Keeping People with Mental Disorders Out of Trouble with the Law

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1 Introduction

This is a report summarizing a yearlong project supported by the Law Foundation of British Columbia and BC Mental Health and Addictions Services, an agency of Provincial Health Services Authority to develop a framework for addressing the need to divert people with mental disorders away from usual justice system processes and into more appropriate care and supports.
The project—building upon a review of diversion practices in Alberta and Ontario—involved summarizing diversion best practices in Canada and other countries, developing a framework based on these best practices, and provincial and regional consultations carried out by a team from the Canadian Mental Health Association BC Division.

The project builds on several common sense assumptions. The first is that the criminal justice system is not an effective means of dealing with behaviour which is driven by mental illness. Second is that a more integrated and appropriate response to individuals with mental disorder who come into contact with the criminal justice system will improve their ability to live stable lives in the community and reduce their likelihood of repeated criminal offences.

The project goals were to:

- Promote evidence-based diversion of persons with mental illness from the criminal justice processing to more appropriate responses
- Reduce the volume of persons with mental illness being processed in the criminal justice system (police, courts, corrections)
- Ensure that appropriate processes are available to engage such persons in a community-based plan for support, skills, resources, and/or supervision to prevent future criminal behavior.

The specific objectives of the project were to:

- Conduct research into evidence-based best practices of diversion of people with mental illness who are, or are at risk of, engagement in the criminal legal process—both in large urban centres and in smaller more remote communities as guided by a provincial advisory committee
- Review these research findings with key stakeholders in each of the five BC Health Authority regions
- Produce a best practices guide and recommendations for diverting persons with mental illness in the criminal process in BC
- Produce a provincial framework for diversion
- Promote the best practices guide to government, judiciary, legal profession, police agencies, health authorities, and communities throughout BC to promote changes based on evidence of best practices.

The provincial advisory committee was selected from key stakeholders in the areas of mental health and criminal justice. The members of the advisory group are listed in *Appendix A*.

The work of the project consisted of:

- Developing a Best Practices Guide through a systematic review of the literature on Best Practices. This was accomplished by Jamie Livingstone a PhD Candidate in Criminology at SFU and Project Manager with the Forensic

Services division of BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

- Developing a Criminal Justice Diversion Framework—a common understanding of the needs of and approaches to the specific issues—to provide direction, consistency and accountability.
- Conducting provincial and regional consultations in the health authority regions regarding the policy framework and the best practices material and to hear about local promising diversion practices throughout the province. Workshops were held in Vancouver (May 13) Kelowna (June 24), Abbotsford (July 8) and Nanaimo (July 15). The forum in Prince George originally scheduled for July 10 was cancelled due to low enrolment and the forum planned for the Sunshine Coast was not able to be arranged in the time frame available to the project. Each forum featured local leaders who described promising practices and issues related to diversion practices.
- Producing summary documents of the research consultations in both an academic as well as a 'plain language' format.

Too Many People with Mental Disorders in Costly Places Not Designed to Treat Them

Since the closure of Riverview, there has been an increase in the number of people with mental disorders caught up in the criminal justice system. BC data reflects this trend:

- In February 2008, the Vancouver Police Department released a report indicating that the police are increasingly dealing with mentally disordered persons on a daily basis. The report *Lost in Transition*, states that 31% and in some areas of the city almost 50% of police calls involved a person believed to be suffering the effects of a mental illness.[i]
- In 1999/2000, there were 52,000 individuals (43,859 adults and 8,234 youth) in the provincial corrections system. Almost 15,000 (29 %) were classified as mentally disordered offenders—nearly twice the rate for the general British Columbia population.[ii]
- The federal correctional system is where more serious offenders serve sentences of two years or more. In 2006, more than one in ten men offenders entering federal custody was identified as having mental health problems, and this proportion has risen since 1997 (7% to 12%, +71%). One in five women offenders entering federal custody were identified as having mental health problems and this proportion has also risen since 1997 (13% to 21%, +61%).[iii]

Who Are We Talking About?

The public mental health system provides services to persons with an "Axis I Diagnosis" which includes schizophrenia, bipolar disorder, anxiety, depression or an eating disorder but excludes many other serious mental health problems.

