CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

Recommendations to :

Glen Bocskei Inquest

Submitted by George Kurzawa, MSW, RSW, CAE

Executive Director

Canadian Mental Health Association, Niagara Branch

Introduction to CMHA Niagara

The Canadian Mental Health Association (CMHA) Niagara was created in 2001 as an amalgamation of two branches of CMHA. Various branches of CMHA have existed in municipalities across Niagara for approximately 40 years. The CMHA National organization was established in 1918 as a national voluntary charitable organization. CMHA is one of the longest established charities in Canada. CMHA Niagara has received recognition for best practice in human resources, employment, homelessness and housing programs.

CMHA Niagara is the largest provider of mental health and concurrent disorder services in Niagara. There are over 80 staff members with educational, employment, crisis, residential, counselling, community support, volunteer and justice programs. CMHA Niagara is operated by a community Board of service providers and individuals living with mental illness.

The vision of CMHA Niagara is: An inclusive community dedicated to the rights and mental health of all people. The mission of CMHA Niagara is: CMHA Niagara is dedicated to leadership in mental health by the delivery of services that ensure full integration and advocacy and education that eliminates discrimination.

CMHA Niagara has a strong culture of collaborative work on behalf of its clients including partnerships with the Crown Attorney's office and Niagara Regional Police. By presenting at this inquest CMHA Niagara wishes for continued engagement with the Niagara Detention Centre in fulfillment of its vision and mission.

History of CMHA Justice Services

In 2001, stakeholders from the region of Niagara held initial meetings to discuss the feasibility of establishing a court diversion program. Over a period of two years members from health services, police, Crown Attorney other legal professionals and consumers of services prepared a community proposal the "Niagara Region Court Diversion Program".

CMHA Niagara was funded in 2004 to provide court diversion services in Niagara. A court worker was hired and situated primarily in the St Catharines Court House. In 2005 additional funds were received from the Ministry of Health and Long Term Care to provide case management services. These were allocated to support the diversion worker and attempts were made to liaise with the Niagara Detention Centre. A community support worker provided mental health support for approximately one year to designated inmates at the detention centre. This relationship ended in

2007 and was re-established in 2008. Justice services currently consist of 1 Court Support Worker, 3 community support workers, and 1 peer support worker.

Estimates of Mental Illness in Ontario jails

According to a 2009 study by Gregory Brown of Nipissing University, it is estimated that 5 % of inmates in Ontario currently demonstrate a high number of severe symptoms of mental illness, and 35.1% of inmates currently have a moderate number of symptoms of a severe mental illness. About 2/3 of inmates demonstrate a need for mental health services to address violent behavior, abuse by others, social functioning and addictive behaviours and 60% have a need for assistance in establishing a social support system. The study also indicated that mental illness is more prevalent among the remand population. A 2007 study[1] indicated that inmates with a mental disorder are likely to be in need of treatment for problems with behavioral lack of control such as self management, aggression, impulsivity and self harm. They also have multiple health needs such as diabetes and heart diseases, stress and anxiety. What is also known conclusively is that people with mental illness have much higher rates of addiction than people in the general population. Rates vary based on various diagnostic problems. In a small Edmonton study cited in the CMHA Ontario web site, almost a third of mentally ill individuals also had a substance use problem, almost a third of those with alcohol dependency also had a psychiatric diagnosis, and among illicit drug users, almost half had a mental illness.

RECOMMENDATIONS

Training

The submission by CMHA Nova Scotia [2] to the Hyde Inquiry suggested the need for increased training for those in the justice system including corrections officers. The submission noted that evidence suggests that all first line responders need initial and ongoing training in appropriate methods of interaction with individuals exhibiting signs of a mental illness. The submission outlined the necessary elements of a training package for officers which would include: understanding and identification of mental illness, communication, de-fusing and de-escalating techniques, suicidality and risk assessment, stigma, knowledge of community services and other issues relevant to working with this population. These elements are now all currently contained in a number of training packages that CMHA Niagara provides.

In our observation, inmates at the Niagara Detention Centre (NDC) have sometimes been treated roughly and without recognition of their mental health issues. Our staff has

indicated that several inmates have reported taunting by the officers. In one example, an inmate was taunted about his delusions. This inmate suffered from paranoia and delusions concerning his belief in a conspiracy about Britney Spears. This inmate reported that he was being taunted with officers making sarcastic remarks such as; Britney Spears is in the next cell.

Recommendation #1

CMHA Niagara recommends that the NDC advocate for a hiring strategy that incorporates skills and sensitivities to mental illness.

