The Roundtable Discussion on Mental Health: First Responders, and a Sane Response

Research and Statistics Division

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Table of Contents

The Roundtable Discussion on Mental Health: First Responders, and a Sane Response

1 Executive Summary

On March 26, 2015, the Department of Justice, along with Public Safety Canada, hosted an informal roundtable discussion on mental health issues and the "first response". Several members knowledgeable or active at the level of community-based responses were approached to write short overview papers about their specific program, and the roundtable was an opportunity for everyone to meet and discuss areas they had in common.

Participants were selected because of the mix of their backgrounds and expertise. Some of the interests they represented included the needs of youth, Aboriginal perspectives, child witnesses, homeless people, and other vulnerable populations. We also invited the head of Mental Health First Aid, and the Winnipeg Paramedic Service to learn about their innovative service delivery. Finally, the human-animal bond concept was included because of its unique contribution, and the fact that it could apply in several of the other areas mentioned.

Members of the Research and Statistics Division (RSD) of the Department of Justice were asked to work collaboratively with members of Public Canada (PS), on areas of common interest. In the fall of 2014, a meeting was convened to discuss possible project areas, with mental health being one area of focus. Given that there are large demands on the criminal justice system, from policing through to corrections, emanating from mental health-related issues, this appeared to be a good first option.

In preparing for an eventual roundtable discussion, wherein participants could discuss their programs or services, or particular areas of need, and how these areas could be considered together as a whole, it was decided that having some background papers on the various areas would facilitate the discussion.

Several participants were approached based on their knowledge and expertise in different areas, and where someone was unable to participate, they were asked if they had a suggestion for an alternate. The number of participants was capped at eight, as this was determined to be an optimal number for discussion purposes at a roundtable meeting.

Papers were drafted and commented on, by members of the RSD of the Department of Justice Canada, and members from Public Safety. A facilitator was brought on board to enable participants to focus on the discussion and not on note taking.

Seven papers were prepared, outlining their program or approach, and indicating the experiences and benefits they have seen in the course of their work.

Barb Afseth wrote about Child Advocacy Centres (CAC), which are in place to assist children when they are victims or witnesses in criminal proceedings. Testifying is often very traumatic in and of itself, and it is challenging for children and families to cope with the length of time involved in court processes, and in appropriately dealing with trauma/anxiety of the incident itself.

Johny-Angel Butera wrote on homeless people and other vulnerable populations who are often victims of power imbalances, if not outright criminal activity. There may be other issues associated, such as social isolation, cognitive impairment, lack of independent living and good coping skills which make these populations likely targets for being taken advantage of. Reaching out to homeless populations to provide assistance can be challenging unless there are targeted efforts.

In a similar vein, community housing provides opportunity for people to establish roots and create social networks. These communities may view police activity differently if it is not well understood, which underscores the importance of community rapport among police services.

Dr. Alan Leschied wrote about providing mental health first aid training to foster parents and those involved in the education system, as two ways of improving the delivery of mental health support to youth in Ontario.

Joanne Moss brought the human-animal bond to the discussion, outlining the potential benefits that arrive with this kind of contact. There is potential for reducing PTSD, improving social skills, reducing anxiety, developing improved insights and communication ability, as well as other benefits.

Meaghon Reid, the Director of Mental Health First Aid Canada, wrote about the training being made available, and what kind of information is being made available. Knowing that people need information to be able to understand where and when to appropriate help others, this training will assist people in recognizing what kind of help might be needed.

Rupert Ross wrote about his experiences in serving as an Assistant Crown Attorney in northern Ontario, and several of the challenges in serving remote, aboriginal communities. The need to

provide family-based, aboriginal-led supports to families coping with youth suicide attempts, intra familial violence and improving communication within families is very pronounced.

An innovative approach is under way in Winnipeg, and paramedic **Ryan Sneath** explained two projects which aim to provide services in a different way. In one program, high users of 911 services were identified and triaged in order to create customized care plans for each individual. Each client was assigned to a social worker to address the psychosocial aspects of their care. Home visits were also conducted. Within the first three months, calls to 911 had decreased by 33%, and transports to the hospital had decreased by 59%. In a second program, a paramedic was placed on staff at the facility which serves as a homeless shelter, detoxification unit, transitional living area, and an intoxicated person's detention area. By having a paramedic on staff, early assessment of problems, referrals, and responses to actual or potential health concerns was delivered. After the first year, ambulance transports decreased by 60%.

Despite the variation in the papers, there was almost an immediate collegiality, and keen discussion at the roundtable. There was energy and high levels of engagement in examining the ways in which each could contribute together to the overall betterment of people in need of assistance. There was interest in continuing discussions, and in convening a follow up call to touch base again in the future.

The Department of Justice will share these papers internally, and provide information on the roundtable discussion; further interest in the papers would be referred to the authors.

The next section of this report will provide an overview of the roundtable discussions, ideas from the papers and provide a visual mind map of the areas discussed. A final appendix includes the papers prepared by the roundtable participants.

2 The Roundtable Discussion

2.1 Background

The first response to a mental health crisis in the community is often to call the police. Limited mental health services in the community have increasingly left the criminal justice system to respond to these issues, despite the fact mental health issues are not strongly related to criminal behaviour, and police are not the most appropriate resource to manage these issues. There has been a continued increase in the demand on policing services and the justice system in this area in recent years.

Justice Canada and Public Safety are interested in hearing from non-traditional stakeholders to help frame the issue of mental health and the demands on first responders and the justice system from different perspectives – fundamentally, to think "outside the box". Justice Canada and Public Safety hosted a roundtable discussion, which took place on the morning of March 26, 2015 at the Department of Justice headquarters in Ottawa.

To set the context for this discussion, the Department of Justice asked guests to submit discussion papers on the intersection of police services with those who experience mental health disorders. A total of 7 papers were submitted and circulated to all participants for review prior to the roundtable. They are included in this report in Appendix.

2.2 Roundtable Objectives and Participants

The objectives of the roundtable discussion were to:

- Initiate a discussion with non-traditional stakeholders on mental health and how to reduce the demands on first responders and the justice system;
- Provide the opportunity for community stakeholders to network and establish contacts amongst each other;
- Identify promising ideas and potential cross-linkages, and;
- Discuss opportunities to move some promising ideas forward.

Approximately 18 participants attended the roundtable, including invited guests from community and partner organizations, and representatives from Justice Canada and Public Safety. The session was professionally facilitated by the Intersol Group. Facilitation technology was used at the session to capture participant input and help prepare this report.

2.3 Discussion Outcomes

Participants appreciated the opportunity provided by Justice Canada and Public Safety to engage with other key stakeholders in the field, hear about successful models and best practices from communities across the country and make linkages between the various initiatives underway. Throughout the morning discussions, the group identified important cross cutting issues that they felt will require the focus of attention moving forward.

Participants identified approaches that they found particularly promising in the areas of:

- Community education and awareness;
- Building supportive communities;
- Police and EMS training and skills development;
- Screening and decision-support tools;
- Prevention;
- Multi-sector collaboration.

A mind map prepared by Intersol Group capturing the essence of these promising approaches was also prepared and is included in this report.

Informed by the cross-cutting issues and promising approaches that were identified, the group crafted a vision that describes a preferred future for the system 2-3 years from now.

3 Welcome and Introduction of Participants

Mental health affects all parts of society. It is very clear from the many reports that have been compiled in the last decade that partnerships across sectors are key to addressing mental health issues. The purpose of this roundtable is to have a good discussion on addressing issues related to mental health and the criminal justice system, envision a preferred future, and discuss how to get there.

Participants were encouraged to share the views, ideas and best practices they heard during the roundtable with their colleagues back home.

4 Setting the Context: Call for Discussion Papers

To set the context for the roundtable discussions, the Department of Justice had asked guests to submit discussion papers on the intersection of police services with those who experience mental health disorders. The specific areas of interest for the Department included:

1. Examining alternatives to police intervention to address mental health issues.
2. A context for differential response based on the nature and degree of the mental health incident.

3. Suggestions for how services could be structured to reduce demands on the criminal justice system.

A total of seven discussion papers were submitted on the topic from a variety of perspectives, including:

- Youth intervention, youth justice and children's mental health;
- Understanding complex vulnerabilities;
- Approaching mental health issues from a community perspective;
- Animal-assisted support services and programming in the justice sector;
- Mental Health First Aid training;
- Whole-family healing as a tailored response to suicide attempts by aboriginal youth in remote aboriginal communities;
- Community Paramedicine;

These were circulated to all participants as reading material prior to the roundtable.

Participant Expectations

Participants had a range of expectations for the day. These included to:

- Hear about new and best practices in the field;
- Gain a better understanding of the scope of the work underway;
- Link professionally;
- Explore commonalities and cross-linkages between various initiatives; and
- See where stakeholders can support each other.

5 Emerging Cross-Cutting Issues

Throughout the morning discussions, participants identified important cross cutting issues that will require the focus of attention moving forward. Highlights of these cross-cutting issues include:

- Lack of public knowledge of how to recognize symptoms of mental disorders and what options/services are available in seeking help. As a result, police end up being the first point of contact in a mental health incident even though they are not the most appropriate service.
- Community mental health services and policing agencies/first responders work independently of each other (lack of coordination).
- Institutional standards of practice (patient confidentiality and privacy agreements, etc.) are barriers to information-sharing between stakeholders (mental health services, nurses, support workers, teachers, addiction workers, psychologists, etc.).
- More focus on prevention is needed. Professionals aren't engaged until a person is in crisis.

- Demands for support services around youth mental health in particular have largely gone unrecognized.
- Fragmented and uncoordinated training options for police/first responders.
- Current state leaves room for improvement to incorporate culture and diversity as critical factors in the success of mental health intervention.
- Lack of awareness of the profound effect and impact mental health incidents/crises will have on first responders, what supports are available to them and how to access these services.

6 Promising Approaches and Cross-Linkages

At a national level, work accomplished by the Mental Health Commission has successfully helped to raise awareness and address stigma attached to mental illness. Numerous smaller, local initiatives have been equally important in doing so.

Throughout their discussions, participants identified a number of approaches that they found particularly promising, and made some linkages between the various initiatives currently underway across the country. The following key themes emerged:

6.1 Community Education and Awareness

- The Mental Health First Aid (MHFA) training program seeks to equip people with the ability to: identify the nature and degree of a mental disorder or crises; relate in a meaningful way to the individual who is experiencing distress; de-escalate an immediate crisis when appropriate, and; refer to other services where necessary.
- Equipping the public with the appropriate mental health first aid training and knowledge of appropriate supports is ideal so they can be adequately prepared to assume the role of a first responder and mitigate unnecessary calls to 911. Training is particularly important for those working with at-risk groups. A young person experiencing a crisis, for example, is more likely to trust and engage with someone they know and trust than a stranger or the police.
- There are many community programs in place across Canada that aim to facilitate honest conversations and breakdown stigmas surrounding mental health issues (e.g. programming by the Mental Health Commission of Canada).

6.2 Building Supportive Communities

- Innovative initiatives to raise awareness, engage citizens and improve health outcomes within communities have been created through collaboration with various community organizations, social service agencies, and other healthcare professionals. There are successful models and frameworks to be emulated across the country.

- Mapping community supports (both formal and informal) such as support groups, community leaders and distress lines is of critical importance.
- Supportive relationships are critical to helping individuals affected by mental illness. The involvement of family members, social networks, neighbours and the broader community is critical to help alleviate social isolation.
- Training and support must be available for the families and caregivers who support individuals affected by or at risk of a mental health problem, illness, or crisis.

6.3 Police and EMS Training and Skills Development

- Culturally appropriate and safe mental health first aid is key in the assessment and referral of individuals to appropriate professional and non-professional supports in order to reduce burden on the justice system.
- Leveraging the MHFA program as a vehicle for delivering training to police and allied agencies will help equip first responders, notably police, with the right knowledge and skills to be able to intervene effectively with people experiencing a mental health problem, illness or crisis and make referrals.
- Successful pilot programs are in place to help first responders understand the impact mental health crises can/will have on them, what support services are available to them and how to access these services.

6.4 Screening and Decision-Support Tools

- Enhanced referral protocols at first point of contact can help prevent thousands of ambulance trips by connecting individuals calling 911 with services other than emergency medical services where appropriate.
- Customized care plans are needed to link pre-identified high users of the system (e.g., common callers, common addresses) with a healthcare team that is able to meet their needs.
- Tools such as the Brief Mental Health Screener (BMHS) developed by InterRAI (currently being piloted within various Ontario police services) can assist both paramedics and police officers to assess the degree of seriousness of a critical incident and identify persons in the community with mental health problems.
- Decision-support algorithms can help assist first responders in making evidenced-informed decisions regarding the disposition of mental health patients. Pilot projects have found a significant decrease in wait times for police officers at medical facilities.
- Screening and decision-support tools need to be adapted to aboriginal, Métis, and remote contexts.

6.5 Focus on Prevention

- Preventative approaches and early intervention improves the odds that individuals with mental health problems or illness are streamed into the right support systems instead of being managed through the criminal justice system.
- Identification of high users of the system and those at risk of becoming a high user are a key success factor.
- Multiple intervention points are critical (e.g., children at risk, vulnerable populations, mental health services, police, courts, corrections).

6.6 Multi-sector Collaboration

- Mental health is a cross-cutting issue. Everyone needs to be around the table. Mental health services, policing agencies and emergency medical services must work towards a more collaborative approach to create sustainable community solutions.
- Improving communication between stakeholders on all aspects of prevention, event response referral protocols and follow-up will help ensure that people with mental health problems receive prompt access to appropriate mental health services.
- Physically co-located multi-disciplinary teams with embedded paramedic or trained mental health staff are a successful collaboration model.
- One key element of success is the ability to communicate with all of the stakeholders involved in the client's care. Multi-stakeholder approaches to problem-solving are needed to overcome issues around information-sharing, patient confidentiality and privacy rights.

7 Preferred Future

Informed by the morning discussions on emerging cross-cutting issues, promising approaches and cross-linkages, participants were asked to describe what a preferred future would look like 2-3 years from now:
Imagine it is 2 to 3 years into the future. We've moved the yardstick forward on some of these issues. We've made a big difference in how we approach the areas of prevention, acute response and post-event. Describe this preferred future where things are going well. What's happening? What do you see? How have we resolved these issues?

The following vision was crafted:

7.1 Prevention

Canadians across the country have a greater understanding and awareness of mental health issues. Stigma surrounding mental health and addiction issues has been reduced. Mental Health First Aid training is promoted and accessed by the public across the country. Community members and other people close to individuals affected by or at risk of a mental health problem,

illness, or crisis, (including caregivers, teachers, family members, friends and neighbours) have an increased ability to recognize symptoms of mental disorders and crises, and have the skills and confidence to guide/support the person to the most appropriate person/service.

Communities are mobilized, have strong support networks and the appropriate knowledge and tools to support vulnerable residents. Evidence-based programs are in place, created and led by the community in partnership with other resources (e.g., frontline workers, police and health care professionals). Social programming helps to alleviate isolation and alienation, and enhance connection and belonging.

Service providers and agencies are physically based in high-need communities, actively serving clients and accessible to individuals not currently linked to services. Efforts are tailored to the particular needs of each community. Best practices are shared across communities, regions and provinces.

Agencies have a common vision and actively collaborate to support communities. There are systems and safeguards in place to allow agencies to appropriately share information on shared clients in order to affect solutions for these individuals that cross agency mandates.

A person-centered approach to planning is used by collaborating agencies. Training and support is provided for the families and caregivers of individuals affected by or at risk of a mental health problem, illness, or crisis.

Police systems are working collaboratively with multiple allied agencies to prevent and address acute crisis situations. At-risk individuals are identified by community partners through a variety of collaborative means and early interventions are in place.