The criminal justice system uses the term "mental disorder," as defined in the Criminal Code of Canada. The term "mentally disordered offender" (MDO) includes persons who have a mental disorder (including but not limited to Axis I diagnoses,

other than anti-social personality disorder) and/or substance use disorder, developmental disabilities (IQ below 70), low functioning (IQ above 70 with limited adaptive abilities), brain injury (organic or acquired) and Foetal Alcohol Effects or Foetal Alcohol Syndrome. It also includes seniors with behavioural and anger management issues.

In this project we have used the broader criminal code definition to look at diversion possibilities for people with a mental disorder who have been, are, or are at risk of coming into contact with the criminal justice system whose mental health needs have not been adequately met in the community. This will include people who have been in previous years excluded from treatment in the community mental health system such as people with brain injury, foetal alcohol spectrum disorder, and concurrent disorders.

More likely than not, a person with a mental disorder who run into trouble with the law will also have an addiction. This combination of mental disorder and addiction (concurrent disorders) is particularly challenging, and results in significantly higher health and human service costs, and greater involvement with corrections. A recent BC report found that health and social service costs for those with concurrent disorders were over nine times higher than those with no psychiatric diagnosis.[iv]

More likely than not, persons with addictions have not received diagnosis or treatment for their addiction. Self report data of substance use disorders is rarely accurate. Researchers examining new clients to the Surrey Pre-Trial centre found that while only 8% of the entire sample had formal diagnoses of co-morbidity noted in their files, about 61% had addiction issues. Alcohol disorders were the most prevalent (24%), followed by cannabis (16.5%) and cocaine (10.2%). Poly drug use disorders were relatively common (15%).[v]

Aboriginal people are overrepresented in this population. Aboriginals represent 18% of the federal prison population although they account for just 3% of the general Canadian population. The best estimate of the overall incarceration rate for Aboriginal people in Canada is 1,024 per 100,000 adults. Using the same methodology, the comparable incarceration rate for non-Aboriginal persons is 117 per 100,000 adults. There continue to be fundamental differences between the concept of justice among Aboriginal communities and in the mainstream justice system, which may contribute to the problem. As well, only a fraction of Aboriginal offenders have access to culturally appropriate programs so that many more Aboriginal offenders are sent into the mainstream system, often triggering negative consequences and reincarceration.[vi]

Although there are more men caught up in this system, in the more intensive service levels of the criminal justice system there appear to be more women than men engaged. In many courts, over 80% of female offenders had received a psychiatric diagnosis, which is up to 30% higher than the corresponding percentage among males. Considerably higher levels of health and human services utilization by females combined with high rates of substance use disorders, mental disorders, and concurrent disorders suggests that court liaison activities might warrant a focus on the specific needs of women within the corrections population.[vii]

Diversion in Other Canadian Provinces

Both Ontario and Alberta have province-wide diversion frameworks to address the needs of this population, although they differ somewhat in how and what was developed. CMHA BC reviewed these initiatives prior to the current project in order to inform our approach.

In Ontario, mental health diversion developed organically at the community level in the early 1990s, spurred by the efforts of community organizations. In 1997, the relevant ministries of the Ontario government began working together to develop a policy framework for mental health diversion. By 2006, the Ministry of Health and Long-Term Care published a Diversion/Court Support Framework and Program to provide provincial leadership and greater consistency to cross-sectoral networks already engaged in this area at the local, regional and provincial level (the Human Services and Justice Coordinating Committees). The first provincial conference of these committees was held in September 2007.

The Alberta mental health diversion strategy was developed through the leadership of the Mental Health and Justice Partnering Deputies Committee (involving Health, Justice, Education, Child Services, Aboriginal Affairs and Northern Development, Human Resources and Employment, Solicitor General, Alcohol and Drug Abuse Commission) and the staff support of the Alberta Mental Health Board. The process in developing the strategy was thoughtful and well planned in stages: a Service Framework (2001), an Implementation Plan for the Service Framework (2002), a Pilot Project in Calgary (2001–2003) and a four-year implementation plan (2003) to bring the Strategy up to scale.

Both provincial strategies have components described as best practice in the literature including, among others: provincial interministerial leadership, engagement of key stakeholders including non-governmental agencies and persons with direct experience, local interagency collaboration, and committed funding for cross training and support service enhancement.
Aggy King-Smith, Manager of the Alberta Provincial Diversion/Mental Health and Justice Community Capacity Building Program, spoke at the project's provincial forum in Vancouver about what they had learned from their experience. The essential elements she described include collaboration, clear protocols, cross-training, review of privacy legislation, and evaluation. Definitions, values, and processes must be broad and flexible to fit different community contexts. At a local level it is important that goals and efforts are shared and that communication is clear, consistent, and continuing. Collaboration is developed both at the provincial (policy) and the local (operational) level.

Existing resources must be used in different and more collaborative ways to limit the need for additional resources. They found that starting small and growing to more widespread implementation is necessary to effectively change systems and to obtain ongoing funding. This was possible through the advocacy of multiple parties in the system, pilot projects with extensive evaluations (showing cost savings and improved outcomes), and extensive support from a practice leader in training and cross training in mental health, addiction and screening for violence. The program also evolved with a consistent and committed program leader who could bring the experiences of the field to the provincial tables for discussion and support.

2 Best Practices

One of the tasks of the project was to review the scientific literature on how other jurisdictions effectively divert individuals from the criminal justice system, or provide appropriate treatment and support in—and upon release from—custodial care. We discovered that there is very little systematic results-based research on interventions in this area, although a national US initiative with credible experience and extensive resources focussed on diversion of this population is the Consensus Project.[1]

From our review of the published and 'grey' literature we determined cross cutting best practices:

- Strong leadership and accountability
- Inclusive cross-sectoral collaboration committees at provincial and local levels to enable policy review and development
- Service integration with boundary spanners
- Active involvement of and agreements between key agencies
- Early Identification and case finding in the justice system
- Specialized programs within the custodial setting
- Standardized training and cross training with and between health and justice system workers, including Mental Health and Addictions
- Enhanced community resources:
  - Housing
  - Case management
  - Recovery-oriented supports

Discussion of Best Practices in BC Communities

This project was time limited but we actively worked to consult with some of the practice and policy leaders in the province and front line providers and administrators in the regions about initiatives currently underway and how they encompass the best practices we gleaned from our research.[2]

1. Strong Leadership and Accountability

There are promising indications of emerging leadership in the transformation of criminal justice areas through the Criminal Justice Reform Secretariat. We recommend increased engagement of all key stakeholders—including government and non-government mental

[1] www.consensusproject.org

[2] **Note**: throughout the course of this project we received a great deal of information on initiatives taking place in different regions of BC, but we recognize that it was not possible for us to know about or acknowledge in this document all of the promising initiatives in the province. Hence we have highlighted only some examples of best practice, which is in no way a comment on the value of initiatives not mentioned here.

health and addiction services and persons with direct experience—through consultation and collaboration to engender comprehensive and holistic solutions.

The creation of the new Ministry of Housing and Social Development is promising, with potential for much greater integration in the areas of housing and homeless policy, employment and income assistance, mental health and addictions services coordination, and community living services. We look forward to seeing the potential of this integration realized, hopefully through more comprehensive and integrated service delivery.

In order for changes in the criminal justice system to be effective, strong leadership is required from the health sector to provide the intensive services that many individuals in these situations require. We are encouraged that this is recognized and that Health Authorities are working to address this issue, as comprehensive integrated strategies would be helpful in providing consistent and effective services.

Recent studies showing the cost effectiveness of providing front end care such as housing and intensive management are helping to generate change in this area.[viii]

2. A Vehicle for Collaboration at the Provincial and Local Level to Enable Policy Review and Development

The Criminal Justice Reform Secretariat was formed in 2007 with representatives from the Attorney General, the Ministry of Public Safety and Solicitor General and Ministry of Children and Family Development to lead the development and implementation of provincial crime reduction and prevention strategies,[3] such as the Downtown Community Court in Vancouver, the Prolific Offender Management Program, and the Bail Reform Project. We recommend the inclusion of mental health and addictions policy leaders at this table, and more community mental health and related resources to support these and other efforts in order to achieve the most effective change. In the regions, many spoke of the former MDO committees established in 1999 by Forensic Services which were intended to be a vehicle for collaboration and joint case management. Over time, without formal mandate and support, many of these committees have dissolved or ceased to meet regularly. Clearly this form of local collaboration needs to be mandated and supported on a provincial level, with opportunity for local committees to share information and exchange knowledge on common issues.

3. Service Integration

Service Integration is alive and well in British Columbia in many different forms. The project heard about the following initiatives which could be thought of as loose linkage models.

- The Concurrent Disorders Project in Nanaimo. Established as a pilot project in 2002 to support individuals with concurrent mental illness and addiction, the Nanaimo project continues and reports success in reducing returns to hospital and jail. This project has not been extended province-wide and continues to operate only in Nanaimo.
- The Prolific Offender Management Project. This is a special project being piloted in six communities throughout the province and hosted by the Criminal Justice Reform Secretariat. The essence of the project involves providing prolific offenders the opportunity to access existing resources in the community through an integrated case

[3] www.ag.gov.bc.ca/justice-reform-initiatives/criminal/index.htm

management approach, while at the same time maintaining close police supervision. The individual may choose not to participate, but is advised that relapse or re-offending will result in "robust" and timely enforcement.[4]

- The Victoria Integrated Community Outreach Team combines the services of a mental health social worker, mental health outreach worker, psychiatric nurse, income assistance worker, probation officer and police, to deliver integrated services to mentally disordered and/or addicted individuals in downtown Victoria. The goal of this collaborative community partnership is the reduction of service fragmentation and the facilitation of access to housing, mental health and addictions services, financial support, life skills and reduced recidivism.

- The Vancouver Intensive Supervision Unit is a specialized integrated service team comprised of probation officers and mental health professionals. The unit provides intensive interventions to court-ordered clients with mental illness disorders in the Downtown Eastside to reduce hospital and jail admissions. This partnership between the Corrections Branch, Vancouver Coastal Health Authority, Ministry of Housing and Social Development, the Forensic Psychiatric Services Commission and Watari Research Association, delivers inter-disciplinary assertive case management, support and supervision in corrections, addictions and mental health. The unit also works to foster community-based connections to provide assistance with daily living such as housing, financial management, medical and psychiatric care, legal issues and leisure activities.

- Integration Initiatives. There are 14 integration initiatives operating across the province which have established and expanded partnerships between social and health program ministries and agencies providing mental health, addictions, justice, employment and housing services. Initiatives vary across the province by individual community, however, each shares a common purpose of facilitating integration and co-location of staff for enhanced service delivery to individuals identified to be 'at risk' due to homelessness, mental health and/or addictions use.

All of the above examples entail the linkage of staff from existing programs either through monthly meetings or through shared location. And while reduced case loads permit more individualized attention, best practice would include fully integrated services for particularly vulnerable individuals with concurrent mental disorders and addictions. Recently Vancouver Island Health Authority, responding to the City of Victoria's Mayors Task Force, has committed to fund four Assertive Community Treatment Teams to provide multidisciplinary 24/7 care to individuals at risk.[ix] This service model is also being considered by the Ministry of Health in the new Burnaby Centre for Mental Health and Addictions.

4. Active Involvement with Key Agency Personnel and MOUs

Service coordination, information sharing, and establishing written Memoranda of Understanding (MOUs) are all necessary parts of coordinated and integrated policies and practices that provide more effective and efficient results. Some examples of this in BC include:

- RCMP Lower Mainland Division's Crisis Intervention Team model of cross-training and team building of community first responders (described in section 7) is an excellent example of service coordination and information sharing which also increases the potential for written MOUs to address issues in first response to mental health crisis in the community.

[4] www.criminaljusticereform.gov.bc.ca/en/justice_reform_projects/prolific_offender_management/index.html

- Richmond RCMP and Richmond Health Services Memorandum of Understanding—while the formal MOU is awaiting final approval, a shorter version (to be signed off within weeks) has been distributed among front-line health workers and police officers. The MOU deals with how the parties will more effectively communicate and facilitate admission to hospital of persons apprehended by police under the Mental Health Act by providing agreed-upon processes.
- Nanaimo's Mental Health and Addiction Services has an Intensive Case Management program for persons with serious mental illness and serious chemical dependency. This agency has agreements with local hospitals for procedures for pre-planned admission of their clients, which assist in timeliness and efficiency for all parties.

The integration initiative described above also supports this best practice of service coordination and information sharing through co-location.

5. Early Identification and Case Finding in the Criminal Justice System

The criminal justice system has become the default system to deal with mental illness related behaviours. This is not its purpose, and this system has had only a limited capacity to identify and find ways to address mental illness and addictions issues in a comprehensive or systematic way, particularly at the early stages of justice system involvement. While some of this function has been taken up by non-governmental agencies,[5] those in direct contact at the earliest stages of interaction—such as police, custodial staff, duty defence counsel, remand Crown counsel, and Justices of the Peace—have not been trained to identify or deal with mental illness or addiction issues. Other system barriers include limits on Crown counsel authority to request an assessment and on mental health professionals' authority to access persons in custody (written consent of Crown and defence counsel is required), as well as extensive waits for assessments (both in and out of custody) due to a lack of psychiatric professionals and forensic beds for persons in custody.

The following initiatives are examples of how this may be changing:

- In a number of communities throughout the province, case finding is happening through homeless outreach workers, although there is not always the interagency collaboration or case management to effectively ensure assessment, treatment, and case management. The homeless outreach project originally initiated by the Ministry of Employment and Income Assistance in Vancouver in 2005 has now been extended to communities throughout the province.
- RCMP Lower Mainland Division's Crisis Intervention Team model (described in section 7) provides dispatchers, the police and other first responders with the skills to bring to light mental health issues at the earliest point of engagement with the criminal justice system, and to refer to appropriate services. The Vancouver Police Department also has a program to provide mental health training to front line officers. Another police initiative in place for a number of years is the mental health-police response vehicle operating in Vancouver (Car 67) and in Surrey (Car 87), which provide a supported response and follow-up to mental health calls. While effective, this type of program is limited in the number of calls to which it can respond and is most effective when combined with other programs.

[5] MPA Society or Native Courtworker and Counselling Association, for example—both of which have court-workers in remand court.

- Mental Health Emergency Services in some communities can do assessments in RCMP holding cells in urgent situations, and Kelowna also has a rapid response clinic for persons identified as needing rapid assessment of mental health issues. Assessment does not always result in treatment however, as client consent is necessary for those who do not meet the criteria for involuntary committal under the Mental Health Act.
- BC Crown counsel services is developing a policy to create 'specialty' Crowns as point persons for issues related to Mentally Disordered Offenders whether or not they fit the criteria for "Not Criminally Responsible by Reason of Mental Disorder." This will assist police and corrections as well as the courts in identifying the need for appropriate services to address underlying mental health issues.
- Vancouver's Downtown Community Court is intended to offer, among other things, rapid referral to mental health and other social and health services for those who need them. This is facilitated by in-house interdisciplinary teams which seek to ensure comprehensive service planning. Accused persons will be screened at the front end to determine eligibility for Community Court; this court is intended to deal most specifically with accused persons who are repeatedly cycling through the criminal justice system, by addressing the underlying issues that are causing repeated criminal behaviour.
- Corrections services (both provincial and federal) are working to improve systematic assessment of inmates at intake to identify and provide services for mental health issues. In particular, Corrections Service of Canada is piloting a computer-based mental health screening tool for all federal offenders arriving at a regional reception centre.[x]
- The Drug Treatment Court of Vancouver, established December 2001, operates under an integrated framework, combining the justice services of a dedicated judge, defence counsel, federal Crown prosecutor, and probation officer with a dedicated treatment program delivered by Vancouver Coastal Health Authority. The program provides services to individuals charged with offences motivated by drug addiction, many of whom may also have a mental illness. An extensive medical, psychological and social assessment identifies the individual needs of each participant to provide individual client centred programming, as well as the support of the group treatment process.

6. Specialized Responses Within Custodial Settings

As noted previously, a large number of inmates are identified as having a mental illness and/or substance use disorders. These inmates do not generally fare well in the general population of correctional institutions, having difficulties in accessing appropriate treatments but also suffering persecution, abuse, and exposure to illicit drugs. Some correctional facilities are addressing this by providing specialty units.

- Nanaimo Correctional Centre offers a substance free environment unit for up to 32 inmates. Urinalysis tests are mandatory and must indicate negative results prior to admittance. Inmates perform regular work duties and must commit to staying substance free with ongoing counselling provided.
- Fraser Regional provincial correctional facility features special living units for inmates who require a higher level of supervision because of psychological, physiological or management problems.

- Corrections Service of Canada is also working toward having a specialized range or unit and mental health professionals in its correctional facilities for inmates with mental health issues that are not severe enough to warrant admission to the Regional Treatment Centre.

7. Standardized Training and Cross Training Between Health and Justice System Workers

There are a number of independent and non-coordinated initiatives for training across the province, and a great deal of interest in expanded training in this area. Some of the promising initiatives include:

- RCMP Lower Mainland Division Crisis Intervention Team Training (CIT) was piloted in Burnaby in 2000 and has been taking place 4 times a year in the lower mainland Division catchment since 2005. This 40 hour training is available to all police agencies (including municipal and transit police) in the district catchment area, and is based on the Memphis model CIT. Several positive ways this program expands on the Memphis model: first, it is a cross-training model for all first responders: dispatchers, ambulance paramedics, psychiatric emergency liaison nurses, (parole officers and Crown counsel have also attended); second, it trains these professionals in their community groups so that relationships and understanding are developed during the training between those that will work together in the community; and third, CIT liaisons are identified and form a community CIT committee for ongoing knowledge exchange and problem-solving after they return to the community from training.
- Over the past several years, the Ministry of Public Safety and Solicitor General has engaged CMHA Vancouver-Burnaby Branch to provide a specially developed Mental Illness First Aid (MIFA) training to sheriff services and community corrections officers. In 2007–2008 MIFA training was provided to first responders in several communities in BC as part of CMHA BC's Mental Health and Police enhancement project.

Addictions and concurrent disorders/dual diagnosis (mental illness and substance use disorder) are a significant issue in this population. Several examples of cross-training in this area include:

- Vancouver Island Health Authority (VIHA) has demonstrated a commitment to a cross-training strategy for managers and staff to become dual diagnosis competent and dual diagnosis enhanced. From 2002–2004 VIHA hired Dr. Minkoff to implement region wide training in concurrent disorders.
- In 2007, the Forensic Services Commission staff received training from Dr. Patrick Smith in addiction management.

8. Enhanced Community Resources

Housing

Decent and affordable housing is a basic need for everyone, but is especially important for those recovering from mental illness and addictions; finding and maintaining stable housing is particularly challenging for those exiting the criminal justice system. Efforts by BC Housing to substantially increase affordable housing stock is encouraging, but lack of affordable decent housing is still identified as a critical issue in all parts of the province. The

need for 'low barrier' and transitional housing that will accommodate challenging behaviours is particularly urgent. Some of the strategies underway that address these needs are:

- John Howard Society of the Central and South Okanagan in partnership with BC Housing, Interior Health Authority, City of Kelowna and the Government of Canada is developing new housing for persons with mental health and addictions who are homeless or at risk of being homeless.
- The innovative Phoenix Recovery Centre in Surrey opened in 2007. Developed with funding from a number of sources and run by the Phoenix Society, the centre combines clinical addiction services with transitional housing, employment and education services. The centre provides 28 early stabilization addiction services beds and 36 transitional housing units. The combination of care levels and services provided ensures residents will have support in a stable environment at all stages in their treatment and recovery.
- Nanaimo has a number of low barrier housing initiatives including a new core area hotel run by CMHA which will act as service hub with HA, MEIA and CMHA staff meeting there, John Howard's forensic housing program based on a therapeutic community model—developed and renovated with the clients, and Crescent House providing supported transitional and long term housing beds.
- John Howard Society has also been proactive in establishing processes for supporting market housing landlords and their mentally ill tenants to resolve issues, respond to crises, and maintain stable tenancies.

Case Management

Assertive case management in the community is needed for persons with severe and persistent mental illness. The challenge lies in ensuring continuity in the kind of focussed and intensive supervision required; without a solid base of sustainable funding and processes to transition people from intensive forensic supervision to intensive community supervision, successful integration in the community will continue to be elusive. There are some promising initiatives in this area, such as:

- Corrections Service of Canada Mental Health Initiative is currently in year three of a five year funded initiative to improve community case management of parolees with mental disorders. It is yet to be seen what will be sustainable after funding ends, and transition to intensive community case management after parole termination remains an issue to work on.
- The Vancouver Intensive Supervision Unit is an example of a fully integrated service team operating under an intensive, assertive case management model.
- Victoria has the benefit of a multi-team approach to assertive community treatment to address the needs of different sectors within the homeless population: the Victoria Integrated Community Outreach Team (VICOT), a Forensic Assertive Community Treatment team (FACT), and an Assertive Community Treatment teams (ACT) are recent and promising initiatives to provide significant support to homeless, mentally ill and concurrently disordered individuals.

Recovery-Oriented Supports

It is encouraging to see greater engagement of persons with mental illness in the development of care and life planning. Recovery-oriented supports empower persons with mental illness to

take more control of their lives, leading to greater engagement, self-esteem, and self-responsibility. Some examples of how this can be effectively achieved include the following models:

- The Wellness Recovery Action Planning program, developed by Mary Ellen Copeland, centres on self-help, recovery, and long-term stability based on five key recovery concepts: hope, personal responsibility, education, self-advocacy, and support. The basic action plan involves the following: list activities for everyday well-being (e.g. relaxation, exercise, proper nutrition, creative activities, social interaction, etc.), identify and track triggering events and early warning signs, prepare personal responses for when they are feeling badly, and create a plan for supports to care for them if necessary.[xi]
- A Therapeutic Community was developed at Nanaimo Regional Correction Centre with John Howard Society in 2007, and plans are currently underway to develop an urban TC in the community. Therapeutic Communities (TC) are full-time residential treatment programs with training and work experience as well as treatment. Individuals in a TC are expected to assume increasing levels of responsibility for coordinating the daily activities of the facility. In this way, individuals are introduced to concepts of community and self-responsibility, and thus learn what it means to participate in a community. The prevailing attitude in the TC is a sense that the individual needs to make major conscious life changes rather than that the person is sick and in need of care.
- The Elizabeth Fry Society of the Lower Mainland provides a Third Party Administration Program which administers funds for the Ministry of Employment and Income Assistance for clients who, due to behavioural concerns, are banned from the local Ministry offices in Langley, Surrey, Maple Ridge, Port Coquitlam, Port Moody, Coquitlam, Burnaby and New Westminster. The Society also provides a number of in-reach (into women's custodial centres), transition, and community-based programs to help women re-entering community from incarceration develop the financial management and life skills necessary for successful community life.

3 Conclusions

This report represents the summing up of a year long discussion/dialogue into an improved approach towards keeping people with mental disorders out of trouble with the criminal justice system. The project was advised by a broad team of experts working in their various fields along the mental health/criminal justice continuum. The project was also informed by the published and informal reports regarding current strategies used elsewhere and a separate document was produced to summarize these findings.

Based on the best practices information and discussion with the Advisory Group, we developed a service framework for working to keep individuals with mental disorders out of trouble with the law. This service framework was workshopped at four different fora convened in Vancouver, Kelowna, Nanaimo and Abbotsford between April and July 2008. At each of these meetings the convenors attempted to bring together individuals with a role to play on the mental health/criminal justice continuum. Frequently we were told these dialogues, considered very beneficial by virtually all participants, were not a regular feature of the service community landscape. The resulting Service Framework from these discussions was also produced as a separate document.

We encountered some resistance to the idea that diversion of people with mental disorders can and does occur across the criminal justice continuum as many saw diversion as an activity that occurs to keep people with mental disorders out of the criminal justice system. We end by offering this wider definition of diversion as we understand that despite everyone's best efforts, people with mental disorders will end up in the criminal justice system and once there, require a specialized response to prevent a vicious cycle of criminalization.

Going forward, we have discovered a tremendous amount of enthusiasm for change. This is guided by a number of key factors:

- Service providers realize that repeated engagement in the criminal justice system by people who cannot access stable community care and supports actually costs more and is less effective than providing the care and supports in the first place. Emerging data studies from the Centre for Applied Research in Mental Health and Addiction at Simon Fraser support this increased cost associated with the status quo.[xii]
- Service providers in the civil mental health system now openly recognize that to not have tight links to the forensic and correctional systems that are supporting people with mental disorders is a recipe for a crisis. As one community mental health system manager said: " We recognize we will see the person one way or another and it is better if we meet outside a crisis and get to know each other in those circumstances. " There is recognition that limiting the public mental health services to people with an Axis 1 disorder omits individuals with serious challenges who also show up in the most expensive intersections of the community service system. Newer service models such as the ACT teams in Victoria or the partnership with the CMHA homeless outreach program in Kelowna and the local Brain Injury Program has resulted in appropriate and safe care for individuals previously excluded from the treatment system.
- The new Ministry of Housing and Social Development which combines income assistance, housing, disability services and

planning for mental health and addiction services promises a more coordinated policy approach to the needs of this population for community support. The inclusion of Community Living BC with the high needs Mental Health and Addictions population is potentially a benefit given that approximately 40% of people with a developmental disorder have a concurrent mental disorder. It is early days to understand how the proposed Ten Year Mental Health and Addictions Plan will fit with this strategic initiative but it is encouraging that this initiative is being lead by a partnering ADM's committee.

- There are a multitude of service integration efforts alive and well across the province and all of these deserve profile as well as thoughtful evaluation. There do seem to be differences in the type of integration that is being supported and further expansion of the various models might benefit from some policy leadership. For example, there is a continuum of integration ranging from loose linkages, to coordinated teams to highly integrated services where all staff work for the same agency. It is likely for individuals with different needs, different types of service integration will be more effective. At the heart of the issue of service integration is the need for integrated and coordinated information about individuals with long and varied health histories. There are policy issues that need to be worked out to respond to the issues involved in sharing information in order to provide effective care and support.
- There are particularly strong linkages developing between the institutional and community corrections side in both the federal and provincial correctional systems and this effort towards continuity of treatment and support is also encouraging.
- There is considerable development in the non profit sector both in terms of expansion of housing capacity and in terms of outreach and service provision. There is richness in the practice that is waiting to be shared in the stories of successful recovery.
- There is an increased willingness to value the role of peer support in the service system and value the direct experience of individuals with mental disorders who have lived the life and experienced recovery. For example, the Fraser Integration Initiative Advisory Group includes the Patient Advocate for Fraser Health Mental Health and Addiction. He provides valuable input to make sure the service configuration actually meets the needs of the clients.

As much as there is reason to be optimistic, there is also reason to be cautious. All discussion participants spoke to the challenges involved in working with this population, and wished for a single solution to the issues. The fact is that there is no single solution that will work in all communities, or even in one community. It is important to realize that innovations such as Community Court or police-mental health teams will not solve all the problems nor are they necessarily the right fit for every community, but in some communities they are important and appropriate pieces of the solution "puzzle". These and other innovations are not stand-alone pieces, but must be integrated with other players in the system. Most importantly such innovations must be backed up by community resources and supports in order to achieve the greatest potential benefit.

We urge policy makers and communities to investigate and discuss a variety of best practice models to determine what will work best in the configuration and context of each particular community. We hope that the

best and promising practices guide developed through this project will provide at the least a starting point for such discussions.

The inconvenient truth (with apologies to Al Gore) is that work in this area with this client group is challenging as much as it is inspiring, and the work that is required is evident. We recommend the establishment of a collaborative provincial level policy table to facilitate work in this area and provide systems leadership. Decent and affordable housing—and particularly low-barrier housing accessible to those with the most challenging behaviours—was an issue of the highest priority for those involved in the discussions. We are encouraged by government efforts to increase low cost housing stocks, and are hopeful that additional low-barrier housing is also on the agenda.

We also recommend the mandating of local level networks to both jointly case manage but also to develop policy and coordination at the local and regional levels. In this regard, we note Ontario's Service Framework for this population has three levels of activity: provincial, regional and local.

We see the need to develop a network to promote what has to be a continuous learning agenda. The areas requiring specific focus include:

- Crisis intervention training with the police and emergency mental health and addictions staff as well as community members. This work must be ongoing due to the changing rotation of RCMP throughout the province.
- Training and cross training for mental health and addictions and outreach staff in working with both mental health and addictions issues.
- Training in how to work with individuals with other mental disorders such as autism spectrum disorder and foetal alcohol spectrum disorder.
- Training for all personnel in the criminal justice system on how to recognize and work effectively with people with a mental disorder. CMHA BC Division and its branches are already engaged in responding to this need through the Mental Illness First Aid training initiative
- Training for staff in the community service sector in how to provide optimum support for individuals with concurrent disorders who have been in trouble with the law. This is practical work and can involve peer support, money management, job coaching and landlord-tenant issues.

There is considerable momentum to capitalize on at this point in time and it is in this spirit that this report is presented.
Carpe Diem!

Appendix A:

Mental Health Diversion Project Provincial Advisory Committee Members

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Endnotes

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iv. Somers et al 2008 op cit.

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vi. Ibid Ogloff 1996 op cit.

vii. Ibid Ogloff 1996 op cit.

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ix. Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness. Downloadable at: www.victoria.ca/cityhall/tskfrc_brcycl.shtml

x. More information on this program is available at www.csc-scc.gc.ca/text//lt-en/2007/32-1/3-pblcteng.shtml

xi. The WRAP website is at www.mentalhealthrecovery.com

xii. Somers et al 2008 op cit.

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BC Division