This recommendation is in keeping with the recommendations of Howard Sapers, Correctional Investigator of Canada, in his 2009-2010 annual report [3]:

"….. *the Service needs to also move to a hiring strategy for front-line staff that places more emphasis on the skills, competencies, knowledge and qualities required to manage an increasingly complex array of mental health issues and disorders. With respect to personal suitability, patience, compassion and empathy are assets that are required to work effectively with a mentally disordered population. Strong communication skills and the ability to work in an interdisciplinary environment are also important personal characteristics for working with mentally ill people. Specific, advanced and continuing mental health education and training are other key elements of a comprehensive approach to frontline staffing in a correctional environment*"

In the video court situation, we observed guards struggling with GB as he was apparently trying to bite or strike the guards.

In our opinion there are a variety of issues including: the detention system and its need to control the inmates, an environment that supports toughness and a corresponding training and skill set that relates to enforcement. With an inmate such as GB these factors can exacerbate the situation. Research indicates [4] that it may be the first few seconds of an interaction between a police officer and person with mental illness that determines whether it is going to be a productive or a problematic situation . Consequently, if the first few seconds are rushed to force compliance, interaction may quickly escalate to violence. If officers use those first few seconds to talk to the person and use verbal de-escalation skills, the interaction may more likely be resolved without resorting to force. Crisis Intervention Training is noted as a promising approach in regard to police training.

Recommendation #2

CMHA Niagara recommends that Crisis Intervention Training be provided to the guards at the Niagara Detention Centre.

Crisis Intervention Training provides an understanding of the symptoms of mental illness and the motivation of the inmate. Crisis Intervention Teams consist of uniformed officers who have been trained in mental health and substance abuse issues who respond to these crises in the community. Also known as the Memphis model, the training has shown a rapid response time and frequent referrals for treatment when utilized by police. CMHA Niagara with other partners has trained over 200 Niagara Regional Police officers in the past 3 years.

This training is not recommended as replacement for the enforcement needs of the Detention Centre, but rather provides an alternative approach in the guards' arsenal of professional skills. The Hyde report [5] cites research that indicates growing evidence of Crisis Intervention Training impacting attitudes and awareness of mental illness while reducing injuries to personnel.

Medication and Treatment

Individuals with serious mental illness have higher rates of co-occurring diseases such as lung cancer, stroke, heart disease, and diabetes with a 25 year less life expectancy [6]. Much of it is due to under diagnosis and under treating, according to the CMHA Think Tank on Diabetes and Serious Mental Illness.

CMHA Niagara has noted apparent inconsistency in the assessment and treatment of inmates with mental illness. For example, in a meeting of June 2, 2009 CMHA Niagara identified the need for a referral process, expressed concern that NDC nursing staff did not have the tools needed to assess an inmate, and that NDC front line workers did not have knowledge of the signs and symptoms to look for to identify mental health issues. At this meeting CMHA Niagara was concerned that they were unable to visit inmates in second floor segregation units because of the need for two officers.

Over the years CMHA Niagara has experienced numerous examples of what appeared to be inconsistent services to the inmates. Some of the situations we have experienced included:

- Some inmates upon arrival are seen by the psychiatrist Dr. Cote and some wait for months after numerous requests
- Inmates who experienced possible "crisis" in the community and did not renew prescriptions prior to arrest did not get any medications in custody to re-stabilize
- Numerous inmates report meeting with physician who determines what inmates will take for medications regardless of previous medications prescribed by a psychiatrist in the community. Inmates report a "brief chat" with the physician

who they report communicates in a dismissive way that he does not wish to hear any concerns. Inmates report if they become assertive they are immediately "shut down" and then they don't receive any treatment.

- One inmate reported being beaten by other inmates, for his medication and consequently all of his medication was stopped.
- We have observed several inmates with a Schizophrenia diagnosis who went unnoticed because of their inability or unwillingness to request services. Some of these inmates also were not referred to CMHA until a behavioural issue was exhibited.
- A number of inmates have reported medical issues that were not addressed by the institution.

CMHA Niagara case workers spend a significant portion of their time in the community developing relationships with psychiatrists and assisting with medication compliance and treatment directives. Medication compliance and treatment works best in an environment of collaboration between the mental health workers, physicians and psychiatrists..

Recommendation #3

CMHA Niagara recommends a clinical management plan be prepared for each inmate with mental illness and shared with relevant community partners.

This recommendation is in keeping with the spirit of the Annual Report of the Office of the Correctional Investigator 2009-2010 which outlines the need for a clinical management plan for federal prisoners.

