

4th Annual Training Conference Notes:

Day 1: Wednesday October 25, 2006

Welcome to Participants

Mr. Larry Cook: Association Coordinator



Conference Opening Comments

Mr. Art Rasmusson: Association Past-President

- Welcome to participants. Since our work is important and challenging it's good to have an opportunity for everyone to get together and get other perspectives (community, political & personal).
- In early 2006, OHHA members discussed the overuse of Statutory Release with Residency Condition with CSC. It was noted that this is overused in ON & QC so discussions will take place on an annual basis with CSC. Also discussed ways to be able to identify contractual renewal process for CRF's and identify the process with CSC District Directors. It was requested that CRF's be allowed input in contract talks.
- Conference enables people to network and get to know their colleagues. Participants introduced selves to the larger group.
- Encourage all participants to get involved, interact and challenge each other to be better at what we do.



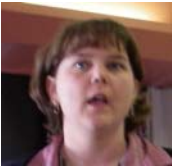
Message from the National Parole Board

Marie Andree Drouin: National Parole Board

- Commended CRF's for having an annual meeting to discuss a critical job. CRF staff deal with offenders during critical phase of their lives. Offenders often have extreme expectations to make up lost time and they can become frustrated.
- Messages from NPB colleagues: people can change if given the right support at the right time.
- Ms. Drouin shared her experience of working during the opening of Grand Valley Institute when staff were new and had no experience working with offenders. Marie-Andree Drouin played the role of offender and was handcuffed and put into segregation two hours, which helped her to realize that it's easy to forget what freedom is about. Although it is difficult to reintegrate it is better than incarceration.
- NPB and CRF's share same purpose in helping offenders reintegrate. The CRF's play a critical role in risk management. Ms. Drouin inquired as to whether or not the NPB decisions and all other important information is passed down for Community Assessment

meetings and indicated that the best tool is information. The NPB have to link conditions to the offender's risk level so CRF's need to know the context of which release is granted.

- CRF's need continued opportunities to share information. Ms. Drouin indicated that when she worked as a PO at the House of Hope she would have Monday night supervision meetings at the CRF and indicated this worked well.
- Ms. Drouin indicated that the NPB finds it helpful to get the CRF's factual, risk-related reports when there is a withdrawal of support. It is also helpful in post suspension hearings to have first hand information from the CRF's, especially when the offender waives the hearing.
- Since CRF's and the NPB have to make difficult decisions, it is important to be objective. If the safety of the community in is in jeopardy, it can't be ignored, even if the offender is doing well.
- Board members and hearing officers have attended CRF's in Hamilton and Toronto to sit in on CAT meeting and were very impressed. Message from the NPB was that CRF's are welcome & encouraged to attend board hearings.
- In past year longer UTA's have been requested by CRF's but message from the NPB is that it is difficult to justify the structure of longer UTA's. Want more sustained information from CRF's prior to granting such a request.
- In regards to post suspensions, the NPB are happy to received detailed info from the CRF's when contraband has been found following a suspension. NPB encourages CRF's to do thorough house checks while the offender is still residing there, as it will provide a better indicator of how he is doing in the community.
- Statutory release with residency - 24% of SR offenders will have residency imposed. Residency stays until WED. Should ability and compliance change and a positive submission is received, the board will review to have it lifted.
- Opened floor to questions on how NPB can help make CRF's jobs easier:
- Has board changed criteria for SR residents? – No, the criteria is the same for initial imposition. Problem is things change and they may not need residency after a period of release. SR residents- would be helpful if the NPB would outline the conditions in which the board would favourable review these cases for lifting the condition- if see the person is really trying to add dynamic risk factors. Have to be careful to not commit to a time frame. But will look at – compliance to conditions, and stability (demonstrating responsibility.) Ultimately it is up to CSC to make the submission. CRF's need to encourage CSC and demonstrate that he has been doing well.
- Is six months the minimum amount of the time the board would consider stability?
 - Depends on case, but six months is the average for DP, so this is a good time frame to go by. Some may need longer. For example, an offender with 35 years of violent offending versus six months of doing good may not give an accurate picture.
- Trend has been happening towards panel hearings. What should CRF's recommend? - Panel hearings slow the process down but it is in the offenders' best interest to have a panel hearing. Offender can input in a different perspective from what is on file. For more serious offences board usually prefers to have panel hearings and may request it. They want detailed information on escalation of risk or details about deteriorating behaviour.



Working with Special Needs Offenders in a Residential Setting

Michele Murray and Paul Fernane



Cody Centre

Cody Centre is solely for federal offenders, which consists of:

- 18 federal beds
- No exclusionary criteria

Gallagher Centre

Gallagher Centre is a multi-use facility which consists of:

- 3 provincial beds (Supported Independent Living Program – S.I.L. Program)
- 3 mental health crisis beds
- 8 federal beds

Supported Independent Living Program (S.I.L.) – Program Goals

- Assisting persons with developmental delays and/or mental health issues address behaviours related to becoming involved in the criminal justice system
- Residential and Non-residential support services are available to address identified need areas in the community.

S.I.L. Program – one to one counselling

- Relapse Prevention – addressing behaviours connected to becoming re-involved in the criminal justice system.
- Living Skills – problem solving and coping skills; daily living skills such as cleaning, hygiene, etc.

S.I.L. Program – Community Participation

- Relapse Prevention – accessing community activities to address relapse prevention goals.
- Group activities – developing a positive support network.
- Personal Development – awareness of community activities; developing a leisure/activity network.

S.I.L. Program – Community Supports

- Professional Support – Medical/psychological and/or social work treatment.
- Resource Support – assisting with government support programs (ODSP/Ontario Works, etc.); educational/vocational training; community agency programs.

Mental Health Program

- Gallagher Centre provides 3 short-term residential beds to persons with a mental disorder.

“...a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom....”

DSM-IV

Mental Health Program

- Priority is given to those persons diagnosed with a serious mental illness, who are experiencing a crisis, and assessed as appropriate for stabilization in the community.
- Mental health and offender risk management needs will be addressed.
- The service will be provided for up to 30 days and will involve crisis counselling, risk management, and the co-ordination of service provision within the mental health, social service, and criminal justice fields.

General Mental Illness Information

Myths & Stereotypes

- People with a mental illness are violent and dangerous – as a group – people with a mental illness are no more violent than any other group. They are actually more likely to be the victims of violence.
- “Violent acts committed by persons with mental illnesses represent a small fraction of the violence perpetrated in our country, yet these acts are frequently highly sensationalized by the media and lead to the continued stigmatization of persons with mental illness.”
 - National Mental Health Association-

Myths & Stereotypes

- People with a mental illness are poor and/or less intelligent.
- Most mentally ill people have average or above-average intelligence. Mental illness can affect anyone regardless of intelligence, social class or income level.
- Mental illness is caused by a personal weakness.
- Mental illness is not a character flaw, it is an illness. It has nothing to do with being weak or lacking will power. Individuals with a mental illness did not choose to become ill and they are not lazy just because they cannot snap out of it.

Myths & Stereotypes

- Mental illness is a single, rare disorder.
- Mental illness is not a single disease but a rather broad classification for many disorders i.e. anxiety, depression, schizophrenia, personality disorders, etc.
- What you can do to fight stigma
 - Educate yourself
 - Watch your language
 - Talk openly about mental illness
 - Speak up about stigma
 - Provide support for agencies that fight stigma
 - Listen to people who have experienced mental illness

How to work with someone who has a mental illness

- Avoid being judgmental – keeping an open mind may help to create a safe environment where they are able to relax and enjoy themselves.
- Talk about what they find helpful – try asking what helps them when things are tough.
- Respect their limits – There may be times when the individual is not able to do something because of their illness. It is important to respect this and not put pressure on them.

How to work with someone who has a mental illness

- Encourage the individual to stay on their medication – the medication may have side effects, which the individual may not like and therefore may not want to take the medication. However, medication is often a crucial part in managing the illness.
- Provide the individual with contact numbers – 24 hr. crisis lines, etc.

How to work with someone who has a mental illness

- Afford the same respect to persons with a mental illness as you would to anyone else.
- Take a strength-based perspective.
- Do not try to cure or rescue the person.
- Do not take things personally; do not get frustrated.
- Be patient
- Demonstrate empathy and genuineness
- Be upfront with clients regarding suicide, etc.
- Watch your language
- Watch your pace and body language
- Reality checks

Individual expressing thoughts of paranoia/delusions/hallucinations

- Reassure client safety
- Help the person separate out what he or she cannot control.
- Sort out those things that could have some basis in reality.
- Anticipate problems
- Communicate honestly
- Avoid confrontation
- Encourage Independence

Individual who is experiencing depression

- Offer them emotional support, patience, and encouragement.
- Encourage participation in activities that once gave them pleasure
- Acknowledge achievements
- Do not state that you understand
- Understand that the person will have ups and downs
- Do not allow the individual to isolate him or herself.

Individual who is experiencing anxiety

- Engage in active listening
- Maintain eye contact and sit in a relaxed position.
- Use open-ended questions.
- Remain calm
- Anticipate problems

Residential Crisis Support Beds MH Program Goals

- Prevent incarceration
- Prevent hospitalization
- Provide stabilization
- Provide a safe environment

Referral Process

Mental Health Program – Referral Criteria

- Adult Males (18yrs and older)
- Diagnosed with a serious mental illness and/or are considered to have a mental disorder
- A) Currently experiencing a crisis that puts the person at risk of becoming involved in the criminal justice system or hospitalization as a result of mental health symptoms
or
B) Currently detained following charges and are eligible for diversion or bail, whereby the person can be managed in a short term residential program to avoid incarceration while safely addressing crisis factors.

Filling a Gap in Service

- Individuals do not need a confirmed diagnosis
- Many individuals have been banned from a number of other agencies.
- A blending of corrections and mental health.
- History of violence does not exclude an individual.

Challenges

- Discharging clients to the community who have been banned from numerous agencies within the community.
- Criminalization of the mentally ill
- Housing
- Medications
- GP/Psychiatrist
- Source of Income – due to living at Gallagher they get cut off of Ontario Works (OW) and Ontario Disability Support Program (ODSP)

Type of Support that is Provided to a Client in the MH Program

- Take clients to appointments
- Assist with Activities of Daily Living (ADL) i.e. cooking, laundry, cleaning, etc.
- Assist with filling out proper paper work for financial support
- Formally meet with the individual on a daily basis

Type of Support that is Provided to a Client in the MH Program

- Assist with medication regime
- Connect the individual with other agencies
- Check in with the individual on a regular basis regarding thoughts or self-harm
- Provide crisis intervention as required

Referral Sources

- ACT Teams
- Addiction Services of Thames Valley
- Canadian Mental Health Association
- Correctional Services Canada
- Crisis Service

- Family Service London
- Hospitals
- Lawyers
- London Police Services
- Men's Mission
- Nokee Kwe
- Probation
- Salvation Army
- Self
- Street Outreach London East (SOLE)
- Withdrawal Management Centre

How do we make risk manageable?

- Staffing Model
- Significant amount of time is spent with client
- Training
- Awareness
- Contracting
- Keep things concrete and simplistic
- Medication compliance

Client X

- Was referred by his probation officer
- Current offence is for criminal harassment against a social worker
- Client X has a lengthy criminal history which dates back to 1987, which includes 4 prior assaults (one involving assault on peace officer), arson, mischief (x10), fail to comply (x10), possession of a weapon, criminal harassment, theft, and possession of B&E tools
- Has been diagnosed with paranoid schizophrenia
- Has a public guardian and trustee
- Has a lengthy history of living on the streets, un-medicated
- Recently kicked out of his residence i.e. supported group home
- Has been banned from Regional Mental Health Care (RMHC), Assertive Community Treatment Team (ACTT), Men's Mission, Salvation Army, Unity Project.
- Attempted suicide in the past by burning self with gasoline
- Some family support
- Result – Client X left Gallagher Centre on his own accord to live on the streets

Client Y

- Was referred by his social worker at Regional Mental Health Care
- Could only be discharged from the hospital if he had a suitable place to reside
- Criminal history consists of mischief
- Has a history of alcohol use
- Is on a Community Treatment Order (CTO)
- Mother is substitute decision maker

Client Y

- History of refusing medications
- Has been diagnosed with schizophrenia
- Does not have a history of self-harm or suicide, but often mentions he is going to kill himself

- Some difficulties understanding English
- Result = Client Y secured suitable accommodations approximately 1 block from Gallagher, where he continues to receive follow-up support. No concerns with medication compliance.

Stats – updated Sept. 25

- 54% of clients are on medications to address symptoms of a mental illness; 49% of clients are on some type of an anti psychotic medication
- The average length of stay is 17 days
- 88% of clients have a history of violence

Stats continued

- 100% of clients demonstrate symptoms of a mental illness; 53% of clients have a confirmed diagnosis
- 39 is the average age of our client.
- 83% of clients have a concurrent disorder.
- 82% of clients have been successfully discharged



Getting it right – Experiences from the Frontline
Elizabeth White and Carole Mallows



The following is an overview of what was discussed during the breakout workshops to identify general practises in CRF's.

Operations:

UTA's what makes it work

- Team Assessing who comes to house (determining fit) Prior relations with the client helps.
- To achieve good client mix, front line staff recommendations
- Good fit based on options for transfer
- How to create awareness without breaching confidentiality?
- Adapt approach to fit resident
- Use house meetings as educational opp. For residents(speakers)
- Encourage residents to gather info and bring to meeting.
- House meeting- mandatory works
- Searches- when? When notice changes in behaviour. Reg. schedule of random searches? No one. CSC and NPB want it more often. CSC talked about once per week random searches. (May not be in the standards yet?) CRF's say – don't disempowering and don't police
- Searches- letting clients know ahead of time (before release).
- Safety- pendants, walkie-talkies and squawkers. Communication important for safety. Security calls b/w different houses. Knowing when and how to get double staffing. Sharing info b/w agencies to find how each other gets funding. (Reduce isolation)
- Paper work (OMS)
- Proper training and usage of OMS.

- At least one week notice for CAT.
- More detailed paper work.

Community Relations

- Inviting neighbours for holiday dinners
- Open house/ community functions.
- Street presence (flowers, garbage bins not left out).
- Community forum.
- Liaisons with other agencies.
- Community assessment team (strong)
- Be a diverse agency.
- Encourage staff to sit on boards.
- Diverse p/t staff pool (other agencies or share our with similarly agencies)
- Students (community and operations)
- Always an ambassador for your agency.
- Staff meeting; start of with reading mission statement

Resident services

- Tracking behaviour (case notes)
- Communication
- Regular counsellor session
- Share info with team
- Outside perspective
- Constant info sharing with co-workers
- Shift change
- Notice and share behaviour change (no matter how small) Isolation, mood swings, changes in dress, hygiene.
- Explain dual role from day one.
- Positives (point out)
- Discharge questionnaire
- Be genuinely concerned and honest
- Sharing meals
- Informal meetings/ charts (usually most informative)
- Get out of office for meetings
- Home like environment
- Problems in house- listen, “reframe” perspectives, and remind of house rules.
- Emphasise on routine and habits
- Staff consistency
- Responsibility- client to staff if possible.
- Colors/Myers Briggs (team buildings)
- Let client educate staff in some ways (we’re not experts) Willing to learn as well as give

Getting it Right – Experiences from the Frontline (Report In)

Carole Mallows & Elizabeth White

Good Practices Manual 2006 looks at 5 key areas:

1. RESIDENCE SERVICES:
 - How are you going to assess and track improvements?
 - Practices for empowering clients.
 - Programs
 - Assessment and building relationships
 - Environment – dignity and respect for clients
2. OPERATIONS:
 - paperwork (how to keep organized)
 - workplace safety
 - parole officers
3. NETWORKING & COLLABORATION
4. REINTEGRATION
5. COMMUNITY RELATIONS
 - neighbours
 - media

In September 2006 there was a meeting of experts to discuss the scope of the project. Mostly Executive Directors attended and wanted to cover such areas as selection, case management, specialized houses, relations with neighbours/media/politicians/other CRF's as well as training, record-keeping, governance, and managing house budgets.

Wrap Up Day 1 – Announcements

Mr. Larry Cook – Ontario Halfway House Association

Day 2: Thursday October 26, 2006



Supportive Housing Beyond the Halfway House

Mr. Darrell Rowe – St. Leonard's Society of Peterborough

Peterborough emphasizes values employment, work skills training in 1992 when CCRA came into effect, provision included for work release. fit into vision of Peterborough. Prior to that had some projects, including establishing the blue box program in Peterborough. Provided work skills training for residents and others in the community, including men & women from provincial system, minorities, handicapped & physically disabled. included skill training (DZ, first aid, emergency response, etc.). In 2000 got into construction. Contracted with Peter. Comm. Housing Corp. to provide safe and affordable housing for those at risk in the community. Main focus was women with children that required housing. Went into building acquired by the Corp and renovated them. Continue to use work training and work on future opportunities. One strategy is to acquire property and use it to help clients (supportive housing)

In 1991, acquired a building (6 one bedroom apartments for those who would have difficulty finding an apt in the community following release from CRF. provided independent living. priority became that the bldg was run well financially. 2/6 apartments are currently being used. association for community living approached SLP to ask if a mentally challenged adult could live in one of the apartments. Tried this out and now have 2 mentally challenged adults living there. 2 federal clients there. Seeing more clients with mental health issues.

Dynamics between neighbours (mentally challenged) and CRF clients is unique and has taught the clients patience, insight & tolerance for others.

Recently acquired 2-1/2 story bldg, which is zoned as duplex but also a rooming house. lower level 1 bedroom apt. 2 & 3 levels will be up to 4-bedroom rooming house. Intent is to provide service to individuals leaving the facility who require additional support. located close to existing facility. Client type for this service is lifers and LTO's (older men). for men who do well in CRF but have trouble upon discharge (age, health, mental health, long term incarceration poses career challenges). Can't apply for ODSP until they've left the halfway house and that process takes a long time. provides transition from halfway house to secondary bldg (in community) and can then start ODSP process. cost to men to move in is minimal as most are on OW so approx. \$200-\$250/month and possibly 3 meals/week at other facility. Also provide training. food prep, hygiene, etc. CRF will be a hub for services.

Controlled environment (staff member and spouse will be in 1 bedroom apt) in order to provide indirect supervision.

SLIDES (pictures of the new facility which is currently under renovations)

overall strategy is to obtain more properties (to provided more cash flow) formula provides money for repairs/taxes, etc. and remaining goes to reserve.

Low cost for clients, still generate positive cash flow and do their own maintenance & rep which provides work skills training.

Four bedrooms, living room, bathroom, kitchen and sm. computer room/library.

Community consultation process - informal - went door to door and spoke to neighbours. An individual involved in organization who lives on the street has become a local spokesman. Those working on renovations do get paid. Interest in palliative care and elderly offenders. Interested in small retirement home in order to provide service to that category of offenders.

Correctional Service Canada – Community Mental Health Strategy

Mr. Rob Campney – Correctional Service Canada

Improving Mental Health Services for Federal Offenders

The Community Mental Health Initiative April 2006

Prepared By: Jane Laishes

Mental Health Services, NHQ

Presentation Outline

To present the key challenges faced by the Correctional Service of Canada (CSC) in providing mental health services to federal offenders.

- To present the comprehensive renewal strategy to address these challenges which support offender rehabilitation and public safety.
- To outline the implementation of the community mental health initiative.

Literature on Offenders with Mental Disorders
has shown...

- they are more vulnerable to arrest because of their behaviour
- more likely entangled in a cyclical pattern of recurrent encounters with both the mental health and criminal justice system
- found in both provincial and federal correctional systems as well as under the care of specialized provincial forensic facilities

Legislative Mandate

Our legislation, the *Corrections and Conditional Release Act*, states that:

The Service shall provide every inmate with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.

Further, CSC policy states that:

“a continuum of essential care for those suffering from mental, emotional or behavioural disorders will be provided consistent with professional and community standards.”

The Rising Numbers of Offenders with Mental Disorders is a Significant Challenge for CSC
Mental health problems are two to three times more common in Canadian prisons than
among the general population – and getting worse...

- Rate of mental health problems in prisons rising dramatically
- 71% increase in offenders diagnosed with MH disorders since 1997
- 80% increase in numbers of inmates on prescribed medication
- Many inmates have both mental health and addiction disorders
- Require more comprehensive diagnosis and treatment

- Offenders with mental disorders are more likely to return to prison
- Up to 50% of offenders living in some community correctional facilities are on psychotropic medications.
- Significant proportion of Aboriginal offenders within the correctional population - requires culturally appropriate approach.

When the rates of current mental illness from a Pacific region study of 202 federal offenders are applied to the approximately 12,500 offenders presently incarcerated, then, on any given day:

- 431 offenders are suffering from a psychotic disorder
- 1046 offenders are suffering from an affective disorder

*This means that 12% or approximately 1,500 inmates as well as about 1000 offenders in the community are currently suffering from a serious mental disorder.

CSC's Renewal Strategy

Correctional Service of Canada's comprehensive mental health renewal strategy provides a full-spectrum response to the mental health needs of offenders:

Intake Assessment

- all offenders receive a comprehensive mental health screening at intake
- those showing disorders receive prompt assessment and diagnosis
- results reflected in individual treatment plans/appropriate placement and intervention

Primary Mental Health Care

Coordinated and comprehensive mental health care to inmates, including treatment; psychological assessment and management; crisis intervention; and health promotion and maintenance in all regular institutions.

Intermediate Care Mental Health Units

Intermediate level intervention for men offenders with mental health disorders who require daily mental health care and support within specialized units in regular institutions.

CSC's Renewal Strategy

(cont'd)

Mental Health Treatment Centres

Upgrade facilities and staffing at CSC mental health treatment centres, to provide professional care for inmates with acute mental health problems equivalent to that offered by community forensic psychiatric hospitals, while meeting correctional security requirements.

Mental Health Support in the Community

Preparation for reintegration and ongoing support during conditional release into the community and transition to the community mental health system with no loss of continuity in support.

Leadership

Provide coordination and leadership in the delivery and development of mental health services, including development of partnerships, data gathering, knowledge management,

integration of gender and culturally sensitive approaches, governance, evaluation, telemedicine/telepsychiatry, and training for all staff working with OMD.

Benefits of CSC's Renewal Strategy

By better identifying the mental health needs of offenders and providing consistently timely and high quality professional treatment, CSC will be able to:

- Meet statutory care obligations to inmates with mental health disorders
- Improve the overall management of correctional institutions
- Reduce the incidence and improve response to disruptive behaviour among inmates
- Improve re-integration of offenders into the community
- Demonstrate federal leadership in providing an effective, efficient mental health system based on collaboration and partnership
- Enhance public safety as a result of effective treatment of mental health disorders of offenders

CSC's Community Mental Health Initiative

Strengthening Communities Memorandum to Cabinet was approved in the February 2005 Budget.

- \$30 million in funding over 5 years announced by the Minister in April 2005.
- Funds received Dec 20th, 2005.
- This is time limited, short-term funding - 5 years with the first year over already!
- An evaluation is required at approx the 3-year mark - RMAF under development.
- One time funding with the hopes of continued funding based on the evaluation data.

Parole Sites selected to receive the mental health specialists and mental health training:

Atlantic	Prairie
Monkton (2)	Edmonton (2)
Saint John (1)	Calgary (2)
Nova Scotia (2)	Winnipeg (2)
Newfoundland (2)	Regina (1)
Quebec	Pacific
Quebec East/ West (2)	New Westminster (2)
Lauren tides (2)	Vancouver (2)
	Kalona (2)
Ontario	
Hamilton (2)	
Toronto (Keeled) (2)	
Kingston (2)	

Objective of the Community Mental Health Initiative

To better prepare offenders with serious mental disorders for release into the community by strengthening the continuum of specialized mental health support and providing continuity of support from institutions to the community.

The key elements are:

- Enhanced discharge planning;
- transitional mental health services and support to targeted offenders;
- mental health specialists to support offenders residing in community;

- training in mental health issues for community staff; and
- specialized services such as emergency psychiatric assessments.

Offenders with Serious Mental Disorders

Offenders with the following conditions are eligible for clinical discharge planning and community mental health specialist services:

- Major Mental Disorders, including:
 - Schizophrenia and Other Psychotic Disorders
 - Mood Disorders (e.g. Major Depression, Bipolar, etc.)
 - Other Disorders (e.g. Obsessive-Compulsive, Cognitive, etc.)
 - *noted if co-occurring substance abuse disorder*
- Personality Disorders with significant functional impairment (e.g. Paranoid, Borderline, Schizoid, etc.)
- Acquired Brain Injury or Organic Brain Dysfunction (including FASD) with moderate to severe functional impairment
- Developmental/Intellectual Disability with moderate to severe functional impairment

New Positions

- Discharge Planners for the Treatment Centres and Institutions – Clinical Social Workers
- Mental Health Specialists for the Parole Officers – Clinical Social Workers
- Mental Health Specialists for the Parole Offices – Community Mental Health Nurses
- Regional Coordinators
- Mental Health Trainers

Clinical Discharge Planners

- Clinical Social Workers – their background training and skills directly relate to discharge planning and working with community services.
- Plan for OMD to go from an institution to the community – 9 months prior to the NPB hearing (where the parole officer is supportive of conditional release) or definite release date– allows time for comprehensive information to be provided to the NPB.
- Addresses the transitional needs of OMD’s prior to their release into the community in an effort to promote a sense of stability in what may be a very vulnerable time for these individuals.

Community Mental Health Specialists

- Clinical Social Workers or Community Mental Health Nurses
- Will work one-to-one to provide direct support to OMD in the community
- Lead interdisciplinary teams in support of the OMD
- Provide annual training
- Flexibility is the Key

- Will establish cooperative partnerships with community-based services
- Nurses will also provide medication management and compliance / psychiatric liaison
Regional Coordinators
- Coordination of the initiative across the region including assuring that the new positions work together with existing services to enhance the reintegration of offender with mental disorders
- Functional Supervision of the Community Mental Health Specialists (MH Nurses and Social Workers) and line supervision of the Discharge Planners.
- Coordination of the community mental health training.
- Ensure regional data is being collected for the evaluation of the initiative

Continuity of Mental Health Care for Released Offenders

This is accomplished by:

- Working collaboratively with the offender, case management team (CMT) and mental health teams to assess the psychosocial needs and public safety risk of the OMD to effect their safe and seamless transition to the community;
- Identifying required community resources and establishing linkages between the offender and these resources;
- Developing a comprehensive discharge plan for timely access to the required treatment and social supports;
- Working closely with CMT and community Mental Health Specialists to ensure the implementation of the discharge plan to avoid gaps in care.

Mental Health Trainers

Training will be developed nationally and delivered locally on an annual basis – 3 days in duration.

Content will focus on:

- Recognition of signs and symptoms of mental disorder and suicide risk,
- Signs of relapse following treatment,
- Basic pharmacological information,
- Communication skills for managing OMD,
- When to refer an offender to a mental health professional,
- Responding to psychiatric emergencies,
- General strategies on management of offenders with major mental disorder (e.g., interviewing techniques, calming approach methods, de-escalation techniques),
- Relationship between mental disorder and criminal risk.

Governance of the

Community Mental Health Initiative

Dr. Andrea Moser is the Coordinator of the Community Mental Health Initiative

Four committees:

- Integration Committee
Mandate - to ensure national coordination of all aspects of the CMHI, i.e. how each aspect works with the other aspects – such as file and information sharing, data collection, etc.
- Steering/Implementation Committee

Mandate - to provide regional input to NHQ regarding the initiative and to inform senior regional managers and stakeholders regarding the strategy and its implementation i.e.; ensures implementation according to the plan, clarifies implementation issues for the region, sharing of best practices, contributes to data collection.

- Advisory Committee

Mandate - to ensure that other Sectors have input and vehicle to provide advice on:

- the parole sites to receive mental health specialists.
- contracts for submission to regional CRBs.

- Evaluation Committee

Mandate - to ensure the framework for evaluation is in place and data is being provided and analyzed.

Vision for Mental Health

As one of the many organizations involved in the management of mentally ill offenders in Canada, CSC's contribution is to provide an integrated continuum of mental health care to offenders from sentencing to warrant expiry and beyond by utilizing trained mental health professionals to complete assessments and deliver interventions that respond to offender mental health needs in the most cost-effective and least restrictive manner.

Community Mental Health Initiative Implementation Team, NHQ

Jane Laishes, Senior Manager, Mental Health
Dr. Andrea Moser, Coordinator Community Mental Health Initiative
David Champagne, Project Manager, Community Initiative
Clarence Turgeon, Project Manager, Community Initiative