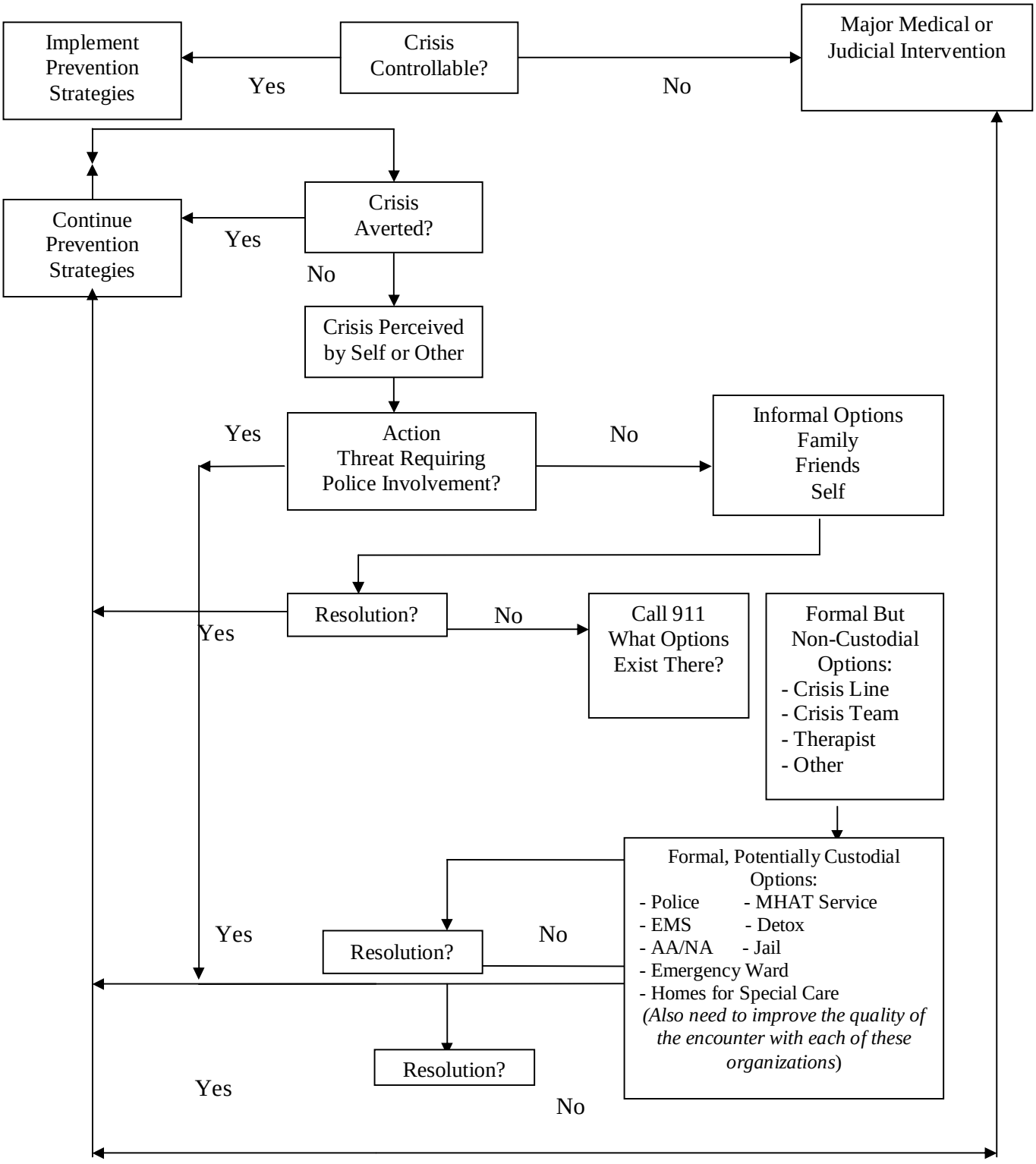
- Mental Health-Criminal Justice Project Organizational Flow Chart
- Police Issues Flow Chart
- Mental Health-Court Diversion Flow Chart
- Insert for Court Diversion Flow Chart
- Community Supervision & Discharge Planning System Logic Model