7.2 Event Response

A coalition of community supports (service providers and agencies) is available to respond to events or crises 24/7 and individuals are receiving the most appropriate care for their needs.

In situations where a person is not at risk of hurting themselves or others, a trained, confident person situated close to the individual in crisis is the first to respond and guides them to the most appropriate service that can help for their particular problem, such as local mental health facilities, distress lines, clinical psychologists, family members, community leaders or support groups.

Dispatch services know who to call in order to respond appropriately to calls involving pre-identified high users of the system or at risk individuals. Police and first responders are trained to intervene when called upon in informed, sensitive and culturally appropriate ways.

Community safety services remain on the scene for several hours after a crisis to help with individuals on scene post crisis.

7.3 Post-Event

Individuals are referred to the appropriate professional and community services post crisis.

Opportunities are provided to care givers and first responders to debrief post-event. Responders are aware of the impact these crises can/will have on them, understand what support services are available to them and how to access these services.

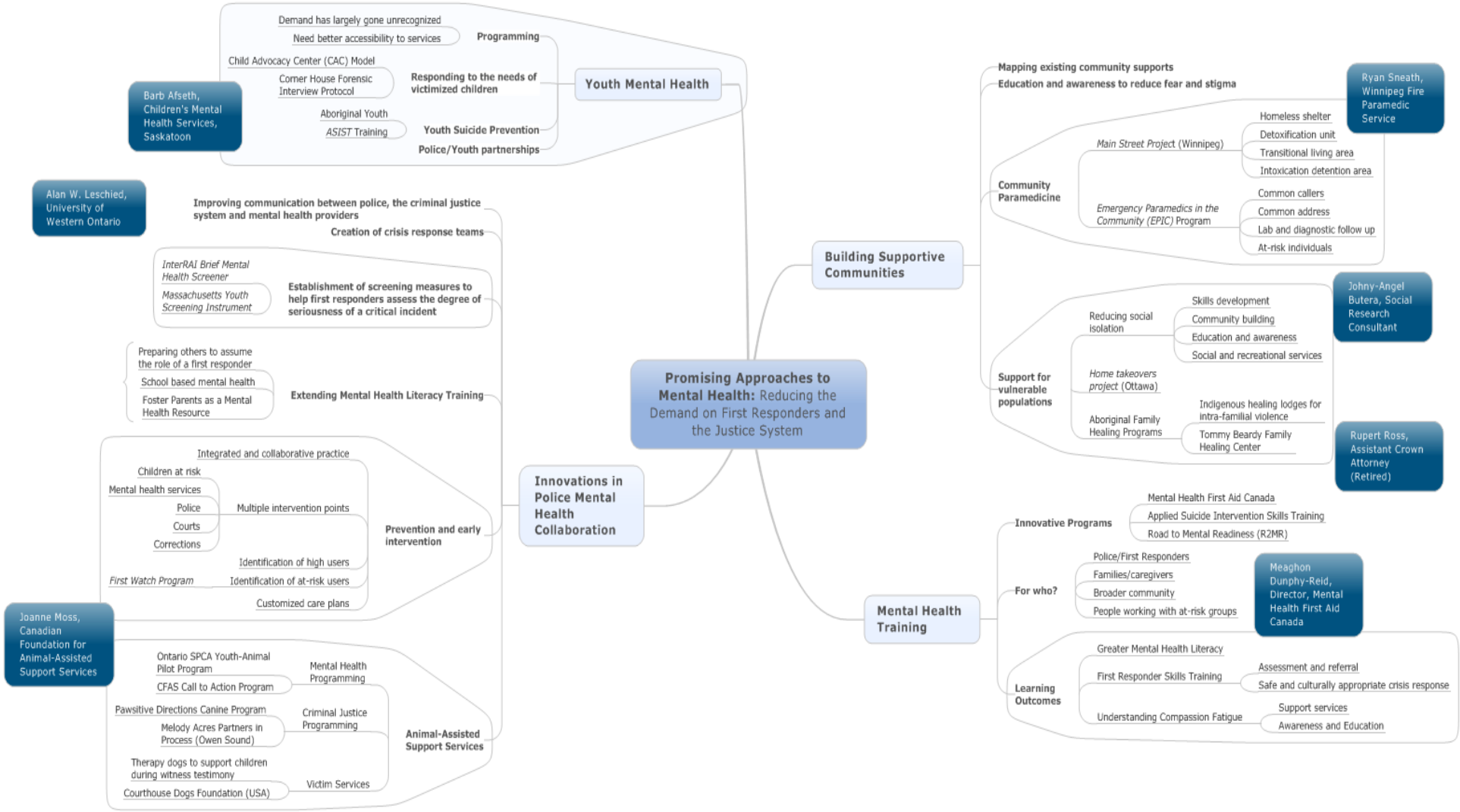
8 Conclusion

Moving the Yardstick Forward

Participants made the following suggestions on first steps to move the yardstick forward towards achieving the preferred future that emerged from their discussions:

1. Come together to share promising models being implemented across the country and learn from what has worked.
2. Share ideas on how to adapt models and best practices in other jurisdictions and roll them out across Canada.
3. Review funding mechanisms to support the preferred future described.

9 Mindmap of Promising Approaches[1]



[1] Prepared by Intersol group

Appendix
The papers

10 Seven Papers

Barb Afseth

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Introduction

The Child Advocacy Center Model (CAC) is a framework that is being supported by Justice Canada to provide a child friendly, developmentally sensitive, multidisciplinary approach to intervening with children who are victims or witnesses to crime. These centers are in different stages of development throughout Canada and the public partners involved in the center are usually Police Services and Child & Family Protective Services. Children's Mental Health Services, Saskatoon Health Region has received funding from Justice Canada over the past 4 years to add a dedicated mental health clinical position to the multidisciplinary team at the Saskatoon Center for Children's Justice (SCCJ). As far as we know we are the only CAC in Canada that has piloted this partnership under this funding. We have demonstrated that mental health has an important role within the CAC model and should be included as a key component of the multidisciplinary team.
This paper will:

1. Share observations around the court process and make recommendations for how to reduce stress to the child and their caregiver as they navigate through it.
2. Share our vision for the role for mental health in CAC's, sharing some of our key learnings related to the project,
3. Make recommendations regarding the qualifications and training necessary to perform responsibilities effectively discuss ideas for funding these positions

Observations and recommendations regarding the court process

i) The needs of the court and the needs of the child are very different.
As part of the role we have had the opportunity to follow some of the cases to and through the court process and we have come to realize that the court process is extremely anxiety provoking and intimidating for the child and their caregiver. We understand there have been many accommodations and testimonial aids added to help make this process easier for the child including; using the recording of the initial interview as central to the child's testimony; testifying from the "soft room" instead of in the open court via the use of video equipment; court preparation by victim /witness coordinator as well as the addition of a support person who can sit beside the child during their testimony.

These accommodations are very helpful; however this process continues to carry an unnecessary amount of distress for both the child and the caregiver due to the unpredictable nature of the court regarding dates for appearances. It would be best for the child if they did not have to appear as a witness during the

court process at all. However if this is necessary, legislation should be created that expedites trials which sets a time limit (i.e. 6 months) between the child's initial interview with the police and when they testify in court. Practices and protocols of how to proceed in cases involving child witnesses would need to be developed based on this legislation.

If the mental health clinician feels that testifying could cause severe harm to the child, their opinion should be considered before making a decision if the child is going to appear as a witness in court.

The last sexual assault trial we participated in the child was testifying at the age of 12 for an incident that happened when she was 9. The impact on the child and family resulted in ongoing stress around having to testify. In this case the video feed was not clear and instead of the child identifying the offender through the use of video equipment which she understood was to happen, she was required to come into the courtroom to identify the offender at the end of her testimony. This was very distressing for her and the impact was clear as her caregiver reported that she slept at home for 7 hours after her testimony.

ii) A child testifying in court would benefit from receiving support while testifying.
Although the support person sits beside the child while they testify, they are not allowed to touch or comfort the child during the testimony, to interact with the court on behalf of the child or make any expression or show any reaction during the testimony. Additionally, the support person is usually the victim/witness coordinator, a person who the child has only met on a couple of occasions. We question how supportive this role actually is to the child.

Suggestions: Therapy dogs should be added to the options for support to the child during their testimony. The canine could play a key role in reducing the physiological stress response in the child while testifying in court without the risk of interfering or leading the child. Canines would also be helpful in working with these children during the initial interview and in therapy.

iii) Experts on interviewing children and in child development should be the staff who performs the interview as supported by the Corner House Forensic Interview Protocol.
http://www.cornerhousemn.org/images/CornerHouse_RATAC_Protocol.pdf

As we are not experts in protocols in police/child protection interviewing, it is important to note that we are not specifically recommending this protocol but are more using it as example of a protocol that uses principles that we feel are important for minimizing distress for the child during the process of investigation.

We would recommend that the CACs dedicate resources into training people who specialize in interviewing children. These professionals should be experts in child development and can be the ones who structure the questions while police and MSS investigators watch to ensure all the investigative

information necessary is collected in a way that meets the needs of the court. This training ensures that the video interview is performed in a way that has the most chance of holding up in court (if the investigation supports a charge) and is as friendly and comfortable for the child as possible. In addition the interviewer could provide expert testimony based on their knowledge of child development, speaking to the impact of the child's development on the way the child may have answered the questions.

Recently we saw cross examination of a child witness. The defense attorney focused on challenging the child's reliability as a witness due to her belief in "spirits" based on a small section of the videotaped interview. We felt that her belief system could have been explained by normal childhood development and the line of questioning was not relevant. The child's details about what happened between her and the alleged perpetrator were very clear and consistent. The defendant was found not guilty.

There are a number of ways in that we feel the system broke down when representing this child in court. We think that this line of questioning should have been seen as not relevant to matter at hand and the objection of the prosecution should have been sustained. We believe if the interview was done by an expert in interviewing children the topic of "spirits" would have been avoided in the interview. If a statement such as this was made by the child in the interview, the interviewer could speak as an expert in court as to the how such beliefs affect the reliability of the child's testimony.

Recommendation: Implement the Corner House Forensic Interview Protocol in CACs across Canada. http://www.cornerhousemn.org/images/CornerHouse_RATAC_Protocol.pdf

The role of mental health on the multidisciplinary team

One of the primary observations we have made during the project is that it takes effort and close proximity to develop a multidisciplinary team. As mental health support was not an onsite service we visited the centre weekly to connect with team members. This regular interaction has significantly enhanced our ability to work collaboratively; however having an onsite mental health staff who could be involved regularly in case discussions and be available to connect with the family while they are at the CAC would be ideal.

The vision for the role of the mental health staff on the multidisciplinary team would be:
i) To provide counselling and therapeutic interventions to children and their families
Traditional services have created many barriers to families requesting support including redirecting or denying families service until the court process has been completed. Many private clinicians are also hesitant to intervene because of an impending court process.

- The ability to obtain information about the progress of the investigation, the response of the child in the interview etc. is knowledge that is needed to inform the therapeutic intervention. Without this partnership this information is not typically available and without this information there is uncertainty as to how to proceed with providing services to the child. (See 3 ii)

ii) To offer coping skills and support as the child prepares for and testifies in court.
iii) To act as a consultant to others on the team providing ongoing information and education regarding child development, effects of trauma both in general and on specific cases.
The professionals on the team came to understand more fully the scope of each other's practice and role during the partnership and this role expanded throughout the funding period.
iv) To develop a referral process and screening tool to identify when therapeutic intervention is appropriate. The screening tool could be used by all members of the multidisciplinary team.
v) To participate on the team as a consultant when reviewing practices to ensure a child-friendly, developmentally sensitive approach and provide recommendations for the CAC's environment and the investigative interview process.

Qualifications, training and considerations of mental health staff

i) The staff in these positions should have a comprehensive understanding of a number of topic areas including; childhood development, the effects of trauma on the developing brain, therapeutic interventions for reducing symptoms of trauma and building resiliency, as well as the expectations placed on the child regarding testimony, the court and investigative processes. It is the intersection of these 2 areas that complicates clinical decision making as the court process supersedes the best interest of the child.

ii) Evidence based treatments for trauma often recommend the child is exposed in a safe and titrated way to disturbing details and elements of the trauma so they become less reactive when memories of the trauma appear.
This is a huge issue as the validity of the child's testimony is often challenged because of their vulnerability of being led. I (Barb) handled this in my clinical practice by regular communication with investigators and only proceeding with a revisiting of the traumatic event after I was sure the child would not be required to testify. In therapy before this point I would discuss feelings around the incident with the child and their family, normalize their reaction to the experience and provide education about trauma reactions but not talk specifically about any details of the event. Prior to becoming a partner of the CAC team, mental health would have waited for the court process to be completed before providing service. It has been a challenge to find information to guide me in balancing the needs of the child while not interfering with the court process. I found little and sometimes contradictory direction in making clinical decisions while being aware of the court process and pending testimony. There needs to be a protocol developed for use across Canada to help mental health staff working within a CAC that outlines clear guidelines for providing clinical service to the child while not interfering with the needs of the court. This protocol would be important for two reasons:

1. It would provide protection to the mental health staff as they develop clinical treatment plans for the child. I often feel that I may be accused of compromising the integrity of the child's testimony in court while trying to support them and there is currently nothing to support me.
2. Existing and relevant research that is presently available needs to be reviewed in order to inform the protocol.

Recommendation: A working group is established to develop a protocol for mental health clinicians providing services to traumatized children who may need to appear in court as a witness. Justice Canada and CACs across Canada take a lead role in organizing and leading the group; recruiting professionals who work in children's mental health as well as those who have knowledge of the law. Once a protocol is developed it is shared with clinicians who are working with this population of children.
iii) Another point of consideration of the type of treatment chosen is the type and complexity of the trauma. Children who have experienced one incident of sexual abuse by a non-family member, i.e. a babysitter and who have supportive parents are easier and less complex to treat, however these cases were few. Most of the children that we worked with through this partnership had a complicated history including; exposure to many traumatic incidents, and/or emotionally unavailable caregivers and/or the family often had many barriers to receiving treatment (i.e. no transportation, addiction issues, their own mental health issues, etc.). Because of this some families may not be appropriate or ready for traditional therapy; however we can still be helpful in consulting around the needs of the child.

iv) It is important the staff receive supervision related to their role on the team. The nature of this work can be very difficult and supervision helps to prevent burnout, provide supports and provide ideas in therapy.

Funding options

We strongly believe it is important to fund mental health positions within the CAC framework.

In order to sustain a multidisciplinary team model that provides a comprehensive and dedicated service, permanent funding is needed. One suggestion is to reallocate the way the Victim's Compensation Fund is distributed. The Victim Compensation Fund is financial support up to $2000.00 that is provided provincially to victims of crime to receive counselling. The way this fund is set up does not work in the service of children for a few reasons: 1) it only supports counselling for the child and not the family. Parents/caregivers are the most important element of supporting a child in their day to day life. They need support to cope with their feelings around the event as well as education to understand their child's reactions and how to support them. 2) Clinicians are hesitant to proceed in working with children that may have to testify in court and currently don't have any access to information as to how the investigative process is going. 3) There is no assurance that the clinician will have the skills or knowledge necessary to provide an effective intervention.

Recommendation: The money currently designated for children in this fund should be directed to create positions for trained mental health therapists that would be dedicated positions on the multidisciplinary team.

Summary

Adverse childhood experience studies have demonstrated that children who are exposed to trauma in childhood are much more likely to have long term issues with mental health, physical health and substance abuse. http://www.cdc.gov/violenceprevention/acestudy/index.html. It is our hope that creating a system that responds to the needs of victimized children in an early and effective way will increase their overall functioning, health and resiliency decreasing their use of public systems which support these individuals later in their lives.

