CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO WINTER 2005

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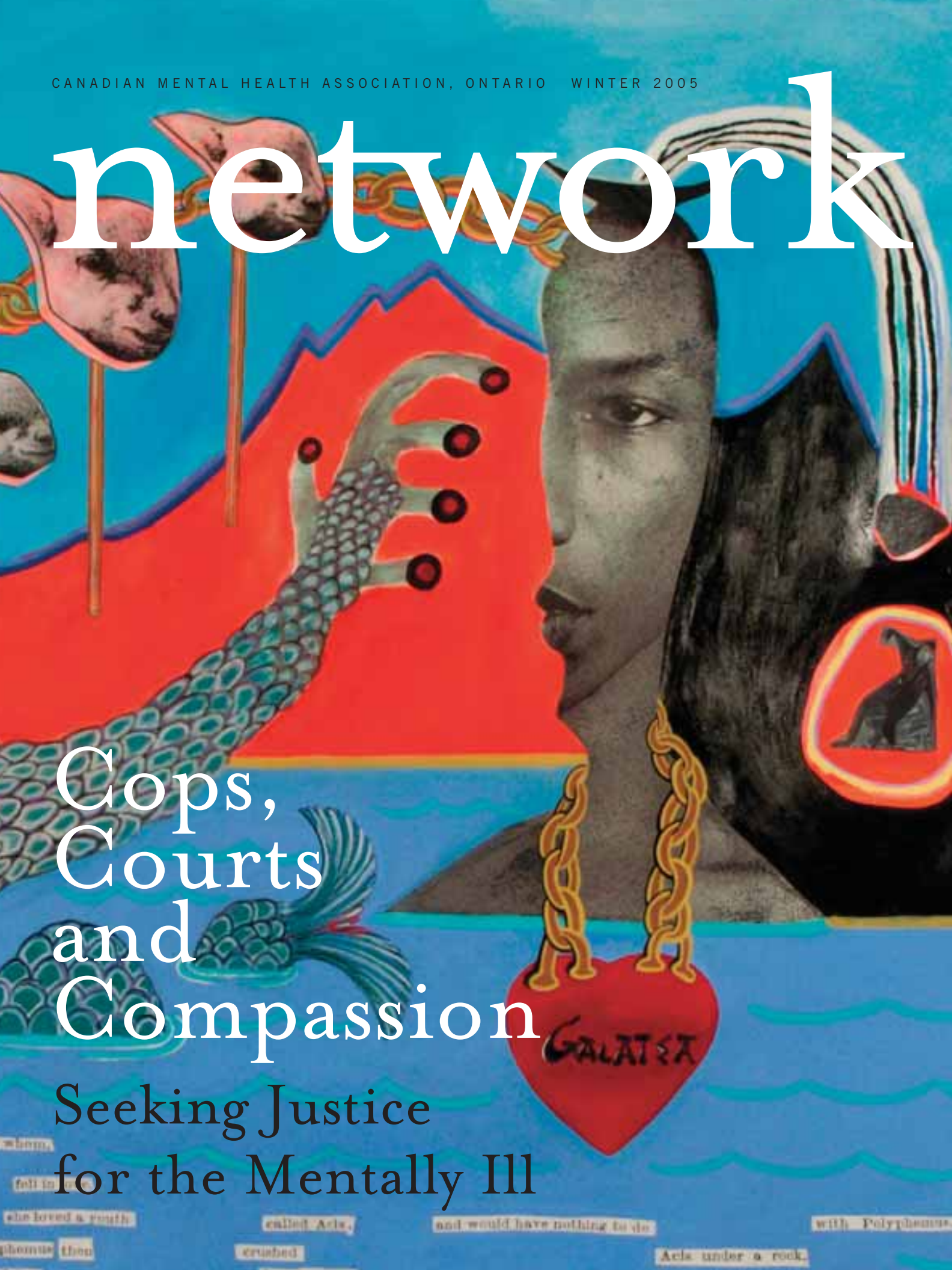

Cops, Courts and Compassion

Seeking Justice for the Mentally Ill

network
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To provide leadership in advocacy and service delivery for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

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Re: Cover

Henry "Banger" Benvenuti, *Polyphemus, Galatea and Acis* (oil on canvas, 5' x 6'). Reproduced by permission. One of nine original paintings, by various artists, inspired by stories from Ovid's *Metamorphoses*. Commissioned by the Workman Theatre Project, in partnership with the Centre for Addiction and Mental Health, for the exhibition "From Myth to Muse." For details, see www.metamorphosisfestival.ca.