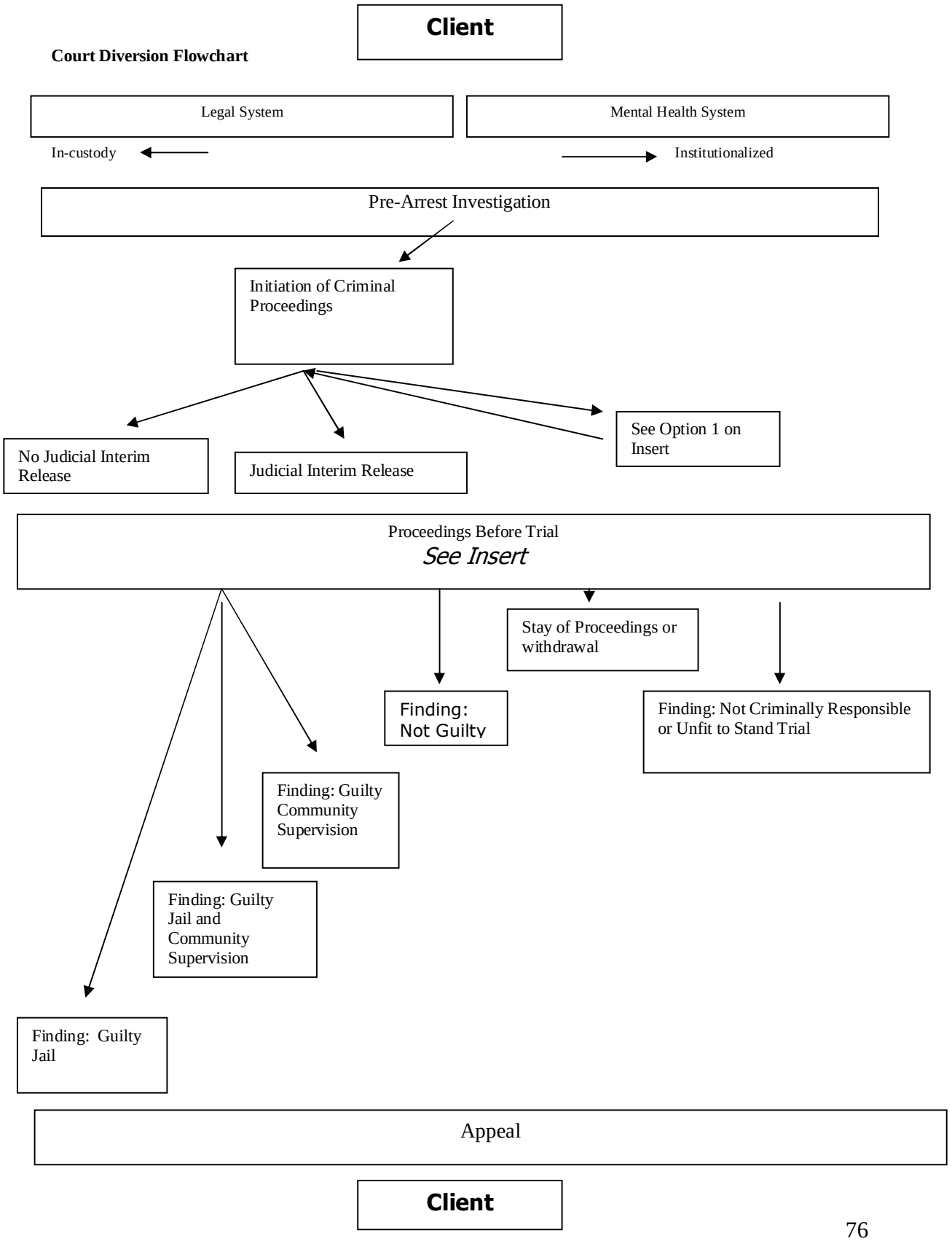
Mental Health Criminal Justice Project
ORGANIZATIONAL FLOWCHART