Work in developing a multidisciplinary response which is child-friendly, developmentally sensitive and collaborative has begun and is very important. Currently the multidisciplinary partners are those that are trying not to further traumatize the child through the investigative process including Police and Child Protective Services. Services that focus on recovery and resiliency for the child and their family are not part of the programming. Typically these services have been provided separately and often have to be organized by the parent. We strongly recommend that we strive to reduce any risk of further victimizing a child by ensuring trained mental health staff are available to provide assessment, consultation and treatment to children who come in contact with the CAC. We hope that the future vision of the CAC includes mental health as one of the keys components of the multidisciplinary approach and we look at creative ways at funding these positions with highly skilled professionals with a similar knowledge base.

Johny-Angel Butera

Introduction

Since the de-institutionalization of mental illness in Canada began, there has been slow growth toward services and supports delivered in the community to persons living with mental illness. This shift has led to a patchwork of community services that vary by province and region. Indeed, there has been a recognition at both a federal and provincial level of the importance of increasing community services, including better supports in areas such as housing, income support, and employment opportunities in creating healthy, safe communities (At Home/Chez Soi, 2014; Open Minds, 2011). We know that someone living with mental illness who has "stability in their living situation – affordable housing, sufficient financial resources, and support – is much less likely to decompensate to a point of mental health crisis than someone who is homeless, hungry and without help" and thus less likely to come into contact with the criminal justice system (Building capacity: Mental health & police project, 2006: p.8). However, the onus on communities to support people with mental illness can be challenging depending on the accessibility and availability of resources and supports to help vulnerable members of the community, and the amount of social capital within the community.

The phrase "mental health incident" evokes the idea of a crisis taking place, either criminal or non-criminal, involving a person with mental illness that precipitates a police response. From this point of view, they appear to be incidents that are singular, isolated moments in time. In reality, people living with mental illness have highs and lows in their patterns of behaviours over time based on their vulnerabilities and often mental health incidents are not simply singular moments in time but instead they are the result of a build up of multiple factors that can be seen coming by those around the individual (such as neighbours, family members, and others within the community). From this perspective, mental health incidents can be looked upon as a part of an overall picture or history of the person living with mental illness.

How do we help these vulnerable people avoid involvement with the criminal justice system? What alternatives are better to address instances where those with mental health issues are involved in incidents where the police are normally called? How should they be structured? Reflecting on my own research experience regarding the prevention and intervention of home takeovers[1] in Ottawa, this "think piece" will attempt to answer these questions, taking into account that: people living with mental illness often have multiple vulnerabilities that put them at a greater risk of contact with police; establishing relationships of trust between vulnerable individuals, police, and service providers can help to ensure those with mental health issues do not needlessly end up in the criminal justice system; mechanisms and resources of support within communities/neighbourhoods play an important role in the prevention and intervention of mental health incidents and in improving the stability and quality of life of vulnerable residents; and finally, alleviating social isolation and loneliness are important in the prevention and intervention of mental health incidents.

Complex Vulnerabilities and Building Relationships

People with mental illness often have concurrent disorders and complex vulnerabilities that can include homelessness, substance misuse, capacity limitations associated with developmental delay or poor health, and physical limitations. These vulnerabilities put individuals at a higher risk of crime and victimization (Criminalization of Mental Illness, 2005). In certain circumstances (i.e. home takeover situations[2]), these complex vulnerabilities complicate the dichotomy of criminal versus victim[3] and require alternative responses from police to ensure that vulnerable individuals are not needlessly entering the criminal justice system[4]. This understanding has led to a significant evolution in the thought process of Ottawa police in terms of crime and victimization.

Building rapport with police. The home takeovers project in Ottawa has led to an improvement in the relationships between the Ottawa Police Service (particularly the Direct Action Response Team), residents, and service providers. There is a better understanding among police that situations involving vulnerable individuals are complicated and as a result there has been a subtle change in how the police approach their interactions with vulnerable people. Rather than appearing only to resolve home takeover situations, the police have attempted to make themselves visible and accessible to residents, speaking with them, handing out cards, and making rounds with social service providers. This means that residents get to know and recognize the officers, building rapport with them so that residents will feel more comfortable going to them when they face an issue they cannot solve. Also, service providers are able to begin to build relationships of trust with the police so they can try work together when problems arise.[5] This highlights the fact that police play an important role in preventing mental health incidents by working with and supporting those living with mental health issues and other vulnerabilities (Coleman & Cotton, 2014).

Identifying vulnerabilities and maintaining relationships in housing programs. With regard to helping people living with mental health issues gain stability in their living situation, services provided by

[2] Home takeovers can be defined as "a situation in which a legitimate tenant or home owner finds themselves unsafe, physically, financially or psychologically, because of the presence of people in their home that they may or may not be able to remove. These situations can range in severity from theft to serious assault; involve a range of relationships from a family relationship to drug dealing; take advantage of the legitimate tenant's vulnerabilities (I.E. addiction, isolation, and capacity limitations associated with developmental delay or poor health); and always render the legitimate tenant or homeowner at risk of losing their home and uncomfortable in their own home" (Home Takeovers of Vulnerable Tenants: Perspectives from Ottawa, 2013: p.1).

[3] For example, in a home takeover situation in which drug dealers have taken over a tenant's home and are using it to deal or make drugs out of, the tenant is a victim of the predatory or exploitive person or groups that has commandeered their home and yet they bear some of the responsibility for their situation. They may have taken payment in the form of drugs, gifts or services and have knowledge of illegal business taking place in their home. In this sense, they are "complicit victims" ("Cuckooing": Unit Takeovers of Vulnerable Tenants, 2012: p.6, Home Takeovers of Vulnerable Tenants: Perspectives from Ottawa, 2013: p.2).

[4] For example, partnering with service providers when a home takeover situation is identified to ensure that the vulnerable tenant receives the appropriate support (i.e. treatment) and is not arrested along with those who have taken over the unit if an arrest is not warranted.

[5] Developing trusting relationships between service providers and sharing information can be challenging based on each agency's responsibility with regard to confidentiality and privacy.

housing authorities should include the early identification of vulnerable tenants and vulnerable tenants should be promptly partnered with the support services and resources necessary to help them become and remain stable. This would require ongoing and long-term support services for vulnerable tenants as well as partnerships with multiple agencies (i.e. addictions specialists, healthcare professionals, housing workers, police, landlords etc.). In situations where individuals are transitioning from street or shelter life to independent housing, this is especially important since they may require extra support to gain stability, establish a network of support, maintain their housing, stay on track with treatments and to prevent situations such as a home takeover.

Where vulnerable individuals are identified in public or private housing, caseworkers and other service providers need to establish relationships of trust with tenants so that they feel comfortable seeking help when they are faced with difficulties and so that they can be connected with appropriate resources when necessary.[6] Services need to be structured such that service providers are able to maintain close relationships with tenants: keeping contact on a regular basis, spending time getting to know clients, following up with vulnerable individuals who are at risk of difficulties associated with their vulnerabilities. This type of intensive support is difficult to provide based on current caseloads of service providers and the resource levels of support agencies but it would aid in the earlier recognition and intervention of situations that have the potential of escalating to mental health crises.

Approaching Mental Health Issues from a Community Perspective

Mental health issues have typically been approached from a clinical, individualistic perspective, but the support that communities (and neighbourhoods) can provide for people living with mental illness plays an important role in helping to reduce demands on the criminal justice system and to possibly prevent mental health incidents from occurring. This includes services along a continuum of care (i.e. treatment and recovery programs, crisis response, programs targeted at reducing problem behaviours, and health promotion) and also services that address the social determinants of health (i.e. housing and income).

Indeed, in recent years we have seen a movement in Canada toward developing and strengthening communities to support those with mental health and addictions issues. There has been recognition of the necessity of providing wraparound supports for those with mental health and addictions issues[7], and also recognition of the need to look beyond the healthcare system to provide resources and to create

[6] Using a home takeover as an example, a service provider who has established a close connection with a client may notice that their client is in distress or their client may inform them that they are in trouble. The service provider is then in the position to help their client resolve the situation and involve partner organizations if necessary (i.e. assisting clients to assert themselves and coaching them on what to say to remove unwanted guests from their homes and identifying and engaging the appropriate resources like a mental health worker, addictions services, or police to help out) (Home Takeovers Meeting Minutes, September/December 2014).

[7] For example, the At Home/Chez Soi (2014) project, a successful, evidence-based Housing First strategy grounded in principles of immediate access to housing with no housing readiness conditions, consumer choice and self-determination, recovery orientation (including harm reduction), individualized and person-driven supports, and social and community integration

supportive communities for those living with mental health issues and other vulnerabilities so that they do not have to suffer in silence[8].

Building Community

Reflecting on this movement toward inclusive, community-based approaches to mental health and addictions, it is possible to see that approaches to building community capacity, encouraging community engagement, and strengthening social capital will help to create supportive communities/neighbourhoods with services in place to support those with mental health and addictions issues (Neighbourhood Approaches to Mental Health and Addictions, 2014). Services structured around empowering communities to offer support to their own vulnerable populations by developing and leveraging the pooled skills and resources from community members and organizations can reduce the frequency of involvement of the criminal justice system with vulnerable populations. These approaches must include mechanisms for the meaningful involvement of individuals with mental illness and other vulnerabilities in decision-making and will include partnership with support agencies and other stakeholders for effective engagement (i.e. family members of vulnerable individuals, mental health and addictions professionals, ambulance/police personnel, hospitals, and community organizations that serve the needs of those with mental health issues).

Alleviating Social Isolation

While medication remains an important part of improving the quality of life of those living with mental illness, attention should be paid to services that can be provided within the community to support people with mental illness and other vulnerabilities. Often they will suffer symptoms that their medications do not address (i.e. inability to hold employment, difficulties associated with independent living, maintaining personal bonds with others, and social skills) due to deficits in attention, memory, planning, social skills, and social awareness (Kurtz, 2013). This can lead to the social isolation of those living with mental illness and other vulnerabilities. Furthermore, fear and stigma associated with mental illness and addiction are major barriers that can prevent individuals that have multiple vulnerabilities or concurrent disorders from seeking access to essential services and support. We need to find new and innovative ways to alleviate the stigma, alienation, and loneliness that often result from living with mental illness and other vulnerabilities and that can lead to decreased quality of life and an increase in the frequency of mental health incidents and/or involvement with the criminal justice system.

[8] *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (2011) outlines Ontario's goals to transforming its mental health services: improve mental health and well-being for all Ontarians; create healthy, resilient, inclusive communities; identify mental health and addictions problems early and intervene; and provide timely, high quality, integrated, person-directed health and other human services.

Strategies include:

Skills development

- Services that help residents to develop cognitive skills that will be beneficial in reducing their social isolation and vulnerability and help to engage them within the community. This might include therapies such as cognitive remediation and social cognition and interaction training programs run by psychologists for persons with schizophrenia (Kurtz, 2013; Liz & Sturm, 2012).
- Vocational services geared toward empowering people with mental health issues and other challenges by helping them to find employment, provide skills development, and breakdown stigmas around their ability to be productive members of society.[9]
- Programs geared toward independent living skills such as managing daily tasks (i.e. banking, grocery shopping, making appointments), accessing services and other resources, seeking out hobbies, finding meaningful employment, and attaining education.
- Services supporting those with lived experience of mental illness to have meaningful roles in their communities to increase social inclusion (i.e. leadership roles), to develop social skills, and to develop the ability to make and keep reciprocal relationships.

Community building

- Services that create a sense of community among those living with mental health issues and provide a space for non-judgmental gathering and support.[10]
- Within housing, services or programs that help to facilitate a "culture of community" that would empower residents to look after one another and report situations or incidents that take place within the building community. This would also include establishing networks of social support for vulnerable individuals where contact is maintained (i.e. with trusted neighbours, friends, family, and support workers) so that those living with mental health issues, addictions, and other vulnerabilities know that they are valued (Home Takeovers of Vulnerable Tenants: Perspectives from Ottawa, 2013).

Education and awareness

- Programs that seek to overcome misconceptions and breakdown stigmas surrounding mental illness and addictions through the use of educational materials, workshops, and events. The development of these programs must include the participation and input of people with mental health and substance misuse issues.
- Creating opportunities for interaction with individuals living with mental illness and other vulnerabilities to improve attitudes and behaviours about those populations, but also to give those vulnerable individuals a chance to share their experiences and connect with their peers as

[9] I.E. Causeway Work Centre (2014).
[10] I.E. Psychiatric Survivors of Ottawa (2014).

well as other vulnerable people (Neighbourhood Approaches to Mental Health and Addictions, 2014).

Social and recreational services

- Develop community activities and "drop in" support that bring community members together and encourage social inclusion, connection, and meaningful interaction (i.e. sense of community projects, neighbourhood events, empowerment projects). Specific examples include: projects that engage those living with mental health issues in creative pursuits (i.e. visual arts, writing, music, yoga, dance), BBQs, community gardens, community-led festivals and outings, peer support programs, cultural events, social clubs for those living with mental health issues, crafting groups and collective kitchens (Neighbourhood Approaches to Mental Health and Addictions, 2014).

Neighbourhoods are spaces for living and working, and where interaction takes place for utility, support, mutual aid, and socialization (Lebel, Pampalon & Villeneuve, 2007). Communities then, when engagement and social capital are high, are well situated to provide (in partnership with more formal mechanisms of support) resources and services to those living with mental health issues and other vulnerabilities so that they can receive care in the communities in which they live.

Conclusion

Preventing people living with mental health issues from becoming involved with the criminal justice system means that we must recognize that they often have multiple vulnerabilities that also need to be taken into consideration when structuring services to support these individuals. Establishing trusting relationships with vulnerable individuals (i.e. with police and service providers) is important to ensuring a more formal network of support is present for help when and if necessary to mitigate decompensation. This would require increasing the frequency and intensity of support provided. Furthermore, much can be done to establish informal networks of social supports within the communities and neighbourhoods vulnerable people reside in. Increasing community engagement and social capital can equip communities with the resources necessary to support their vulnerable population. Alleviating social isolation and promoting social interaction and integration will play a large role in preventing individuals living with mental illness from coming into contact with the criminal justice system.

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Meaghon Dunphy-Reid

Exploring the Use of Effective Mental Health First Aid as a means to Reduce Demand on the Criminal Justice System (discussion paper)

This paper addresses the importance of enabling first responders, notably police, with the right knowledge and skills to be able to intervene effectively with people experiencing a mental health problem, illness or crisis and make referrals to appropriate professional and non-professional supports in order to reduce burden on the justice system. For the purposes of this paper, the aforementioned knowledge and skills are acquired through effective and appropriate mental health first aid training. This paper also stresses the need for a whole community approach to supporting people with mental health problems or illness in order to reduce the number of interactions with the criminal justice system.