GUEST EDITORIAL

Willie Gibbs, BA, MSW
President, Canadian Criminal Justice Association

Criminalization and Mental Illness

History has a tendency to repeat itself. Centuries ago, individuals with mental illness were feared as being possessed by the devil. Later they were placed in institutions and chained like criminals. Mental health and criminal behaviour continue to intersect. Today, unfortunately, we find too many cases of the mentally ill languishing in prisons for lack of assessment space in psychiatric hospitals. Worse, large numbers of criminal offenders suffer from mental illness. This prompts the question of whether mental illness led to their crimes in the first place. It also points out the problem of inadequate mental health services in our society.

Many of us recall seeing the famous Jack Nicholson movie *One Flew Over the Cuckoo's Nest*, which portrayed psychiatric hospitals in the poorest light. At about the same time, the deinstitutionalization movement became prominent. Advocates, including the Canadian Mental Health Association, argued that it was better to treat the mentally ill in the community, where they could maintain their connection with families and loved ones, strengthening their resolve to benefit from treatment.

While many still agree with this approach, the results have not all been rosy. Community treatment programs and facilities have not replaced the "institutions" in adequate numbers, due to chronic underfunding. The result in many cases, rather than a choice between a psychiatric institution and community treatment, is no treatment at all. For many people, this lack of support has led to increased contact with police and the criminal justice system, often for minor offences. Deinstitutionalization has in fact become criminalization.

Ontario has had a number of tragic experiences as a result of the lack of assessment capacity in psychiatric hospitals. Courts will frequently order psychiatric evaluations of offenders to determine whether they should be subjected to the criminal justice system in the first place. When beds are not available, they are placed on waiting lists for psychiatric assessment and then confined to local or regional prisons. While in prison, a number have been killed or assaulted by other prisoners.

In November 2004, an Ottawa judge ruled the practice unconstitutional and illegal. The province has decided to not appeal this decision and has promised to fix the problem. How this will be done and how long it will take is not clear, but at least those who are thought by the court to be mentally ill will not be kept with other criminal offenders, prior to a finding of guilt.

The solutions are neither simple nor obvious. Investment will be required in program development, enhancement and research. Clearly action is required to identify those suffering from mental illness at the first possible event involving contact with a criminal justice official and then streaming them into diversion programs. This is secondary prevention and far better than offering them "treatment" in penitentiary.

Willie Gibbs, BA, MSW, is president of the Canadian Criminal Justice Association. He began his career in corrections as an institutional parole officer with the Correctional Service of Canada (CSC) and rose through the ranks to become Senior Deputy Commissioner of CSC and then chair of the National Parole Board. In the latter part of his career, he also served as chair of the National Joint Committee of the Canadian Chiefs of Police and Senior Federal Correctional Officials, and international vice-president of the Association of Paroling Authorities, International. His new book, *The Cons and the Pros*, is based on his journey in prisons and parole.

the girl with the curl on her forehead

There Was a Little Girl
There was a little girl,
Who had a little curl,
Right in the middle of her forehead.
When she was good,
She was very good indeed,
But when she was bad she was horrid.
– Henry Wadsworth Longfellow

A father talks candidly about his journey with his daughter through the criminal justice system.

Do you have a specific intention or goal you hope to accomplish through doing this interview?

I just wanted to see if there is any way I can help other people going through the things I went through who maybe weren't as lucky as I was. Karyn Baker, with the Family Outreach and Response Program in Toronto, was able to help guide me through the system.

What were the circumstances for you or your relative prior to your family member coming in contact with the criminal justice system?

I guess I'd go back to my first wife's family where there was a history of mental illness. My first wife was bipolar and passed away – she committed suicide when my two daughters were quite young. It didn't look like we were going to have any problems with the family until my daughter had just graduated from university and gone overseas to teach – as an interim step before she started teaching in Canada. When she got back, in fact the day she got back, she started exhibiting signs of psychosis, and at that point we were able to get her into the hospital.