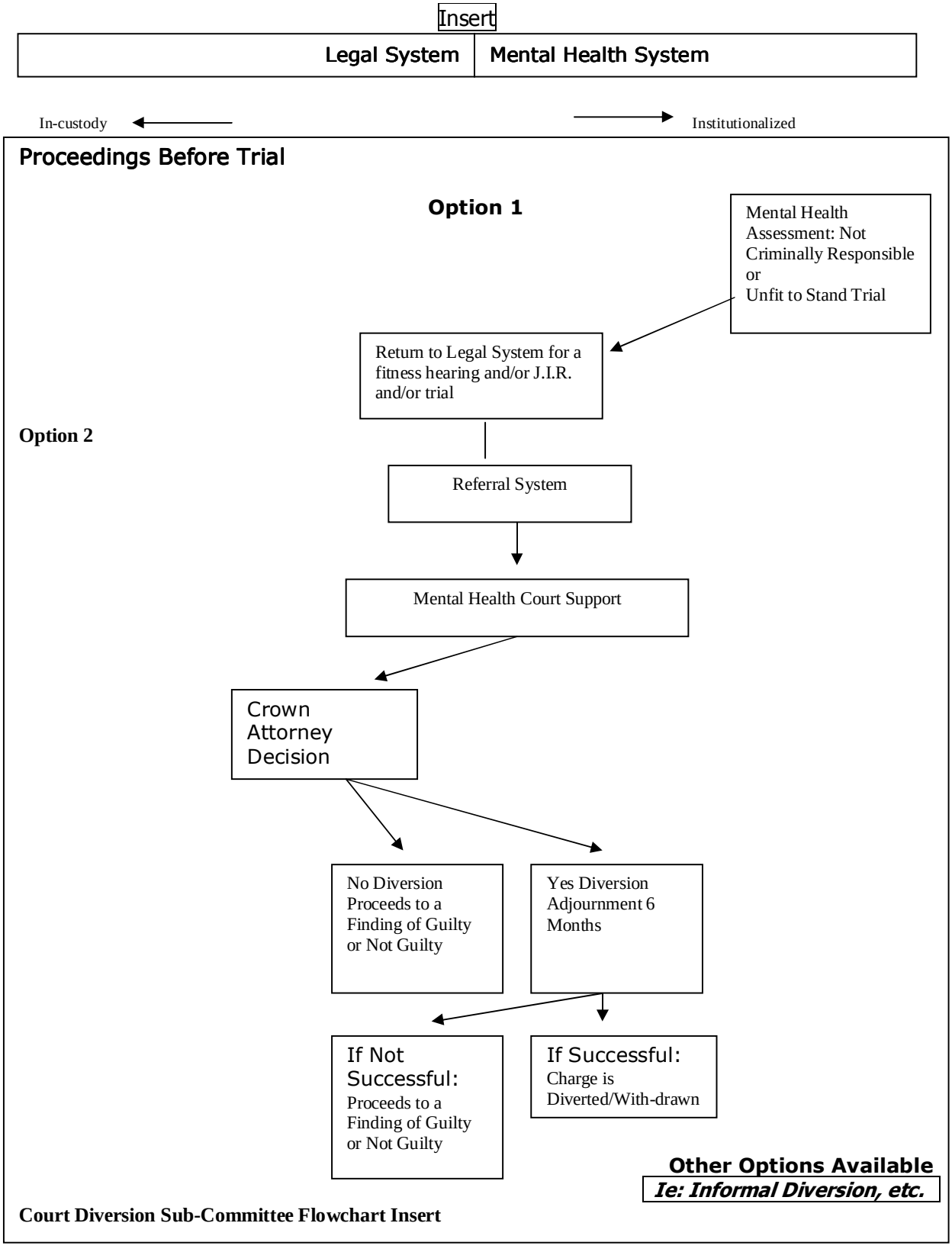


POLICE ISSUES SUB-COMMITTEE FLOWCHART

PRE-CRISIS

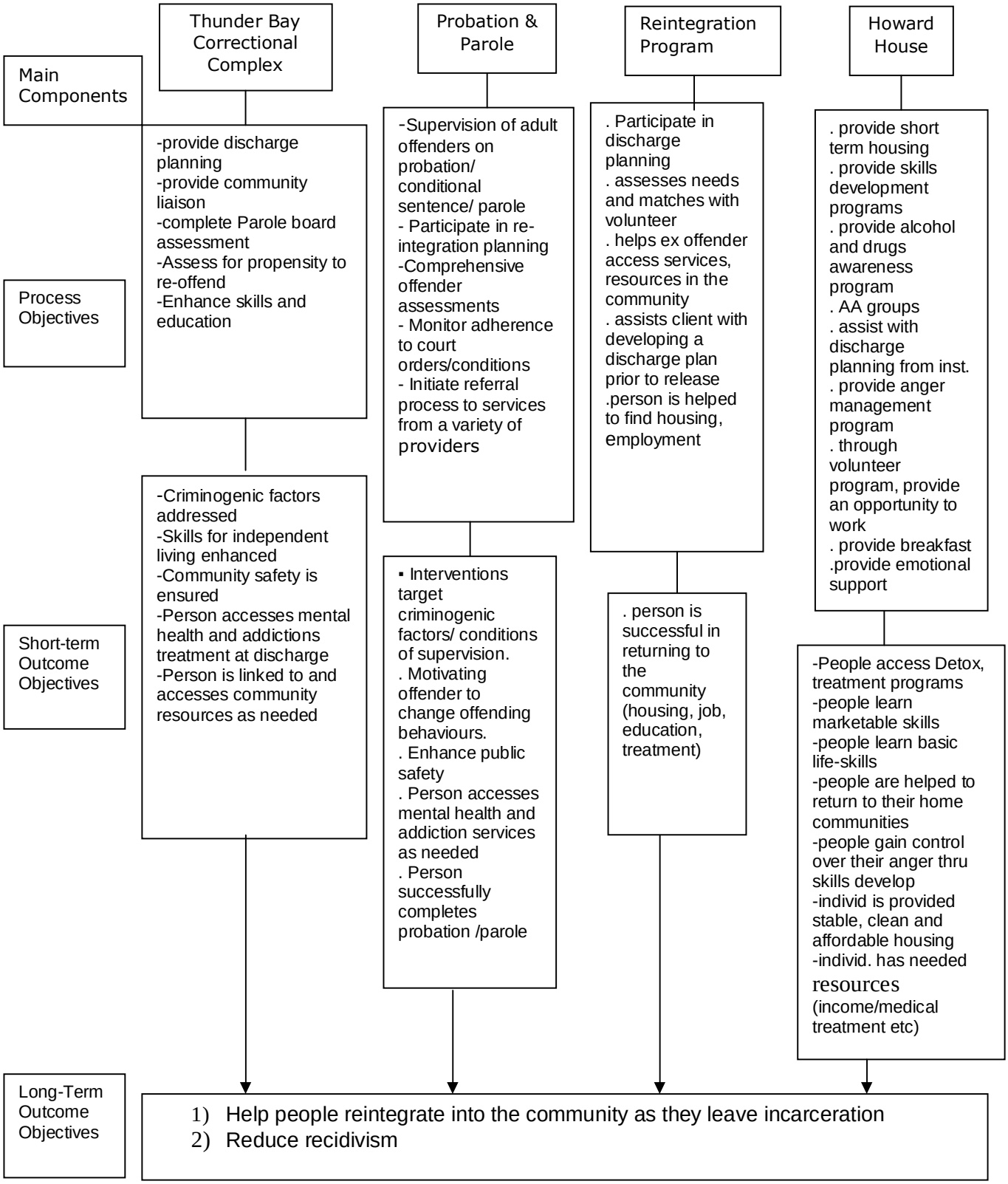



Client
Court Diversion Flowchart
Legal System
Mental Health System
In-custody
Institutionalized
Pre-Arrest Investigation
Initiation of Criminal Proceedings
No Judicial Interim Release
Judicial Interim Release
See Option 1 on Insert
Proceedings Before Trial
See Insert
Stay of Proceedings or withdrawal
Finding: Not Guilty
Finding: Not Criminally Responsible or Unfit to Stand Trial
Finding: Guilty Community Supervision
Finding: Guilty Jail and Community Supervision
Finding: Guilty Jail
Appeal
Client