Definitions

For the purposes of this paper, 'mental health incident' is defined as incident where a mental health problem or illness precipitates a police response. Mental health problems are defined as the changes that occur in thinking, mood, and behaviour associated with significant distress and impaired functioning. Mental illness is defined as mental health problems that are diagnosed and treated by mental health professionals. This would include such problems as depression, bipolar disorder, anxiety, social phobia, schizophrenia, and personality disorders[11]. Mental health literacy is defined as the knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems.[12]

About mental health first aid

In Canada, there is evidence that there is a deficit in the public's knowledge of how to prevent mental disorders, the recognition of when a disorder is developing, the knowledge of help seeking options and treatments available, and the skills to support others affected by mental health problems[13]. Mental health first aid is the support provided to someone who is experiencing a mental health problem, illness, or crisis. Similar to physical first aid, the aims of mental health first aid are to preserve life where someone may be in danger to themselves or others, to provide support and comfort to the individual, and to guide/refer the person to the appropriate help. Mental health first aid does not teach people to be therapists, just as physical first aid does not teach people to be doctors. A critical component of mental health first aid and focus of this paper is the referral to appropriate supports. Those supports can be professional, defined as the most appropriate person/service that can help for their particular mental

[11] Secondary Education Definitions: Mental Health vs. Mental Health Problems, Mental Wellness vs. Mental Illness. In CAMH online. (n.d). Retrieved from http://www.camh.ca/en/education/teachers_school_programs/secondary_education/Pages/secondary_education.aspx

[12] Mental Health Literacy in Canada: Phase One Draft Report Mental Health Literacy Project. In CAMIMH online. (2007). Retrieved from http://camimh.ca/wp-content/uploads/2012/04/Mental-Health-Literacy_-_Full-Final-Report_EN.pdf

[13] Hadlaczky G, Hokby S, Mkrtchian A, Carli V, Wassmerman D. (2014). Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis**.** *International Review of Psychiatry.*

health problem (including mental health therapists, clinical psychologists/psychiatrists) or non-professional supports. Non-professional supports can include, but are not limited to, family members, friends, community leaders, distress lines, and self-help and support groups.

Mental Health First Aid Canada is the primary training program that teaches Canadians how to apply mental health first aid. This evidence-based course shows that participants demonstrate an increase in mental health literacy, a reduction in stigma towards people with mental health problems or illness, and an increased confidence in helping behaviors/increased likelihood to use their mental health first aid skills for someone experiencing a mental health problem, illness, or crisis. In addition, there are several more general mental health training programs in Canada regularly used by police organizations that are designed to enhance the participant's knowledge of mental health problems and illnesses. These include, but are not limited to the Road to Mental Readiness (R2MR) and Applied Suicide Intervention Skills Training (ASIST). Additionally, the TEMPO report outlines how mental health first aid training can be used in a framework that aims to provide ongoing, integrated learning that improves the quality, outcomes and perception of police/pmi interactions.[14]

For low-priority or non-criminal incidents, what alternative(s) is/are better to address instances where those with mental health issues are involved in incidents where the police are normally called?

Several police services document that responding to mental health issues uses a significant amount of police resources. In one example outlined by the Vancouver Police Department (VPD), mental illness is believed to contribute to 21% of incidents handled by VPD officers and 25% of the total time spent on calls where a report is written. In the 1990s the VPD only had 1.5 full-time employees assigned to deal with those suffering from mental illness and addiction. However, in 2013, this has increased to more than 17 full-time employees[15]. This is a trend that is reported by several police agencies across Canada. The prevalence and growth of police time spent managing mental health incidents implies, in part, the lack of use of other mental health resources as a first point of contact for those with mental health problems or illnesses. An increased ability for both community members and police that interact with people with mental health problems or illness to 'recognize and refer' could have a transformational effect on the burden to the justice system, particularly for low priority and/or non-criminal incidents. De-institutionalization and the limited services for mental health in the community have increasingly left the criminal justice system to deal with those who have a mental health problem or illness[16]. A lack of community coordination to identify its own comprehensive understanding of available mental health resources coupled with this same lack of knowledge for police referrals means that police and other first responders end up being the first point of contact in a mental health incident.

[14] Coleman T, Cotton D. (2014). TEMPO: Police Interactions: A report towards improving interactions between police and people with mental health problems.

[15] Vancouver's Mental Health Crisis: An Update Report. (2013). Retrieved from http://vancouver.ca/police/assets/pdf/reports-policies/mental-health-crisis.pdf

[16] McCann. (2013). Policing and the Mentally Ill: A Review of Issues Related to Mental Health Apprehensions by Police in British Columbia.

It is widely accepted that prevention and early intervention lead to better mental health outcomes for people with mental illness. This early intervention starts with a recognition of the most common mental health disorders affecting Canadians, including mood disorders, substance related disorders, anxiety disorders, and psychotic disorders. This is supported by *Recommendation 2: The Learning Spectrum* outlined in the TEMPO report which calls for an understanding of the symptoms such as hallucinations, delusions, paranoia, thought disorder, mood disturbances, intellectual impairments, memory problems, disinhibition, behavioral disturbances and other signs and symptoms that may accompany major mental illnesses and related problem. [17] By recognizing the signs and symptoms associated with each of the common disorders, community members and police can better select the appropriate referral systems to promote diversion from the criminal justice system into more appropriate supports. Early intervention increases the likelihood that those with mental health problems or illnesses stream into the right support systems instead of being managed through the criminal justice system.

The concept of mental health first aid skills' effectiveness for use in the justice system, notably with police, has been studied internationally. In the UK, a report produced by the Sainsbury Centre for Mental Health indicated that 15% of incidents dealt with in the UK on a daily basis were mental health related with negligible numbers of diversion and referrals into the community in relation to mental health linked to police custody. An examination of options to mitigate burden on the police outlines mental health first aid as an initiative as a useful vehicle for delivering training for police and allied agencies as well as other justice officials to understand more about mental health issues and implement procedures and to engage within communities with local agencies more effectively. Similar to the recommendations in this paper, the report also recommends that Crime and Disorder Reduction Partnerships be implemented in community to ensure a multi-agency community response when dealing with a mental health incident. The report states 'police should not be relied upon as a '24-hour social services, but should be further downstream to act as a flag raising and directional service, providing links to other agencies enduring more appropriate placement for an individual with mental health problems.' [18]

In the US, Mental Health First Aid training has been designed for officers to utilize not only during a mental health crisis response, but also during their routine consensual encounters with victims, witnesses, homeless people, missing persons, and other community members appearing distressed. Several police departments around the United States have added Mental Health First Aid to their training programs with positive results. In one case study at the Rhode Island Municipal Police Academy, where 1, 100 public safety officers are trained in mental health first aid skills, a recent case study cited that mental health first aid was a key factor in providing meaningful and effective response to the estimated 10 percent of behavioral health–related calls for service in his community, stating that

[17] Coleman T, Cotton D. (2014). TEMPO: Police Interactions: A report towards improving interactions between police and people with mental health problems.
[18] Rather P, Fitzpatrick R, Rutherford, M. (2008). Briefing 36: The police and mental health. Retrieved from http://www.centreformentalhealth.org.uk/pdfs/briefing36_police_and_mental_health.pdf

"providing the maximum number of officers with mental health first aid training demonstrates to the community we are committed, not as a de facto public health agency, but a professional agency that recognizes and accepts its legal and caretaker responsibility." [19]

An alternative then for low-priority or non-criminal incidents is twofold. Firstly, working with community supports who may be the first line of communication with persons with mental health problems or illnesses (such as shelter workers, community volunteers, etc) to become familiar with mental health supports for referral depending on severity including local mental health facilities, distress lines, faith-based groups, family members, or friends as a first method of referral for situations where someone is not at risk to themselves or others. Secondly, equipping police with the right skills to assess mental health problems and illnesses and to create a comprehensive list of professional and non-professional supports available in their community, provincially, and nationally to make these referrals after appropriate mental health first aid training has been received.

Is there a different response required, in urban settings or rural settings, in different political jurisdictions, for different types of mental health incidents? What makes these responses "better"?

There are several considerations to undertake when employing mental health first aid in different settings. Including:

Severity of mental illness in response to mental health incidents

Mental health problems and illness occur along a spectrum from mild to severe. The undertaking of mental health first aid equips the participant with the skills necessary to intervene throughout the spectrum, but employs different referral tactics depending on the severity of the incident. In the absence of a criminal act, very few incidents require the support of police or others in the criminal justice system. Those that would still involve police interaction are those instances of crisis first aid where someone may be in danger to themselves and where the mental health act may be invoked. Referral to appropriate professional support will differ depending on the mental health disorder indicated. Considerations in regard to this spectrum not covered by mental health first aid include dual-diagnosis, which may also be an important factor in ensuring further engagement with the criminal justice system after an initial mental health incident.

Urban and rural capability to handle mental health incidents

The identification of appropriate community and non-professional supports is a major consideration when applying mental health first aid in rural and remote settings, where professional supports such as hospitals, intake centres, etc. may not exist as they do in urban settings. In these settings, police and other first responders are often called on to be the primary mental health supports in many cases. In this

[19] Gibb BV. Mental Health First Aid for Public Safety— Three Case Studies. (n.d). Retrieved from http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display_arch&article_id=3547&issue_id=112014

instance, mapping community informal supports (community leaders) and remote supports (online or mobile resources, provincial/territorial distress lines) is of critical importance.

Cultural competency to handle mental health incidents

Culturally appropriate and safe mental health first aid and referral is key in the assessment and referral of individuals with mental health problems or illness. This is most prominent in First Nations, Inuit and Metis populations, where a recognition of traditional supports, including but not limited to the use of Elders and noted community leaders can play a critical role in deescalating mental health incidents and providing support over the long term for a community member. This ability to ensure referral to community based supports and a concrete understanding of culturally competent and safe approaches with First Nations, Inuit and Metis communities is of importance when engaging a with a person experiencing a mental health problem or illness in order to maintain relationship and guide the individual to appropriate support.

In relation to diverse populations, an evaluation of mental health first aid in a diverse community setting conducted in 2012 suggested that Mental Health First Aid training increased participant recognition of mental illnesses, concordance with primary care physicians about treatments, confidence in providing first aid, actual help provided to others, and a reduction in stigmatizing attitudes. A 6-month follow up also yielded positive long-term effects. [20]

What services are needed, and how should they be structured, to reduce demands on the criminal justice system and ensure that only those who should be in the criminal justice system, are?

Currently, the amount of in-service education centred on 'recognition-referral' /mental health first aid training varies amongst police organizations, ranging from mandatory training to none at all. Combined with a lack of lack of community support systems that has led to the number of people with mental illness within the criminal justice system. Contained below are initial suggestions on the steps to implementing services that would support communities and police to decrease the number of people with mental health problems and illnesses interacting with the criminal justice system.

Develop a comprehensive mental health first aid training plan coordinated across police agencies

Currently, several police organizations and agencies are responsible for the creation and delivery of mental health first aid training (i.e. police college level, in-house agency training, CPKN, etc.). A comprehensive training plan that takes into consideration the police/first responder environment that equips participants with the skills to be able to recognize and refer, along with the creation of a training

[20] Morawska A, Fletcher R, Pope S, Heathwood E, Anderson E, McAuliffe C. Evaluation of Mental Health First Aid training in a diverse community setting. *International Journal of Mental Nursing, 2012; doi: 10.1111/j.1447-0349.2012.00844.x.* Abstract

baseline for these skills that is common across all jurisdictions would be recommended. Tailoring of this training for police and other first responders could include enhanced de-escalation training and the inclusion of curriculum pertaining to dual-diagnosed individuals. Mental Health First Aid USA currently has a mental health first aid curriculum for public safety officials that has trained over 100 000 police officers and other public safety professionals with encouraging early evaluation results.

Identify community supports that interface with people with mental health problems or illness on a regular basis

In order to decrease the frequency and potential severity of interaction mental health incidents with the criminal justice system, equipping community members who interface with the public on a regular basis with the appropriate mental health first aid training and knowledge of appropriate supports is ideal. This would be particularly useful for community supports that interact with people in high-risk groups for mental health problems and illness.

Identify professional and non-professional supports

There are a number of formal and informal supports available for individuals who may be experiencing a mental health problem, illness, or crisis. A process of identifying common national or provincial professional supports would be a recommended first action. Secondly, the development of community or regional task group would be useful in identifying appropriate local professional supports. Appropriate mental health first aid training will equip police/first responders with the skills to identify non-professional supports such as family members, friends, co-workers and community leaders (i.e. Elders) for referral. Knowledge translation of these supports to police/first responders and other community members is critical to success in this model. Information should be current and accessible to the mental health first aider.

Track referral in relation to demand on criminal justice system

The ability to track the use of mental health first aid in relation to decreased demand on the criminal justice system is key to refining its use as a tool. Systems should be put in place to track the number of times a person involved in a mental health incident was referred to professional or non-professional supports and if that referral decreased demand or further engagement with the criminal justice system.

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Abstract

The first response to a community mental health crisis is often to solicit the support of the police. This submission to the Department of Justice highlights why this is not the preferred intervention in the vast majority of cases, and how a police presence can often further provoke an already compromised individual. This submission focuses primarily on young people who may come into crisis. It summarizes the nature of the most common mental health disorders with youth which first responders are likely to be challenged by. It also suggests ways in which those who work most closely with young people and where such crises occur, such as with teachers and foster parents, can be educated through on line mental health literacy training, to be effective in identifying crises early on and help deescalate, if not prevent, the need for further crises management.

Acknowledgment

Appreciation is extended to the numerous sources of input for this submission that included those in policing, mental health and education. Noteworthy, I would like to acknowledge: Chief of Police John Pare and Superintendent Bill Chantler of London Police Services; Melikie Joseph of the London Police Services Family Consultants; Dr. Ian Manion, Executive Director, The Ontario Centre of Excellence in Child and Youth Mental Health and Steve Cordes, Executive Director of Youth Opportunities Unlimited. A review of relevant literature also provided a context for this submission to the Department of Justice.

The Questions

The Justice Department's request for a submission related to the intersection of police services with those who experience mental health disorders recognizes, what would appear from media coverage and personal reports by service providers, to be an increasing prevalence of individuals who are experiencing minimal to severe emotional disorders and crises in the community. And, regardless of whether these critical incidents are of a formal legal nature, de facto, police services are often the first point of contact in many of these incidents. The specific areas of interest for the Department of Justice included:

1. Examining alternatives to police intervention to address the mental health issues by other first responders who could be viewed as being on the 'frontline' of providing some form of human service to those in need.
2. A context for differential response related to the nature and degree of the mental health incident.

3. Suggestions for how services could be structured to reduce demands on the criminal justice system.

The Definition of a Mental Health Incident

For the purposes of this submission, a *Mental Health Incident* [MHI] is defined as:
1) A behaviour on the part of an individual that is of such magnitude that it demands a response from someone within the vicinity of the person who is in crisis; 2) The MHI requires someone external to the person for it to be deescalated; 3) The etiology of the behaviour stems from an emotional reaction that is either reactive in nature, such as to an external or triggering event, or a result of an internal rumination that escalates to a worrisome degree; 4) That the incident takes place within a public forum or venue that engages atleast one other person; 5) The incident is of such magnitude that there is a high likelihood of the police being called to respond.

The Context

This submission is written primarily in the context of how these questions relate to youth, although the latter areas of this submission relating to online mental health literacy training and *Mental Health First Aid* will relate equally to an adult population.

The focus on youth reflects the author's expertise and years of working and conducting research in the youth justice, children's mental health, child welfare and educational systems.

This review provides a context for youth mental health related to the extent and nature of disorders that will help situate the questions relating, in part, to why the criminal justice system - primarily police services - are called at such a high frequency to intervene and what alternatives need to be considered. The first section of this submission serves as a guide to the nature of the mental health disorders that emerge in youth. The second section speaks to innovations in police mental health collaboration. The third section explores the potential of extending mental health literacy training in two contexts for mental health intervention, the education and foster care systems, along with a discussion of the broader potential of such training within the model of *Mental Health First Aid*.

A. The Nature and Degree of Mental Health Disorders in Youth

We Have Underestimated the Need. While Canadians are accustomed to data reflecting that 1 in 5 young people will experience some form of mental health disorder [MHD] in their lifetime, more recent commentaries regarding prevalence rates of youth MHDs indicate this number to be much higher. Leschied, Saklofske and Flett (2014) indicate the actual percentage will more closely approximate up to two thirds of youth under the age of 18 will experience some form of MHD, and that while all of these youth will not achieve diagnostic clinical levels such as in the 1 in 5, these two thirds of youth are at risk and in potential need of requiring some form of service from the community.

The Extent of Demand in Youth Mental Health has Largely Gone Unrecognized. Canada's Mental Health Commission Report (2006) Out of the Shadows at Last characterized our youth mental health system as falling so far below what the need requires, that it warranted the characterization as the 'orphan of the orphaned mental health system'. Recent data from Statistics Canada (2014), in noting the increase in reports of young people with mental illnesses, highlighted the inaccessibility of youth psychiatric and psychological mental health services, with a call for re-evaluation of the funding structure to support increased accessibility to such services.

Accessibility. Reviews abound such as the one produced by the Ontario Centre of Excellence in Child and Youth Mental Health (2010) regarding access and wait times in child and youth mental health. The data we have now reflects that, and if we stay with the 1 in 5 statistic of youth who meet a clinical diagnosis of MHD, only 1 in 5 of those youth will obtain a service related to their MHD (Kutcher, 2012) and this is due to either wait times or services being inaccessible such as in rural or more remote areas of the country.

> *"When it comes to young people who are in mental health crisis we cannot get beyond the fact that there are severe restrictions on access to the children's mental health system due to a lack of capacity within that system and the level of complexity attached to navigating within it."*
>
> *Chief of Police John Pare, London Police Services*

Nature of MHD with Youth. The leading MHDs characterizing our young people relate to depression, anxiety, ADHD, addictions and suicide. The latter remains among the leading causes of death in young people under the age of 18 years, and on occasion even eclipses accidental death (i.e. motor vehicle). In certain communities it far exceeds any other cause of death amongst the young. In addition, among the more recent increases in prevalence of MHDs in young people is non suicidal self injury [NSSI] which is now included as a separate diagnostic category in the DSM V. NSSI characterises young people who self harm to the extent of tissue damage but without the intent of taking their own lives, as reflected in suicidal intent. Recent studies estimate that NSSI in Ontario has a prevalence rate of 1 in 20 within a non-clinical high school sample (Bethel, Bondy, et. al., 2013), and 1 in 5 within a child mental health sample (Stewart, Baiden and Theill-Honey, 2014).

Relevance of MHD in specific groups of youth. While the above summarizes the general nature, and to some degree prevalence of MHDs in youth that police and other first responders will have a higher likelihood of interacting with, certain groups of youth will have a much higher rate of certain disorders, one of which being those youth who are justice-involved. Our own reporting of the MH data in justice-involved youth indicates that 50% and up to 75% of youth in the justice system will have a diagnosable MHD (Leschied, 2011). Rawana, Gentile, et al. (2015) indicate that the rate of MHD in justice-involved youth reflects "five times as many comorbid mental health issues than their community counterparts". The most common MHDs for these youth include a substance abuse disorder, major depressive disorder, and trauma as a result of being vicariously or directly traumatized by violence.

"I believe that we need to look at non-traditional sources for support to keep mental health issues involving youth from becoming police matters. Communities of support build resilience and build buffers in which ego preservation becomes not so compromised as to involve the police, who, by their very nature, ramp up control and power and introduce elevated states for people already under duress. When families and other supports break down, other communities of support need to step in".

Steve Cordes, Executive Director, Youth Opportunities Unlimited, London, Ontario

What Youth MHDs are First Responders Likely to Interact With? There is no data that alerts us to who those youth are that present to first responders when they are in crisis. We can extrapolate however from the general prevalence data as cited above, that these youth will represent the full range from low, to those most highly distressed. We can also now appreciate that even the most highly distressed youth will not necessarily be receiving any psychological service due to the reasons indicated above that relate to capacity limits on available mental health treatment and services being unavailable at the time of the crisis. Other reasons will include stigma attached to being seen for treatment, and the trend to provide non residential services thereby keeping more young people who experience serious MHDs in the community, a fact that is also reflected in the youth justice system where there has been a steady trend over the past 10-15 years towards non custodial sanctions and community based options as court outcomes.

The conclusion is that, what will bring first responders into the lives of MHD youth will likely be for reasons related to, and this is not in any specified order:

1. Reactive depressive disorders that will be either episodic in nature or linked to an ongoing depression.
2. Traumatic responses of a youth due to violence that triggers an already traumatized young person who will have had a previous experience with violence.
3. Suicidal youth.
4. Self harming behaviour that is not suicidal in intent.
5. Anger and threatening behaviour that could be either episodic or reactive in nature or associated with a prevailing conduct disorder.

B. Innovations in Police Mental Health Collaboration

Situating Police Services in the Context of MHD Youth. As the Department of Justice has identified in this call for submission, in many if not most communities, police services are the first line of defence when the concerning behaviour of a person is identified. This will be the case where there is:

1. No existing service provider currently involved in the young person's life.
2. Existing services are not available in the moment.

3. The young person is perceived as being a threat to others.
4. The young person is perceived as being a threat to himself or herself.
5. Expertise is lacking within the system at the time where the young person is experiencing distress (i.e. at school, a foster home, a street youth).

Numerous commentaries regarding why police services are the first responders called in most of these matters suggests the following:

1. Police are readily available and mobile.
2. Police present the physical means by which the person who is often seen as volatile and unpredictable can be controlled.
3. Police are assumed to have an understanding regarding MHDs due to the frequency with which they interact with such individuals.

But are the police the most appropriate first responders in these matters? It is evident that where there is a threat to physical safety, be it as a threat to others or to the person themselves, there is a role for the police to take physical control of the situation. While this may be related to a MHD, it is noteworthy that there need not be MHDs in all cases where such behaviour is evident, such as in the case where the behaviour is driven by consumption of a substance; alcohol, prescription or illegal drugs. In fact, there is literature that indicates the presence of the police can be a provocation for certain individuals that can actually escalate a crisis, and that not only are the police not the most appropriate first responder on the scene, but their presence may even be contraindicated in acting as *a provocateur* to the emotionally distressed individual (Brink, Livingston et al, 2011).

> *"I think people would be surprised to know what the limits are to what the police can do in a mental health crisis. We can invoke the criminal justice system. In rare cases we can utilize appropriate laws and statutes related to provincial mental health law. Many people think the police have greater access to the mental health system than they do. This is simply not the case".*
>
> *Superintendent Bill Chantler, London Police Services*

There is also the limitation on what the police can do. They can view the events as a criminal justice matter; invoke in extreme cases relevant provincial mental health legislation; or in a certain minority of cases, use physical force where necessary to de –escalate a crisis.

> *"I am concerned about the potential to criminalize youth while they are waiting to access mental health services. In most situations when a young person experiences a mental health crisis, it should be the mental health system that is the first point of contact not law enforcement".*

Melikie Joseph, London Police Family Consultants

There is now a convergence of opinion within police services that the police are called upon, not because they are the most appropriate service, but due to a lack of education regarding what the police can, and most importantly cannot offer, there is deference to the police in matters where there is a lack of understanding regarding the circumstances around an individual's too often inexplicable behaviour. Most misunderstood is the idea that the police have access to the mental health system. This can only be the case where there is an already existing notice out for an individual under provincial law or where there may be a possibility of such an order being made.

Police and Mental Health Collaborations. There are a number of discussion and research papers that speak directly to police service and mental health collaborations. Noteworthy are, in Canada, The Canadian Mental Health Association (2003) and the Human Services and Justice Coordinating Committee of Ontario (2011), and in the U.S., The U.S. Department of Justice (2010) and The National Centre for Mental Health and Juvenile Justice (2013). These reports speak to the more traditional sources of collaboration between police, the criminal justice system and mental health providers. These reports highlight the need for unique responses that join the police and mental health services through: 1) Improving communication between the police and hospital or residential based mental health services; 2) The creation of crisis response teams, which are the most researched aspect of the police and mental health interface; 3) Creation of police 'reception centers' where the police can take those suspected of a mental health disorder; 4) Establishing screening measures that help first responders assess the degree of seriousness of a critical incident. The most commonly cited in promoting police and mental health collaborations being the Massachusetts Youth Screening Instrument (Grisso, Fusco et al., 2011), and the interRAI Brief Mental Health Screener that is being piloted within various Ontario police services (Hoffman, 2013).

"In Ottawa, Police Services have partnered with Youth Net to provide an easily accessible pocket guide to youth community resources vetted by youth. Police/youth partnerships can provide great insights into process issues around how to effectively engage youth at an individual and community level. It also lets youth champion the supportive aspects of the community policing role".

Dr. Ian Manion, Executive Director, Ontario Centre of Excellence in Child and Youth Mental Health

C. Extending Mental Health Literacy Training

Preparing Others to Assume the Role of a First Responder. Awareness related to MHDs is experiencing unprecedented attention in the media and is now a part of our public awareness. Note for example PSAs related to stigma reduction in mental health and coverage related to the impact of bullying / cyber bullying. In addition, and what is also increasingly apparent, is the acceptance that, in the youth mental

health sector, there is currently not, nor will there ever be, adequate funding or resource allocation to accommodate the level of need. As a result there is strong emphasis currently in educating those who naturally occur within the young person's environment to assume the role of "front line mental health provider". Two examples follow regarding how this is being provided.

School Based Mental Health. Considerable momentum now exists to situate mental health resources within schools. The logic is obvious. First, this is where young people spend the vast amount of their time. Second, there is a workforce present that is child/youth friendly and highly educated, albeit not specifically trained in mental health. Recent findings from a cross-Canada study on teacher attitudes regarding their role as a frontline mental health service provider for youth suggests there is an awareness of their willingness and responsibility, while also recognition that they are not currently well prepared to assume this role (Rodger, Leschied, et al., 2014).

Foster Parents as a Mental Health Resource. Similarly, there are others within the natural world of a young person who, by virtue of their position, could also be a front line of service provider in addressing mental health need. Children/youth who reside in foster care within the child welfare system present with a high degree of mental health disorders, often as a consequence of the factors that contributed to their being placed in care, such as through the impact of neglect and violence (Stewart, Leschied et. al. 2013). Yet foster parents are frequently not provided with the knowledge to appreciate, nor respond meaningfully to young people who are in crisis.

Mental Health Literacy Training. As a result of the two previously cited contexts for young people who experience MHDs, and where police are called on a high frequency basis to respond to crises, has been our approach to deliver mental health literacy training with the intent to equip, in these two cases, teachers and foster parents, to respond with understanding to support young people in deescalating crises. Such training has been developed with current technology and support using online training platforms that draw on pedagogically effective instructional methods. The delivery of mental health training with online access meets the need for persons who are unable to attend training in person or where geography presents challenges to attendance.

There is we believe, an as yet untapped potential in online mental health training delivered to persons who heretofore may have viewed themselves as wanting to provide support in certain contexts but who were without the sufficient knowledge to respond meaningfully and responsibly.

Situating Mental Health Literacy Training in the Context of First Responders. This is not to suggest that putting mental health knowledge and literacy training into the hands of teachers and foster parents as examples, will make these front line supports fully fledged mental health interveners. This is neither the intent nor the desire. The intent is to equip those who work closest to youth who experience MHDs with the ability to: 1) Identify the nature and degree of the disorder; 2). Relate in a meaningful way to the

youth once having identified the nature of the presenting challenge; 3) When necessary, deescalate an immediate crisis; and 4). Triage and refer to more intensive services where indicated.

Our work in this area has generated the mental health program content, and online learning platforms in extending mental health training thus far to: 1). Teachers; 2) Teachers in preparation within faculties of education, and; 3) Foster parents who work within the child welfare system.

Findings from Mental Health First Aid. There is the potential to extend online mental health training to other groups who routinely interact within the naturally occurring world of young people, and who heretofore, may not have been able to access knowledge that would enable them to be aware, and effectively intervene, in times of need. We view this level of intervention as occurring in contexts where there is a high probability of distress with a young person, and where past experience has suggested that other first responders such as the police are called to deescalate a potential or actual crisis. This statement capitalizes on findings that suggest a young person is more likely to trust and hence engage with a known person as opposed to a stranger or the police who, by their presence, may actually escalate an already risky situation, and who, as aforementioned, are actually quite limited in what they can do once they are called.

The Mental Health First Aid[21] [MHFR] initiative is an example of a program that situates mental health support close to the person who is experiencing distress and is delivered by someone who is known, familiar with, and/or physically close to the individual. MHFA is help "…provided to a person developing a mental health problem or experiencing a mental health crisis. Just as physical first aid is administered to an injured person before medical treatment can be obtained, MHFA is given until appropriate treatment is found or until the crisis is resolved". The Mental Health Commission of Canada's (2014) review of the evidence regarding MHFA supports the belief that putting mental health knowledge into the hands of individuals who may not previously have had such expertise can be enabling in addressing mental health crises.

The knowledge that MHFA can be effective, particularly in situations where other first responders such as the police are usually called, suggests this may be one increasingly relevant aspect of delivering an effective adjunct, or in certain cases, alternative to, the demand on first responders. Within this context, is it necessary to increase mental health training to others within the young person's environment? This could be effected within the model of online mental health instruction that has been developed, piloted and evaluated as previously discussed in this report, with teachers and foster parent care givers[22].

[21] Details regarding *Mental Health First Aid* in Canada can be found at: http://www.mentalhealthcommission.ca/English/initiatives-and-projects/mental-health-first-aid

[22] A general discussion regarding these initiatives by the author and his colleagues can be found at: http://www.edu.uwo.ca/research/newsletterCMS/fall_2014-V3_I1/Story3.html. The actual content of these courses are available from the author.

There is of course a cautionary note to encouraging mental health literacy training. Once an individual is in crises, and after de-escalation has been achieved, there often remains a need for mental health follow-up. This once again raises the specter of inaccessibility to the mental health system [MHS] and argues for placing first response to a crisis within the mental health system such as with crisis intervention teams who work within a continuum of service and where sources of support within the MHS can be readily accessed.

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A One-Health Approach – Multi-Sector Interdisciplinary Collaboration

The One Health Initiative is a worldwide movement for advancing healthcare in the 21st Century and a strategy for expanding interdisciplinary collaborations and communications in all aspects of healthcare for humans, animals and the environment[23]. What does this global movement have to do with the justice sector and this paper?

The One Health concept echoes the conclusions that arose from the Building Bridges: Mental Health and the Justice System, a Symposium to Promote Collaboration held in Calgary, Alberta May 25 and 26, 2011. The Canadian Foundation for Animal-Assisted Support Services (CFAS) concurs that cross sector, interdisciplinary collaboration and partnerships are vital to responding to mental health challenges within the justice system.

In light of the fragmentation of Canada's service and companion animal community CFAS is well acquainted with these challenges. As such, our vision is to be the philanthropic leader that sustains the innovation, coordination, and integration of Animal-Assisted Support Services within Canada's health care, social service, and justice sectors in order to improve the quality of life of people with physical, emotional, and social challenges.

In order to address these gaps CFAS created a single-point of entry to unite and engage a host of stakeholders in order to explore interest in collaboration and the development of a sector that does not currently exist. The absence of national benchmarks in some areas, inconsistent or non-existent legislation, and lack of Canadian clinical research make it difficult to have these services and activities recognized within the justice, healthcare, and social service sectors. The cost for some services have skyrocketed such as in the service dog realm ranging anywhere from $3,000 to $50,000 per dog[24].

Vulnerable people continue to fall through the cracks in our health, justice, and social services systems because developing strategies to address the division between people, sectors, and organizations is no small undertaking. Over the years, the CFAS has discovered that without a cohesive, recognized Animal-Assisted Support Services Sector, anyone can set up a service animal business or organization with little or no accountability or support. Additionally, the fierce competition for resources creates tension between service providers making the current environment exceedingly challenging to navigate and harmonize.