She was treated – as it turns out, inappropriately – for depression. It was totally the wrong thing. She was in the hospital, as luck would have it, for only a very short period of time and then she came out and was able to cope.

Melissa [not her real name] is a very aggressive and self-motivated girl – quite bright. She immediately decided she was going to travel in Europe. When she flew back to Canada after about eight to 10 months she had another episode, but this time in the Montreal airport, and she ended up in a hospital in Montreal.

When Melissa is a patient she's a very difficult patient. She's kind of like the little girl with the curl on top of her forehead. When she's good she's really good. When she's sick she's terrible and she won't cooperate. She fights, she argues... she becomes belligerent. The doctors in Montreal I thought were quite good, but they couldn't come up with a diagnosis. They knew it wasn't depression. It didn't, as the doctors said, smell like schizophrenia. Her doctor thought it might be some kind of multiple personality disorder – he wasn't sure. In any case, she went AWOL and came back to our house in the GTA [Greater Toronto Area].

We tried working with her for a while, and it just became impossible in the house and she ended up moving into Toronto. Very shortly thereafter she was picked up by the police, taken to the Clarke [Institute of Psychiatry] and was treated there. Once again they were treating her for depression. They simply went back to what she had been treated with before.

And then she had a manic episode in the hospital. The long and short of it was after lots of discussions with the psychiatrists and staff at the Clarke, who were excellent, the doctors finally came up with the proper diagnosis – bipolar. They started treating her as a bipolar patient and she got well rather quickly, and it looked like she was back on the mend again.

She came out and went to live in Toronto and immediately stopped taking medication. At that point she hadn't really come out of the cycle, and ultimately... she ended up kind of wandering around neighbourhoods and she was walking by someone... a lady was taking her child to school. She had left her car in the driveway running and my daughter just kind of jumped in the car and took off. Melissa doesn't know why she did it, or understand it for any other reason. She was apparently on the loose for a couple of days. She obviously wasn't thinking very straight and was using her VISA card to buy gas for this car.

Do you think your daughter had any insight into her illness at that time?

She might have but she was in total denial. Then the police picked her up after a couple of days. It wasn't a car chase. She just came to a rolling stop. And she refused to tell the police who she was, or anything about herself. They luckily traced back through the VISA – they found out who she was. And I got a phone call at 2 o'clock in the morning from the police and that's when it started.

What was the encounter like, dealing with the police, for yourself or your daughter?

They were very understanding, but at the same time they didn't understand her. They thought she was just a rotten person and wasn't cooperating. On the other hand, they knew she wasn't a down-and-outer. She wasn't a hooker. She wasn't truly criminal, but she was totally uncooperative and acted, they thought, quite superior to everyone and like she didn't have to answer to anyone. They were pretty frustrated. I kept trying to explain to them that this was an illness. They were very good with me after I explained things – oh here's what's happening – but they were ready to throw the key away. Ultimately, she ended up appearing the next morning in the court downtown.

There was a charge laid?

Yes, there was a charge laid, a criminal charge. She was even in court quite belligerent. At that point I had called Karyn at the Family Outreach and Response Program. She showed up with my wife and I in court. We didn't really get to speak to Melissa because she was first led in in handcuffs, but at that point we were able to go see a COTA mental health court support worker. Between Karyn and the COTA worker they knew the ropes. They knew what I should do to protect Melissa and how to negotiate the system – which is very daunting at best.

There I had a very bad experience with the justice of the peace, who was just absolutely the most unfeeling petty bureaucrat I've ever met in my life. I was very upset with him. But ultimately we had to play the game, and we got through that. The COTA worker advised us which lawyer would best be suited for Melissa's case. We obtained a lawyer and then started working our way through the court system.

Then the COTA worker lost her job, or that program was cut back or cut out. I don't know exactly, but she wasn't available anymore.

> The police were pretty frustrated. I kept trying to explain to them that my daughter had an illness. They were very good with me after I explained things... but they were ready to throw the key away.

We did see a court psychiatrist who I guess was helpful... but was totally overworked and didn't have the patience to work extensively with Melissa who was... who did not want to take medication and who didn't appear to want to help herself... so it wasn't a totally good experience but it wasn't a bad experience.