Recommendation #4

CMHA Niagara recommends that it review its health unit operations with a focus to best practice particularly as it pertains to mental health treatment.

We have heard of one protocol such as a 30 day medication reviews, it does not appear to happen routinely.

Alternative to Segregation

Overcrowding, lack of sufficient staffing and a danger to self and others has led to containment and isolation from other prisoners. Unfortunately, it is not the most therapeutic choice for the inmate and it is not the best way to assess the inmate. Howard Sapers the Federal Correctional Investigator of Canada has stated that overcrowding creates warehouses that make criminals more likely to re-offend when they are released. According to Howard Sapers, conditions inside overcrowded prisons are preventing rehabilitation. These conditions are leading to more incidents of violence and preventable deaths in custody, and the people hit hardest will be the most

vulnerable segments of the population, including those struggling with mental illness. While this report refers specifically to Federal penitentiaries, similar conclusions can be found in provincial settings such as the NDC.

Our staff has seen that inmates are often deemed most appropriate for placement in segregation cells due to their illness. This in turn, decreases the programming and resources available to them as many services are limited in segregation areas. Inmates struggling with anxiety and depression or psychotic symptoms placed in segregation comment feeling overwhelmed with symptoms. Their isolation and the general lack of distractions contribute to their reporting of deteriorating mental health.

GB was held in lower segregation, during his stay at the NDC.

Recommendation #5

CMHA Niagara recommends that the Niagara Detention Centre pursues the establishment of a mental health unit for the Centre.

Our recommendation relates to the therapeutic necessity experienced by increasing numbers of mentally ill persons in the jails. We are aware that the Niagara Detention Centre has submitted interest in a mental health unit. We support this as a more humane treatment option for this population. While this is not feasible for remand prisoners given their short and sporadic absences' from the centre, there can be brief programs established that provide some support.

Coordination with Community Services

In June 1997 A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario, was approved by the Human Services and Justice Coordination Project a cooperative project of the Ministries of: Attorney General, Community and Social Services, health and Long Term Care, Solicitor General and Public Safety and Security. It was developed to improve coordination of resources and planning for people with mental health in conflict with the law.

In December 2003 the Ministry of Mental Health and Long Term Care released the Central South Mental Health Implementation Task Force Final Report. The report specified the need for district; regional and provincial coordination mechanisms to facilitate cross sectoral communication and problem solving. The first meeting of the Niagara Regional Human Service and Justice Committee was held on March 10, 2004.

In May 2005 the Ministry of Health and Long Term Care formalized the structures of Human Service and Justice Coordinating Committees at the local, regional, and provincial levels. The Niagara committee reports to the regional committee, located in Hamilton, which in turn reports to the Provincial committee located in Toronto.

The main function of the Niagara Human Service and Justice Coordinating Committee is to create outcomes identified *in A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario* (1997) is to improve the coordination of resources and services for the identified target groups and to improve the system planning process. The Niagara group provides a forum for information sharing and awareness building amongst the various sectors. Representative organizations on the committee include; the Niagara Health System, Crown's office, Niagara Regional Police, Niagara Detention Centre, and community agencies. In 2010 a study [7] regarding the effectiveness of the Regional committee (which includes the local sub region committees of Haldimand Norfolk, Hamilton, Brant and Niagara) concluded that the Human Service and Justice Structures were effective. One of the findings stated that: *The structure of the HSJCC has served a purposeful role as both an independent and a collective voice in identifying and advocating services in need, as well as addressing systemic challenges.*

Recommendation # 6

We recommend that the designated Niagara Detention Centre staff member attend regular meetings of the HSJCC.

The Niagara Detention Centre has made some attempts to place a representative on the Niagara Human Service and Justice Coordinating Committee, but over the past 7 years they have been mostly absent. To their credit, they have made a commitment to rejoin the committee in the past year but their absence has still been noted.

The Niagara Detention Centre health unit rarely makes referrals to CMHA Niagara staff. Communication between the health unit, other units of the Niagara Detention Centre and CMHA Niagara is inconsistent and appears to be based on personal interest rather than procedures. Consequently, it is recommended that protocols and procedures be implemented with CMHA Niagara and other relevant services, for the expedient and necessary case management of inmates. These protocols and procedures should at a minimum describe the common service principles, respective roles and duties, rationale and minimal times for case management meetings.

Recommendation #7

CMHA Niagara recommends that the NDC establish and maintain a formal, with terms of reference, committee of relevant NDC health care and social work professionals and community partners.

The Mental Health "Committee" that once involved several CMHA Staff and NDC Staff from different departments dissolved several years ago. In April 2009 discussions

began again between the Social Worker and CMHA Staff to start up some services for inmates with mental health issues. Since the programs began, there have been meetings occasionally between CMHA Niagara Staff and the Social Worker to discuss progress with inmates and there treatment. Twice over the past two years we have requested that the Health Care Coordinator attend meetings to discuss strategies for improvement. There has been a lack of consistency to the meetings and there certainly is no formal established committee. These meetings are generally requested by CMHA and they involve either Social Work or Health Care, but never both together.

Stigma

The Mental Health Commission of Canada has recognized that stigma and discrimination plays an important part in the lives of people living with mental illness. Stigma refers to the beliefs and attitudes that lead to negative stereotyping of people living with mental illness. Views are often based on ignorance, misunderstanding and a lack of information. A common belief, for example, is that all people with mental illness are violent. In fact, except for a small minority of people with paranoid schizophrenia and substance abuse issues, most individuals with mental illness or no less or more violent than the regular population. CMHA Niagara acknowledges that stigma is a major barrier to appropriate treatment, services and funding. It is often a subtle form of discrimination whereby the illness is taken as a character flaw of the individual, rather than a diagnosable and legitimate illness when compared for example to cancer. As an example, cancer has limits on waiting times for certain treatments, mental health does not.

Stigma and discrimination against those with mental illness is well documented. It's persistence is real and damaging, and according to the Mental Health Commission of Canada, stigma has played a significant role in the historic marginalization of persons with mental illness. Caution with the language we use and understanding the history of those who have been marginalized and the negative effects of stigma can provide a powerful incentive to change attitudes and behaviours.

Our clients and staff suffer from stigma and discrimination. Our clients experience the stigma directly and our staff experiences it vicariously. On numerous occasions when requesting to meet with an inmate or potential inmate of CMHA, officers say harsh derogatory comments about the inmate such as " Moron", "Annoying", " Attention Seeking" and " Pain in the Ass ". Comments heard by staff members are: You are "wasting your time." It "won't make a difference anyway." It is also very common to hear officers and lieutenants swearing at potential clients and engaging in what appears to be power and control struggles.

Recommendation #8

CMHA Niagara recommends that officers monitor and use appropriate language when referring to inmates with mental illness.

The Hyde Inquest [8] provides examples of appropriate language when referring to inmates with mental illness.

The delivery of educational sessions, is particularly poignant and powerful when provided by individuals who have experienced the discrimination and stigma. CMHA Niagara has been recognized for success with its speakers bureau of individuals who live with mental illness and other disabilities. We commend the social worker at NDC who recently attended a Crisis Intervention Training Conference with a CMHA Niagara staff person. We are also encouraged with discussions regarding the possibility of two officers attending the next Niagara Police CIT Training.

Recommendation #9

It is our recommendation that two officers attend the next session of CIT training and act as "champions" to assist in the development of organized training for their peers.

Recommendation #10

CMHA Niagara recommends that all staff of the Niagara Detention Centre receive at least one information session from the CMHA speakers' bureau particularly related to stigma and the impact on people living with mental illness.

Recommendation #11

CMHA Niagara recommends that the Niagara Detention Centre develop and incorporate regular mental health orientation and education for its staff and management.

Diversion

Mental health diversion programs have been growing across Ontario as the population with mental health issues has been increasingly involved with the justice system. CMHA Niagara has been promoting mental health court for a number of years, most recently through communication with the Niagara Crown attorney. Mental Health Courts (often referred to as therapeutic courts) are increasing as the evidence of their success mounts. Mental Health Courts provide service in a single docket for mentally ill or substance abuse offenders, and others. They typically consist of a designated crown,

judge and defense lawyer and strong interaction with the mental health service community.

Mental Health Court would have been a benefit to GB. Not only would they have been able to acknowledge and recognize that this inmate was suffering from chronic and persistent mental health issues, but they would have hopefully been able to deal with this matter in a more "humane" way. The results for GB could have been less appearances in court, within a therapeutic jurisprudence approach, that may have reduced his extreme stress and anxiety. One of the elements of a mental health court is the recognition of expeditious treatment of persons with mental illness. They are often in a confused and stressful state, and a traditional court can exacerbate their situation. It would be difficult in this situation to make an argument that GB should not have been incarcerated; he was facing a serious charge of attempted murder. However, he should have had expeditious access to mental health services through St. Joseph's Forensic Services. This would have eliminated the three video appearances. A court order for an assessment by St Joseph's Forensic service might have been made on his first video appearance.

Recommendation #12

CMHA Niagara recommends that persons identified with mental health issues be referred to St Joseph's Forensic Services with minimal delay.

Recommendation #13

CMHA Niagara recommends that the Crown develop a task force to study and implement a mental health court capacity in Niagara.

Conclusion

The first asylum was opened in 1850 at what is now the Addiction and Mental Health Services Corporation (formerly the Queen Street Mental Health Centre). For the next century, the provincial public mental hospitals provided treatment, shelter, asylum and custody for the seriously mentally ill, criminals, the homeless and other marginalized members of society. At a later time they de-generated into little more than holding pens or prisons for the mentally ill.

The catalyst for the de-institutionalization of Ontario hospitals began in the early 1960s with the introduction of psychotropic drugs for treating mental illness. While these drugs could not affect a cure in most patients suffering from a mental illness, they were often capable of reducing or controlling symptoms. This allowed patients to be discharged into the community and find acceptance within society. Patients began to be discharged

into settings like Homes for Special Care, community hospital psychiatric units, private hospitals and other community settings.

The therapeutic advances, which have allowed earlier discharge and de-institutionalization, have not been matched by a development of appropriate community services. There has been an acknowledged failure by governments to maintain appropriate funding and design a strong mental health system capable of providing a continuum of care for patients. Consequently, a growing proportion of persons with mental illness have ended on the streets, charged with crimes, and ultimately in prison. It is a conundrum that while the crime rate has been decreasing the rate of people needing services in the justice system has been increasing. Community services have not been adequately funded to provide for the need and changes to the Criminal Code have meant that more low risk offenders have been re-directed to mental health services for treatment and assessment. The end result is that we have in fact re-institutionalized this population, in our prisons, with a minimum of therapeutic intervention.

CMHA Niagara believes in a philosophy or recovery for individuals with mental illness. In a paper co-authored by this writer: *"…. a philosophy of recovery provides a beacon of hope where, too often, people are told that mental illness means certain decline into unemployment, poverty, and disability. The promise of recovery is that it will lead to fuller lives for people with mental illness. However, recovery is not to be confused with cure. People who have recovered may still experience symptoms and struggle with the consequences of their diagnosis. For those who have experienced this journey first hand, recovery is defined as living consciously and fully despite life's burdens. The need for change in Ontario's mental health system is urgent because people with mental illness are not faring well. They are over-represented among the homeless population. They are being criminalized – picked up by police and jailed rather than receiving help."*

CMHA Niagara appreciates the difficulty that the intersecting justice and mental health systems have in serving this population. While CMHA Niagara has gathered some expertise in community treatment of persons with mental illness, we are certainly not the experts in the courts, police and detention centre, and we are continuing to evolve and learn about the intersection of these sectors. We offer these recommendations in good faith believing them to be complimentary to the best service for our mutual clients.

Submitted on behalf of CMHA by George Kurzawa Executive Director, with the assistance of Debbie Alder, Court Support Worker, Katherine Vindis Community Support Worker (Justice Program) and Kelly Falconer, Program Manager (Justice Program).

Summary of Recommendations

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Recommendation #2

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Notes and References

1. Morgan et al (2007) were cited in the Gregory Brown study presented at the Human Service and Justice Coordinating Committee 2009 Annual Conference in Niagara Falls
2. The Report of the Fatality Inquiry into the Death of Howard Hyde, (Hyde Inquiry) was completed by Anne S. Derrick Provincial Court Judge, Halifax Nova Scotia. CMHA Nova Scotia was an expert witness at this inquiry and submitted their May 2010, recommendations authored by Carol Tooton, Executive Director.
3. Howard Sapers, The Correctional Investigator of Canada, provided in his 2009-2010 Annual Report and presented to Vic Toews, Minister of Public Safety.
4. Watson et al. Improving police response to persons with mental illness: A Multi-level conceptualization of CIT, Published online 2008 July 15th
5. Hyde Inquiry, p. 280
6. Gold M, CMHA Think Tank on Diabetes and Serious Mental Illness, April 30th 2009
7. Kindiak, D, Four Year Review of LHIN 4 and Local Human Service and Justice Coordinating Committees, June 16th 2010
8. Hyde Inquiry, Part VI, Chapter 39
9. Everett, B. et al, with George Kurzawa one of the contributing authors, was developed for the policy branch of the Canadian Mental Health Association of Ontario as Recovery Rediscovered: Implications for the Ontario Mental Health System, March 2003