Despite the gaps and fragmentation in this emerging sector, interest in Animal-Assisted Support Services continues to flourish. Recent newscasts pay homage to such testimonies, especially concerning Canada's war veterans[25]. CFAS hosted two national military summits in 2013. Following the summits,

[23] One Health Initiative. http://www.onehealthinitiative.com/
[24] Dube, Dani-Elle. 2 March 2015. "Buyer beware for autism service dogs." *Ottawa Sun*. http://www.ottawasun.com/2015/03/02/buyer-beware-for-autism-service-dogs Accessed 6 March 2017
[25] Canadian Foundation for Animal Assisted Support Services. http://www.cf4aass.org/call-to-action---the-major-general-lew-mackenzie-fund.html

CFAS submitted a New Work Proposal to the Canadian General Standards Board (CGSB) to research the feasibility of Developing of a National Standard of Canada for Service Dogs. CGSB's research confirmed the feasibility of this project. Thanks to Veterans Affairs Canada, the project is being rolled out in 2015.

There are many well-intentioned people across the country doing great work in the field; however, this work is not able to benefit the entire country because the infrastructure to support efforts is still lacking.

It is also important to note that not all services are therapeutic from an epidemiological perspective. For example, "hippotherapy is a form of physical, occupational, speech therapy in which a therapist uses the characteristic movements of a horse to provide carefully graded motor, and sensory input."

Hippotherapy[26] should not be confused with the benefits of recreational riding that may also be described as being therapeutic. Consequently, defining terminologies, applications, and processes through cross-sector interdisciplinary collaboration and in some instances evidence-based research is important in order to establish more realistic expectations and relevant evaluation criteria. CFAS recognizes these gaps as opportunities to work with Animal-Assisted Service Providers to build a credibility chain to ensure a consistent level of quality, safety, and satisfaction of those served. Acupuncturists' massage therapists, and chiropractors have had to address similar concerns in order to have their services accepted as well.

In the following pages, examples of animal assistance programs in the justice system in Canada (and some in the United States) that are currently underway will be described. In addition, the paper will address how to move this community forward in ways that could benefit Canadians with mental health disabilities.

CFAS launched the One Health for People, Pets, and Partners Initiative to demonstrate its commitment toward the One Health collaboration concept. Even before the opportunity to endorse this global movement presented itself CFAS was engaged in activities that upheld the intentions behind this global movement by hosting events to unite and include a variety of non-traditional and traditional stakeholders to share different perspectives and approaches in order to find ways to learn from each other and forge ahead together.

Companion and service animals have played a significant role in Canadian society throughout history; therefore, CFAS is convinced that they could play an integral role within the justice sector given their versatility and past successes.

CFAS is uniquely positioned to host justice-focused events, initiate and/or support research, implement pilot projects, and support the development of national and provincial programs.

Canadian Mental Health Programming

Vicarious trauma and compassion fatigue are serious issues facing first responders, making them susceptible to physical and mental illness. In order to help address the impact of these challenging

[26] American Hippotherapy Association, Inc. "What is hippotherapy?" http://www.americanhippotherapyassociation.org/ Accessed 6 March 2017.

professions CFAS introduced the "Call to Action Program." Even though CFAS's corresponding Major-General Lew MacKenzie Fund focuses primarily on Canadian troops, veterans, their families, and support staff, the program is available to first responders as well. The aim of this program is to bring together stakeholders to identify common goals to help develop a collective strategy in order to make the best possible use of time, energy, talents, expertise, and resources.

In 2012, The Mental Health Commission of Canada recommended that diversion programs be the next alternative with an emphasis of community supports being in place through the development of a national mental health strategy[27].

One such strategy could be working with CFAS to develop a national youth program with local impacts. For instance, the Ontario SPCA's Youth Animal Pilot Program involved troubled youth who were matched with dogs that would be euthanized if they were not adoptable at the end of the 11-week pilot. The participants learned how to: be more responsible, manage their anger in ways that are more constructive, become better communicators, and control impulsive behaviour.

Replicating projects like this by creating more opportunities to build community supports and partnerships would not only help these young people from entering the justice system, but foster youth advocates that could mentor other youth.

Justice Canada's Victims Fund supported the first victim services dog in Delta, BC, starting in 2010. Since then, support dogs have joined victim services – both police-based and community-based – in Edmonton, Calgary, and Camrose in Alberta and York Region in Ontario[28].

Programs like Pawsitive Directions Canine Program, Melody Acres - Partners in Process and Horses Refining Hearts provide opportunities for prison inmates, troubled youth, and victims of crime to learn critical life skills and in some cases work related skills[29].

To address the sustainability of programs like these CFAS`s national strategy includes the development of a National Annual Grants Program by 2020, a credibility chain and best practices that build bridges between sectors making a way for service providers to focus on service excellence rather than competing for funding and other resources[30].

Criminal Justice System Programs

Animals in Corrections

External bandages do not heal internal wounds - that`s why programs like the Wild Horse Inmate Program (W.H.I.P) at the Colorado Correctional Industries (CCI), and the Prison Trained K-9 Companion Program (PTKCP) exist.

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[27] Current Issues on *Mental Health in Canada: Mental Health and the Criminal Justice System*, Publication No. 2013-88-E, 16 December 2013

[28] McDonald, Susan and Lara Rooney. 2014. "Let's 'Paws' to Consider the Possibility of Using Support Dogs with Victims of Crime." Victims of Crime Research Digest, issue 7. http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd7-rr7/p4.html

[29] Canadian Foundation for Animal Assisted Support Services. http://www.cf4aass.org/crime-prevention.html

[30] Canadian Foundation for Animal Assisted Support Services. http://www.cf4aass.org/annual-grants-program.html

W.H.I.P. is a sustainable equine intervention program for prison inmates in Colorado. A distinctive partnership between the CCI and the Bureau of Land Management (BLM) made training mustangs possible and then putting them up for adoption enabling them to lead productive lives with youth riding organizations, therapeutic riding organizations, riding stables, and government agencies. The Prison Trained Dog Program operates in a similar fashion. Once trained, the dogs go on to being family pets, resident dogs in various community organizations, and assistance dogs. The Wild Horse Redemption Documentary[31] provides a powerful glimpse into the many advantages of teaming up hard-core inmates and these majestic creatures.

Both humans, and in many cases, troubled horses and dogs are set free in these types of programs due to the bond created during the process of socialization, training, and husbandry. The inmates learn critical life-skills and relevant trades to prepare them for reintegration into the community, while providing a vital service helping to build healthier communities through the human-animal bond.

Dogs in the Courtroom

The Courthouse Dogs Foundation in the USA has developed its own best practices for Courthouse Facility Dogs. Nevertheless, they too recognize the need for uniform nationwide standards. Moreover, they discourage the use of volunteers serving within the criminal justice context with their pets due to the lack of training and screening. Further, there are no national registered standards or third-party certification programs in the USA or Canada with respect to the credentialing process of dog trainers with various specializations.

Whether responding to low-priority or non-criminal incidents in rural or urban communities all have something in common – the need for citizen, cross sector, and interdisciplinary engagement in order to build healthier and safer communities[32].

Moving Forward

While there are certainly examples of animal-assistance programming both with persons with mental health disabilities and in the justice sector, there is a great deal that could be accomplished by establishing a sector to make animal assistance both CREDIBLE and accessible.

Given the growth of and interest in human-animal interventions, the time has never been better to address how to work together for mutual success.

Quality management would encompass activities such as:

- conducting an environmental scan and gaps analysis to consider forming a sector council,
- research in the Canadian context on the impact of Animal-Assisted Activities (AAA) in the different sectors,

[31] The Wild Horse Redemption. http://www.pointgreypictures.com/wildhorse/wildhorse.htm
[32] National Children's Advocacy Center. 2014. Animal Assistance: Research and Practice: A Selected Bibliography. Huntsville, AL.

- developing National Occupation Classifications,
- identifying best practices,
- defining terminologies,
- cultivating professional development opportunities,
- participating in public policy development, and
- where necessary, developing national registered consensus-based standards of Canada and third-party certification programs.

Once adopted, registered standards of Canada could be referenced in existing legislation across Canada promoting continuity and consistency to provide guidance and protect the public. These attributes would revolutionize Animal-Assisted Support Services within the justice system.

Impact

There is a body of research on the impact of AAA. Research indicates that some of the many well-known benefits associated with the human-animal bond/interventions are[33]:

- increased motivation and active living;
- decreased depression and anxiety;
- enhanced communication;
- physiological improvements;
- improved insights into behaviors;
- living in the moment;
- motor skills stimulation;
- encourage playfulness;
- reduced stigma associated with treatment;
- formation of a bond and improved social skills; and
- alleviate or compensate for functional limitations.

While CFAS's Research Library is still in its infancy stage, it possess a multitude of useful links to studies that are often difficult to track down[34]. Expanding this resource with a searchable database is another feature of the foundation's proposed Learning Community Portal. This could be a very valuable resource to the justice sector in that it would aid in the decision making process as to how best to utilize Animal-Assisted Support Services within the justice environment.

The Delta Society TASK Program is a good source of information. The UK has made great strides in this burgeoning field along with international counterparts such as Animal Jobs Direct, the International Association of Human-Animal Interaction Organizations (IAHAIO), and the International Society for Anthrozoology.

[33] Canadian Foundation for Animal Assisted Support Services. http://www.cf4aass.org/research.html
[34] Canadian Foundation for Animal Assisted Support Services. http://www.cf4aass.org/research.html

Put simply, AAA, in many cases, are treasured gifts that empower the beneficiary. Measuring the value and impact of related interactions in conventional ways is not always possible. For example, when a baby smiles for the first time no one questions the joy a parent feels when they make this wonderful connection; when a child giggles and marvels in all that surrounds, him or her there is a part of us that yearns to be so content, intrigued, and playful. It would be very difficult to measure the value of these special moments in time. Considering these nuances when constructing evaluation metrics is key in order to quantify the benefits these activities produce.

Canadian Research

As a starting point, an inventory of current services would greatly benefit the sector and would need to include, but not be limited to, what services are currently offered and by whom. Who would be willing to provide services if given the opportunity and support to do so? Which services are offered free or for a fee? What are the credentials of the service providers and are their services clinical (Animal-Assisted Therapy) or non-clinical (Animal-Assisted Activities). Are the services primarily volunteer driven, for-profit businesses or independent clinicians?

Programming Ideas

With a growing infrastructure, CFAS could build partnerships to help design a national job creation strategy and a national volunteer program to help prevent people from getting involved in the criminal justice system in the first place.

Whether the application is prevention, early intervention, emergency preparedness, or compensating for functional limitations the versatility of court dogs, canine victim crisis intervention, Animal-Assisted prison inmate programs, canine and equine leadership development, equine assisted learning, counselling, or therapeutic farms animals in society unite people, pets, and partners (animals in service) building healthier and safer communities.

Co-creating nation-wide community supports with a goal of reducing the current demands on the justice system requires a process of appreciating the best of what is on the way to what is possible ("pawsible"). One way to facilitate this type of engagement is to use Appreciative Inquiry (AI) a tried and true methodology that opens the way for meaningful conversations. AI inspires candid dialogues whereby people make inquiries to clarify and better understand one another. Common goals and the identification of community assets become the motivation for nurturing new partnerships.

A relevant illustration of AI within the justice context is when community partners in Yellowknife, Northwest Territories met to address matters such as the Healing and Renewal of Family Roles and Responsibilities[35].

In order to develop cost efficient strategies, programs, and services CFAS could build an accessible portal (which would include the Learning Communities Portal) and a virtual Centre of Excellence that

[35] Healing and Renewal of Family Roles and Responsibilities. http://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/annex-annexe/p110.html

would bring a multitude of stakeholders together to cultivate opportunities that would not otherwise be possible.

Facilitating virtual and other opportunities to train and support people as they serve and mentor, would be possible through the development of national peer support programs, communities of practice, and a national speaker's bureau.

Promoting Mental Health

Mental illness is a disability regardless of whether it is due to an organic imbalance, brain injury, cognitive deficiencies, alcoholism, trauma, workplace injuries, or abuse; all are defined on various levels of constructs.

According to an article published in the *Vancouver Sun* on December 8, 2010, many Canadian convicts have Fetal Alcohol Spectrum Disorder (FASD). The number of people with FASD in Canadian prisons is not known, but estimates vary -- from 15 to 80 percent. This article posed the following question -- can prison help them?

CBC reported on November 19, 2013 that a Yukon MP was promoting a private member's bill on FASD[36].

Public Safety Canada supported a gathering in March of 2008 to explore FASD in relation to the criminal justice system in Canada[37]. Their first goal was to provide an opportunity for workshop participants to share thoughts and experiences around the issue of FASD and the criminal justice system. The second goal was to share strategies for addressing FASD and incarceration.

According to US findings, people with FASD often get into trouble with the law because they lack self-control and insight into the consequences of their behavior due to a range of neurological impairments incurred while in the womb.

Offering Animal-Assisted Support Services as a FASD intervention would help address these important issues. Additionally, these services would extend hope to people that do not respond to conventional therapies and activities, while promoting mental health among support workers. This is where cross-sector and interdisciplinary methodologies intersect, for more information visit CFAS's FASD page to consider the pawsibilities[38].

Creating opportunities for children, youth, and adults to partner with, or be exposed to, companion, service, and farm animals teaches them to live in the present. The animal becomes an icebreaker a means or a channel in which to connect and bond with others. Some human rights codes refer to service

[36] CBC News/North. 20 November 2013. "Yukon MP plans private member bill on FASD." http://www.cbc.ca/news/canada/north/yukon-mp-plans-private-member-bill-on-fasd-1.2431740 Accessed 6 March 2017.
[37] Public Safety Canada. 2008. "Fetal Alcohol Spectrum Disorder and the Criminal Justice System." https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ftl-lchl-spctrm/index-en.aspx#s
[38] Canadian Foundation for Animal Assisted Support Services. http://www.cf4aass.org/fetal-alcohol-spectrum-disorder-fasd.html

dogs as another form of a remedial device that compensates for a person's disability or challenge (functional limitations).

When people compare their insides with someone else's outsides they can either feel a sense of superiority or inferiority, but this is not so when interacting with animals. The conveyed language of love and acceptance is often unspoken, demonstrated through visual cues such as body language and facial expressions. Many people, regardless of age, with FASD, for example, interact well with animals.

Animals social and survival instincts are in many ways emotionally intelligent. They can see how their behaviour effects those around them and will alter it accordingly. They are good teachers.

When a person focuses on the animal's welfare, it draws them out breaking through the person's preoccupation with self and their fears; this window of opportunity fosters attentiveness and bonding. The story of Shagra and Phyllis is a wonderful illustration of the transformation that takes place between humans and animals.

Responding to competing priorities is difficult for all sectors; however, with a national One Health Fund in place by 2020 CFAS envisions launching an Annual Grants Program that would eventually contribute to the work of hundreds of organizations/charities in the health, justice, and social services sectors.

The equine industry in Ontario alone is worth billions of dollars not to mention the revenue generated in the pet industry. Imagine the good we could do by bringing together government stakeholders, the voluntary sector, and businesses to develop a nationwide action plan coupled with community-based strategies and support mechanisms in place.

Building on shared capacity and a common vision would undoubtedly help shape healthier and safer communities addressing the challenges facing the justice system.

The human-animal bond is a pathway that nurtures belonging among people, pets, and partners (service animals). It inspires, motivates, and reminds us there is always hope no matter what the situation. It teaches us to treat others, as we would want to be treated. This precious natural resource is a powerhouse waiting to be tapped into.

Canadians share a responsibility to maintain the well-being of people, the welfare of animals, and responsible stewardship of the environment. This is the road to One Health in a just society.

About the CFAS

Our mission is to improve the health and quality of life of people with physical, emotional, and social challenges through partnerships with companion and service animals.