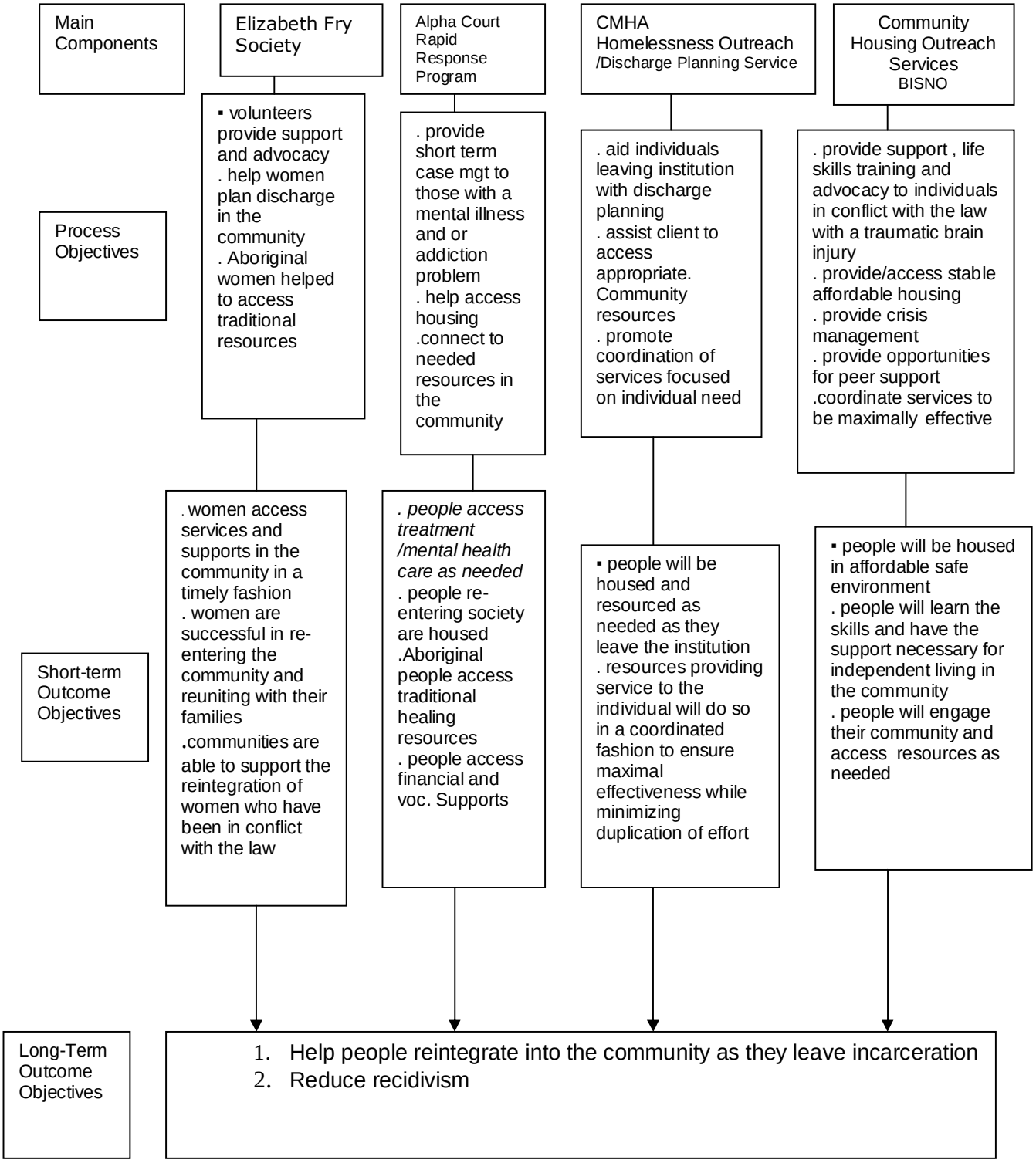


Court Diversion Sub-Committee Flowchart Insert

Community Supervision & Discharge Planning Logic Model



Thunder Bay District Mental Health Services and Supports System Logic Model, continued



NOTES: