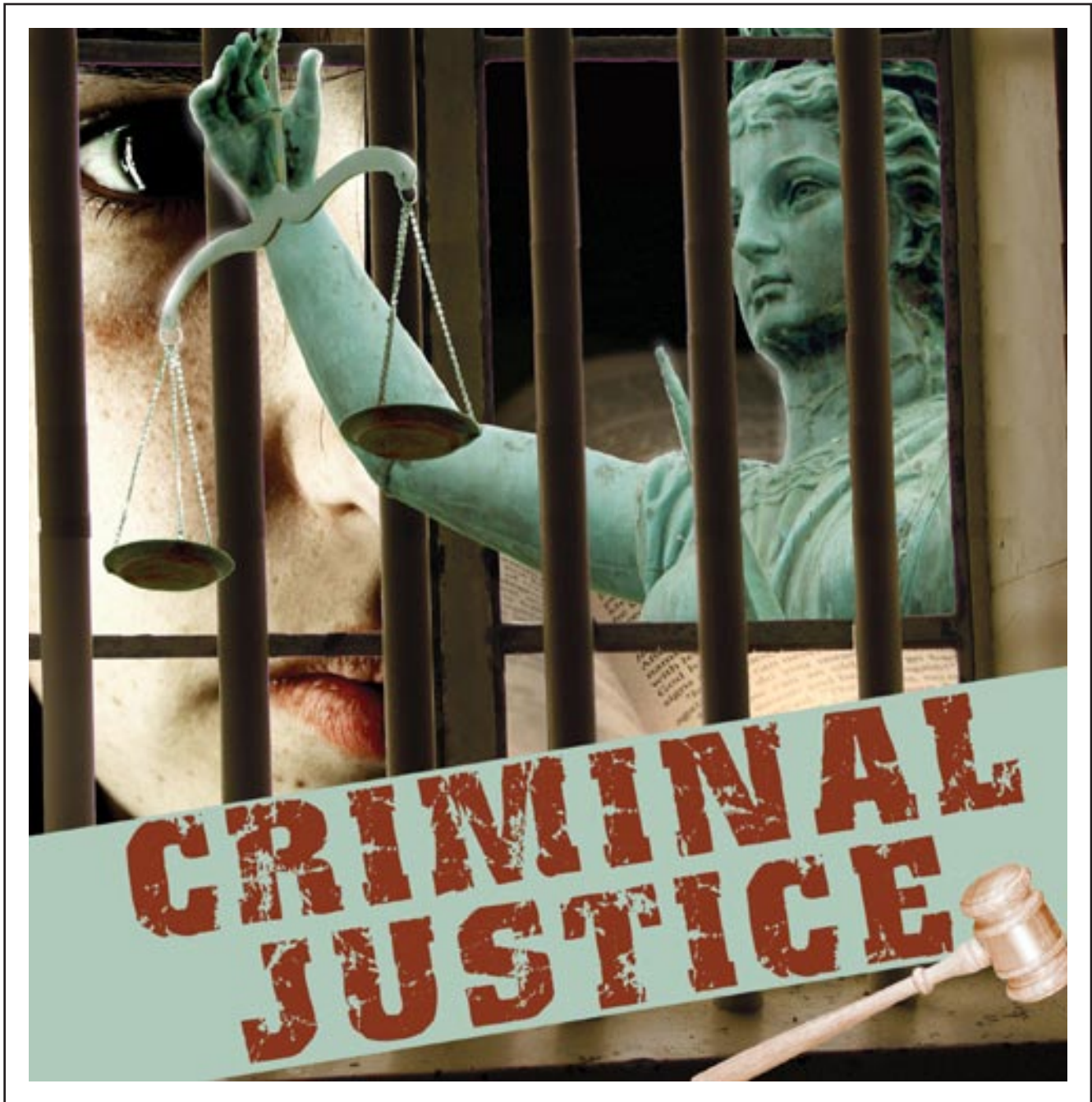


Visions

BC's Mental Health and Addictions Journal

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bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, Awareness and Networking around Disordered Eating, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to the Provincial Health Services Authority for providing financial support for the production of *Visions*



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We've all read at least one newspaper article where the commission of a horrendous crime has been linked to someone's mental state. But how often have we read one where the *victim's* mental state led to them being targeted for crime? The reality is people with mental illness and/or addictions are much more likely to be the victims of crime than the perpetrators. And yet, media of all types continue to sensationalize certain situations and generate the typical calls for better services, better care, better response. These calls have very little staying power, however, because the stereotypes generated from the reporting feed into two widely held social beliefs: one that persons with mental illness and or addictions are not responsible for their actions (ever); and two, that persons with mental illness and or addictions are dangerous.

Dangerousness and criminality are intricately linked in the perceptions of the general public as is evidenced in some of the articles in this issue. Crime is a serious matter but when mental illness becomes the rationale for assuming dangerousness, the criminal justice system becomes a predominant mechanism for dealing with health issues. One only needs to look at the prevalence of mental illness in our prisons—or even more disturbingly in the prisons of our neighbour to the south—to realize that we have replaced one institution (the asylum) for another (the prison) without addressing the failure of governments to adequately fund social systems working with persons with mental illness. Crime is a symptom of an inadequate social and health systems, not of mental illness.

This issue of *Visions* attempts to address some of the issues for persons involved with the criminal justice system. There are some glaring gaps however. While people of First Nations descent make up 5% of the Canadian population, they make up 34% of the prison population. We were unable to secure an article addressing mental health issues in the incarcerated aboriginal population and for this I apologize in advance. Issues for women and persons of different ethnic backgrounds are not separated out from the main issue of the criminalization of mental illness and addictions, but the criminal system has definitely been criticized for its biases from gender, class, race, and disability perspectives. This issue is only the beginning of conversations that, I hope, last longer than the horror of yet more sensational coverage of the effects of social failure for persons with mental illness.

Christina Martens

Christina is Executive Director of the Canadian Mental Health Association's Mid-Island Branch. She has an MEd in Community Rehabilitation and Disability Studies and is working towards her doctorate in Policy and Practice in the Faculty of Human and Social Development at the University of Victoria

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If you have personal experience with mental health or substance use problems as a consumer of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge (one free copy per agency address). You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are \$25 (Cdn.) for four issues. Back issues are \$7 for hard copies, or are freely available from our website. Contact us to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online. See www.heretohelp.bc.ca/publications/visions.

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The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the member agencies of the BC Partners for Mental Health and Addictions Information or any of their branch offices.

Mental Illness and Criminal Justice

Where tolerance breaks down...

Stephen D. Hart, PhD



Dr. Hart is a professor of psychology at Simon Fraser University. His research interests include psychological assessment including violence risk, psychopathy, personality disorders and mental health issues in incarcerated populations. He has provided consultation services for lawyers in Canada and the US, with the police and RCMP in Canada and Her Majesty's Police Service (United Kingdom), and with forensic psychiatric hospitals in BC and Norway. He is also co-editor of the International Journal of Forensic Mental Health

Canadians. Consider our national character. We are, in general, an orderly people. Canada achieved independence not through revolution, but through a gradual process of negotiation. The goals of our founding fathers in drafting the Constitution Act of 1867 were to ensure “peace, order and good government.”¹ In public opinion surveys, Canadians frequently express their concern with maintaining a society that is free of crime and violence. The most recognized and loved of all Canadian icons is a police officer—a Mountie, resplendent in red serge.

Canadians are also pretty tolerant and compassionate. We believe it is possible to be a good Canadian without hiding or abandoning one’s cultural heritage. The Charter of Rights and Freedoms prohibits discrimination based on race, national or ethnic origin, or colour, as well as religion, sex and age.² And we can be proud of the fact that ours is one of the few constitutions in the world to also prohibit discrimination based on mental and physical disability. We cherish the concept of universal health care, provided on the basis of need rather than the ability to pay.

Sometimes, however, our desire for order conflicts with our tolerance and compassion. This is certainly evident when we look at the plight of people with mental illness—and/or addiction—who enter into the Canadian criminal justice system. Our Criminal Code is based on the assumption that people are rational: their perceptions of the world are accurate, their reasoning skills are intact and their behaviour is organized and controlled. Of course, the Criminal Code also recognizes that this assumption does not always hold true. It contains special provisions for trying to ensure the fair treatment of people with mental illness who are accused of crimes. But research conducted in Canada and other countries makes it clear that the criminal justice system is a trap for people with mental illness. Compared to others, people with mental illness are more likely to get into the system, have a harder time navigating through it, and have more trouble getting out of it.³

Getting in

Symptoms of mental illness increase the risk for a wide range of interpersonal conflict, including conflicts that result in the police being called. In rare instances, mental illness causes violent or other criminal behavior—people act directly in response to symptoms they

are experiencing, such as delusions or hallucinations, often in an attempt to protect themselves from perceived danger. Much more common, however, are situations in which members of the general public misinterpret the behaviour of people with mental illness as aggressive or threatening and call the police for assistance. In many of these cases, the only violation that has been committed by the person with mental illness is a violation of social norms—talking too loudly, self-neglect, incoherent speech, mannerisms and so forth.

Once the police have been called, people with mental illness are more likely than others to be arrested.^(REF7) Although modern police training devotes considerable attention to identifying and managing problems related to mental illness, it is still the case that symptoms such as incoherence, agitation, irritability and suicidality increase the risk of conflict with first responders.

And people with mental illness are more likely than others to suffer injury while being arrested.⁴ Conflicts with first responders can be deadly.

Navigating through

Mental illness can impair people’s ability to communicate with criminal justice professionals, such as police officers, corrections officers and lawyers. It should come as no surprise, then, that people with mental illness are more likely to have problems obtaining good legal representation—especially given cutbacks in legal aid over the past decade—and more likely to be convicted of offences.⁵ Put simply, mental illness can make it difficult to get a fair trial.

“Compared to others, people with mental illness are more likely to get into the system, have a harder time navigating through it, and have more trouble getting out of it.”

People with mental illness also are more likely than others to spend time in secure facilities. Before trial, they may be remanded in custody due to fears that they will not attend future court dates. After conviction, they may be imprisoned due to a perceived risk to public safety. While in custody, they are prone to being bullied by other offenders for being “bugs.” They may be placed in administrative segregation to prevent victimization or because they simply can’t handle the demands of a regular living unit. They are likely to have difficulties getting along with corrections officers and accessing mental health care services.⁶

Getting out

All else being equal, people with mental illness are less likely than other offenders to receive a conditional release from custody (e.g., parole).⁷ This may be due to, among other things, problems communicating with correctional and parole board staff, as well as to the lack of adequate aftercare in the community. The same lack of resources that makes it difficult to obtain release also makes it more likely that people mental with illness will suffer a recurrence or exacerbation of symptoms after release,⁸ which may result in a return to custody or new charges.

The preceding summary paints a bleak picture of life in the criminal justice system for people with mental illness. The reality—so difficult to convey in a few words—is actually much worse. Prisons and jails have become de facto ‘treatment’ facilities for people with mental illness. Among incarcerated offenders, prevalence rates for many mental disorders—including schizophrenic disorders, bipolar mood disorder, major depressive disorders, mental retardation and substance-related disorders—are several times higher than those observed in community settings. Tragically, on any given day in Canada, there are more people with mental illness sitting in correctional institutions (often untreated!) than there are in psychiatric wards or hospitals.⁹

But there are rays of hope. In every part of the criminal justice system, there are professionals committed to improving conditions for people with mental illness. They have developed an incredibly diverse range of resources, including education and training, diversion, and mentorship programs; specialized police and court services; and improved programs for delivery of institutional and community-based treatment and support.

I hope you find that this issue of *Visions* helps you to understand the unique problems faced by people with mental illness in the criminal justice system, and inspires you to follow in the footsteps of those people who are trying to make the Canadian system better reflect our values of tolerance and compassion. ■

footnotes

references available on request

Most people in a suicidal crisis are ambivalent about dying and it seems to me that they talk to a helping professional about their suicide ideation with the reasonable expectation that they will receive help in staying alive. As a Suicide Intervention Counsellor at SAFER I’ve often been invited into the conversation over whether people had the right to commit suicide, an invitation I usually decline. Instead I discuss my belief that most people are quite capable of killing themselves and don’t need my help in doing so.

My own way of staying ethical in this matter has to do with informing a client right at the first session that I will do my best to protect their confidentiality, but that there are circumstances under which I might not be able to guarantee confidentiality. They know that imminent suicide risk is one of the situations where I may break confidentiality. It is surprising to me that so many clients who have previously been in some form of therapy have never been informed that there are any conditions under which confidentiality may be breached. Only rarely has a client decided not to engage in therapy with me based on the exceptions to confidentiality presented. Rather than undermine the trust essential to the therapeutic relationship, informed consent seems to put people at ease. In regard to suicide, a client knows that I will always position myself on the side of their safety.

As Dr. Kluge concludes, the decision to break confidentiality is always a judgment call, and one none of us should make lightly. A few high profile cases have brought this issue to the public’s attention recently and this issue needs to be discussed and debated more openly.

—Peter Durand, SAFER Counselling, Vancouver

I have just read Vol. 2, No. 7 (Suicide) of your journal and it is so very excellent—every single article was pertinent.

—Carole Itter, Vancouver, BC

Thank you for the opportunity to receive invaluable information on the matter of Suicide in *Visions* magazine. I’d never read your magazine until I unintentionally requested it. Your magazine opened my eyes to realize there are other people like me.

I read your magazine from cover to cover because so much that I read was my personal battle: coming from another cultural background (I am a black, Caribbean descent 48-year-old female), an alcohol problem complicated by concurrent disorders, a high suicide risk all my life since my teen years growing up in Montreal, and constant self-harming behaviour. I have been in and out of hospital for multiple suicidal overdoses. Complicating it all is that I was also brought up in a strict, religious environment that taught us of the sin of taking a life.

With a good mental health team and supportive help from the community, my psychiatrist and medications, my suicidal risk is next to nothing now. I see myself improving slowly. I stopped the alcohol with intensive counseling. I still self-harm but am not suicidal. I am proactive about my recovery, but it’s still a long road.

It is wonderful to have your magazine and the various input you have received from other mental health consumers and practitioners helping those who, like me, suffer in silence. I know what it is like to close my eyes and wish I never had to live another day. So few understand what it is like to not want to live because life is brutal.

There is so much I’d like to say about each and every article in your magazine—each one touched my heart because I could relate to something in it. What a relief to know I am not the only one suffering in silence all these years.

—A.M.R., Vancouver

we want your feedback!

If you have a comment about something you’ve read in Visions that you’d like to share, please email us at bcpartners@heretohelp.bc.ca with ‘Visions Letter’ in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.

A Long Way to Go



Patrick Storey, MSW, and
Jim White, MSW, RSW

Patrick works full-time with the National Parole Board. He has worked in a variety of mental health settings in BC and Alberta for the past 25 years and is a member of the Canadian Mental Health Association's BC Division

Jim has worked within the Correctional Service of Canada for 30 years, in both community and industrial settings. He is currently working on a project to facilitate better bridging of services between community and mental health agencies

The number of people with mental illnesses in prisons across Canada is increasing. The Correctional Investigator, an ombudsman for federal inmates, has recently reported that the numbers of men and women in federal prison with significant identified mental health needs has more than doubled over the last decade. In his last annual report, it is estimated that at least one in eight incarcerated federal prisoners has a diagnosed mental illness; or, 1,500 in a population of approximately 12,500 inmates.¹ Additionally, a 2001 study of men sentenced to federal custody in BC found that 30% met the criteria for a mood disorder, 8% for a psychotic disorder and 18% for an anxiety disorder.²

This dramatic increase in inmates with mental illnesses in prisons is generally thought to be the result of deinstitutionalization from psychiatric hospitals, along with a failure to provide adequate support services for these people in the community. Without the appropriate supports, many people with mental illness experience a decrease in their quality of life, become involved in substance misuse, end up in trouble with the law, and face incarceration. Despite this “reinstitutionalization” process, appropriate services inside prisons have not grown to meet the need.

Inmates with mental illness face serious problems in federal prisons. Not only is their mental health threatened by the stress of prison living conditions, but they are often unable to access a full range of treatments for their illnesses, are often exploited by other prisoners, spend more time segregated and at higher levels of security, have more difficulty accessing correctional programs, and serve a greater proportion of their sentence in prison than do offenders with similar offences who do not have a mental illness.³ Federal mental health staff have been creative in their efforts to better serve this population, but their resources are too thinly stretched to reach all in need.

There are also significant jurisdictional problems faced by inmates serving federal sentences. People with mental illnesses in federal prisons typically do not have access to provincial legal or advocacy services, nor are they permitted to access general mental health resources offered by health authorities. The BC Mental Health Act itself states: “The director of every provincial mental health facility must ensure that no person with a mental disorder is admitted to any provincial mental health facility from a penitentiary or jail, reformatory or institution under the juris-

dition of Canada unless the government of Canada...undertakes to pay all charges for care, treatment and maintenance of that person.”⁴ This provision and the policies it inspires, effectively deprives even lifelong residents of the province access to service simply because they are serving a federal sentence.

And, as a member of the National Parole Board charged with reviewing parole applications for prisoners who may have a mental illness, it is troubling to see how men and women who have a mental illness come to the table without the advantages enjoyed by other offenders. With incident reports

strategy that includes:

- complete clinical assessments for people entering the system
- specific enhancements of current treatment centres
- intermediate mental health care units within existing institutions to provide ongoing assessment
- treatment and community mental health services to support individuals on conditional release

So far funding has only been secured for the provision of some community mental health support services for prisoners on conditional release. Funding for institutional

People with mental illnesses in federal prisons typically do not have access to provincial legal or advocacy services

about troublesome behaviour, no reports of successfully completed programs, and release plans that do not include appropriate mental health services, it is much more difficult for Board members to assess the risk posed by a particular individual. Consequently, people with mental illnesses are often less successful in obtaining a release on parole.

Correctional Service of Canada has recognized this growing problem and in 2004 approved a comprehensive mental health

programs and more staff and facilities has not been forthcoming.

Efforts are being made by federal correctional staff to establish agreements with provincial agencies and health authorities, to better meet the needs of the people they serve. Provincial mental health staff are interested in helping, but are also faced with significant resource issues. However, progress is being made, sometimes on an office-by-office basis.

The present restrictive approach to managing ►

An Enduring Stereotype

Criminalization of Mental Illness in the Media

Law and Order: Criminal Intent is one of many spin-offs of the popular television crime drama *Law and Order*. The show presents a unique perspective by telling stories from the point of view of the criminal, from inception to execution. This allows for deeper character development of each episode's antagonist, and a closer relationship between the criminal and the audience, which has the potential to lead viewers astray by conveying negative attitudes or flawed information about people who commit crimes. The produc-

ers of *Criminal Intent*, however, endeavour to promote accuracy in the realm of mental health. The series' protagonist, Detective Bobby Goren, is a knowledgeable and empathetic character who understands and relates to mental illness: Goren's mother has schizophrenia, and he visits with her weekly.

To keep its facts straight, *Criminal Intent* employs a former forensic psychiatrist, Dr. Park Dietz, as a script consultant. Dietz acts as a psychologist for the characters, diagnosing behaviours presented to him by the writers. He concedes that crime dramas such as *Criminal Intent* showcase a high incidence of people with mental disorders as criminals, but he strives to ensure honest portrayals of people with mental disorders in the entertainment world.¹

So what is the incidence of mentally ill criminals on television? In a study of 14 prime-time dramas that contained at least one character with mental illness, 10 shows depicted serious crime associated with mental illness—and the diagnoses of these illnesses were typically generic, vague and undefined.² Most of this crime was attributed as the direct result of the mental illnesses. Another study conducted on 184 prime-time television programs found that in a two-week period violent crimes had been committed by 3.2% of all characters. When the rate of violent crime carried out by characters with mental illness was examined, however, this number jumped to 30.2%.³ These crimes included murder, rape, robbery and assault. Again, the illnesses were fairly generic, most of them being indefinable or attributed to psychosis. In daytime soap operas, more than two-thirds of the characters who have a mental illness are criminals.⁴

Studies on the representation of mental illness in news media have shown high proportions of reports linking mental illness with crime. One study noted that, of people with mental illnesses portrayed in television news shows, 65% were linked to violent crimes.⁵ Studies of newspaper reports have shown similar results: mental illness linked to crime ranges from 46%⁶ to 83%⁷ of all articles related to mental illness. In a telephone interview of 1,022 adults 18 years and older conducted by the US-based National Mental Health Association in 2000, half of the respondents categorized mentally ill characters portrayed in the media as “drug addicts, alcoholics, and criminals.”⁸

If we consider that our media purportedly reflects our reality, it may seem that a very high proportion of people with mental illnesses are criminals. How

Kim Meier

Kim is an undergraduate student in cognitive science at Simon Fraser University, currently on a co-op term at Canadian Mental Health Association, BC Division

A Long Way to Go | *cont'd from previous page*

people with mental illness who are serving federal sentences in a prison setting or in the community is particularly ironic. Though the media and certain politicians would have us believe otherwise, the majority of offenders use their prison sentences as opportunities to change their lives. And research consistently shows that this group of people is significantly less likely to commit a new offence after release than are other offenders.⁵

Adequate resources and effective intergovernmental and interagency working relationships are needed. Prisoners with mental illnesses must get the help they need while in prison and must have safe and well-supported conditional release opportunities. A period of supervision in the community, which includes the resources and services they need, is instrumental to a person's success after their sentence is over.

Our foremost goal, however, must be to prevent the unnecessary incarceration of people with mental illnesses. This completely preventable abuse of the rights and freedoms of our most vulnerable citizens can no longer be tolerated in Canadian society. ■

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it may simply be easiest to play on an already-held stereotype of the 'criminally deranged.' For example, the entire Batman series—comics, TV shows, movies—is based on having Batman fighting criminally insane opponents. The antagonists have been created to fit textbook descriptions of

accuse the news media of distorting the truth, selecting stories that are exciting or that provoke reaction from viewers, and sensationalizing their reports. However, this doesn't make it acceptable. Misrepresenting mental illness in a negative light is as serious as racism, sexism or any other type of discrimination—except that it goes undetected.

Media will continue to criminalize mental illness only as long as we—the audience—allow it to continue. What can be done? Pay attention when you sit down to your favourite TV show, catch a movie or watch the news. Speak up if you notice something that offends you. Write to the production companies, TV or radio stations, companies whose advertisements are seen or heard during the program, local newspapers, or anyone else who will listen. Explain to them the negative impact of unfairly criminalizing an already marginalized group of people. ■

accurate is this? The truth is that these numbers are way off the mark. In fact, the crime rate among people being treated for mental illness is the same as the crime rate among the general population in North America: less than 4%.⁴ And generally speaking, most of the crimes are not of the nature depicted on television. For example, in a 2005 report by the BC Justice Review Task Force on street crimes in Vancouver and chronic offenders, they found that the most common offences commit-

ted by people with mental health problems are thefts under \$5,000, assaults and breaches of court orders.⁹ In the same vein, note the rate of mental illness among criminals: in Australia, the prevalence rate of mental illness among homicide offenders is less than 5%, but among the general population, it is approximately 20%.⁷

Since truth is so different from fiction, why is it distorted so much in the entertainment and news media? In terms of prime-time dramas and movies,

their respective disorders. The Joker has antisocial personality disorder; Two-Face is plagued by a dissociative identity; the Riddler is obsessive-compulsive; and the Mad Hatter struggles with bipolar disorder. These villains are easy to work with when they come in nice little packages based on stereotypes. Whether or not viewers buy into the stereotypes doesn't matter—to be dramatically effective, the stereotypes just need to be recognized.

It's not rare for one to



Treatment of Substance Use Disorders in BC What's Missing?

Treatment of addiction

Substance dependence is recognized as a medical, psychiatric and psychosocial disorder. People with substance dependence are entitled to protection

from discrimination and should qualify for quality, evidence-based treatment. Unfortunately, substance dependent people often receive second-rate care that would not be tolerated with other illnesses.

A large and growing body of research evidence

shows the effectiveness of certain types of treatment for substance dependence. As with other complex medical disorders with biological, psychological, social and spiritual components, treatments combining different modalities of therapy have better

outcomes. Cognitive therapy (identifying and correcting negative ways of thinking), motivational enhancement therapy (using techniques that convince clients to change their behaviour), and mutual support group facilitation have all shown impressive

effectiveness. Outcome studies following residential treatment have shown that the initial improvement in health and function seen at completion of the inpatient program can be maintained with higher rates of prolonged success through mutual support group involvement and individual or group psychotherapy.

Effective pharmacological interventions include methadone or buprenorphine for people with intravenous heroin or morphine dependence, bupropion and nicotine replacement for nicotine dependence, and acamprosate and naltrexone for some people with alcohol dependence. Pharmacological treatments for substance dependence are much more effective when combined with psychosocial and behavioural interventions and support.

People with psychiatric comorbidity (mental illness as well as addiction) have much better results when their psychiatric condition is treated at the same time they receive addiction treatment.

Contingency management

Contingency management refers to rewarding a person for participating in treatment and allowing certain natural negative consequences to occur if someone chooses not to follow their recovery plan. Disability health insurers do this when they withhold benefits from a person who is off work with an addictive disorder, but who is unwilling to get help. Employers do this with safety-sensitive employees suffering from addictive disorders: return to work is contingent upon the worker adhering to an abstinence-based treatment and a relapse prevention program. This approach has also proven effective in drinking driver diversion programs, in drug courts and in programs used for rehabilitation of substance dependent pilots and health professionals. If a substance dependent pilot or physician chooses to continue to use addictive drugs, they are not permitted to function in an occupational setting that could cause harm to others.

Is harm reduction a good thing?

Harm reduction refers to offering treatment to substance dependent patients without insisting they be abstinent as a condition of treatment. Certain types of harm reduction, when carefully administered, are effective in decreasing the number of deaths and the substance-related health consequences while improving function and quality of life in substance dependent populations. Safe injection sites, for example, have shown promise, especially when they are structured as a portal to engage drug users with a comprehensive network of treatment services.

If poorly done, however, well-intended harm reduction programs can cause harm. It is important to recognize enabling: that is, sheltering a competent person from the consequences of their repeated behaviours. Substance dependent people continue to use mood altering drugs because they are effective: the benefits of

drug use seem to outweigh the costs or consequences. In order to get help, the dependent person needs to “hit bottom” (i.e., become convinced, at least for a little while, that the cost of their substance use outweighs its benefits.) The sheltered, drug dependent person may never come to this realization.

Despite research trials in three countries, the evidence supporting heroin substitution as a cost-effective harm reduction therapy is unconvincing. And, interestingly, countries such as Switzerland, which has demonstrated remarkable success using harm reduction to minimize street drug activities, always have a robust police enforcement component reminding the addict of the consequences of their behaviour choices.

What is the current status in BC?

As a long-time addiction medicine clinician, it appears to me that British Columbia (and Canada) has decided on an ideological approach that represents a cynical, negative way of thinking: “The war on drugs has hurt more than helped.” “Our way of doing it has not worked.” “The problem is the law; if we make drug use legal we will solve many of the current problems.” But, we must be careful not to throw the baby out with the bathwater.

Intervention approaches that stress harm reduction components (needle exchanges, injection sites, addictive drug distribution) at the expense of adequate, evidence-based treatment (drug-free housing, therapeutic communities/support recovery houses, inpatient detox, residential and outpatient treatment programs) represent an ideological shift rather than a rational and balanced approach using scientific evidence to deal with a complex issue.

what is addiction?

The term substance dependence (alcoholism, drug addiction) is used to describe a continuum of conditions that are considered diseases or disabilities by both legal and medical authorities.

Increased risk for addictions may be inherited, but, as with many other illnesses, it may be acquired due to other risk factors such as early or heavy use of addictive substances, sustained emotional discomfort, a history of emotional trauma, or concurrent psychiatric disorders.

The abnormality within the brain that characterizes drug dependence is believed to result from a relative under-functioning of the circuitry responsible for reward, pleasure and the ability to maintain a balanced mood. This results in a person with substance dependence being unable to soothe or comfort themselves during times of emotional distress. The affected person receives powerful reward or reinforcement when they use addictive substances (or engage in other behaviours associated with a risk for addiction, such as gambling) known to activate these “pleasure centres” of the brain.

With continued excessive drug use, further changes occur in the structure and function of parts of the brain. These changes are believed to be only partly reversible. For this reason, addictions are viewed as chronic disorders, and treatment should be followed by long-term relapse prevention.

Ray Baker, MD

Dr. Baker is Medical Director of HealthQuest Occupational Health Corp. and Assistant Clinical Professor in the UBC Faculty of Medicine. He specializes in addiction medicine and provides consultation on addictions and mental health. He also designed and directed Addiction Medicine and Intercollegial Responsibility (AMIR), an award-winning UBC undergraduate program

Almost a decade ago Vancouver instituted a four-pillar approach,¹ based on the four pillars program (prevention, enforcement, treatment, harm reduction) initiated in Switzerland. In transplanting the Swiss program, however, they seem to have neglected some of the pillars (enforcement, prevention, treatment) and supported others (needle exchanges, safe injection sites, methadone maintenance, heroin substitution). BC already had one of the largest needle exchanges in North America during the late 1980s, well before experiencing the Western world's highest rate of HIV infection during the early '90s. With safe injection sites

If addiction is considered a bona fide health disorder, we could be accused of violating the Canada Health Act by failing to provide adequate treatment for people with addictions and by permitting barriers to treatment, such as user fees for residential treatment and methadone maintenance programs.

Additionally, we lack adequate integrated care for people with psychiatric disorders complicated by addictions. In most Canadian medical schools, post-graduate counselling psychology programs, schools of social work, and nursing education programs there is no systematic addictions curricula.

We are missing an opportunity within the criminal justice and corrections systems to provide therapeutic interventions.

Greater than 50% of incarcerated

youth and adults suffer from substance use disorders. Treatment is actually less expensive than incarceration. There is also good evidence from many studies showing that not only is treatment effective, but that treatment of substance use disorders results in economic benefits for society (e.g., reduction of crime, decreased health costs, increased employment).¹ Although some corrections facilities offer treatment to inmates, many do not. Some of the money spent incarcerating offenders, whose crimes were related to drugs, could be used for effective, contingency-based treatment programs.

There is a great deal of evidence on approaches that work, but we have not rigorously applied them. Perhaps it is time we did. ■

“Illicit drug production is thought to be BC's second leading industry”

in place and a small heroin substitution program operating, deaths from illicit drug use are still alarmingly common. The open drug scene in Vancouver and other BC cities is thriving, even growing. There is an epidemic of property crime, widely acknowledged to be due to the drug problem. Illicit drug production is thought to be BC's second leading industry.

In terms of treatment, we still lack adequate drug-free safe housing, residential treatment resources such as therapeutic communities, or support recovery houses where substance dependent people can stabilize while receiving outpatient services. We lack intensive residential treatment centres capable of safely treating a substance dependent person with concurrent psychiatric or medical illness.

footnote

1. MacPherson, D. & Rowley, M. (2001). *A framework for action: A four-pillar approach to drug problems in Vancouver*. Vancouver, BC: City of Vancouver.

The Criminalization of Individuals with Mental Illness

David Simpson **An alarming trend**

David is Acting Director of the Psychiatric Patient Advocate Office, an arm-length program of the Ontario Ministry of Health and Long-Term Care. The PPAO protects the legal and civil rights of inpatients in Ontario's current and divested provincial psychiatric hospitals

Over the past several years the Psychiatric Patient Advocate Office (PPAO) has watched a troubling trend develop—the criminalization of individuals with mental illness. The trend began with the deinstitutionalization of individuals with mental illness—which was, theoretically, a positive step because

individuals would have an opportunity to live in their home communities and participate in society. However, deinstitutionalization was not supported with the necessary resources, which has led to: lack of bed-based care; lack of appropriate, safe and affordable housing; premature discharges from hospital; inability to gain admission



to hospital in some cases; lack of adequate income and work opportunities; and inability of individuals to access the services and supports they require. The problems created by this lack of resources have led to a societal environment of intolerance and a “get tough” attitude toward those with mental illness.

In our experience, many individuals who come into conflict with the law are at the low point of their illness. A mental health crisis may begin a journey through a complex and legalistic process, where an individual’s vulnerability and fragility becomes all too evident.

Many of these individuals become disconnected from services, supports, friends and other individuals. Many have relied so heavily on their families over the years and the course of their illness that their loved ones have nothing left to give, are burnt out, and experiencing both caregiver and compassion fatigue.

Some clients may be homeless or have a transient lifestyle due to the cyclical nature of their illness, and may become ‘known’ to the local police due to their mental health histories. In smaller and rural communities, it may be difficult for mental health clients to escape the attention of the authorities. In contrast, individuals with mental illness become invisible in larger urban centres. Large urban communities may afford individuals the anonymity needed to avoid undue scrutiny, disguise symptoms of illness, and help them to

blend into the population at large. In each instance, individuals with mental illness may fail to access or be connected to needed and wanted services and supports. Interactions between law enforcement agencies and individuals with mental illness can be positive or negative for the individual, depending upon the attitude and training of law enforcement personnel.

For individuals with mental illness who are incarcerated in a correctional facility, the experience is often both negative and bleak. Many will languish without appropriate mental health care and treatment. Many will be isolated and segregated from other inmates, while some will find themselves harassed and belittled by fellow inmates who take advantage of their vulnerability. An individual’s mental health history may be exploited to demean and dehumanize them. Such mistreatment at the hands of others will not speed recovery or enhance mental health. Indeed, for vulnerable individuals, incarceration will exacerbate symptoms of mental illness and accelerate decline in well-being. Continued incarceration often places an individual at risk, at times with tragic results and at the expense of both their physical and mental health.

The correctional system is not capable of providing the level of care and supervision required for this vulnerable population of inmates. Those working in the correctional system have become mental health practitioners by

“Many will languish without appropriate mental health care and treatment. Many will be isolated and segregated from other inmates, while some will find themselves harassed and belittled by fellow inmates who take advantage of their vulnerability”

default, as they are now more and more called upon to provide service to individuals with mental illness—but without the appropriate resources to do so. Correctional facilities are not conducive to supporting individuals in their quest for wellness, recovery and rehabilitation.

Many individuals with mental illness who are incarcerated would be better served by receiving care and treatment in a hospital or through community-based programs that are capable of developing an individualized plan of care and providing a full range of mental health services and supports. Their care must be provided by qualified health practitioners in a health care environment that supports a recovery model of care.

Some individuals who are found unfit or not criminally responsible for their actions are hospitalized in a forensic mental health program, instead of being sent to jail. There are those who believe this system provides a “gold standard of care,” but sadly, this is not the experience of many in care. Some of these forensic programs look more like correctional facilities than hospitals, as they struggle to balance care and treatment versus safety and security. One cannot be at the expense of the other,

as that has an immediate impact on the quality of care and life of the individuals receiving care and treatment in the forensic program. The forensic mental health system has also been slow to embrace the recovery model or to explore how the principles of the model could enhance the services they provide and prepare individuals for reintegration into the community.

Additionally, individuals who have been involved in both the criminal justice and the “forensic” system have to deal with the stigma for the rest of their lives, which complicates their recovery and reintegration into the community. For the public, the forensic label generates a negative response, fear and a sense that everyone in the forensic mental health system has been charged with a heinous crime. More education is required to dispel this myth and smooth transition back into the community.

Ontario has taken some positive steps to address and stem the trend of criminalization of individuals with mental illness, including the creation of a mental health court, diversion programs, and investment in community-based programs and services. However, issues related to housing, income, employ-

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ment, education, social and recreational opportunities, access to a full range of community mental health services and supports, and an enhanced standard of living and quality of life remain outstanding.

Reversing the trend

This trend toward correctional 'solutions' to mental health problems must be reversed. We must provide access to appropriate care and treatment, including a full range of treatment modalities, not simply view incarceration as the solution.

The first step would be to introduce an independent advocacy and rights protection program for inmates, addressing inequities, power imbalances and the lack of access to resources, and enabling inmates to better defend their interests before the courts. Independent and partisan advocates would assist individuals at all stages of the criminal justice process, ensuring that their rights are protected, linking them to services and supports, and assisting them to meet their individual needs. The advocate would have a unique role, distinct from that of a court support worker or volunteer advocate: they would empower the individual by following that person's instruction and by providing information about their legal options while ensuring their rights are fully protected.

Education will be a key component of any plan to reverse the trend toward criminalization, with health practitioners, court workers, lawyers, police, the public and

families jointly learning about the unique needs of individuals with mental illness and relevant mental health legislation.

And, we require a national action plan that sets standards, provides access to care and treatment, and vigorously protects the rights of individuals with mental illness so that they do not become criminalized and incarcerated. Canadians have an expectation that individuals with mental illness will have their rights protected, will not be marginalized or disenfranchised, and will be given access to appropriate care and treatment. These are not unreasonable expectations in a fair and just society that prides itself in a Charter of Rights and Freedoms that is supposed to guarantee equality under the law for all—including those with mental illness.

As the late Hubert Humphrey, former vice-president of the United States, once expressed, a society is judged by how it treats its most vulnerable citizens. We must pause and reflect on how history will judge our efforts and the way in which individuals with mental illness who come into conflict with the law are treated by Canadian society. Will we be found wanting? Or will history recognize our efforts to preserve and support human dignity, autonomy, and human rights as a caring, compassionate and respectful society? The choice is ours. And we need to act now. ■

Preventing Homelessness Following Prison Release

all too often, the people I find sleeping in doorways, alleys and public parks have spent years of their lives incarcerated. Usually they entered the prisons with a head injury, a mental illness, an addiction and/or a chaotic lifestyle. They usually left prison relatively healthy, with a community reintegration plan in place. Yet, now they are sleeping outside—cold, hungry, and without medication, housing or supports. They tend to remain in the streets for years, until they are hospitalized or re-incarcerated. The staff they work with need to place more emphasis on the realities of living in extreme poverty.

There is nowhere in the Lower Mainland and perhaps nowhere in Canada that alcohol and street drugs cannot be readily obtained. However, in the urban core of most cities—in spite of the prevalence of social problems—it is possible to find an affordable room within walking distance of the supports and services ex-offenders need. Affordable, secure housing is the cornerstone to accessing mental health and recovery services.

Living away from the urban core tends to cut a person off from access to services. A missed welfare appointment often results in the welfare file being closed, loss of all income, eviction for non-payment of rent, and so, living in an alley.

The toll of “living rough”

People who live rough experience constant, overwhelming stress. Within the first two weeks of living outside, most people have their backpack, bedding, watch and wallet stolen. With this theft, they lose their ID, the last of their mementos (i.e., children’s pictures), and the names and phone numbers of people who could help them. This theft usually involves violence, facial injury, and physical and emotional trauma. Beatings, serious threats, recurrent thefts of panhandled money, even theft of shoes from their feet is a fact of life for people who live outside. The blanket may be taken from their body while they sleep, by another cold, tired, homeless person, a final disillusionment. There may also be unsavoury encounters with police. With the loss of a home base, they have lost identity, companions, possessions, status, safety, ritual, structure, hygiene and grooming. Not surprisingly, their mental health deteriorates quickly.

When people live “dormer à la belle étoile” (“sleeping under the beautiful star,” in absolute homelessness),

they soon begin to exhibit a cluster of symptoms. The full cluster of these symptoms did not apply to the person while they had a home, and most symptoms disappear within days or weeks, once the person moves into a room of their own. This full cluster of symptoms is specific to people who are living outside, and includes the loss of trust, inability to hope, sleep deprivation, blood sugar swings, ennui (boredom or weariness), alienation, confusion, inability to plan, loss of most abstract thought, inability to respond to complex questions, disbelief that their actions can lead to predictable results, extreme fear, and the inability to envision a realistic future. In addition, during homelessness, most people lose awareness of time and date. Without a regular sleep pattern, hours, days and weeks blur. Further clouding perception may be the psychosis, depression, FASD, alcoholism or other addiction, and/or the broken heart that contributed to the original incarceration.

Life is spent grabbing sleep in three to four hour stretches, standing in food lines, waiting in line to use a phone, a shower, a toilet. Time may be spent overcoming aversion to panhandling, “dumpster diving” and prostitution. Relapse to addiction is inevitable.

There is almost no mental health outreach into the homeless population, and there is no welfare outreach. At this time, there is little possibility that a homeless person with co-existing disorders will find their own way through the system and back to indoor living. Those with prison experience often gravitate to small colonies of people living rough with those who share their background. Time is spent participating in underground economies and in drug use. Consequently, they avoid supportive services, become inaccessible to the little outreach service that does exist, and rely solely on the shelterless subculture in which they are living.

We can ignite sufficient hope in a homeless individual that they will allow us to lead them through the system from welfare to housing, but only if we can produce results within a few days. Producing results quickly in the current political climate is a near impossibility. And while a person can be led, they cannot, while homeless, be sent to complete tasks with any expectation of success.

Homelessness is a disability in and of itself—more disempowering than all the other disabilities put together.

Judy Graves

Judy is Coordinator of the Tenant Assistance Program at Vancouver City Hall. To find the homeless “at home,” Judy walks the city overnight—counting, waking, interviewing and assisting the people who make their homes outside

Realistic release strategies must plan on housing and support

It is imperative that a release plan, based on establishing a welfare file and securing housing close to services, be in place before people are released from incarceration. Prison staff preparing people to go back into the community must work with full awareness of the constraints of living on a welfare income. To survive, people need to be near food banks and soup kitchens, medical staff, neighbours who are not afraid of them, and mental health services with food and activity programs. These needs are not met in upscale neighbourhoods, where the street drug availability is hidden.

Pre-release planning may need to include living in an urban core neighbourhood where drugs are sold in plain view. Such a neighbourhood will also provide tolerant landlords, more flexible welfare offices, advocacy services to prevent eviction, and addiction recovery services. A small room in a residential hotel in the city's core provides sustainable housing where ongoing services can be secured, giving people realistic hope of achieving other goals they have.

An addict seeking to relapse will find a ready supply of drugs in any community, no matter how invisible the drug market is to those who do not use street drugs. At the same time, our media has done a disservice by failing to portray how readily sobriety can be sustained

in urban core neighbourhoods. It is a well-hidden secret that many who live in deep poverty use no drugs whatsoever, and that the majority of people living in the urban core are not addicted. Hidden behind an all too visible drug market, is a vibrant and healthy community where people enjoy meaningful lives. ■



“Homelessness is a disability in and of itself—more disempowering than all the other disabilities put together.”

Canada's Penitentiaries Not equipped to care for growing numbers of prisoners with mental illnesses

Howard Sapers

Mr. Sapers is the Correctional Investigator of Canada and Federal Prison Ombudsman

As Correctional Investigator of Canada, I have expressed my concerns about deficiencies in mental health services in Canada's correctional institutions. In my *Annual Report 2003-04*,¹ I included a special section highlighting the Office of the Correctional Investigator's concerns about the delivery of appropriate mental health services to federal offenders. By and large, the section reflected support for the mental health strategy developed by the Correctional Service of

Canada (CSC). The CSC's strategy acknowledges that the proportion of federal offenders with significant, identified mental health needs has more than doubled over the past decade. The strategy was released at approximately the same time as the CSC's study on health care needs of federal inmates was published in the *Canadian Journal of Public Health*.²

The study on inmates' health care needs shows that inmates have consistently poorer physical and mental health as compared

to the general population, regardless of the indicator chosen. Indicators included such socioeconomic measures as level of education and unemployment; health behaviour, such as smoking and substance abuse; chronic conditions, including diabetes and heart conditions; infectious diseases, such as HIV and tuberculosis; mental health disorders, including schizophrenia and mood disorders; and mortality, such as homicide and suicide.

In my latest *Annual*

Report 2004-05,³ I stated that mental health services offered by the Correctional Service to offenders with mental health issues have not kept up with the dramatic increase in numbers. The level of mental health programming available is now seriously deficient. This has been further highlighted by a recent review on mental health, mental illness and addiction conducted by the Standing Senate Committee on Social Affairs, Science and Technology, chaired by the Honourable

Michael J.L. Kirby. In its interim report,⁴ the committee concurred with the Correctional Service's conclusions:

- The Correctional Service must have a greater capacity to respond to the needs of offenders to gain access to mental health services and addiction treatment
- The Correctional Service's five treatment centres are not resourced at levels comparable to provincial forensic facilities
- Psychologists are primarily engaged in risk assessment for conditional release decision-making as opposed to treatment and rehabilitation
- There is no specific training for front-line correctional staff on mental illness and addiction

The need for enhancements to community support for offenders on release was also identified as a priority, to provide services throughout the course of the sentence and beyond.

The Correctional Service's strategy promotes the adoption of a continuum of care from initial intake through the safe release of offenders into the community. The strategy indicates that significant investments are required in four major areas:

- Comprehensive clinical intake assessment
- Specific requirements for enhancing the Correctional Services's current treatment centres
- Intermediate mental health care units within existing institutions to provide ongoing

treatment and assessment during the period of incarceration

- Community mental health to support offenders on conditional release

The OCI was pleased that this past year the Executive Committee of the Correctional Service of Canada fully endorsed the above four-point strategy, and that funding was secured for many aspects of the community component of the strategy. Unfortunately, the CSC has not secured or identified funding for the other three key components of its strategy.

Again, the OCI welcomed the news of new investments in community mental health. Mentally

disordered offenders will be better served as they prepare for release and during their release into the community. However, strengthening the back end of the CSC's mental health system provides only a partial solution. Properly assessing the offender population at intake and ensuring that their mental health needs are adequately addressed throughout their sentence is what should be done. This would enhance public safety by maximizing safe reintegration into the community. And it would fully capitalize on the community mental health component of the Correctional Service's strategy.

At my news conference on November 4, 2005, I called on the Cor-

rectional Service of Canada to swiftly address the serious deficiencies in the delivery of mental health services to this vulnerable group of offenders by fully implementing its own strategy within the year. I also emphasized that this will require new partnerships and actions on the part of others, beyond the walls of correctional centres. Stronger partnerships between correctional staff and mental health providers will be essential.

My press conference was followed by a news conference of community partners, which included a representative of the Canadian Mental Health Association (CMHA). Penny Marrett, CEO of CMHA, said that "correctional systems are being forced to assume the burden of the country's failure to properly diagnose and care for those with mental illnesses and other mental health problems." She went on to urge Minister McLellan,⁵ other elected officials, and the heads of correctional agencies, to ensure that mentally ill prisoners receive mental health services consistent with community standards of care, and to call for rules that prevent placing prisoners with mental illness in isolated confinement. ■



footnotes

1. Correctional Investigator of Canada. *Annual Report 2003-04*. Retrieved March 20, 2006, at www.oci-bec.gc.ca/reports/AR200304_e.asp.
2. Correctional Service of Canada. (2004). A Health Care Needs Assessment of Federal Inmates in Canada. *Canadian Journal of Public Health*, 95(Suppl. 1). Retrieved March 20, 2006, at www.cpha.ca/shared/cjph/archives/CJPH_95_Suppl_1_e.pdf.
3. Correctional Investigator of Canada. *Annual Report 2004-05*. Retrieved March 20, 2006, at www.oci-bec.gc.ca/reports/AR200405_download_e.asp.
4. Standing Senate Committee on Social Affairs, Science and Technology. (2004, November). *Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada*. Retrieved March 20, 2006, at www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report1/repintnov04vol1-e.pdf.
5. Anne McLellan was Minister of Public Safety under the Liberal government at that time. The current Minister of Public Safety is Stockwell Day.

office of the correctional investigator of canada

- The Office of the Correctional Investigator (OCI) was established in 1973 under the federal Inquiries Act, and in November 1992, as part of the Corrections and Conditional Release Act, the OCI was entrenched into legislation.
- The mandate of the Correctional Investigator is to function as an ombudsman for federal offenders.
- The Correctional Investigator is independent of the Correctional Service of Canada (CSC) and may initiate an investigation on receipt of a complaint by or on behalf of an offender, at the request of the federal minister or on his own initiative.
- The OCI also has a responsibility to review and make recommendations on the Correctional Service of Canada's policies and procedures associated with individual complaints.
- In this way, systemic areas of concern can be identified and appropriately addressed. The Correctional Investigator is required by legislation to report annually, through the Minister of Public Safety and Emergency Preparedness Canada, to both houses of parliament (i.e., the House of Commons and the Senate).

After the tabling of his Annual Report 2004-05, Howard Sapers, Correctional Investigator, told reporters that "Canadian prisons have become warehouses for the mentally ill."

Criminalizing Mental Illness

Camia Weaver

Camia coordinated the Building Capacity: Mental Health and Police Project (BC:MHAPP). The Project, led by the Canadian Mental Health Association's BC Division, aims to improve interactions between police, emergency services, and people with mental illness. This fact sheet excerpt, one in a series of eight, was produced in 2005 as part of the BC:MHAP Project. For the full text of all eight fact sheets, see www.cmha.bc.ca/advocacy

...The range of mentally disordered offenders currently in jails and prisons is somewhere between 15 to 40%; highly disproportionate to the occurrence of mental illness in the population at large. A number of factors contributing to the disproportionate incarceration of persons with mental illness have been identified:

- **Lack of sufficient community support including housing, income, and mental health services.** Persons with mental illness have a harder time finding employment and housing, and maintaining consistent contact with friends, relatives and treatment providers. It is estimated that 30%–35% of Canada's homeless population have a mental illness. Many become isolated, homeless, hungry, and poor due to their symptoms.
- **High rate of substance abuse.** Over 50% of people with mental illness have a co-occurring substance use disorder. Co-occurring disorders are more difficult to treat than either mental illness or substance abuse alone, and there are insufficient treatment programs for the growing demand.
- **The 'Forensic' label.** Treatment is sometimes refused to persons who have committed a criminal offence or have been previously incarcerated. Hospital staff

may refuse admission because it is considered a criminal matter, or the person may be considered too dangerous or disruptive for treatment by community resources—even if the offence for which the person was arrested or convicted does not involve violence.

- **Problems with treatment.** Some persons with mental illness try numerous treatments without success. Others refuse treatment because they cannot accept that they have an illness, they dislike medication side effects, or due to symptoms of the illness itself. Lack of sufficient housing, income, and support also interfere with the ability to maintain treatment.
- **Lack of specialized cross-training for both criminal justice and mental health professionals.** Both systems need to provide information and training to staff on understanding mental health and law enforcement issues, respectively, in order to create successful collaboration.
- **Lack of timely access to mental health assessment and treatment.** Easy access is necessary for early intervention and prevention of deterioration, and also to provide law enforcement, courts, corrections, and communities the ability to access appropriate treatment for individuals in a timely way... **i**

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How Did You Get Into That?

what does being a policeman have to do with mood disorders?



I am retired from one career. When you retire, many things change. Tracks get lost: the people you knew ‘BR’ (before retirement) lose track of you, just as you do of them. And so, when you meet up again, one of the first questions they ask is: “So, what are you up to?” I find that when I tell them I’m the executive director of the Mood Disorders Association of British Columbia, there is a pause... Then the question: “How did you get into that?”

For 28 years, four months and 22 days I was a policeman with the Vancouver Police Department. I did the things that all ‘coppers’ do. I directed traffic, made vehicle stops and wrote tickets. I walked the beat and patrolled in cars. I drove a wagon and I drove a desk. I investigated, arrested, fought with, counselled, consoled, comforted, asked questions of, ordered, yelled at, spoke to, advised (both for and against), locked horns with, held hands with, laughed and cried with, negotiated with, cajoled, and pushed and pulled many people on my way through a police career. I made friends and enemies on both sides of the line. And that was my life. Well, professionally at any rate.

To my neighbours I was “the cop who lives over there.” My friends were my friends with the knowledge that they had

to plan our social events around a shift calendar. Kids on the teams I helped coach were at times more excitedly curious about my day job than about the ball-handling drills that bored them. My ‘clients’—those people with whom I had a single or casual interaction—knew me as a uniform who was there to maintain some order, get a job done or resolve a situation. My co-workers knew and accepted me as one of them—although it was not an easy party to crash, and not an easy room to work once you got through the door.

When I tell my former colleagues in the police force what I do now, and when they get over their initial confusion and we talk for a minute, they come to see the logic. Even as they ask the question—what does being a policeman have to do with mood disorders?—the light begins to dawn. Because, you see, the ‘jurisdictions’ are much the same.

The people I dealt with on the streets of the Downtown Eastside or in Kitsilano or even in Shaughnessy have the same issues as people who have mood disorders. A great many street

people have mental illness. There is a qualitative difference in the lives of my new constituents, and mental illness may manifest itself in less obtrusive ways, but the similarities to those living on the streets are there. In both cases they are out of work or underemployed, socioeconomically disadvantaged, and marginalized or ignored by the system. They have problems with relationships or dealing with other people. Some become alcoholics; some become addicted to other drugs, gambling, sex or some other perhaps less devastating vice. The main difference is that when street people become dependent on the relief they seek through self-medication, they perform crime to support this drug use.

Before too many hackles get raised, let me emphasize that to be mentally ill is not to be a criminal. But many criminals are mentally ill. Prisons have a disproportionate number of people with mental illness in their population. Mental illness does not cause crime. It does, however, cause people to be in situations that lead some to criminal choices. That downward path, once taken,

is seductive and slippery. Mental illness comprises diseases that have symptoms like exhibiting poor judgement, engaging in risky behaviour or making inappropriate decisions—all key ingredients in the recipe for becoming a criminal. And many of the mentally ill are victims too. People who betray a lack of self-confidence or out-of-the-ordinary behaviour become targets of bullies or opportunists.

Crime is about conflict: conflict with society’s rules; conflict with strangers; conflict with friends, spouses or co-workers; conflict with poverty, repression, discrimination or other human conditions; and even conflict with nature, human and otherwise.

Mental illness, with its attached problems of addiction, self-medication and stigma is also about conflict: conflict with one’s self; conflict with others’ expectations; conflicts with society and with what others call ‘normalcy.’ Conflict with medications prescribed to help sends some people to seek relief through unregulated substance use. Many of those people find it necessary to resort to antisocial (e.g., criminal) behaviour to continue an addictive lifestyle. Mental illness induces others, including mentally healthy loved ones, to strike out physically—most likely, and paradoxically, at someone

Rennie Hoffman

Rennie is Executive Director of the Mood Disorders Association of BC

they care about—as a result of terrible frustration or an inability to cope with the disease, either their own or someone else’s. Some cannot deal with the unremitting pain or the destructive thoughts or impulses and as a result set into motion a chain of events that spurs them to do regrettable things—often before they end their own life or try to.

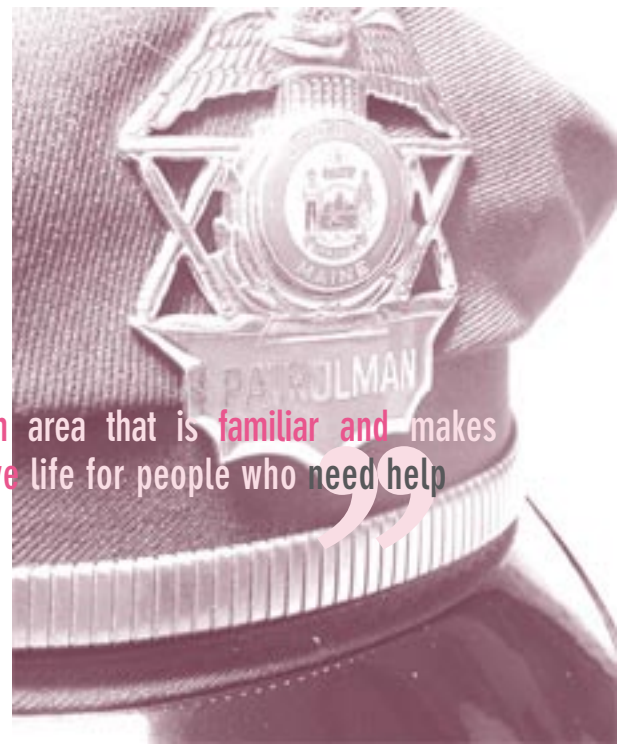
Is it any wonder that the Chief Justice of the Supreme Court has identified mental illness as a “huge problem”¹ in terms of criminal justice?

Policing is about crime. Simply put, if there were no crime or threat of crime, we would not need police. I have stated in the past—and I caution that this is my personal estimate—that criminal behaviour would be reduced by more than 80% if we eradicated men-

tal illness. Some people look askance when I say that—but not my police friends. And now, when I give this estimate to my new mental health acquaintances and we discuss it in the light of my police experience, many of them no longer shake their heads in disbelief.

“I’m working in an area that is familiar and makes sense to me, to improve life for people who need help”

The how or the why of my being executive director of the Mood Disorders Association of BC (MDABC) needs no explanation. It seems a natural progression. I am working in an area that is familiar and makes sense to me, to improve life for people who need help. My MDA constituents struggle with the very things that help create the necessity for my



previous career choice. So, it turns out, I struggle with the same enemy I struggled with as a policeman. Yes, I’m in a different arena, using different

tools and methods, and my goals are different. But I see the same enemy. Only now, I’m more focused on the ringleader. ■

footnote

1. McLachlin, B. (2005, February 17, 18). *Medicine and the law: The challenges of mental illness*. Remarks of the Chief Justice of Canada at the Honourable Mr. Justice Michael O’Byrne/AHFMR Lecture on Law, Medicine and Ethics, Calgary and Edmonton, AB.

Doing Time: My Story

Curtis Arthur

Curtis is a childhood abuse survivor, mental health consumer and recovering drug user. Catalyzed to change by the death of his brother, Curtis is now a junkie for ‘clean’ time. He looks forward to release from prison and rebuilding family relationships. For the first time he is happy to be alive

My name is Curtis. I’m a federal inmate doing five years for crimes that I accept full responsibility for; crimes that stem from an eight-year addiction to heroin. I have now been clean for 16 months.

I know the exact date I quit using, because it was the day my best friend, my older brother, died. He was 27—the same age I am now. Heroin killed my brother. He didn’t die of an overdose—he suffered through the last couple of months of his life with a disease similar to mad cow disease, caused by a chemical reaction when heroin is smoked off of tin foil.¹

I wasn’t able to physically be with my brother while he was dying because of my sentence, but I was fortunate to be given the opportunity to visit him a few weeks before he died. There is a photo of us tacked to my cell wall: he is in his hospital bed, clearly dying from a powder that we thought brought nothing but pleasure; and I, the more impulsive of the two of us, am shackled to his bed, under the watch of two correctional officers.

My brother and I are the ‘poster children’ for “don’t do drugs.” I promised him that day—as I said good-bye, knowing it was the very last time I would ever see him alive—that I would change my ways.

Some people might expect that I was in the ideal place to change my behaviour. Based on their limited, mostly media-driven knowledge of the justice system, they might think that prison time in Canada is as much about reforming ‘bad’ people as it is about punishment and protecting public safety, and that I would have access to the resources I needed to change.

Let me summarize what my “treatment” program has been. It took 18 months for me just to get into a drug and alcohol program that ran for about six weeks, weekdays for 90 minutes. The program gave me an opportunity to “think” about my addiction and gave me great insight, but when the program ended there was no follow-up. I could “think” about my addiction, but wasn’t given any additional tools to apply what I had learned.

What is more disturbing is that I waited 27 months to do a highly recommended violence prevention program, only to be told that, because I was doing time for my first violent offence, I wasn't considered violent enough to participate. When I informed my wife I'd have to wait until my *next* criminal conviction to take a violence prevention course, she couldn't believe it until I showed her the official paperwork.

If these two examples are not confirmation enough that prison acts as a warehouse and should not be a default treatment system, I don't know what is. In my humble opinion, half of the men I live among would be better served in a psychiatric hospital than here. We are entitled to just three hours a year with a psychiatrist.

After my brother's death I was given my three visits with a psychiatrist, at my request, because I was feeling suicidal. I'm sorry I ever reached out for help. I wasn't aware of the three-hour limit. I divulged some of the most personal details of my sorrows, of a life filled with abuse, loss and self-hate. After three sessions—just enough time for me to start opening up—I was left feeling raw, and in the weeks following I became increasingly depressed and suicidal. If it wasn't for my wife's support (that is truly heaven sent!) and an extended family who always knew I had the potential to change my life, I would have been left to struggle through my grief and confusion on my own—as do so many of the men in here, who have no one to supporting them and who rely entirely on this system.

Prison is a warehouse—and the university where you learn bigger and bolder crimes. If its purpose is punishment, then for me it was successful. Prison means being separate from the people I love. It meant that at my brother's funeral I was not able to touch or to be comforted by anyone. It meant grieving without being able to express my emotions, since in prison that is an expression of weakness. If prison's purpose is to protect the safety of the public, it could be argued that at least while a criminal is incarcerated they can not inflict harm on society. However, the public should really fear that the time in prisons is not well spent and that in the end a more malicious, skilled and antisocial criminal may be released.

Finally, if the purpose of prison is rehabilitation, then, at least from my experience, it's a dismal failure. The majority of men call prison 'home' because of their issues with mental health or drugs. But prison can not be considered treatment: there are more drugs in here than on the street, and your cellmate could very well be your drug dealer. Where do you think I tried heroin for the first time? We need more treatment services—mandatory, lock-up treatment even. To believe we have that now is to be misinformed.

I have begun to make the changes I promised my brother—and later promised myself—I would. I quit all drugs, am nearly completely weaned off methadone, have stopped smoking, am working on completing my GED (General Educational Development) secondary

school equivalency certificate, and have repaired many of the relationships I took for granted while I was using.

I am going to make it because I have given myself many reasons to stay clean. For the first time since I was four years old, I am happy that I'm alive. Today, I live my life for me and my brother—there must be some reason for his death. But for the rest of the men I live among, the story is one I have known—one of being very alone even while you live with hundreds of other people. There is only one sure thing that an inmate does in prison. Time. **i**

I promised him that day—as I said good-bye, knowing it was the very last time I would ever see him alive—that I would change my ways



footnote

1. Smoking is how many kids today become addicted to heroin. Smoking has less of a stigma than shooting does, but it's no less deadly when smoked.

More Good Than Harm? **I don't think so!**

It was a damp and windy evening in February 2004 when the phone rang. It was around 9 pm. I had come to recognize phone calls at this hour as usually bearing bad news and this one was no exception.

It was David* calling, in a panic. I could tell by the sound of his voice, as well as by what he was saying, that he was in trouble. He was focused on not being able to do his chores at the psychiatric group home he lived in—that was of greater concern to him than getting out of the hell-hole that is known as the Main Street jail.

David was in jail for the first time in his 27 years. The only prior brush with police he'd had was when he ran away from hospital on four occasions. He had been involuntarily certified, so the hospital phoned the police, warrants were issued and police returned him to the hospital. On another occasion, David's mental health team called Car 87 to take him from his apartment to hospital.

And so began a 20-month odyssey through the so-called justice system.

What did this young man with schizophrenia do to warrant being snatched

Howard Fluxgold

Howard is a freelance writer living in Vancouver

* pseudonym

by Vancouver's 'finest' just as he was sitting down to supper at his group home? To warrant being locked up for five days?

David had decided that he needed to return to the hospital, where he had spent much of the last year—and the best way to get admitted was to act 'crazy.' It makes perfect sense to me. He started jumping on cars on the Burrard Street Bridge at rush hour. He was chased down by police, including the Chief of Police, who was stuck in traffic on his way home. But before he was caught, David had dented a few cars and had pushed or punched a bus driver who had stopped to help. He was eventually taken to a hospital, where he spent another two weeks before being released to the group home.

The police told the hospital emergency staff on two different occasions during the two weeks David was there to notify them when he was being released, so they could charge him. According to my son's lawyer and the hospital, the police had no legal right to make that request, and the hospital had no legal obligation to honour it—but honour it they did.

After being notified of David's pending release from hospital, the police did not show up. Instead,

they waited a couple of weeks before arriving at David's group home on a Thursday evening at supper time.

Did they know that this would mean at least a night in jail for David, if not more? Did they care?

David was taken to jail on that Thursday evening, and appeared in court the next morning, totally unable to fend for himself. He was represented by duty counsel (a lawyer available to give advice on the day of a court appearance), because I was unable to find a lawyer overnight. The duty counsel, who didn't know David at all, agreed with the Crown to keep him in jail for a psychiatric assessment. Because the psychiatric assessment didn't take place until the Sunday, David spent several more days waiting in jail, waiting for the assessment.

Now, here is someone who has spent at least half of the previous 24 months in hospital, has a psychiatric support team guided by one of the best doctors in Canada, and lives in a psychiatric group home—yet the court required another doctor's opinion! I didn't know whether to laugh or cry. And when I saw the psychiatrist's report I was truly astounded. Handwritten in a childish script on one sheet of foolscap, the report said that David

"appeared depressed." Even someone without a mental illness might be depressed after spending five days in jail—especially if they had no criminal record and had never been in jail.

The psychiatric assessment determined David was fit to stand trial. By his next appearance before a judge, David did have his own lawyer. But for some reason, the Crown attorney was treating this case as though it were a serial murder. The Crown representative refused to agree on a guilty plea in exchange for a conditional discharge, which would mean no criminal record. David's lawyer told me that either a stay of the charges, or a conditional discharge with community service, was the standard way of dealing with similar cases. He was uncertain as to why the Crown, during the next six monthly appearances, refused to settle the case that way. But that is what happened.

Finally, the Crown and lawyer agreed to set a date for trial—about one year from the date of the incident. It was all I could do not to fall off my chair in fits of hysterical laughter when the judge, the Crown and the lawyer agreed to set aside a full day of court time for a case in which David was willing to plead

guilty. It is no wonder our courts are clogged. No one could ever have felt more contempt for the justice system than I did on that occasion.

Fortunately, just before the trial began, the Crown attorney reversed his position and offered to drop the charges in return for community service.

Coda

Several months after David's arrest, I attended a conference on mental health and the law. At a panel discussion on what was working and what was not, Vancouver Police Chief Jamie Graham said that when it came to the mentally ill, "Police action must do more good than harm." What, I wondered, was the good that came from this police action? What is the purpose of throwing someone with no criminal record, who is charged with public mischief and common assault—anyone, let alone someone who has a mental illness—in jail for five days?

Not long after David's incarceration, he attempted suicide in June 2004, and spent a week in the trauma unit. That was followed by several months back on a psychiatric ward, where psychiatrists urged us to deal with the charges as quickly as possible because of the stress they were causing. But it ►

David had decided that he needed to return to the hospital, where he had spent much of the last year—and the best way to get admitted was to act 'crazy.' It makes perfect sense to me.





Mental Health in the Courtroom

One Judge's Perspective

What percentage of court cases have a mental health component? That depends on how mental health is defined. For starters, there is a large section of Canada's Criminal Code that governs what should happen if someone charged with an offence is "not criminally responsible as a result of mental disorder" (NCRMD).¹

Consider some numbers. The most recent census found about four million people living in British Columbia. Out of that number, last year there were over 100,000 new criminal and youth files opened in both the Provincial and Supreme courts. Out of those, there were 692 requests for a psychiatric assessment to determine if an accused

person understood what was going on in a court or at the time of the offence. Only 11 people were found to be NCRMD.²

The 692 requests for psychiatric assessment suggest, at the very least, some kind of behaviour that either police, sheriffs, lawyers or the judge thought needed to be investigated before charges could proceed. In only 11 cases did a psychiatrist decide the person should not go through a court proceeding because they would not understand what was happening in that process.¹ The remainder of people might be diagnosed, medicated or involved in some other program—or not—while their charges proceeded

through the courts.

If you consider that drug or alcohol misuse, antagonism toward authority, ready use of violence or coercion, and other 'typical' antisocial behaviours have some mental health element, the number of psychiatric assessment requests is misleadingly low.

The vast majority of cases involve problems with alcohol: "liquid courage" before an event; constant and debilitating use as a depressant; binge consumption with no care about the consequences; or an "out-of-character," one-off incident with a host of negative consequences. Non-prescription drugs such as cocaine, crystal meth, marijuana and heroin present other problems—typically, with younger adults or youth.

Are people who use and abuse substances suffering from some form of mental illness? Such an assertion could never provide a defence in court, but it is often used as an explanation if the matter gets to sentencing.

Using an extremely broad definition of mental ill-health, one could say that perhaps every criminal case has a mental health component. Criminal problems typically

involve emotional, traumatic and sometimes life-altering situations, and the people charged, witnesses, and even the people who merely listen to media descriptions are all affected.

The range of human behaviour encompasses the good, the bad and the ugly, and people's reactions to problems are the daily fare in our courtrooms. The court is a place where people, using words and logic, can tell their stories and possibly resolve their conflicts. Overall, the pain in what one hears described is horrendous. It helps to remember that we see a small percentage of the population—about 3%, and fewer still if you consider that there are repeat offenders.

What resources are available to the courts to help deal with such difficult problems? Primarily, our in-house human resources. It is extremely important for court personnel to maintain a healthy state of mind. Almost without exception, the people working in the courts are careful listeners, who are able to remember and pass on ideas about what might work better in similar situations. The best are those who, above all provocation, treat people with dignity and patience.

Judge Judith Gedye

Judith Gedye, a former psychiatric nursing assistant, has a master's degree in psychology (community corrections). She practiced law for 22 years as criminal defence counsel, before being appointed as a provincial court judge in Vancouver in 1999. Judge Gedye currently hears criminal, civil, family and youth matters in North Vancouver



More Good Than Harm | *cont'd from previous page*

was more than a year before the matter was brought to a conclusion.

As I watched David's journey through the justice system unfold, I couldn't help but become even more cynical. I noted that another 'danger to society' arrived at the courthouse in a limo with his high-priced lawyers. I noted that he didn't spend any time in jail, although he was, like David, charged with common assault—for breaking someone's neck and perhaps ending their career. I noted that the court didn't think he was 'crazy' for doing so, nor did the Crown seek a psychiatric exam. And the court quickly accepted a guilty plea in exchange for a conditional discharge.

Yes. There is one law for a professional hockey player—and another for those who have a mental illness. ■

footnotes

1. Criminal Code of Canada, RSC 1985, c. C-46, Part XX.1.

2. Thanks to Caroline Shandley, Ministry of the Attorney General Court Services Branch, for providing these statistics.

Resources available outside a courtroom, and their effectiveness, remain largely a mystery to most judges. Defence counsel may make suggestions to a judge during a sentencing, but they are not trained as social workers and often only hear of treatment resources from their clients. Judges typically hear how someone is doing only if there is a breach of probation or a new charge. If we find someone guilty, the resources for sentencing

are either expensive (e.g., jail, which has limited positive rehabilitative results) or underfunded. Probation officers have excellent counselling skills, but they also have large caseloads. There are unlicensed recovery programs, with varying levels of success and which are often used merely to avoid jail. Our front-line police forces continue to play a professional role in arresting people in an increasingly frustrating “charter”

world. It is largely up to the individual to find the rare community resources that typically have long waiting lists. Most important are the medical, religious, family and friendship networks that people may be able to turn to when they need help.

Ultimately, the only thing a judge has control over is the atmosphere in their courtroom. If a convicted person can be persuaded that there has been a fair and reasonable

process and that there is a better way of handling their problems in the future, and if they can be persuaded to participate in and benefit from whatever punishment or help is offered, there is a better chance they’ll change to healthier ways of dealing with problems. We can only try all that is humanly possible, within the court structures as they currently exist, to help people change. **i**

Panhandling Restrictions in Vancouver Discriminatory and Hypocritical

Cynthia Row

Cynthia is Editorial Assistant for Visions

begging for money on the street, otherwise known as panhandling, is an area of increasing vilification in Vancouver, and is part of the focus of the Street Crime Working Group.¹ The practice of society’s second-oldest profession has been increasingly restricted, and some politicians and downtown merchants are calling for an outright ban.

Laws already exist to deal with aggressive panhandling and harassment on our streets. In April 1998 Vancouver city council unanimously passed a by-law to regulate and control panhandling.² It was subsequently repealed, but restrictions to prevent “obstructive solicitation” were incorporated in the City’s Street and Traffic By-law in June 2004.³ This was further reinforced by the provincial Safe Streets Act, which came into effect in January 2005.⁴ Under the Safe Streets Act, it is illegal to panhandle or solicit within a certain proximity to anyone using bank machines, pay phones or public washrooms; anyone at a bus or taxi stop or on public transit and anyone in a stopped car or getting in or out of a parked car.⁵

These restrictions blatantly discriminate against poor, homeless, mentally ill and addicted people, and serve only to marginalize and render invisible an already marginalized population. It is also exceedingly hypocritical, and as citizens of a ‘progressive’ city, we ought to be ashamed.

Glaring evidence of this hypocrisy can be found at any downtown SkyTrain station (places where panhandling is aggressively discouraged by authorities). One just has to exit the Granville Street station, or walk

down the stairs at the Main Street/Science World station to know what I’m talking about. You cannot walk for three blocks in any direction after emerging from the Granville SkyTrain stop without being accosted on every corner by bright-vested representatives of 24-Hours or Metro tabloid publications. These tabloid distributors are annoying and aggressive, and as uncomfortable to encounter as any dishevelled panhandler. They do not stand unobtrusively to the side as you try to make your way; they stand in the middle of the sidewalk at intersections, or three feet from the bottom of SkyTrain stairs, forcing pedestrians to walk around them. As you attempt to avoid them, an eager arm thrusts forward a copy of whatever tabloid they are promoting, likewise forcing all passersby to engage in an act of acceptance or refusal of their offerings—a clever co-opting of the time-honoured tradition of panhandling.

I remember a down-and-out man who used to peddle copies of a street paper outside of the Granville Street station. He would politely stand to the side of the exit doors and say “hello” as you passed, hoping to sell a paper or take a donation. He is no longer there, having been supplanted by an army of tabloid employees—though to be fair, the tabloid distributors are just trying to make a living themselves, and are engaged in ambush marketing techniques at the direction of their employers.

I am also regularly accosted in front of my local socially progressive bank, coffee shop and retailer—not by panhandlers, but by ‘sanctioned’ solicitors for a variety of charitable organizations (this is allowed if the

footnotes

1. The Street Crime Working Group is mandated to develop new criminal justice responses to street crime and disorderly behaviour in Vancouver. For more information see www.bojusticereview.org/working_groups/street_crime/street_crime.asp.

2. City of Vancouver. (1998, April). *Panhandling By-law No. 7885*. Retrieved online February 8, 2006, at www.city.vancouver.bc.ca/bylaws/15254v2.pdf.

institution gives the charity organization permission to solicit in front of their doors). The most annoying incidents of street solicitation I experience are not from street people, but from the representatives of these 'legitimate' organizations. On one occasion, I declined an invitation to make a contribution from an organization rep who was stationed in front of a bank. The vendor proceeded to heckle me as I walked away, capping off her harassment with a familiar and sarcastic comment: "Have a nice day!" I had to cross the street to avoid walking in front of the bank for the rest of the day. I am rarely intimidated or inconvenienced in this way by local panhandlers.

The message is clear: corporate panhandling is acceptable and is welcomed in our city, while begging by the disenfranchised is to be discouraged. It is acceptable for a politician to stop me in the street and ask for my vote, an evangelist for my devotion, a tabloid for my attention, a charitable organization for my money and a lost tourist for directions. But it is becoming increasingly unacceptable for a mentally ill, addicted or hungry person on the street to ask me for anything. In other words, it is acceptable to be harassed for global and organized group causes, but not for local and personal ones.

The discrimination and hypocrisy are obvious, and we ought to think of the consequences of legislating against panhandling. Such legislation would be a misguided and short-sighted approach to the problems of poverty, illness and addiction in our society. ❏



footnotes

3. City of Vancouver. (2004, June). *Street and Traffic By-law (2849), Section 70A*. Retrieved online February 20, 2006, at <http://vancouver.ca/bylaws/11188v17.pdf>.
4. British Columbia Safe Streets Act, SBC 2004, c. 75. Retrieved online February 20, 2006, from www.legis.gov.bc.ca/37th5th/3rd_read/gov71-3.htm.
5. BC Public Interest Advocacy Centre, BC Civil Liberties Association & Legal Services Society of BC. (2005, October). *Safe Streets Act*. Brochure retrieved online February 18, 2006, at www.bcpiac.com/pub/currentInterest/SafeStreetsAct-brochure.pdf.

Arrest or Treatment? The Vancouver Police Department speaks up for treatment...

Shouldn't all people who suffer from mental disorders receive appropriate and timely treatment and services so they don't end up in situations that place them in contact with the justice system? Shouldn't we have systems in place that effectively deal with people who are continually involved in a cycle of crime due to mental disorders and addictions? Perhaps these seem like unattainable goals, but I believe they must be the goals to strive for. People who have an illness must receive the treatment they need, so they can live healthy and productive lives.

All too often Vancouver police officers deal with chronic offenders who have drug addictions, mental disorders or a combination of both. This is frustrating for police, as it is very apparent that the justice system is not equipped to address the underlying issues that lead to these offences. Let's face it: some people commit crimes because they cannot control themselves due to mental illness and/or drug addiction.

Vancouver is certainly seeing first-hand the devastating effects that occur in communities as a result of drugs, mental illness and chronic offenders. The Downtown Eastside and, more recently, the downtown core bounded by False Creek, Burrard Inlet, Stanley Park and the Downtown Eastside, have become areas where

Steve Schnitzer

Steve is a 25-year member of the Vancouver Police Department and is currently Commander for District One, which comprises most of the downtown core of Vancouver

many people commit crime because they are addicted, or simply cannot help it due to mental illness or other unfortunate circumstances. Simply arresting people time after time for the same offence is not an approach that the police want to take—especially since, in most cases, medical treatment and other social services could provide longer-term solutions.

To illustrate the magnitude of the problem, the Vancouver Provincial Court sees from 35 to 40 offenders with symptoms of mental illness appear each day in relation to criminal charges. There are also more than 9,000 intravenous drug users in the Vancouver area. Some more heavily addicted drug users need to break into as many as 20 cars per day to satisfy their addiction.¹

In the past few years, two major reports have been released in response to some of the issues facing Vancouver. In 2001, *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*¹ was released in response to the drug problem in the Downtown Eastside. In 2005, *Beyond the Revolving Door: A New Response to Chronic Offenders*² was released in response to the increasing level of street crime and chronic offenders in Vancouver. Both reports highlight the need for more services from those traditionally outside the justice system and for more partnerships between stakeholders inside the justice system and those traditionally outside the justice system.

At the present time, although there are ways to divert some of these offenders from the justice system into

treatment programs, the number of programs and services available simply cannot keep up with the demand.

Another question to consider is: should we wait for a person to commit a crime before offering them appropriate services? Services and programs should be proactively available to keep mentally ill and addicted persons from having contact with the justice system.

Much needs to be done to address these problems facing Vancouver. However, it is encouraging that, during the last several years, stakeholders are now coming to the table to discuss them. At the very least it is now recognized that some of these social and medical problems cannot be solved by the police and justice system alone, and that it takes a number of stakeholders to address the issues. Ultimate solutions will not be easy, but having the appropriate agencies at the table makes it more possible to achieve solutions.

The Vancouver Police Department continues to sit on many stakeholder committees advocating for more funding and services so that mentally ill and addicted people can receive the treatment they need, so they do not commit crimes. Future change in this direction will not only benefit these offenders, but will also increase the quality of life for all members of the community through reduction in property crime and street disorder. From the police perspective, it would be far preferable to arrest and charge only people who are in control of their actions—and not those whose actions are influenced by their mental illness or their drug addiction. ■

footnotes

1. MacPherson, D. & Rowley, M. (2001). *A framework for action: A four-pillar approach to drug problems in Vancouver*. Vancouver, BC: City of Vancouver.

2. BC Justice Review Task Force. (2005). *Beyond the revolving door: A new response to chronic offenders*. Victoria, BC: Author.

Compassion by Law Enforcers More Common than May Be Expected

Frank G. Sterle, Jr.

Frank edits two community newsletters: *Community Connection*, published by the South Surrey branch of Canadian Mental Health Association; and *Whale Tales*, put out by Whale House, a clubhouse operated by OPTIONS: Services to Communities.

Frank lives in White Rock, BC

* pseudonyms

The police, and the justice system as a whole, are reputed to criminalize rather than recommend treatment for people with mental illness who are suspected and/or convicted of having committed a crime. There are, however, noteworthy instances of compassion by police toward people with mental illness, even though they have indeed committed crimes.

For example, there's Jordan.* He was arrested by store security after shoplifting a large bottle of extra-strength, off-the-shelf

painkillers, as well as six bottles of 20-tablet, store-shelf sleeping-aid pills. Two police officers escorted him to his residence; they said they needed to see some identification, which Jordan was not carrying with him. Granted, his hands were unnecessarily and uncomfortably cuffed behind his back as the police officers escorted him out of the store—possibly to make the experience disturbing enough to deter Jordan from repeating such an offence. However, Jordan says that even the store security man was

quite sympathetic when he learned that Jordan was under the care of a psychiatrist and was consuming large quantities of the stolen sleeping aid (20 to 30 extra-strength tablets at a time) in an attempt to relieve his chronic anxiety, among other mental illnesses. Jordan was told the store would not charge him because he was under a psychiatrist's care. And the police, after removing the handcuffs from his wrists, said they would not charge him, but insisted he tell his psychiatrist about the incident.

Then there's Dan,* who was stopped by police after doing an 'eat and run' at a restaurant. Now it should be known that Dan is normally not in the least a thief; indeed, he's the type who would rather give away \$100 that belonged to him than take \$50 that was not his. Dan was in the midst of a schizophrenic episode, and was so ill at the time that he left his vehicle in some deserted Burnaby back alley, where it was

continued on page 26

Adolescent Addiction and Corrections

My Journey



By the time I was 16 I had a serious drug problem. My parents knew I was likely to end up with serious mental and physical health problems—if I was lucky enough to survive my addiction into adulthood. My mother, father and stepfather all practiced in the mental health field as psychologists and were in despair at not knowing what to do with me. Finally, right after my 16th birthday, they organized an intervention designed to send me for six weeks of treatment at a government facility for treating adult addicts. That was the day I left home, plunging headlong into years of drinking, drug-ging, crime and going in and out of institutions.

At 20 I was arrested, charged and convicted for cultivating marijuana, trafficking, and weapons offences. I was sentenced to three months, which I served on weekends. My fear of jail evaporated the day I arrived once I had smoked my first joint with other prisoners. Drugs and booze were readily available, and I smuggled my own supply in as well. Jail sure wasn't a deterrent, and I was far from being rehabilitated.

By the time I was ready for help, six years after I left home, there was finally a place in Western Canada

for treating young people: the Alberta Adolescent Recovery Centre (AARC) in Calgary. Until AARC opened its doors, kids from BC had been sent to the US for treatment, as well as to some adult facilities and one short-term centre in Saskatchewan. The majority of these young people, as well as the ones being treated in BC outpatient facilities, were continuing to use drugs and hardly missed a step when they got back into their communities.

I entered AARC at 21 and was there for a year, along with young people from BC, Saskatchewan, England and the US. Treatment in a long-term facility was ideal for me. After 10 years of sustained, daily drug and alcohol use it took me a month just to detoxify. With guidance and help I began to go back to school and to associate with 'regular' people.

I was reintroduced to the life of an addict involved with the correctional system when I started volunteering at the Calgary Young Offenders Centre as a mentor to young people who are incarcerated. Two of the young men I became involved with had gone through several treatment centres, and were continually in trouble and going to

jail for crimes such as theft, assault, drugs and even aggravated assault for stabbing an adult crack dealer. Neither of these bright, funny, articulate middle-class kids was getting help for their addiction, and in fact, they were exposed to drugs within the facility. One overworked addictions counsellor oversaw from 75 to 250 kids. These young offenders were offered one hour-long AA meeting per week, and the rest of their time was spent talking to other young offenders about their glory days of crime and drugs, day dreaming about getting high, and plotting new crimes with other inmates.

Every week my two young friends told me how badly they wanted to get sober, to be a part of their families again, to go to school, have jobs, and perhaps girlfriends, and how, when they were lonely, hurting and depressed, all they could think about was drugs. I was the only person they could talk to honestly about their cravings, fear and shame. To be vulnerable with those thoughts around other prisoners would result in being laughed at, confrontation and exploitation.

So where are these young addicts destined to go? Well, adolescent addicts and offenders be-

come adult addicts and offenders. I did. And the worse the drugs consumed, the more difficult it is to be sober. Cocaine, methamphetamines and other chemicals numb the pleasure centres of the brain, so when drug use ceases it can take months, even years, to feel good again—even with successful accomplishments and relationships. How many young people can handle that frozen numbness? Without long-term, supervised treatment and care, any hard-core addict will seek what works—drugs—especially if they are going through tough times.

There is no question that addiction is a mental health issue. Paranoia, depression, suicidal ideations, violent tendencies, hallucinations and a host of other symptoms can be present in an addicted person.

The actions of someone with an addiction affect all of us—communities, families and businesses. A huge number of incarcerated offenders have drug problems as well as other mental health issues, and they continue to offend over and over again in order to survive and feed their addiction. It is time to focus on treating addiction effectively if we want to deal with crime. ■

David Grant

*David is the author of **The Demon and the Monk: My Life of Crime, Addiction and Recovery**. He speaks to groups on issues of adolescent addiction, treatment and recovery*

David can be reached through www.demonandmonk.com

Compassion | cont'd

completely stripped down for parts by thieves. Dan had been so ill he could not recall, even after his illness was treated, where he'd left his vehicle. However, instead of charging him with theft, the police, seeing that Dan was mentally ill and untreated for that illness, took him to the local hospital.

Police are also known to assist people with mental illness even when a crime has not been committed: When the police spotted Dan sleeping on the sidewalk, they helped him phone his worried mother.

Interestingly and encouragingly, a 2003 story in the *Kingston Whig-Standard* reported that, according to a study by Queen's University professor and psychologist Dorothy Cotton, Canadian police are "more understanding and benevolent toward people with mental illness than [are] the general public."¹

Cotton had 150 officers, from Kingston, Ontario, eastern Ontario Provincial Police detachments and Port Moody in British Columbia, complete a questionnaire that was designed to show whether a police officer could be categorized as "authoritarian, socially benevolent, socially restrictive or oriented towards community integration." Officers were also asked about the role of police in working with people who are mentally ill. Results showed that 80% of those surveyed feel the mentally ill are "far less dangerous than most people suppose," 94% think society should have a more tolerant attitude toward people with

mental illness, and 93% believe the mentally ill should not be denied their individual rights.¹

According to the article, Cotton compared her findings to a 1981 survey of the general public, in which citizens were asked the same questions Cotton asked the police officers. Cotton believes society's attitudes haven't changed much since 1981. And, she says: "Society at large is extremely uncomfortable with mental illness... We still won't talk about [having] them. The good news is that the police are not the problem, and that's exciting and heartening to see."¹

Cotton, apparently, was somewhat surprised to find that police are more protective of people with mental illness than the average person [is]. She is quoted as saying: "The type of people who become cops in the first place are people who are generally concerned with the welfare of society and keeping people safe... Before, I had much of the attitude that I think most people do, that the police are bullies. Now that I've done a lot of work with them, I would never say that."¹

Like Dan and Jordan, I have experienced the compassion of police. As a young man, I committed a fairly serious though non-violent crime. But I, too, was shown compassion by my arresting officer, especially when he learned of my mental illness. I compensated my victim and did not have to undergo the intimidating experience of facing a criminal court judge—thanks to that police officer. ■

Developing Service Partnerships in Vancouver's Downtown Eastside

With an estimated one in five Canadians experiencing a mental disorder in the course of a year, effective treatment and support networks are needed in every community. Successful community integration and treatment have been achieved for many clients who use the mental health system, and many people with active or past diagnoses of mental illness live and work successfully in communities across the country. However, a general lack of resources (e.g., affordable housing, employment training, etc.) make it difficult for many people with mental illness to receive the help they need. When people with serious mental illness (including substance abuse) do not receive sufficient treatment and are homeless and in crisis, the resulting disruptive behaviour often brings these people to the attention of law enforcement agencies.

In order to address gaps in the existing service system, many advocates have voiced the need for mental health programs and services for individuals with long-term, serious mental illness that incorporate multiple systems and stakeholders. A strategic action plan is required that involves collaboration between federal, provincial and municipal government agencies as well as the community.

The Vancouver Intensive Supervision Unit (VISU)

The Vancouver Intensive Supervision Unit (VISU) and its predecessor, the Inter-Ministerial Project, are examples of programs funded, administered and staffed by multiple stakeholders at the regional district and provincial levels (i.e., Forensic Psychiatric Services Commission, BC Corrections Branch and the Vancouver Coastal Health Authority).

VISU opened its doors in April 2003 in response to a growing need in the Downtown Eastside for services that address the complex needs of individuals who have severe mental illness and frequently come into contact with the justice system. These "multi-problem offenders" typically present with a combination of chronic mental illness, severe interpersonal and behavioural problems, poly-substance abuse and multiple encounters with the criminal justice system. The lives of these individuals are characterized by a repeated series

Adapted from the original, published on *The Writer's Circle Online* at www.nisa.on.ca

Frank can be contacted at www.mentalhealthconsumer.net/FrankGSterlejr

footnote

1. Fitzpatrick, M. (2003, January 23). Police more understanding than public about mental illness, new study finds. *Kingston Whig-Standard*, p. 1.

of crises, which lead to cycling through various parts of the legal, health and social service systems. There is often little benefit to the individual and staggering costs to the multiple service systems and institutions with which they come into contact. Creating and implementing programs that are effective in serving this population, while still remaining flexible and sustainable, has been a challenging endeavour.

Traditional office-based interventions, which require adherence to scheduled appointments, have generally failed to maintain these individuals in the community. Few multi-problem offenders are likely to take advantage of these services on their own initiative. Furthermore, multi-problem offenders have often experienced multiple barriers to accessing services and/or have had very negative experiences with various social service systems, such that trust is very hard to establish with these clients. Finally, the different systems involved may have no history of, or interest in, cooperating or coordinating services—thus, the client is always “somebody else’s problem.”

At VISU, a small group of dedicated staff with backgrounds in probation, health and occupational therapy work from an assertive case management model, building relationships with clients in their own community. A primary focus of the work is building trust, a difficult task for reasons noted above. Once clients have engaged with a caseworker, the team works to stabilize clients by connecting them to services and supports in the community (e.g., housing, employment, obtaining

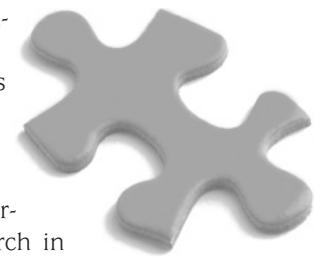
identification, navigating the welfare/disability and health care systems, money management, etc.). This work requires an enormous amount of patience, persistence and skill in negotiating and building trust, and in repairing trust when it is broken.

An evaluation of VISU is currently underway through the Centre for Applied Research in Mental Health and Addiction (CARMHA) in the Faculty of Health Sciences at Simon Fraser University.¹ The evaluation is looking at VISU’s ability to increase the community tenure of its clients, including effectiveness in reducing re-offending and admissions to psychiatric and correctional institutions.

CARMHA is also interested in investigating the active ingredients of change, from the perspective of both VISU staff and clients, and other community agencies. This research will further our understanding of VISU’s niche in the Downtown Eastside community, as well as our understanding of assertive case management in general, and will thus inform future program changes and refinements. **i**

footnote

1. The Centre for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University came into being in January 2006 under the leadership of Dr. Elliot Goldner, Dr. Julian Somers and Dr. Paul Waraich. Formerly part of the Mental Health Evaluation and Community Consultation Unit (Mheccu) at UBC, CARMHA works with provincial, federal and international organizations interested in conducting research on mental health policy.



Michelle Patterson, PhD, RPsych

Michelle is a clinical psychologist who works at the Centre for Applied Research in Mental Health and Addiction (CARMHA), an interdisciplinary research group in the Faculty of Health Sciences at Simon Fraser University. She is currently working on several projects that examine overlap among corrections, mental health and human resources systems

Treating Offenders with Mental Disorders

While crime and prisons are never far from the minds of the media, many dimensions of prison life are little known and often distorted in the eye of the public. Perhaps no other segment of the prison population is as poorly understood as those who suffer from mental illnesses. Typically, they are men and women with major psychiatric disorders—schizophrenia, bipolar disorder, and major depression, for example. An array of developmental disabilities frequently compounds their illnesses and, all too often, they bear the physical and psychic wounds of family violence. Add to these disadvantages substance abuse and you have a formula for individuals who occupy the lowest rungs and maintain the feeblest grasp on our social ladder.

Some offenders with mental disorders are incarcerated in the federal correctional system rather than in provincial mental health facilities because they have been judged responsible for their crimes despite their illnesses. Their histories of abuse often fill the records

of social agencies, police, courts and prisons. They can be dangerous, mostly when not treated; they are often unpredictable and, for the majority, reintegration potential is low. These are the inmates that CSC employees—psychiatrists, psychologists, nurses, and security staff—deal with every day at regional treatment centres across the country.

An Increasing Population

Their numbers are growing. Statistics show that over the past seven years there has been an 80 % increase in the number of inmates who on admission to CSC facilities are taking prescribed medication for a mental health problem. There has been an increase of 61 % over the same time period in the number of inmates who, on admission, report having a psychiatric diagnosis.

Each region has a treatment centre to deal with the most seriously mentally disordered offenders. At the Ontario Regional Treatment Centre (RTC) inside the walls

Bill Rankin

Communications Officer, Communications and Citizen Engagement, Correctional Service of Canada (CSC)

of Kingston Penitentiary, at the time of writing, 114 inmates were being treated. They have been admitted on a priority basis while others, back at their parent institutions, await their turns. Fifty-five are lifers and 99, in total, have little chance of ever being freed on statutory release. They come from institutions across the region where they could not fit or function in the mainstream population. Often preyed upon by more able prisoners, these mentally disabled prisoners get moved into segregation for their own protection, they have withdrawn into themselves or, conversely, acted out in an aggressive manner. By the time they reach the RTC, they are in serious need of further treatment.

The Acute Care Unit

On 1B, the RTC Acute Care Unit, stabilization is the first goal. “Men arrive here in crisis,” says Correctional Supervisor Les Jung. “If we can stabilize them so that they can function within the normal correctional environment and participate in their correctional plan at their parent institution—that is one of our measures of success.”

From a therapeutic angle, the measures are different explains Occupational Therapist Crystal Grass. “Success here is measured not only from a correctional standpoint but by mental health measures from the time they arrive at the acute care ward to the time they are living in a more communal setting, getting up and showering in the morning, holding a job in the institution or going to school. These are the real measures of success from our point of view.”

The Cornerstone of Treatment

Psychiatrist Dr. James Hillen is one of the first of the interdisciplinary team to assess an inmate who presents with symptoms of mental illness. “When they come to me, it’s because they want help. I listen to what they say and, more importantly, how they express it. I’m judging their ability to process thoughts, first by asking them very open-ended questions that require thought organization. In someone with a mental illness, that thought-processing ability has broken down.”

Dr. Hillen says that medication is the “cornerstone” of treatment. The right combination of drugs helps to stabilize inmates so they can once again comprehend their surroundings. “We have no cures for mental illness but we can treat the symptoms very effectively. Medication affects neurochemistry and re-establishes equilibrium within the brain,” Hillen explains.

Not all the inmates are willing partners in their own treatment. Some are so disturbed when they first enter

an RTC that a psychiatrist must certify them as a danger to themselves or others in order for them to be treated without their consent. It takes anywhere from 8 to 12 weeks for patients to stabilize.

Spotting Trouble Early

“Ideally, we try to spot early signs of illness in these men before there is a need to send them to the RTC,” says Dr. Hillen. “If the illness is identified in its first stages and treated, the prognosis is better. The cost of medication is small compared to that of treatment and care later on in the disease process.”

Once stabilized, a patient is moved from the acute care unit to another unit where he can interact with inmates and staff and deal with issues that are part of his correctional plan. He benefits from the expertise of psychologists, social workers, occupational therapists, and others who have special experience dealing with inmates with mental disorders.

Cost-Effective Innovations

In the same vein, medical staff at the RTC, Pacific Institution launched a pilot project for identifying mental illness in its early stages. Psychiatric nurses carried out a comprehensive screening process of all new inmates. RTC interdisciplinary teams (and case management for follow-up) targeted those at greatest risk, and treating their mental health needs became the first priority in their correctional plans. Those requiring immediate psychiatric care were quickly moved from the general population to the RTC before they had a chance to deteriorate.

A secondary benefit of the project: psychiatric nurses were able to deal with their patient’s fears and anxieties, which many new inmates experience when first incarcerated. As a result, correctional officers reported the number of disturbances had dropped inside the reception centre.

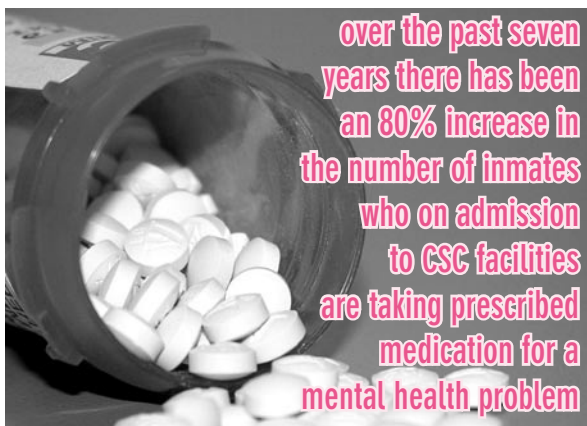
Dr. Art Gordon, Executive Director, Pacific RTC comments, “We were able to reach out to more inmates who otherwise might not get the chance to see a mental health professional. It was an excellent project and we are hoping to get it funded and back in operation.”

A second project in Pacific Region involves two ambulatory psychiatric nurses, Dave Kereliuk and Trevor Nicholl, who last year made more than 1,400 contacts at institutions across the Pacific, following up with inmates who had been treated previously at the RTC. The goal of the project is to assist staff at regional institutions to support and maintain gains that have been made at

margo butler

Correctional Programs Officer, Regional Treatment Centre

► “We focus on the positive and try to build [inmates] confidence. Many of them have had little positive reinforcement in their lives. Although the measures of success are different than those for the general population, the rewards from helping to alleviate the torment of their mental illness are great.”



CX || Larry Sharpe and inmate in 1B

RTC acute care unit

the treatment centre. The nurses will also accept referrals from any institution and pass them along to RTC psychiatrists concerning potential new cases.

“Their input is of great value to the case management team,” says Dr. Gordon. “They make a huge number of contacts; it’s an extremely valuable service that we hope can expand into the community so we can ensure continuity of care. Again, we hope to get funding for this extremely effective and relatively low-cost service to continue.”

The Intensive Healing Program

Moving eastward across the country from Pacific Region to Saskatoon, it is worth noting the work done in the Intensive Healing Program at the Churchill Women’s Unit of the CSC Regional Psychiatric Centre. Its goal is to improve the mental health of women offenders, often through the use of short-term behavioural agreements and monitored behavioural checklists. When treatment goals have been reached, patients are discharged to their home institutions, much as they would be discharged to their homes if they were hospitalized in the outside community. The Churchill Unit is the only CSC-based option for the intensive care of women offenders experiencing episodes of acute mental illness. The Unit has admitted women from each of the five CSC regions, as well as Saskatchewan women on remand, and on provincial sentences.

Audrey Hobman, a program officer in the In-

▶ Despite the daily difficulties in handling inmates with mental disorders on the acute care unit, Correctional Officer II Larry Sharpe balances security enforcement with compassion. He goes out of his way to bring the inmates small comforts and encouraging words. Once stabilized, inmates move out of high-security acute care to a more open environment. Other correctional officers at the RTC, such as Kevin Sweeney, are qualified psychiatric nurses as well as possessing security training. “At the RTC, we have the opportunity to interact with inmates on a more personal level,” he says, “and work closely with medical staff, teachers and parole officers.”

tensive Healing Program comments, “Components of the program have a special Aboriginal perspective due to the large numbers of Aboriginal women participating. We add Native teachings, a touch of humour, and we depend on the counsel of Elders who are an integral part of the program.” Audrey, a Naktotan woman from the Carry the Kettle, First Nation, has shared some of the hardships that many of her patients have been through. She, too, was a part of what Native people call the “1960s scoop” during which Aboriginal children were taken from their families and placed in non-Aboriginal foster or adoptive homes.

“Not only did they lose their families but their language, their culture and their community connections as well. This loss of identity,” says Audrey, “has contributed to their illnesses and to getting into trouble with the law. We help them understand what their family roles can be outside of the institutions and help them prepare to be those things—mothers, daughters, aunties—once they are released. We try to make them see that they are something besides ‘offenders’ and that they can fit in somewhere else.”

Into the Community

Over the years, regional

treatment centres across the country have expanded their roles, arranging interdisciplinary community supports for those about to be released. This is not an easy task; both provincial and municipal resources have shrunk in recent years and psychiatric beds are in high demand. “And there is still the stigma connected with mental illness,” says Ontario RTC Psychologist Dr. Dorothy Cotton. “Ordinary people react with fear to the mentally ill. They often equate their odd appearance or behaviour with danger. And not all halfway houses are equipped to handle these people, nor are they obligated to accept them.”

New Demands on the System

In a presentation to the Kirby Senate Committee on mental health in February 2005, spokespersons for CSC pointed to four areas where new funding is needed: thorough mental health assessments for all offenders at reception; maintaining consistent standards in all five RTCs across the country; establishing intermediate care units in some regular institutions; and creating a community mental health strategy that will ensure continuity of care for inmates once they are released.

Recently, Minister Anne

McLellan announced that almost \$30 million in new funds will be available over the next five years for the community mental health strategy.

The psychiatric problems of federal offenders are numerous, complex and longstanding and the quality of treatment provided by CSC has a direct effect on the success of releases into the community and, ultimately, on the safety of the Canadian public. Despite the many obstacles they must overcome, including increasingly tight budgets, staff at RTCs across the country are working hard to ensure that offenders with mental disorders receive the best care possible. ■

greg kane

Registered Nurse, Regional Treatment Centre

▶ Greg Kane, a 31-year veteran of the Service, is a nurse on 1B—the acute care psychiatric unit—where inmates are first admitted to the RTC, many of them in psychotic states due to full-blown mental illnesses such as schizophrenia. They may be homicidal, suicidal or attempting to injure themselves and require round-the-clock monitoring for their own safety, the safety of staff and for treatment.

“We have some of the most dangerous offenders in the entire country here,” Kane comments. “Staff must use extreme caution in their day-to-day interactions with them. People work in this stressful environment because that’s where they choose to be. They want to be here. And there are benefits: everyone on the team is part of the decision-making process; we take pride in doing our jobs well, knowing that we are effective. We can see the positive results in the inmates.”

Mental Health Court in Ontario

The Honourable
Justice Edward F.
Ormston

*Justice Ormston works at
the Ontario Court of Justice,
Old City Hall, Toronto*

*From Psychiatric Patient
Advocate Office (2003).
Mental Health and
Patients' Rights in
Ontario: Yesterday,
Today and Tomorrow –
20th Anniversary
Special Report at
[www.ppao.gov.on.ca/pdfs/
pub-ann-2002.pdf](http://www.ppao.gov.on.ca/pdfs/pub-ann-2002.pdf)
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Ontario's first courtroom dedicated exclusively to dealing with mentally disordered offenders opened on May 11, 1998, at the Old City Hall Court House in Toronto.

It had become evident to those working in the criminal justice system that the numbers of mentally disordered accused appearing before the courts were increasing drastically. There were a variety of reasons for this. The number of provincial psychiatric hospitals had been reduced. Alternative housing never materialized. A provincial network of clinics to provide medication and monitor patients was nonexistent or inadequate. Homelessness became the most public sign of the problem, while at the same time voters were seduced by politicians who raised the specter of rising crime rates, and more jails and prison were built. The price of mental illness for the homeless became arrest. Jails were the only public institution left open to the homeless mentally disordered 24 hours a day. They were not well served by a justice system seeking efficiency, often falling through the cracks and spending inordinate amounts of time in jail for many offences which were more nuisance than criminal.

A loose coalition of interested parties who experienced this population on a daily basis began to meet. The group included social workers, crown attorneys, defence lawyers, court staff, security, psychiatrists and judges. Eventually a plan emerged. This plan involved the cooperation of the Ministries of Health and Long-Term Care, Attorney General, Solicitor General, Community and Social Services, Corrections, Metropolitan Toronto Police Services and the Centre for Addiction and Mental Health. No new funds were required.

A specific court (102) was provided on a daily basis to deal with mentally disordered accused from Old City Hall and College Park Courts who were in custody and required a fitness hearing before further procedures in the Criminal Code¹ could be triggered. This courtroom had the advantage of adjoining holding cells and office space. This allowed easy access to the prisoner by psychiatrists, social workers, lawyers and families. This also removed the fragile population from the "Bull Pen" atmosphere of the normal cells.

A key feature of the court is the

utilization of people with exceptional competence and interest in dealing with the mentally disordered. The court is non-adversarial; the rules of procedure, decorum, and evidence are relaxed. Everyone, including family members and the accused, participates in the dialogue. Psychiatrists are on-site every day to conduct fitness hearings, speak to families and provide advice to the staff.

Specialized duty counsel and crown attorneys staff the court. Judges who have expressed an interest and have expertise in dealing with mentally disordered offenders sit in the court. Other court staff, clerks, security, and assisting officers have attended educational programs on their own time, given by psychiatrists, on how to deescalate tension in the mentally disordered.

One of the most important components of the court is the on-site presence of Mental Health Court Workers, who facilitate diversion as well as provide a more extensive outreach program to the mentally disordered accused. The Mental Health Court Workers are social workers who have an intimate knowledge of the mental health and social service facilities. They assist the accused in connecting with the appropriate service agencies or treatment centres and follow up any referrals. They also ensure that the accused gets to scheduled appointments and will in general assist with maintaining a higher than usual level of compliance. This aggressive outreach slows down the revolving door phenomenon, which is a conspicuous feature of the mental health system.

Ideally, a mentally disordered accused who is arrested will be identified and sent to the Mental Health Court. He will be seen by legal aid, social workers, and psychiatrists. He will have a fitness hearing immediately followed by a bail hearing. If unfit, a hospital bed will be booked for further assessment or treatment. If fit, the accused will usually be released on bail with terms to deal with risk management, counseling and re-integration. The same procedure applies to those found unfit, once fitness is achieved. The accused is released from custody and ordered to re-attend court on a frequent basis at first, to monitor and encourage compliance. After a period of four to six months, if the accused is stabilized, reintegrated and has not reoffended, the social workers gather supporting documents and speak to the Crown Attorney about staying the charge or agreeing to a non-custodial sentence if the Crown determines the matter cannot be diverted.

This form of "therapeutic jurisprudence" has at its core a philosophy that most of these offenders are not

This form of "therapeutic jurisprudence" has at its core a philosophy that most of these offenders are not evil, but ill. It believes that one of the purposes of the justice system is to heal as well as protect

evil, but ill. It believes that one of the purposes of the justice system is to heal as well as protect. It believes that the accused must be heard and participate in the planning. It believes that positive encouragement, rather than threat, creates a better atmosphere for healing.

The goal of the court is to expedite case processing, create effective interactions between the mental health and criminal justice system, increase access to mental health services, reduce recidivism, improve public safety and reduce the length of confinement in jails for mentally disordered offenders.

The court has dealt with approximately 3000 persons to date. A scientific evaluation has been attempted, but changing circumstances and an unreliable database have hampered it. The empirical feedback has been positive.

The court provides its facilities to the Ontario Review Board upon request. The courtroom is far more convenient for counsel and witnesses and less oppres-

sive for the accused than holding hearings at the jails.

The court is in its fifth year of operation and is facing significant issues and challenges. These include the coordination of treatment for those who have concurrent disorders of mental illness and drug addiction; dealing with the developmentally handicapped; standardizing protocols between the service agencies; and the root problems of lack of housing and poverty.

Should the court be expanded to include the mentally disordered clientele from the other Toronto courts? Should the court include an on-site clinic? Should the court be promoting a "safe house" option for the police, such that the mentally disordered who come in conflict with the law can be brought there, instead of jails or traditional hospitals?

These issues will all be part of the ongoing debate. The court is not perfect, but it is a good start at solving the problems of a mentally disordered person caught up in the criminal justice system. ■

footnote

1. R.S.C. 1985, c. C-46.

Behind the Scenes at a Forensic Psychiatric Clinic

Staff at six Forensic Psychiatric Services (FPS) outpatient clinics across BC and at the inpatient Forensic Psychiatric Hospital (FPH) assess the mental status of people on trial, when the court orders a psychiatric assessment. They determine whether people are mentally fit or unfit to stand trial, or are not criminally responsible due to a mental disorder. The FPH provides in-custody assessments and treatment, and the FPS clinics provide out-of-custody assessments. Clinic staff also offer outpatient support for adults with mental illness who are granted a conditional discharge.

"We supervise people found not criminally responsible or unfit to stand trial, who are living in the community," explains Sheila

Dankwerth, a registered nurse and clinical case manager at the Victoria Forensic Psychiatric Services (FPS) clinic.

The other clinics are located in Vancouver, Nanaimo, Prince George, Kamloops and Surrey. Their multidisciplinary teams include nurses, psychologists, psychiatrists, and court liaison and jail liaison workers.

The Victoria clinic serves an urban area, where clients have fairly ready access to the clinic and community resources. In contrast, the forensic clinics in rural areas, such as the Kamloops and Prince George clinics, cover vast distances and clients may reside in remote communities. Here, staff support clients on an outreach basis and through acting as a liaison with community

service providers.

Under the Criminal Code of Canada, the BC Review Board must regularly review the cases of people, both in and out of custody, found not criminally responsible or unfit to stand trial. For those living in the community, the case manager and psychiatrist produce a report outlining a client's response to treatment, substance use management and integration into community living to help the Board make a decision about future conditions. The Board can order clients who need hospitalization to FPH, or can extend the conditional discharge, which clinic staff continue to oversee.

"We monitor clients' progress in treatment and adherence to the Review Board conditions," says

Dankwerth. "We also assess and treat offenders on bail, probation and parole."

A day in the life at the Victoria FPS clinic

"My morning usually begins with a few appointments at the clinic," says Dankwerth. "When new clients come in, we do an intake assessment to determine their mental health status, substance use patterns and support needs. With regular clients, we discuss how they're doing and what's been happening in their lives to assess whether their mental status and situation are stable. We check on their housing and relationships with friends and family.

"Over the day, I work with my colleagues to provide support services like medication, anger and substance use management.

Lisa May

Lisa is a freelance writer working with BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority that provide forensic psychiatric services in BC

If It Is Not Broken, Then Break It

Changing the way we work with mentally disordered offenders in the community



Just shoot them all!” “We have enough clients without trying to deal with those people.” “Lock them up and throw away the key.” “Put them all back on the bus to where they came from.” These are commonly held sentiments in reference to best dealing with particular client populations. Not surprisingly then, the most significant challenge to doing the work of helping others is the public attitude that exists toward certain client groups—in my case, for example, criminally involved and at-risk youth and adults.

Shelley Cook, MA

Shelley is Executive Director of the John Howard Society of the Central and South Okanagan, located in Kelowna, BC. She has worked for more than 15 years with criminally involved youth and adults in the community and in institutional settings

If public attitude today seems harsher than in the past, there are a few reasons this might be occurring: increased worry about safety and security that comes with an aging population; divisiveness between community stakeholders on how to best address social- and health-related problems; and sensationalized media accounts informing us of the constant threat of crime and violence in our own communities. ▶

Behind the Scenes at a Forensic Psychiatric Clinic | cont'd from previous page

We also update each other on new developments. For example, I might talk to the court liaison worker about a client's experience in court, or with a physician about treatment plans.

“We talk to probation officers as well. Some clients are concerned that what they tell us at the clinic is shared with their probation officer, but it's not. We simply touch base to ensure clients are attending appointments. And I may attend Review Board hearings with a client and psychiatrist, where the living conditions for the next year are set.

“Some days I take new clients for their first visit to Laurel House, a drop-in centre for adults with mental illness, or to pools in the region that offer discounted rates for people on low incomes. We help clients access Vancouver Island Health community

mental health services, like life skills, work readiness, job coaching and drug and alcohol programs. And we link people with the Cool Aid Society's REES Network (Research, Education, Evaluation and Support), which offers training, peer support, education and a casual labour pool that matches people looking for work with employers.”

Concurrent disorders

About 75% of clients have concurrent disorders—a mental illness and substance use problem. Dankwerth is one of many FPS staff who have taken drug and alcohol counselling training in the last year and a half. Now more clients can get counselling quicker, as a result.

FPS conducted three phases of training for clinic and hospital staff across BC:

- **Nearly 300 staff** across BC participated in a

two-day training session to learn the basics about substance use

- **22 specially trained staff** delivered a one-week course to FPS colleagues, so all treatment team members have substance use treatment skills
- **20 staff completed** a Substance Misuse Counselling Diploma program and a 200-hour practicum; they provide one-on-one and group counselling for clients

“I worked with several other community agencies as part of my practicum,” notes Dankwerth. “Most communities are grappling with the social consequences of mental health and addictions, and health authorities are working to coordinate services. Fortunately, the forensic service has done a good job of combining these services.

“Clients often face a range of problems: they may be homeless, poor and have a mental illness and addiction. We try to address the spectrum. We help clients maintain as healthy a situation as possible, recognizing that people often relapse with addictions. Safe shelter is vital, because it's tough to be stable if you don't have anywhere to live.

“Our goal is to help clients get stabilized on the right meds, obtain housing, reduce drug or alcohol use, maintain stable mental and physical health, reconnect with their peers and/or family, build life skills and find work opportunities. Ultimately, we want clients to be able to live independently with support and take better care of themselves. Our job is to support clients to live safely, and help keep the community safe as well.” ■

The majority of people may well recognize the value of innovative programs that address root causes of criminal involvement, such as addictions and concurrent disorders. As a society, we may also appreciate the fact that we cannot solve our social and health-related problems through incarceration. But the allure of simple solutions to complex problems can be very powerful and difficult to resist.

Public attitude and concern is destructive to the goal of making our communities safer when public opinion and not research and best and promising practice, drives the creation of legislation that ultimately serves to punish and further marginalize the disenfranchised. The public expects incarceration to deter crime by teaching people a lesson, but harsh punishments do nothing to address the important factors that contribute to crime, such as addictions, mental illness and other disabilities. Prison will not address any of these issues; it just hides the problem away—for a while.

Public attitudes are also destructive when they encourage increased division between service organizations; when the fear and anger of the community is heaped upon individuals in need of service and, in some cases, on the organizations working to meet the needs of these individuals; and when public education on what will actually work to improve the lives of individuals and the community as a whole is lacking.

Greater public concern and criticism has resulted, however, in some important lessons about the future of services—that is, that they be evidence-based, be comprehensive, and involve a range of organizations and services working together in new partnerships.

The John Howard Society of the Central and South Okanagan has developed the Collaborative Justice Program as a way to build upon lessons learned. The program promotes public involvement and brings together community resources and expertise. It is based upon emerging best practice in the use of meaningful diversion for adults with addictions and/or disabilities such as mental illness. Individualized services are wrapped around high-risk and high-need individuals to address underlying root causes of criminal conduct and to prevent re-involvement with the criminal justice system.

Hand in hand with the development of the Collaborative Justice Program has come public education. In an effort to highlight what is currently having an impact within the mentally disabled offender population, our agency held a public symposium in early December 2005 called Community Restoration and Social Justice: Integration and Collaboration from Criminal Justice to Community.

The one thing that united all the programs featured during the symposium—whether it was the Vancouver Intensive Supervision Unit (VISU), which works with mentally disorder offenders on the Downtown Eastside of Vancouver, or Project Link out of New York State, which deals with repeat offenders with serious and persistent mental health issues—was that these programs are true egalitarian partnerships between departments

and professionals that historically have not worked together. For example, Project Link is a university-led consortium that integrates criminal justice, health care and community support services, and VISU represents a partnership between BC Corrections and the Provincial Health Services Authority. There is willingness on the part of those involved to throw out old service boundaries and also to work together in the space that exists between traditional service lines.

It is clear there is a lot that can be done that works; the aforementioned programs are just two examples. The best thing that we can do as Canadians is prevent individuals with complex health and social needs from getting caught up in the criminal justice system. We need to decide that our criminal justice system will be based on best evidence about what works, and that means resisting the appeal of one-dimensional solutions to multidimensional problems. ■

acknowledgements

John Howard Society would like to acknowledge the Vancouver Foundation and the Central Okanagan Foundation for their financial support of the Collaborative Justice Program. The society would also like to thank the sponsors of our symposium: the City of Kelowna, the law firm of Pushor Mitchell, Interior Savings Credit Union, the Coast Capri Hotel and CS Printmaster.

An International Study of Crime and Violence Risk

Understanding community outcomes of people with serious mental illness

Although violence is a behaviour of concern among people with a serious mental illness, they are far more likely to be the victims of violence than they are to be violent themselves. Data collection for this study included information on victimization; further analyses will explore this topic area.

a number of large population-based studies

have shown increased rates of violent and non-violent criminal offences among people with serious mental illness (SMI), in particular among those with schizophrenia.¹ Additionally, higher rates of schizophrenia have been reported in prison populations than in the general population.² While there is agreement that the social and economic costs of crime and violence are high, few studies have evaluated the impact of treatments and services

on these outcomes.

The goal of the Comparative Study of the Prevention of Crime and Violence by Mentally Ill Persons is to provide evidence-based information that will promote the development of an integrated model of community mental health care—a model that will reduce the risk for violence and crime and help improve outcomes in people with a major mental illness living in the community.

In each of the four participating countries (Canada, Finland, Germany,

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Sweden), patients from civil psychiatric and forensic psychiatric hospitals were invited to participate. Participating patients from each of these hospital types were matched (on age, gender, diagnosis and ethnicity) so that individuals with similar characteristics could be compared across the different systems of care (i.e., civil vs. forensic). Baseline assessments—including chart reviews, interviews with patients and interviews with a family member or caregiver—provided information on social, demographic, clinical and risk variables. Follow-up assessments were completed every six months after discharge for a two-year period.

Participants

Out of a total of 255 individuals participating in the international study,³ 120 were from British Columbia. BC participants were mostly single (94%), Cau-

casian (80%), unemployed (86%), and without a high school education (53%). Most (89%) had previously been hospitalized for psychiatric reasons a number of times (5) and from a young age (24 years). Diagnoses of schizophrenia or other psychotic disorders (91%) and a recent history of substance misuse (56%) were common. About 80% had an adult history of criminal charges resulting in either a conviction or a judgement of not criminally responsible due to a mental disorder (NCRMD),⁴ and 30%, a history of juvenile offending.

Comparing the two groups of patients in the BC sample, the civil (RVH) participants tended to:

- be younger
- have been hospitalized from a younger age and more often
- show more severe psychiatric symptoms, lower levels of functioning and fewer past criminal

...if those with high negative symptoms attend treatment less often, does it suggest that a lack of engagement in treatment may result in poor outcomes? Or does it instead reflect a clinical judgement by treatment providers that their clients are not in need of more services?

offences

- have a shorter stay in hospital and be less likely to get released under an outpatient commitment order (conditional discharge/extended leave)

Community outcomes

Even though BC participants stayed in the community for most of the first year after discharge, one in two (52%) were readmitted to hospital at some point, and one in six (15%) to the hospital emergency room. About one in five participants were violent during this year. With a few exceptions, most violent incidents were not serious.

Amongst 248 males with schizophrenia in the international sample:

- Rates of violence were low in each six-month period—from 6% to 16% of participants. Civil participants were more likely to engage in violence than were forensic participants, but this group difference disappeared once symptoms of psychosis were statistically controlled for.
- After taking into account diagnoses of antisocial personality disorder and past substance dependence, severe positive symptoms

of psychosis (hallucinations and delusions) increased the likelihood of violence. Neither depot (i.e., injected) medications nor outpatient commitment orders (i.e., extended leave or conditional discharge)—both presumed to improve treatment compliance—dampened this relationship.

- A past diagnosis of conduct disorder (CD) was associated with substance misuse, earlier onset of illness, and length of time spent in hospital, and, taking these into account, CD remained an important predictor of violence.⁵
- Amongst 98 BC males with 12 months of follow-up, those with recent substance misuse were four times more likely to be violent in the first year than were those without recent misuse.⁶

Despite the fact that delays in the criminal justice system have resulted in incomplete criminal history data, thus far, about 7% of the BC sample has been charged and either convicted or found NCRMD in the follow-up period.

Service use

In order to properly understand the factors that influence violence and crime, or indeed any hu-

footnotes

1. Brennan, A., Mednick, S. & Hodgins, S. (2000). Major mental disorders and criminal violence in a Danish birth Cohort. *Archives of General Psychiatry*, 57, 494-500.
2. Teplin, L.A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health*, 84(2), 290-293.
3. Hodgins, S., Tengstrom, A., Osterman, R. et al. (in press). A multi-site study of community treatment programs for mentally ill offenders: Design, measures, and the forensic sample. *Criminal Justice and Behavior*.
4. This number is high because half of the BC sample was recruited from the Forensic Psychiatric Hospital, and all of these 60 patients were in hospital as a result of having been found NCRMD for a criminal offence. Another 36 civil patients (60% of this group) also had a criminal record.
5. Hodgins, S., Tiihonen, J. & Ross, D. (2005). The consequences of conduct disorder for males who develop schizophrenia: Associations with criminality, aggressive behavior, substance use, and psychiatric services. *Schizophrenia Research*, 78(2-3), 323-335.
6. Ross, D., Wayte, T., Vincent, G. et al. (2005, November 28-29). A comparison of treatments and services used by civil and forensic psychiatric patients following release from hospital: The BC Aftercare Project. Poster presented at the Mental Health Research Showcase, Banff, AB.

about the study

►The Comparative Study of the Prevention of Crime and Violence by Mentally Ill Persons is an international research project on the community management of risk for crime and violence among discharged civil and forensic psychiatric patients. ►It took place in Canada, Finland, Germany and Sweden between 1998 and 2005. ►The international project was headed by Dr. Sheilagh Hodgins, a professor and chair of Forensic Mental Health Sciences at the University of London (England), and was funded by the European Economic Community's Biomedical II grant program. ►In Canada, patients were recruited from the Forensic Psychiatric Hospital (FPH) and Riverview Hospital (RVH), both provincial psychiatric hospitals in British Columbia. ►The BC project site was headed by Dr. Stephen Hart of Simon Fraser University. ►BC site funding was generously provided by Riverview Hospital, the Forensic Psychiatric Services Commission, and Simon Fraser University's Mental Health, Law, and Policy Institute.

man behaviour, we must look beyond the factors that lie within the individual. Amongst people who are living in the community, we must attempt to understand what in the community is contributing to these behaviours.

One important aspect of community living for people with an SMI is the use of mental health services. Recent studies have suggested that most people with a diagnosable mental illness do not seek help, and that certain features (e.g., gender, age, diagnosis) influence service use.⁷ This suggests that not all those who might benefit from services are actually getting them.

Among BC participants in this study, the use of mental health services was high—all were seen by a mental health professional and most (77%) attended services twice per

week or more. However, there are indications of gaps in service, as suggested by the following:

- Although both groups showed similar rates of service use generally, the forensic outpatients were more likely than the civil outpatients to attend group therapy and to use psychologists' services.
- Those who used services most intensely were likely to be less educated, unemployed, with high positive symptoms of psychosis (e.g., delusions) and low negative symptoms (e.g., withdrawn), suggesting the possibility that those with more education and employment, and those with higher negative symptoms, may not be obtaining needed services.⁸
- Those with recent substance misuse

were eight times more likely to attend self-help groups—suggesting a willingness to address their substance use—and yet they were six times more likely to visit hospital emergency rooms—suggesting poor outcomes in these individuals despite attending treatment.

Next steps

The research team aims to transfer knowledge gained from this study to mental health policy and service provision for people afflicted with an SMI. Future analyses are needed to better understand gaps in service and unmet need. For example, if those with high negative symptoms attend treatment less often, does it suggest that a lack of engagement in treatment may result in poor outcomes? Or does it instead reflect a clinical

judgement by treatment providers that their clients are not in need of more services? In order to tease apart these relationships, we need to take into account outcomes (e.g., violence), as well as treatment non-compliance. A better understanding of gaps in service within certain subgroups of people will provide useful information for effective discharge planning and for community-based service provision that is tailored to meet the needs of all consumers.

Finally, while it is important to establish what factors predict outcomes such as violence and crime in this population, future efforts need also to examine factors that 1) protect people from such outcomes, and 2) contribute to positive outcomes in spite the challenges of living with an SMI. **i**

footnotes

7. Vasiliadis, H., Lesage, A., Adair, C. et al. (2005). Service use for mental health reasons: Cross-provincial differences of rates, determinants, and equity of access. *Canadian Journal of Psychiatry*, 50(10), 614-619.

8. *Positive symptoms* are characterized by an increase or distortion in some normal function or by experiencing something unusual (e.g., hallucination or delusion). *Negative symptoms* are characterized by a decrease in, or loss of, some 'normal' function or an individual's normal level of functioning (e.g., withdrawing socially). These terms are used most often in reference to psychosis and schizophrenia, but can also be used to describe depression or dementia. See the PANSS Institute website at www.panss.org for more information.

For further information about this project, contact Deborah at 604-524-7301 or dross@bcmhs.bc.ca



Street Crime and Social Disorder in Vancouver

In March 2002, a Justice Review Task Force was created to find ways to make the justice system more responsive, accessible and cost-effective. One priority of the Justice Review Task Force was to respond to concerns about street crime in Vancouver. People who live and work in Vancouver had been expressing serious concerns about street crime such as open drug use and dealing, auto theft and other property crimes. Some also expressed concern about social disorder, such as public mischief, panhandling, people sleeping in doorways and alleys, and people on the street who appear to have symptoms of mental illness.

In March 2004, the Justice Review Task Force formed the Street Crime Working Group to examine the street crime problem and identify possible solutions to street

crime and social disorder in the downtown Vancouver peninsula, bordered on the east by Clark Drive. The 14-member Street Crime Working Group included representatives from all levels of government, judges, lawyers, police, and corrections and social service providers.

What the Street Crime Working Group did

The Street Crime Working Group held public consultations, meetings and interviews with Vancouver residents, business owners, police and other justice system staff, and health care and social service providers. The Working Group also reviewed information and statistics from police, courts, and the health care system. The purpose was to find out how much street crime there was in Vancouver, what type of people were committing street

Sherri Lee

*Sherri Lee is a senior policy analyst with the Criminal Justice Reform Office of the Ministry of Attorney General. Sherri collected statistics, compiled information from consultations, and developed a needs assessment, which informed the Street Crime Working Group's report, *Beyond the Revolving Door*.*



crimes, and what could be done to reduce the street crime.

The Street Crime Working Group also heard from people who have mental health problems, those who have drug addictions, and some who have both a mental illness and a drug addiction. These people talked about their experiences with the criminal justice system. Some said they committed crimes to support their drug addiction. Others believed they had committed crimes because their addiction or mental illness caused them to engage in risky or irrational behav-

our. Many said they felt that people who work in the justice system do not understand mental illness and addiction issues.

The relationship between chronic offending and health and social challenges

Based on information that the Street Crime Working Group collected from these consultations and from justice and health care statistics, it became clear that many of the 'chronic' street crime offenders struggle with health and social problems such as a drug or alcohol addiction, mental illness or homelessness. Chronic offenders are people who have been charged with five or more criminal offences in one year, or have had five or more criminal convictions in the last four years.

The justice system was not designed to deal with health and social problems and generally does not work closely with health and social service systems. Therefore, offenders who have mental health issues or addictions, or who are in need of social supports, often do not receive the treatment and support they need to break their cycle of crime. Since their health and social problems are not being helped, they continue to experience problems that may lead them into trouble with the criminal justice system over and over again.

Recommendations

The Street Crime Working Group's report was released in October 2005. The report contains recommendations that are aimed at:

- Getting justice, health and social services systems to work more closely together
- Giving residents, business owners and other community members opportunities to participate in the justice system
- Identifying and separating offenders who should be

in jail from those who could be helped by treatment, services and supports

The recommendations are focused on Vancouver, but if the recommendations work in Vancouver, they might be considered for other areas of the province.

A 'community court' is recommended

One recommendation is to create a community court in Vancouver. A community court is a special type of problem-solving court that responds quickly and meaningfully to offenders. A community court:

- Involves a judge, prosecutor, defence lawyer, probation officer, community coordinator who acts as a link between the court and the community, and a health coordinator who acts as a link between the court and health services—all working together, and with the community, to find the most effective responses to the crime and the offender
- Ensures that the judge has all the necessary information about the offender and the circumstances of the case to make meaningful decisions
- Helps offenders connect with a wide range of health and social supports, including drug treatment, mental health services, housing, financial assistance and other supports

How is the community involved in the community court?

The community is involved by:

- Participating on the community advisory board and letting the justice system know what their biggest crime concerns are
- Identifying the kinds of community work service that offenders could do to help the community
- Working with justice, health and social services system staff to develop solutions to street crime-related problems

When will the Street Crime Working Group's recommendations be put into action?

Some of the recommendations have already been put into action. For example, justice and health partners have been working together to develop a coordinated health and justice response to chronic offenders in Vancouver who have mental health or addiction issues.

Many of the recommendations require the cooperation of other partners, such as the police, health and social service agencies, and the community. The Ministry of Attorney General has started meeting with these partners to talk about how the recommendations could be put into practice. These discussions will continue over the next year, as government and non-government partners work together to take action against street crime in Vancouver. **i**

The report is available online at www.bcjusticereview.org/working_groups/street_crime/street_crime.asp

Searching for Justice

Mental Health Advocacy in the Court System

a man with a mental illness has been yelling and causing a disturbance in a public place. Out of fear, someone calls the police, who arrive at this street in a usually quiet neighbourhood. The man is frightened, agitated and reacting negatively to people in uniform because of previous trauma and fixed delusions. The police are uncertain what to do in this situation: they could either take him to the local hospital and have a long wait in the emergency department, or they could arrest him and take him to the police station.

The man is arrested and taken to jail. The jail cells are cold, loud and confined. It's midnight, and the man with mental health issues is being held in custody to await a bail hearing the following morning. Noises and voices echo in the halls and adjacent cells; bright lights accentuate the harshness of the stark environment. The man has been fingerprinted, has had his photo taken and is sitting in a single cell under observation because of his unusual and difficult behaviour. He is wearing a white paper suit, and his belongings have been taken from him.

This is a scenario for many clients who are introduced to the services of the Motivation, Power and Achievement Society (MPA)

court program. As advocates at the Vancouver Provincial Courthouse, we work as liaisons between our clients and the various links in the criminal justice system. Even for a person who is not suffering from a mental illness, the criminal justice system is intimidating, confusing and overwhelming at the best of times.

A court worker will visit the person with mental illness and identify what issues need to be addressed. Do they have a lawyer? Do they have legal aid coverage? Do they receive treatment or care in the community? Do they know where they are? Do they have a home? Do they have a family?

MPA court workers assist in making appropriate arrangements to get an individual oriented within the court system and then supported in the community if released. If they have never been charged before, we will explain the court process to them. If they need counsel, we will help to organize the assistance of an experienced, knowledgeable and compassionate lawyer. If housing is required, we will try to secure shelter so that the courts will be more likely to release a person on bail, rather than keeping them incarcerated (since having shelter is usually a requirement of attaining bail).

It is our job to make the court system become more manageable in the minds of people who may be anxious and frightened or experiencing psychiatric symptoms—to make the process as easy as possible for our clients, in an effort to maintain a sensitive and accessible service for consumers.

In the event that a person is so acutely ill that they are unable to understand court proceedings, MPA court workers will assist in arranging other procedural options, such as forensic assessments, to enable the courts to make appropriate release decisions. These assessments also help to engage clients with the mental health system, and to receive the treatment and care necessary to stabilize them in the community. This step is also very helpful in reducing the likelihood that a person will reoffend.

The MPA Society is a nonprofit organization that advocates for persons with mental illness. Our court services program has been in existence for more than 20 years. There are three court workers on staff who diligently assist the courts in making decisions on behalf of our clients around bail, probation and, sometimes, sentencing conditions. To complement the program, three other staff members provide outreach services. They help

consumers make court appearances, bail and probation appointments, and doctor appointments, and also help clients to access housing and financial services.

Education is another component of our service. On a daily basis, the court workers find they must provide information to various people in the courthouse and in the community. Often, this information is related to mental illness and the issues our clients are dealing with as a result of their situations. We also conduct presentations to organizations about what we do as advocates for mentally ill people in the criminal justice system.

It is vital that we reduce the stigma surrounding mental illness and, wherever possible, advocate for those who need help in having their voices heard. ■

Liz Roberts

Liz is Supervisor for the Motivation, Power and Achievement Society court services project. She and her team advocate for consumers who are charged with criminal offences filed at the Provincial Courthouse in Vancouver

“even for a person who is not suffering from a mental illness, the criminal justice system is intimidating, confusing and overwhelming at the best of times.”



BC's Forensic Psychiatric Hospital

Lisa May

Lisa is a freelance writer working with BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, which provides forensic psychiatric services in BC

For more information, visit www.bcmhas.ca

When someone with a mental illness goes on trial for committing a crime, the defence lawyer or judge can call the client's mental status into question. With the defence lawyer's consent, the judge can order a psychiatric evaluation to determine if the defendant is able to understand that committing the crime was wrong, or if the defendant is mentally fit to stand trial.

"At that point, court proceedings stop, and the defendant is referred for a psychiatric assessment," explains Clem Poquiz, clinical services manager at the 190-bed inpatient Forensic Psychiatric Hospital (FPH) in Port Coquitlam. "The judge can order an in-custody psychiatric assessment at FPH, or an out-of-custody assessment at one of our six outpatient clinics in the province. The decision depends on the level of concern about the defendant's mental status and risk management issues."

FPH serves adults 18 and older who are remanded for assessment and/or treatment in a secure inpatient facility. It's the only hospital in BC for patients in custody, with people referred from throughout the province.

When an in-custody assessment is ordered, the sheriff transfers the patient to FPH. A nurse meets new patients, takes their history, and provides new clothes. Personal belongings are stored until patients are ready to leave the hospital. Staff escort male patients to the 22-bed remand unit and show them around. FPH has a separate remand and treatment area for women, who account for 20% of cases. Each patient has a private room. Staff members provide a general orientation of the units and regular routines such as meal times, activities and family visiting hours.

"We try to make patients as comfortable as possible," says Poquiz. "Some people are quite ill when they arrive and want to be left alone, but we give them a lot of support and supervision. Others may be anxious and not understand why they were sent here."

"The courts give us up to 30 days to complete a psychiatric evaluation, although this period can be extended in complex cases. Psychiatrists, social workers and nurses work together to assess whether a patient was mentally disordered at the time their crime was committed. The most common diagnosis is schizophrenia, and about 75% of our patients have concurrent disorders—a mental illness and substance use problem."

A psychiatrist then writes an evaluation report for the court, with one of four recommendations:

- The person is mentally unfit to stand trial (in other words, not able to understand the impact of the crime)
- The person was not criminally responsible due to a

mental disorder (NCRMD); for example, someone was delusional

- The person understood the crime would cause harm
- The person understood the nature of the crime, but has a mental disorder, and follow-up care through a forensic clinic is suggested

This report goes to the court registry, which schedules a court date. The accused may travel between the court and hospital, or participate through videoconference if the courtroom is far away.

For a mentally unfit or not criminally responsible verdict, a judge can order the patient to stay at FPH for treatment. FPH has three levels of security: secured, closed and open. Patients move to the next level as they become more stable, and have greater access to privileges. Eventually, patients live independently in onsite houses, doing their own laundry, budgeting and cooking. The entire facility is surrounded by a monitored fence, but is situated in a park-like setting.

"Our treatment teams develop individual treatment and rehabilitation plans," says Poquiz. "The BC Mental Health Act gives us the authority to order medication for our patients, and our psychiatrists have access to some of the most up-to-date psychotropic medications."

"We offer a number of drug and alcohol counselling programs, psychotherapy, anger management groups, occupational therapy, music therapy, and vocational and social skills programs."

For example, patients can attend school at FPH, take computer training, learn woodworking, work out in the gym, watch TV and read in a quiet room.

The BC Review Board regularly reviews patients found NCRMD or unfit to stand trial. The Board decides whether patients need to stay at the hospital for additional treatment, can reintegrate into the community with supervision, or are ready for an absolute discharge with no limitations, based on their progress and stability. Before release, the Board must be convinced the patient no longer poses a significant risk to public safety.

"Our goal is to manage patients' risk by stabilizing their mental state and behaviour so they can reintegrate into the community," says Poquiz. "When patients are ready to return to the community, we link them with support staff in our regional forensic clinics and community mental health teams. We also help them find work and volunteer opportunities at agencies in their home communities. And if someone isn't doing well in the community and requires hospitalization, we have a safe, efficient process for returning them to FPH." ■

related resource

BC Schizophrenia Society and Forensic Psychiatric Services Commission. (2004). *Forensic Psychiatric Services: Information for Families*. www.bcss.org/support_centre/information_for_families or call 1-888-888-0029

General Resources

- Ministry of Attorney General, Criminal Justice Branch. (2003). **Mentally Disordered Accused and the Justice System in British Columbia**: www.ag.gov.bc.ca/public/criminal-justice/mentallyaccusedWEB.pdf
- Canadian Mental Health Association. (2004). **Citizens for Mental Health Project: Criminal Justice**. Backgrounders and helpful links: www.cmha.ca/citizens
- **Crime Scene**. Free newsletter of the Canadian Psychological Association, Criminal Justice Section. www.cpa.ca/CJS/CJS_Publications.html
- **National GAINS Center**: gainscenter.samhsa.gov. Funded by the US federal government, provides information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system.
- **Criminal Justice/Mental Health Consensus Project**. www.consensusproject.org. Coordinated by the Council of State Governments (US).
- Kupers, T. (1999). **Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It**. Jossey-Bass. At Chapters Indigo and Amazon.
- Hartwell, S. (2004). **Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system**. *Criminal Justice Policy Review*, 15(1), 84-99.
- *Behavioral Sciences & the Law*. Special Issues. **Co-Occurring Disorders and the Criminal Justice System**. (2004), 22(4); **Diversion from the Criminal Justice System**. (2005), 23(2).

Organizations

- **John Howard Society of BC**: www.johnhoward.bc.ca. Society offers a wide range of programs and activities for adults and youths involved in conflict with the law. Nine regional societies operating in 15 communities throughout BC.
- **Canadian Association of Elizabeth Fry Societies**: www.elizabethfry.ca. Network of community-based agencies dedicated to offering services and programs to marginalized women, advocating for legislative and administrative reform and offering fora within which the public may be informed about, and participate in, aspects of the justice system that affect women.
- **Canadian Criminal Justice Association**: www.ccja-acjp.ca. National voluntary organization promoting rational, informed, and responsible debate in order to develop a more humane, equitable, and effective justice system.
- **Canadian Families and Corrections Network**: www3.sympatico.ca/cfcn. Coalition of individuals and organizations affirming the importance of families in the Canadian criminal justice process. Services include a toll-free information and referral for families affected by incarceration and reintegration (1-888-371-2326), education, policy and program development, and Visitor Resource Centres.

- **Justice Institute of BC**: www.jibc.bc.ca. BC leader in justice, public safety and human services education and training. A number of programs and services relevant to mental health and substance use issues as they pertain to police training, dispute resolution, corrections and community justice.
- **Native Courtworker and Counselling Association of BC**: www.nccabc.ca. Helps Aboriginal people in conflict with the law and ensures they participate fully in the justice system through a holistic approach to prevention and intervention.
- **Motivation, Power and Achievement (MPA) Society**: 604-482-3700. Court workers give assistance during the criminal court process to clients with a mental health disability who are charged with a criminal offence at Surrey or Vancouver Provincial Courts.

this list is not comprehensive and does not imply endorsement of resources

Legal Resources

- **Community Legal Assistance Society (CLAS)**: www2.povnet.org/clas. Seeks to reform laws relating to people who are economically, socially, physically, and mentally disadvantaged. Operates a UBC-based legal advice program and a drop-in legal resource centre (Vancouver). 604-685-3425 or 1-888-685-6222.
 - » CLAS Mental Health Law Program. Provides free legal representation for mental health patients at review panel/board hearings. Takes on test cases, charter cases, and human rights cases concerning mental health law.
- **Legal Services Society**: www.lss.bc.ca and www.lawlink.bc.ca. Nonprofit society. Offers legal aid to BC residents with low incomes. Provides services through seven regional centres at more than 20 local agent offices across BC; operates a provincial LawLINE phone service and LawLINK website. Services include referrals to lawyers, brief legal advice, and legal information (print, online, or by phone). 604-408-2172 or 1-866-577-2525.
- **Law Courts Education Society**: www.lawcourtsed.ca. Nonprofit society. Provides educational programs and services about the justice system in Canada and BC and helps the public understand how the justice system works.

Reports, Articles and Tools

- BC Justice Review Task Force. (2005). **Beyond the Revolving Door – A New Response to Chronic Offenders: Report of the Street Crime Working Group to the Justice Review Task Force**. www.bcjusticereview.org/working_groups/street_crime/street_crime.asp
- Livingston, J.D., Wilson, D., Tien, G. et al. (2003). **A follow-up study of persons found Not Criminally Responsible on Account of Mental Disorder in British Columbia**. *Canadian Journal of Psychiatry*, 48(6), 408-415. Full text at www.cpa-apc.org/Publications/Archives/CJP/2003/july/livingston.asp ►

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- Hemphill, J.F. & Hart, S.D. (2001). **The assessment and treatment of offenders and inmates: General considerations.** In R.A. Schuller & J.R.P. Ogloff (eds.), *Introduction to psychology and law: Canadian perspectives*. Toronto: University of Toronto Press.
- Canadian Centre for Justice Statistics. (2002). **Special Study on Mentally Disordered Accused and the Criminal Justice System.** [www.statcan.ca/english/freepub/85-559-XIE/85-559-XIE00201 .pdf](http://www.statcan.ca/english/freepub/85-559-XIE/85-559-XIE00201.pdf)
- **Correctional Service of Canada – Addictions Research:** www.csc-scc.gc.ca/text/rsrch/addictions/publicat_e.shtml
- **Proceedings of the 29th Canadian Congress on Criminal Justice.** (2003). Focus in addictions, drug policy and concurrent disorders. View index or order at www.ccja-acjp.ca/en/report.html
- National GAINS Center (US). **Brief Jail Mental Health Screen for Incoming Detainees.** Free, downloadable, evidence-based: gainscenter.samhsa.gov/html/resources/MHscreen.asp.
- World Health Organization. (2000). **Preventing Suicide: A resource for Prison Officers:** www.who.int/mental_health/media/en/60.pdf

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Special Populations (FASD, Youth, Aboriginal, Women)

- **FASD Connections – Justice and Legal Issues Links:** www.fasdconnections.ca/id84.htm
- Canadian Department of Justice. (2004). **Fetal Alcohol Spectrum Disorder and the Youth Criminal Justice System: A Discussion Paper.** www.justice.gc.ca/en/ps/rr/rep/2003/rr03yj-6/rr03yj-6_01.html
- American Bar Association Juvenile Justice Centre (2000). **Mental Health Assessments in the Justice Sys-**

- tem: How to Get High Quality Evaluations and What to Do With Them in Court.** Module 3–Understanding the Adolescent: A Juvenile Court Training Curriculum. www.njdc.info/pdf/maca3.pdf
- Erickson, P.G. & Butters, J.E. (2005). **How does the Canadian juvenile justice system respond to detained youth with substance use associated problems? Gaps, challenges, and emerging issues.** *Substance Use and Misuse*, 40(7), 953-973. Special issue: Innovative Strategies in Working with High Risk Youth.
- Howell, T.M., and Yuille, J.C. (2004). **Healing and treatment of Aboriginal offenders: A Canadian example.** *American Journal of Forensic Psychology*, 22(4), 53-76.
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Journals

- International Journal of Forensic Mental Health
- Behavioral Sciences and the Law
- Canadian Journal of Criminology and Criminal Justice
- Criminal Behavior and Mental Health
- Criminal Justice and Behavior
- International Journal of Law and Psychiatry
- Law and Psychology Review
- American Journal of Forensic Psychiatry
- Psychiatry, Psychology and the Law
- Journal of Forensic Psychiatry and Psychology
- International Journal of Offender Therapy and Comparative Criminology