Rupert Ross,

Assistant Crown Attorney (Retired), Kenora, Ontario

The proposal

It is proposed that Justice Canada act as the coordinating agency bringing together various federal agencies to jointly fund a northern pilot project in whole-family healing as a tailored response to suicide attempts by aboriginal youth in remote aboriginal communities.

Youth suicide amidst family violence in First Nations communities

I recall flying in to a remote First Nation to conduct court, only to find that the police had not summonsed witnesses for a number of trials. When I asked one officer why that had not been done, tears formed in her eyes as she explained that in the last two weeks she and her fellow officers had cut down 5 youngsters who had tried to commit suicide by hanging themselves. Four were dead, and the fifth was in hospital in Winnipeg. All the names were familiar to me; I had prosecuted all of them, and some of their parents, at various times and for a range of offences.

I also recall being in a newly-built sweatlodge in tiny, remote community. When we got to the 'round' that is dedicated to children, the men inside that sweatlodge broke into loud, anguished songs and prayers that carried on for much longer than is usually the case; I later found out that thirteen youth had committed suicide in that community over the prior two years, and these men were all related to them.

We routinely have to cancel courts, at the community's request, due to suicides and burials. Cancellations often happen in mid-air, and the cost in airplanes, judges, staff and legal professionals is huge.

Statistics tell us that aboriginal youth commit suicide at a rate 4 times the national average, and that the Inuit youth rate is 8 times higher. I believe those statistics fail to capture the real magnitude. Coupled with those suicides is the fact that domestic assault in those communities is five times higher than the national average, and suicidal children often come from those families, plagued by violence and addictions that no one seems able to stop. Aboriginal agencies struggle to provide travelling trauma teams aimed at preventing "clusters" of suicides, but they are often only able to point to contributing factors like poverty, poor housing, gross over-crowding, inferior education, bad water and the influence of alcohol and drugs. They have neither the time nor the resources to dig deeper.

I recently met with the Chief of a remote First Nation who did start digging deeper. After his son committed suicide, he took his family to an indigenous healing lodge (Kiikeewanniikaan) in southern Ontario for their five-week program. Using traditional Teachings, they were helped to begin building healthier relations instead. He is determined to bring a similar healing center to First Nations communities in northern Ontario.

Residential schools and today's youth suicide

In my view, family violence and addictions are the primary causes of youth suicide in northern communities, and both happen at an alarming rate across the north. We have to ask why. A substantial answer comes from a 2004 paper[39] by three UBC psychologists who described their assessments of the "emotional intelligence" of 44 non-aboriginal men who had been convicted of spousal assault. They explained that EI was not a fixed, genetic or predetermined thing; instead, it involved emotional 'skill-sets' that people might, or might not, have developed. Their assessments suggested the following about those 44 men:

- "… because they are **unable** to express their feelings and needs, they resort to intimidation and aggression."
- "… they lack insight into how their emotions arise… such that **all** arousal-producing emotions get expressed as anger, which in turn gets translated into aggression."
- "… they are **unable** to modulate thoughts, emotions and behaviours to correspond to changing environment and demands…"
- and "… they might not be **aware** of their emotions…"

Another psychologist explained that such skill-sets normally arise primarily within the parent-child relationship where "socialization practices are posited to teach children how to label and interpret emotions, when emotional expression is appropriate, and how to manage emotional arousal."[40]

That seldom happened in residential schools. When children as young as 5 were put into those schools and began to experience fear, loneliness, grief, anxiety, shame and anger, no one wanted to hear them talk about how they felt. In fact, they learned to **never** talk about those feelings, but to bury them instead. Maggie Hodgson, an internationally recognized Cree healer, sees it this way:

> *"Water spirit is the gift we use when we cry. In residential school, many people learned not to cry. When children cried in residential school and there was no response except "I'll give you something to cry for!' they learned to shut down sadness…When children cried themselves to sleep because they missed their parents so much, they eventually learned that they could cry all they wanted but they were still not going home…After one hundred years, there was not much water spirit left; in its place was hopelessness, a deep sense of abandonment, and anger."*[41]

[39] "An Exploratory Study of Emotional Intelligence and Domestic Abuse", Jason Winters, Robert J.W. Clift and Donald G. Dutton, Department of Psychology, University of British Columbia, Journal of Family Violence, Vol. 19. No. 5, October, 2004.
[40] "Socialization of Children's Emotion Regulation in Mother-Child Dyads", Kimberley L. Shipman and Janice Zeman, Development of Psychopathology 13 (2001) Cambridge University Press, p.318.
[41] Maggie Hodgson,, "Reconciliation; A Spiritual Process", a chapter in *From Truth To Reconciliation: Transforming The Legacy of Residential Schools*, Aboriginal Healing Foundation Research Series, 2008, at p.366

In my view, the violence within today's families is directly traceable to residential schools and their failure to create circumstances in which children could develop the skill-sets necessary to handle the emotional ups-and-downs of adulthood. When those children hit 16, they took their unresolved feelings, almost all of them powerfully negative, home with them. When they then had their own children, they could only model what they knew: the habit of neither examining nor resolving those emotions. That habit has continued through the generations ever since. When the pain of unresolved and unexpressed emotional burdens became too great, alcohol and drugs helped numb the pain; unfortunately, they also contributed to explosions of violence, the escalation of trauma and an even deeper need to bury.

Cynthia Wesley-Esquimaux, a leading aboriginal educator in Ontario, wrote about the feelings those students had "unconsciously learned to deny, suppress and hide within themselves". She argued that those feelings "were not given appropriate acknowledgement and therefore any accurate expression", and she concluded that those deep emotions had not been "brought into consciousness where they could be processed and healed."[42] Maria Yellow Horse Brave Heart, a leading aboriginal educator in the United States, wrote something similar: "You shut down all feeling because you are trying to avoid the pain. It helps you get through the immediate crisis and the trauma. But if they persist, if they go on for a long time, they become a problem and you don't feel much of anything. You numbed yourself from the pain, but you stunted your feelings, your warmth and your joy."[43]

In my view, the elevated levels of family violence in aboriginal communities is primarily a manifestation of people's limited ability to understand, access, express and modulate their emotional lives, an inability directly traceable, through generations, to residential schools. Generations of children have never developed the emotional skill-sets necessary to deal with the violence that surrounds them. In the result, many choose to kill themselves as the only way out.

There are other forces traceable to residential schools that make the situation even worse. Children in those schools, so lost and alone, had a special need to be part of some social grouping. As a result, they formed gangs in many schools. Relationships within those gangs were not based on healthy, traditional values like sharing, respect, humility and love; they were instead built on values like intimidation, power and fear. Older boys preyed on younger ones, and the younger ones took over when their time came. The aggressive and narcissistic nature of their relations, however, remained.

It was precisely those warped relational values that youngsters then took into their relations with the opposite sex when, at age 16, boys and girls first began to establish relations with each other. That hadn't happened at residential school, simply because boys and girls were kept completely separated. Even brothers and sisters knew each other only across the school yard. When those new inter-gender relations finally began on their return to home communities, boys and girls not only lacked the

[42] "Inside Looking Out, Outside Looking In", Cynthia Wesley-Esquimaux, First People's Child and Family Review, Vol.3, No. 4, 2007, pp. 62-71.
[43] "Inside Looking Out, Outside Looking In", Cynthia Wesley-Esquimaux, First People's Child and Family Review, Vol.3, No. 4, 2007, pp. 62-71.

emotional skill-sets necessary for managing their emotions, but both believed that all relationships were built on negative values. That had been the sum total of their experience to date.

And now we wonder where all the violence and despair come from. It has gotten so bad that, in one community of under 500 people in my region, on a single court day several years ago, 54 people faced 285 Criminal Code charges, including 19 Assaults, 3 Assault Cause Bodily Harm, 6 Assault with a Weapon, 1 Sexual Assault and 4 Robberies. People live in a state of constant fear and depression, a state they have come to feel is "normal" for them. I recall going into that community for court one day to find that over 20 of the children had been found waist-deep in the lake the night before, all of them sniffing gasoline, all of them howling their lungs out at the moon. I despaired of ever reaching them through criminal sanctions.

A personal experience

I prosecuted a man from a northern reserve for assaulting his wife with a hockey stick in a drunken rage, breaking her arm, with his two daughters yelling "Stop, Daddy, Stop." His wife insisted that their entire family go to the Tommy Beardy Family Healing Center at the Muskrat Dam First Nation in remote northern Ontario. After five weeks of traditional teachings alongside four other families, the changes were dramatic, healthy and long-lasting. We waited a full year to be certain he would not relapse, and he didn't. Just before sentencing, I asked his wife what they had learned, and her answer was shockingly simple: "We learned how to talk with each other." She explained that they had both grown up in alcoholic, violent families, but they had never told each other those 'family secrets'. Using ceremony, sharing circles, storytelling and teachings like the Seven Grandfathers, the center had helped them escape their parents' patterns of escalating violence, where even the slightest disagreement triggered anger and aggression. They learned instead how to explore all the feelings they had hidden for so long, to understand where they came from, to establish trust with each other and to share their emotional lives with each other. They also learned that the four other families at the centre had been captured by the same patterns of escalating violence, patterns traceable not to individual failures but right back to what their parents and grandparents had learned – and not learned – at residential schools.

She also told me how grateful she was that her children had been part of the healing process. They needed to learn that the violence did not erupt because of something they did or didn't do, and they needed to learn how to avoid being captured by the same patterns of abuse themselves.

In my view, what happened in Muskrat Dam needs replication, but with three significant modifications. First, the trigger to healing should not be spousal violence, but youth suicide attempts. In that way, the lives and struggles of the youth are shifted onto center stage where all can agree that something must be done. While there, the family context can be explored so that everyone can understand its dynamics, positive and negative. In that way, the focus moves to intergenerational healing within a group, as opposed to primarily individual treatment of someone who has caused harm.

Second, there should be overt discussion of the failure of residential schools to help children develop the emotional competencies that everyone needs to handle the stresses in life. Several programs already exist in Canada that are designed to bring emotional competencies back to center stage for indigenous people, and they should be consulted. The Seabird Island First Nation in British Columbia has a "Seeds Of Empathy" program to teach pre-schoolers "how to express and feel emotions appropriately", having concluded that "a lot of our children don't know how to express emotions, which can lead to some behavioural challenges". There is also a Mohawk woman, Peggy Shaughnessy, who has created the 12-week RedPath Program to bring emotional competencies back to aboriginal adults, and she conducts it across Canada. Finally, there is Lee Brown, a Cree man from the prairies, whose PhD Thesis was called *Making the Classroom a Healthy Place: The Development of Affective Competency in Aboriginal Pedagogy*, and who is now Director of the Institute of Emotional Health in Vancouver. Much could be learned from them.

Third, the program should expressly focus on traditional teachings about the nature of healthy relations, whether within family and community, between individuals and all non-human beings within Creation, or between the mental, emotional, physical and spiritual dimensions of each individual. The program must do more than simply identify relational struggles and try to prevent suicide attempts; it must also set families on a path towards good relational health.

Structure of the family healing program

The following are, in my view, essential aspects of a successful family-healing and suicide-prevention program:

1. At least 4 or 5 members of each family must attend and learn about healthy relations as a group. Parents and children must together be taught the essential emotional skill-sets, creating the start of a healthy family. They will need each other when they return home to face all of their old friends and less-healthy habits. Only with each other's help can they hope to resist the negative pressures in their home communities.
2. Children must be centrally involved, learning to shed the guilt they feel about not having done enough to prevent the family violence they have suffered through and beginning to see both parents as troubled but caring people who need help along the way. They must be given healthy traditional teachings to shape their engagement with life ahead.
3. The healing process must involve several families working together at the same time. Only then can they begin to learn that they are not alone in their violence or addictions, but have instead been shaped by colonization forces. They must begin to understand that their family issues are just small parts of an historical problem of wide dimensions, suffered by a large number of other families. It is not just their problem, nor does it flow from their own, individual moral failures. They must begin to see themselves as products of violence, rather than as instigators in their own right. Just as the National Native Alcohol and Drug Addiction Program has recently decided that most indigenous addictions should no longer be treated as "diseases" but as the consequence of

colonization trauma instead, so must the violence within indigenous families be seen in a similar way.

4. The centre must be kept small, with only four or five families at any one time. That number is large enough to create shared experience, but small enough that people will not feel lost in too wide a circle of others. Everyone can then begin to develop confidence in new ways-of-relating and to start building perhaps their first experience of healthy relationships with others.
5. It is also crucial to avoid putting families into healing processes in their home communities. In their healing, they must be able to talk freely about family histories, with all of the intergenerational abuse and neglect that was part of them. They do not want those stories to get out into their home community, nor do they want to be blamed for raising past trauma issues. They can speak much more freely in a community of strangers, all of whom are sworn to secrecy. For the same reason, there should not be two families from the same community at any one time.
6. The workers at the healing center must be given the same training and the same reporting duties. They must speak with one voice, and avoid the present fiasco suffered by some communities that have over a dozen workers all engaged with the same troubled families but coming at them out of different training, with different reporting duties, and an absolute ban on sharing information. We must avoid shunting troubled families back and forth between inconsistent treatment models.
7. If possible, the healing center should be located not in a First Nation so that it retains its independence, and far enough from any urban centres to reduce the temptation to further indulge in drugs or alcohol. It is also important to recognize that a central tenet of indigenous healing involves the lessons that can be learned from "the land". There may be under-utilized NNADAP addiction centers that could be converted to family-healing and suicide-prevention instead.
8. We must encourage the use of indigenous healing techniques, including ceremonies and storytelling within groups, whether we understand them or not. We cannot require the use of western therapies or healing processes. This is *their* healing, not ours.
9. We must also guard against imposing onerous reporting/supervision duties that hamper the programs too greatly. Staff should be focussed on their healing duties, with reporting to outside agencies kept to a bare minimum.
10. Evaluations should include much more than the likely reduction in suicide attempts among youth. They should focus as well on any reductions in addictions and in the use of violence by all family members.

Closing

I propose that the Department of Justice take the lead in coordinating other federal agencies logically involved in aboriginal and mental health issues to fund a two-year project where 5 families could attend the center together in 5-week programs. That would bring healing to 200 families over the course of two years, each of whom would take what they learned back to extended families in their home community. I expect that such a program would directly save a number of lives, as well as give rise to emotional

skill-sets bringing healthier relations within presently troubled families and so extend its benefits far into future generations as well.

Ryan Sneath

WFPS-WRHA Liaison Officer, Director of Community Paramedic Programs

Winnipeg Fire Paramedic Service: Community Paramedic Program

Winnipeg Fire Paramedic Service— 2nd Floor, 185 King St. Winnipeg, MB, R3B 1J1

Introduction

Mental Illness not only affects individuals, but has a profound effect on the community, family, social network, and public agencies that support these individuals. Mental illness is widespread and can take on many forms. With recognition, appropriate support, and supportive prevention strategies many of these concerns can be alleviated. Manitoba Health (2012-2013)[44] reported that approximately 25% of Manitobans age 10 and older received medical care for at least one of the following mental illnesses: depression, anxiety, substance abuse, personality disorder, or schizophrenia.

Often 911 operations are called upon to respond to mental health concerns. In 2014 the Winnipeg Fire Paramedic Service (WFPS) responded to over 4200 individuals with a primary complaint of a mental health concern, excluding substance abuse calls. This is a 22% increase from just 4 years ago. These responses included both non-criminal acute psychiatric crisis, and simple failure to cope events like loneliness or depression. Not all of these events would elicit a response from police, but many of these incidents are screened by police communication operators prior to being sent to Emergency Medical Services (EMS). Like many other EMS agencies across the country, the WFPS has seen a dramatic increase in calls for service in the past 10 years. With a 74% increase in call volume, it is at times a struggle to keep up with the demands for service. Aging populations and shortages in healthcare professional are partly responsible for this increase, but many other factors that have played a role.