At that point we were put in touch, at one of our many appearances in court, with the CMHA worker at the court. She was terrific and she showed up in court with us when we appeared before the judge, and I think just her being in the courtroom made a difference. And our lawyer was kind of exceptional. So between the two of them we were able to get the charges stayed and then she got better. And then Melissa was good for two years and was teaching again.

Were you able to find within the system that you could get support for your daughter?

We could get support but it was generic support. More or less it wasn't really tailor-made to her case. It was very much a case of a holding tank situation until luckily she was properly diagnosed. I appreciate how difficult it is to do that, but they're overworked – psychiatrists are overworked, social workers are overworked, everybody is overworked, so they don't have the time unless they're forced to take the time to really pay attention to give someone the attention that they deserve. And that's not a knock on anybody, it's a knock on the system.

Was there a crisis team involved in helping your daughter stabilize and recover?

She was assigned a social worker in the community who was terrific. And that helped a lot. Melissa could actually relate to this person. And that worked out extremely well.

Were you involved in treatment options and was your knowledge of your daughter's history taken into account?

Yes, I was involved all the way through the process. Melissa had signed off [on a Form 14, giving permission to share her health record], and I was allowed to have information, show up, and help her choose various directions.

How were you coping with your daughter prior to the incident with the car? And now?

Now I'm doing fine because she's fine. I do okay and I help... I think I'm instrumental in helping her when she gets sick... but as a father it takes a lot out of you.

Do you think there was something that was key at the time that helped your daughter? Was there a turning point and then something that made a difference?

No, it's still ongoing. She's back on track now. Since that episode, she went out west and ended up being rehospitalized. She ended up coming back within the system to Ontario and basically waiting out the cycle. Now she's back off medication and back at the top of her game. Each time she goes through this she gains a little more awareness. She knows that she's sick. She knows, for instance, that I'm talking to you and she was fine with that.

She has a GP at least. She has told him her story and he's keeping an eye on her right now... we are too. Since her cycles seem fairly long in terms of being good, we're hoping she might go two or three years and then be only six months down. I don't blame her if she doesn't like taking medication on a permanent basis. She should hopefully know when to get on them and stay on them until she's feeling okay again. That will be the secret to her success, that awareness – it's kind of trial and error.

What are your dreams for your daughter and family now?

My dream is for her to recognize her disease. I think the best-case scenario is that she recognize when she's going to get sick and does something about it before it gets so bad that she develops it, and she flips into psychosis and does something silly. She gets very impulsive.

So before she gets to that stage, my dream is that she gets treatment and then when she gets better she can get off medication. It does not appear to be a problem because she can go for two or three years and be fine. So that would be the best-case scenario, that's most realistic... unless there is some great medical discovery.

Looking back, with hindsight often being 20/20, what would you like to have seen happen before or after the incident that didn't?

The problem is it's a very difficult thing to assess someone and pin it down as to what they are. But I certainly would have liked to have seen a recognition of her disease earlier and the proper diagnosis earlier. But it may not be realistic to think that that could happen on the first try. It probably does take three or four times. It is a very difficult thing. I would like to have seen that happen earlier... but that may not have been feasible.

Is there anything else you feel needs to be said?

I think in terms of the court system, it's a question of being understaffed. Certainly, in the case of the justice of the peace, I still harbour resentment for the guy. He had no compassion whatsoever, but I realize he had been hardened by the system. On balance, you know the fact that there was someone there shows that the court does recognize that this situation exists and they can't just treat everybody the same. And in her case it worked, luckily. Her court case was stayed and her records were destroyed. So hopefully she doesn't do it again.

DOCUMENTARY FILMMAKER LAURA SKY AT WORK WITH HER CINEMATOGRAPHER, JIM AQUILA, CSC.

crisis call

Documentary filmmaker Laura Sky wants to work with police to change the way they respond to people in psychiatric crisis. First she made a film about it, and now she's stepping out from behind the camera to engage first-hand in changing the system. Last September, Sky helped launch the Mental Health and Criminal Justice Project in Thunder Bay, which brings police together with psychiatric survivors and other members of the community to create new policies and practices for police and mental health services when they respond to people who are experiencing a crisis.

Sky Works Charitable Foundation, the organization through which the filmmaker delivers her own brand of community education and social advocacy, has undergone "a very significant change," according to Sky. "We started out making documentary movies – we've always loved doing that, and we've always worked with community groups – but now we have an equal emphasis on actually using the films when they're done. Not only using them for one-shot screenings, but working with communities to maximize the effectiveness of the film over the long run."

That approach has been remarkably successful. In fact, Sky's most recent documentary, *Crisis Call* (2003), inspired the Mental Health and Criminal Justice Project in Thunder Bay, where much of the research and filming took place.

Crisis Call begins with the death of Edmond Yu, a homeless man with schizophrenia who was shot and killed by Toronto police in 1997 during a

A SCENE FROM *CRISIS CALL*: THUNDER BAY'S EMERGENCY TASK UNIT ON A TRAINING EXERCISE WITH SERGEANT ALAN MCKENZIE (CENTRE, LOOKING BACK).

"We've now learned, through a hard lesson, that people who are psychiatric survivors in crisis are, in fact, in crisis – not criminals."

– SERGEANT ALAN MCKENZIE

confrontation on a downtown bus. Exploring the role of police in situations of crisis, the filmmaker asks whether people with guns should even be the ones who respond. "Have police become the new frontline mental health workers?" she wonders.

"My own feeling," says Sky, "is that we should be talking about diverting people long before they encounter police or the courts. The real diversion has to include an alternative to either hospitals or jails. The medical model is often more restrictive to people than the jail system is. Sometimes it's very helpful, and there are really good people in the health system, but it's often not an option that survivors prefer."

"If you speak with survivors, many say they would prefer to be in a safe place, with a group of peers who can just give them the space they need and work with them to resolve the issues that are leading them into crisis. Being relentlessly poor and homeless would bring any of us to crisis in six minutes."

Sky has worked with the psychiatric survivor community before, notably on the film *Working Like Crazy* (1999), a profile of six people who overcome the challenges of poverty and unemployment by creating their own jobs and support systems. "One of the key people in that film," recalls Sky, "went off to a groundbreaking conference in July 2000, a coming together of psychiatric survivors, cops, lawyers, judges, the whole gamut, in an effort to deal better with what happens to people when they get into crisis." When she realized that the police had never sat in the same room with survivors in an official way, Sky immediately saw an opening.

"That said to me there was a possibility for some kind of work together around an issue that cops and survivors agree about. In fact, cops and survivors want to be seeing a whole lot less of each other when survivors get into crisis, and that agreement alone made me believe that some kind of systemic change was possible."

Creating films as a catalyst for change is something Sky learned during her early years with the National Film Board. "It's a model I learned in the 1970s when I worked in the NFB's Challenge for Change program. The purpose of our work was to provide tools to communities that were involved in social change. That's what we're doing now. It's a wonderful, hopeful process."

Explaining how *Crisis Call* got started in Thunder Bay, Sky recalls the existence of three important conditions: "There was a police officer on the board of the local branch of the Canadian Mental Health Association, a community organizer who happened to be a cop. We also knew that the CMHA in Thunder Bay had particular credibility with the survivor community, as a good advocacy group. And we knew that survivors in Thunder Bay

were organized. So I went up to do research on how those issues were living out in Thunder Bay, and I discovered really amazing people, who were very honest and direct about the problems."

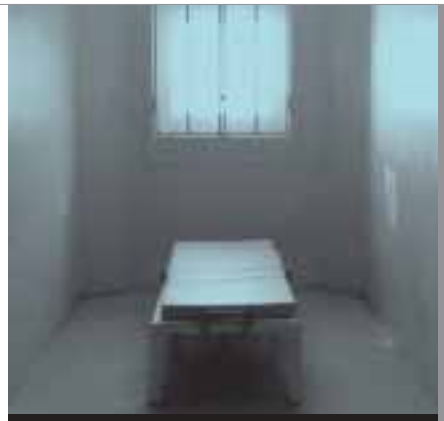
During the filming of *Crisis Call,* Sky interviewed police and psychiatric survivors in several communities, including Montreal and Toronto. One of the most engaging portraits in the film is that of Andria Cowan, a police officer who was involved in the shooting of Edmond Yu. Cowan speaks openly of her experience and how it changed her views about police interactions with people in crisis.

"I felt that society had let him down," says Cowan, who feels "haunted" by the shooting. "[Police] have the authority under the Mental Health Act to make an assessment and take someone's liberty away, but we don't have the authority to make an assessment to get someone the help they need."

Participating in the film "was a very courageous act on Andria's part," agrees Sky, "because she really reveals her own difficulties and her own vulnerabilities – and certainly her own strengths. I really value her courage."

"As soon as I realized that a woman police officer had been involved in the shooting of Edmond Yu," Sky continues, "I had a very intuitive feeling that one day we would have an important reason to tell the story of what happened. I waited to approach Andria, because I knew that she had been very traumatized by the experience, but from the minute we sat down, we knew we would be doing important work together. We just had this connection, and we continue to have it. We work together and we travel with the film on the road often."

For the past two years, *Crisis Call* has been travelling throughout Ontario. Not only has it screened and been the subject of panel discussions in communities from Hamilton to Rainy River, but it has also been picked up by the police as a training film. "The reaction from police is everything we hoped for," Sky declares. "It's used in many centres across the country as a training film by cops, including in Toronto and in Aylmer, Ontario, where the police college is located. That makes us very happy."



A SCENE FROM *CRISIS CALL*: SOLITARY CONFINEMENT. MINISTÈRE DE LA SÉCURITÉ PUBLIQUE/ CENTRE DE DÉTENTION DE MONTRÉAL, QUÉBEC.

"Our hope is that this film will change behaviour. I wanted to say to police, 'We think you're capable of positive change,' rather than just to scold them and give up."

– LAURA SKY, DIRECTOR OF *CRISIS CALL*

"Our hope is that this film will change behaviour," says Sky. "One of my goals was to keep cops in the room when they were watching the film, to give them enough surface of identification, and give them the opportunity to think about these things in a different way than they were used to thinking about them. I wanted to say to them, 'We think you're capable of positive change,' rather than just to scold them and give up."

"Of course, it's one thing to make a movie, but it's another to say, 'Okay, how are we going to work on concrete change – social change, institutional change?' So we went back to Thunder Bay, where the space for that kind of exploration exists."

The new project is a partnership between Sky Works and the Canadian Mental Health Association, Thunder Bay Branch, with funding provided by the National Crime Prevention Strategy, Community Mobilization Program. "We now have a group of 65 stakeholders involved in this process," says Sky. "We're just at the point of agreeing on priorities. To find a basis of unity for 65 stakeholders is a pretty tall order, aside from everybody acknowledging that there are inadequate resources."

"What we really wanted to do with the film was create an opportunity for people to sit down at the same table together. We didn't want to create a falsely rosy picture by saying, 'Everything's fine, and if you've had a bad experience it's just your problem.' We wanted to say, 'If you can find your own hopefulness, then take a look at this and let's figure out how we can build a coalition to make things happen – not only to make things better for people in crisis, but to prevent crisis.' Because we all know that people who find themselves in a psychiatric crisis are often there because everything else has failed – because they haven't gotten the services or support they needed, they're poor, they're isolated... So we wanted to work with people who wanted to address those systemic issues. We were hoping we would find survivors and police officers who would feel that that was possible."

Both the Thunder Bay Police and the Ontario Provincial Police are now sitting at the table with other community members. "That was a big goal for us," says Sky. "And they're sitting beside survivors, aboriginal survivors, people who never expected to be sitting together at the same table in the same room, trying to fix things. It's pretty amazing!"

For more information about Sky Works Charitable Foundation, see www.laurasky.org.

Out of the Darkness

Toronto's Mental Health Court is the province's only criminal justice court for accused persons suffering from mental disorders

BY SHELDON GORDON

"What is the purpose of the courts of law?" asks Judge Ted Ormston of the Ontario Court of Justice. "It used to be to punish, to deter, to rehabilitate. Now, therapeutic jurisprudence realizes that an element of healing can also be involved. Often, it's the first time people realize that their sickness has brought them before the courts. They have to deal with it, and the [Mental Health] Court can help in that process."

That's the fundamental premise behind Court 102, the Toronto Mental Health Court (MHC). Headquartered in a small, austere chamber in the basement of Toronto's Old City Hall that once sat empty and unused, a new type of criminal justice court now convenes there every weekday.