This increasing strain on already scarce resources has placed additional pressure on EMS to look at alternative ways to meet the needs of the individuals accessing our services. The WFPS recognized that clients accessing 911 were not always receiving the most appropriate care for their needs. Patients that are being transported to the Emergency Department (ED) by ambulance often have to wait several hours before receiving definitive care. This prolonged offload of patients to the ED has at times exhausted EMS resources and caused significant delays in emergency response for the community. Furthermore, the WFPS identified that many of the patients that are being transported could be more appropriately cared for in a primary care setting.

Community Paramedicine

In 2009, the WFPS partnered with the Winnipeg Regional Health Authority (WRHA) to create an innovative program that placed a paramedic on staff at the Main Street Project (MSP). The MSP is a unique facility that consists of a homeless shelter, detoxification unit, transitional living area, and the intoxicated person's detention area. The MSP provides services to some of the most vulnerable citizens in Winnipeg. Many of these citizens suffer from substance abuse issues and mental health concerns. The role of the paramedic is to provide medical clearance for intoxicated individuals being admitted to the intoxicated person's detention area, assist in policy development, provide medical assessments, and provide emergency care for the entire facility. On an annual basis, the paramedics assess over 15, 000

[44] Manitoba Health. (2012-2013). *Annual Statistics.* Manitoba: Manitoba Health: Health Information Management.

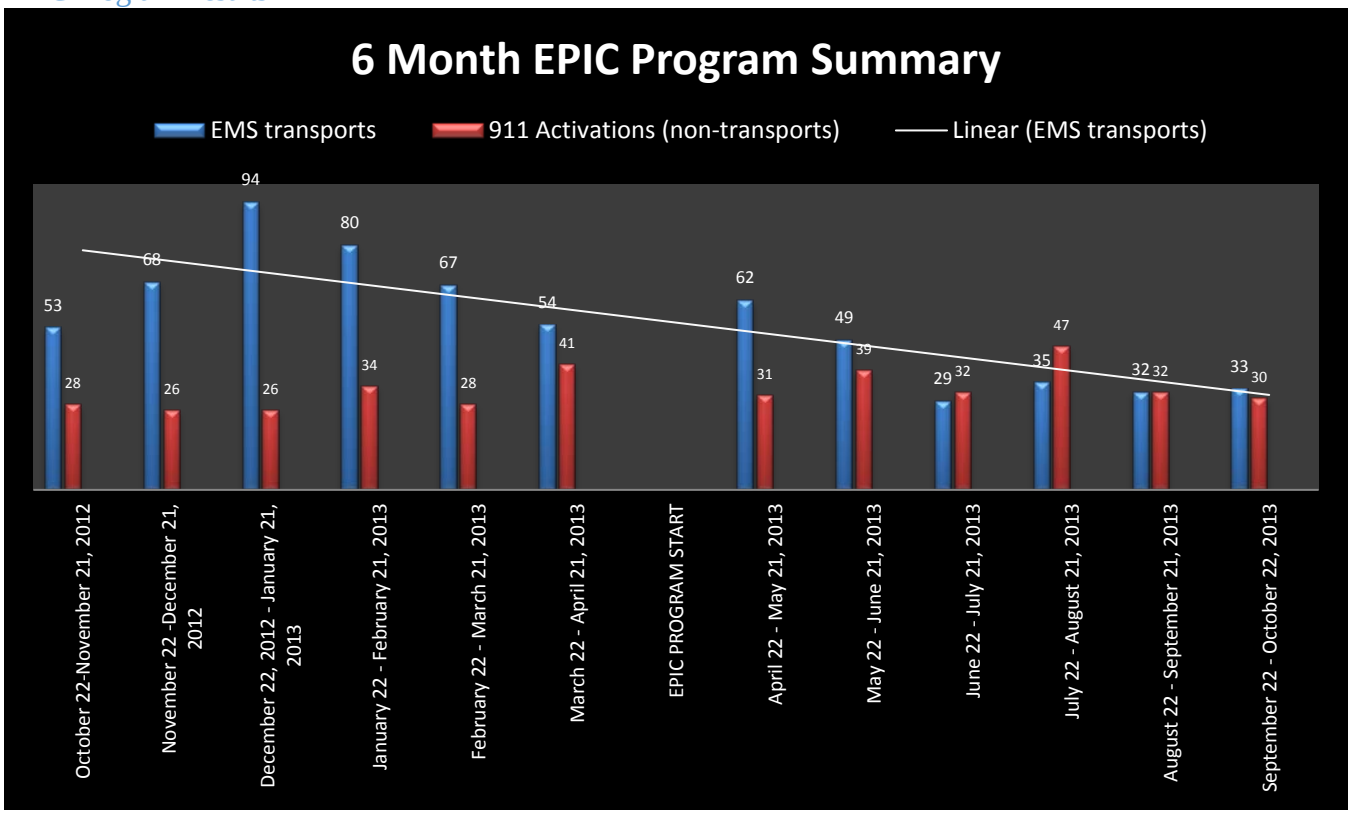
patients. The project has been successful in providing early assessment and response to actual or potential health problems and health promotion needs, as well as planning appropriate interventions with a client-centered focus. It has also proven to be a more cost effective way to deliver healthcare. Within the first year of the program implementation, the ambulance transports from the facility had decreased by approximately 60%. This is directly attributed to the paramedic's ability to provide prevention strategies and triage complaints to the appropriate resource. The paramedics have partnered with programs to end homelessness, addiction foundation, WRHA resources, primary care clinics, and many other agencies. These partnerships have been integral to the success of the program and have mitigated over reliance on emergency agencies such as police and EMS. The role of the paramedic has drastically improved the safety of the intoxicated individuals being detained within the facility, and the safety screening tools implemented have saved lives and avoided costly inquests. This initiative has been recognized by the courts as an integral part of the safety of the individuals residing at the MSP.

Based upon the success of the MSP Paramedic Program and focusing on the concepts of integrated and collaborative practice, the WFPS and WRHA conceptualized the Emergency Paramedics In the Community (EPIC) Program. The EPIC Program focuses on identifying gaps in current service provision. Innovative initiatives to improve the level of health care within the community have been created through collaboration with various community organizations, social service agencies, and other healthcare professionals. This is in line with several of the strategic directions of the WRHA to enhance patient experience, improve quality and integration, foster public engagement, and build sustainability.

The EPIC pilot program has focused on four (4) primary areas of interest; common callers, common address, lab and diagnostic follow-up and at-risk individuals. Common callers are identified as individuals who have accessed EMS greater than 10 times in the past six (6) months. The common caller list contains the top 40 users of EMS in Winnipeg. During the six (6) months prior to the start of the EPIC Program, this group of individuals activated EMS an average of one hundred (100) times per month, and were transported an average of seventy (70) times per month to a hospital. Once the needs of the client are identified and the profile is created, the EPIC team and the WFPS medical directors develop customized care plans to address these needs. Each of the clients on the common caller list is assigned a social worker to address the psychosocial aspects of care. The EPIC Program provides home visits to focus on the objectives of the developed care plan and also responds to all 911 calls for this group of individuals to assist in directing and managing the clients care. Care plans are continually evaluated for efficacy and adjusted as required to ensure that they are meeting the identified needs. Once the clients are connected with the appropriate resource, it significantly decreases the patients need for EMS and ED services. Out of the 40 highest users of EMS services in Winnipeg, 30% of them had primary complaints of a mental health concern. All of these individuals were part of a community mental health team and were actively being followed by mental healthcare workers. Even with these continuous supports many of these individuals had continued to access EMS and policing services. The importance of understanding the reasons when and why people were accessing 911 was integral to success of developing an appropriate care plan. Within the first three (3) months of the program, the

calls to 911 had decreased by 33%, and the transports to hospital had decreased by 59%. These individuals were linked with a more appropriate healthcare team that was able to meet their needs and address their healthcare concerns.

EPIC Program Results



In addition to identifying the needs of the clients, it was equally important to identify what resources and healthcare team members were already involved. Often many of the mental health clients had multiple care providers that had never met. In one particular case the client had nine (9) different care providers, and none of them had ever met to discuss what services they were providing or what efficiencies they could derive from a collaborative effort. The WFPS met with many key stakeholders within the mental health community and developed key strategic partnerships with Mobile Crisis teams and Crisis Response Centres. These groups traditionally would not receive referrals from paramedics and required a medical clearance prior to assessing the mental health concern. Through mutual understanding of each other's roles, these resources partnered with the WFPS to ensure that these mental health patients received timely assessment and appropriate disposition. The EPIC Program needed to be able to respond in both an emergent fashion for requests for service but also work with these clients during regular preventative home visits. The key element of success was the ability to communicate with all of the stakeholders involved in the client's care. The Winnipeg Police Service (WPS) Vulnerable Persons Unit worked closely with the EPIC Program on many of these cases, and through joint efforts were able to link these patients to the appropriate resource. WPS also recognized a significant reduction in the use of

policing resources, and four (4) of the patients did not call 911 at all in the last three (3) months of the pilot program.

Prevention

Although it was important to identify the individuals who are high users of the system, it was equally or even more important to search for ways to identify those who were At-Risk of becoming a high user. EMS and policing agencies need to search for ways to include preventative measures into their current scope of work. The WFPS has developed an intervention on its Electronic Patient Care Reporting (ePCR) system to assist WFPS crews in identifying and reporting individuals within our community that are considered 'At-Risk'. At-Risk individuals are those who are accessing services for current health needs and have other needs that may interfere with their ability to access or receive medical care currently or in the future. The intervention focuses on identifying concerns of hoarding, infestations, social isolation, safety concerns, cognitive impairment, communication impairment, lack of social supports, and mobility concerns. Once this intervention is selected, the FirstWatch® Program identifies the incident and emails the information to the EPIC Program. Working in conjunction with the Emergency Social Services Branch (ESS), Fire Prevention Branch, WPS, and the WRHA, WFPS is able to refer these individuals to the appropriate community resources for follow-up, assessment, and development of a process to help support the client. Early identification and implementation of prevention and health promotion strategies are key factors to the success of maintaining population health. This process allows for early assessment and response to actual or potential health and safety problems, and plan appropriate interventions with a client centered focus. Creating a uniform reporting structure for these types of issues has allowed WFPS to track these types of concerns, deal with them appropriately, and better support the community we serve. The WPS has begun to work on the development of electronic referral pathways to the EPIC Program to assist with the identification of At-Risk individuals within the community.

Due to the nature of the work, Emergency Services have the unique opportunity of being present in multiple homes each and every year. This presence allows for the opportunity of an assessment for individuals who may be at-risk for health decline. Providing first responders with the appropriate tools to identify concerns along with a method for referrals, has the potential to ensure individuals are receiving the care that they need in a timely fashion. Utilizing tools such as the Brief Mental Health Screener (BMHS) developed by InterRAI™ can assist both paramedics and police officers to identify persons in the community with mental health problems. Furthermore, the decision support algorithms help assist the first responder in making evidenced-informed decisions regarding the disposition of mental health patients. These tools have been piloted in the Niagara Health region by the Ontario Provincial Police (OPP) and they have found a significant decrease in wait times for police officers at medical facilities. The success of this tool can be linked to improved knowledge regarding mental health concerns, improved skill in recognizing mental health indicators, and it teaches the police to use more clinical language allowing them to be more effective communicators to health care. Communicating in a common language can help increase the understanding of the assessment and ensure that people with

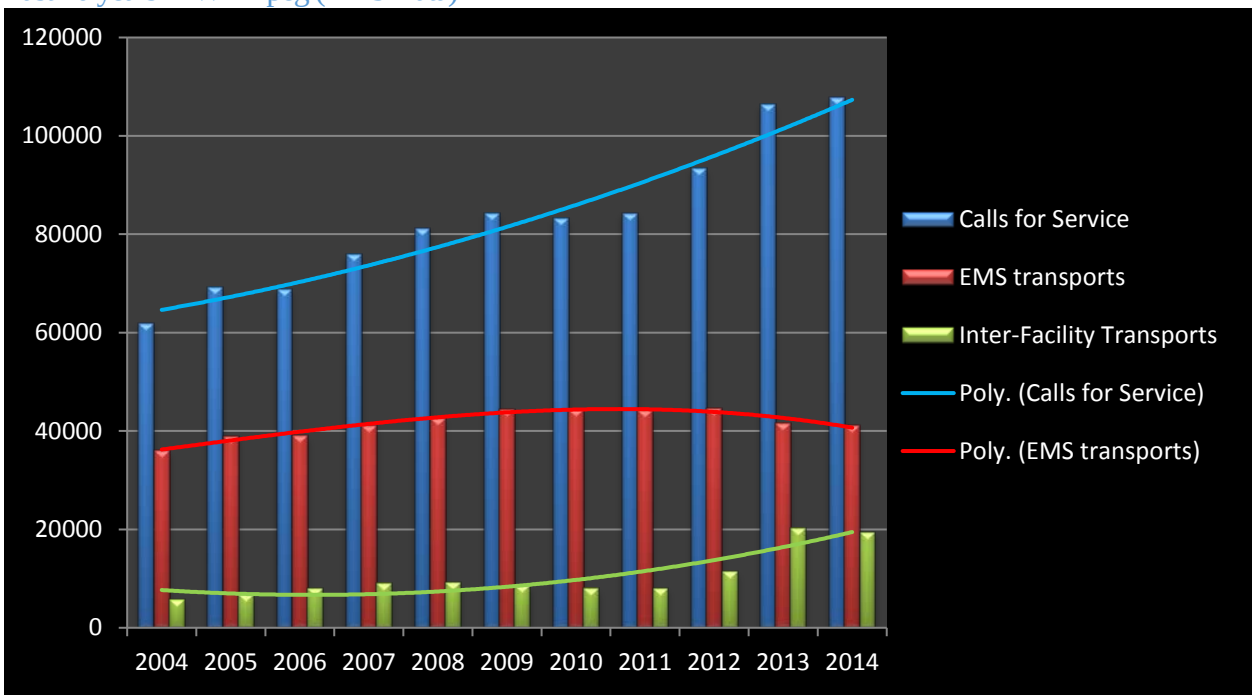
mental health problems who are in contact with both police and EMS receive prompt access to appropriate mental health services. Work is currently underway to pilot a program in Winnipeg with both the WPS and the WFPS utilizing the BMHS and some decision support algorithms. The hope is that this will improve interagency communication, decrease wait times at the hospital, and prevent unnecessary transports to the ED.

Summary

Both the MSP and the EPIC Program have demonstrated positive results in mitigating unnecessary calls to 911, and have prevented thousands of ambulance trips to the ED. These programs have further demonstrated significant success in managing not only chronic medical conditions, but also acute health care concerns. When surveyed, the participants in the program self-reported a better health status and greater satisfaction with the current service delivery model. The success of these programs started with identifying a problem, that many individuals accessing 911 services did not require the services of an ED. The WFPS estimates that just over 50% of the individuals accessing 911 could be better cared for in a primary care setting, and this included the mental health patients.

Since the implementation of the MSP Program in 2009, and then with the start of the EPIC Program in 2013, the WFPS has been able to connect patients calling 911 with services other than the ED. This unique role has allowed the paramedics to function in a non-traditional way and provide a more effective service to the citizens we serve. The combined effect of these programs has reduced the number of patients being transported to the hospital, despite an increase in the calls for service.

Last 10 years in Winnipeg (EMS Data)



EMS and Policing agencies can no longer work independently of each other, or of other available community supports. These emergency agencies must work towards a more collaborative team approach to create sustainable solutions for the community that we serve. If EMS and police fail to recognize these opportunities, the continued increase in the demand for service will overwhelm the capacity to manage it.