Court 102 is the only MHC in Canada that sits on a full-time basis, five days a week, according to Judge Ormston, co-founder of the project. Started in 1998, it was just the second mental health court in North America (Fort Lauderdale, Florida, claims the first). While the U.S. now has 600 MHCs, and Australia and New Zealand have also instituted them, Court 102 remains the only one of its kind in Canada.

In the past two years alone, an estimated 3,000 to 5,000 accused persons, afflicted with a variety of mental illnesses, have appeared before the Toronto court. (The number on any given day ranges from two to 20.) "They may be depressed or psychotic, have Tourette's Syndrome or engage in manic behaviour," says senior Crown attorney Paul Culver. "We see pretty well everything."

Several judges take turns presiding over Court 102. In addition to legal professionals who wish to work with the mentally ill, the court also has mental health workers who do assessments on site, maintain files on "repeaters" and try to contact their family members.

Their mental illnesses are not so severe, however, that the accused are unable to "understand the nature and consequences of their act" (the definition of criminal insanity in section 16 of the *Criminal Code*). Nor are they so ill that they are unfit to stand trial. "These are usually people who have gone off their medications or don't follow their treatment plans," says Culver. "They are usually charged with nuisance offences, such as breaking windows or stealing from stores." Violent offenders who are mentally ill are still processed through traditional criminal court.

The Toronto MHC has rarely, if ever, been the setting for a trial. Rather, it operates in the early stages of the

criminal justice process when the accused has a bail hearing. "It was frustrating to see the same people keep coming back in," says Culver. "One of the few alternatives was not giving them bail. But little could be done with them except lock them up for short periods.

"Now, psychiatrists attend at the courthouse prior to a decision being made on bail. It's better than the system we had before." Ted Kelly, who has represented hundreds of clients in Toronto's Mental Health Court, calls the tribunal "an unqualified success," praising "the speed with which matters are dealt with when people are ill, the support that they get."

When mentally ill persons are arrested, they have to be assessed to determine if they are fit to stand trial. Before the MHC was created, a judge would see them first, then remand them back to the Don Jail; from there, they would go to the hospital about three days later. There they would be seen by a psychiatrist for about 25 minutes, be returned to the Don Jail for another three days and then finally appear in court.

"The round trip took anywhere between 10 and 15 days," recalls Judge Ormston. "Now, we do that in five or six hours," because the Centre for Addiction and Mental Health has moved its Brief Assessment Unit to the courthouse, making early assessments possible.

"If they are unfit and need to be assessed for a longer period, or can benefit from treatment, the process whereby they get into the hospital is just far faster," says Kelly. "And those who are found fit can sometimes be released on [bail] the same day, or the next day, while their charge is before the courts.

"Why is it easier for people to get released? Because there are mental health support workers right there who can assist people and provide them with basic things, like clothing and referrals to community support programs and to shelter."

While free on bail, the mentally ill offender is required to report back to the court weekly for an extended period. "We encourage them to keep on their programs," Judge Ormston says. "Then they come back to court monthly. About six months later, when they're stabilized on their meds and doing well, the Crown attorney usually withdraws the charges against them. So they're not criminalized by the process."

Of course, not everyone who passes through MHC is able to regain a normal life. "We have our 'frequent fliers,'" says the judge, referring to the court's repeat offenders. But he estimates that fewer than 10 percent of the accused fall into that category. "It's far fewer than it was previously," he says, "and we're finding that their appearances in court are becoming further apart."

The MHC, he says, deals with a segment of society that "was formerly slipping through the cracks, as provincial criminal courts are asked to deal with more and more social problems, mental illness being one. They aren't well treated in the regular adversarial court processes.

"Mental Health Court allows us to step back, close the book and open your heart."

inSIDE

Courtroom 102

PHOTOS BY SUSAN KING

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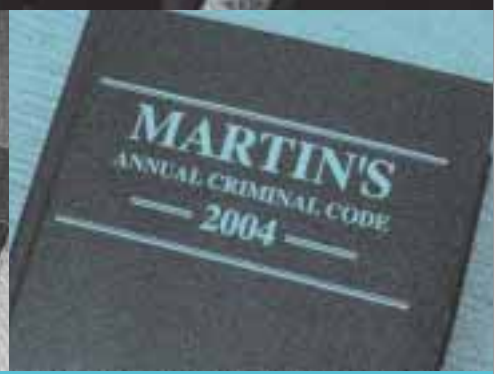

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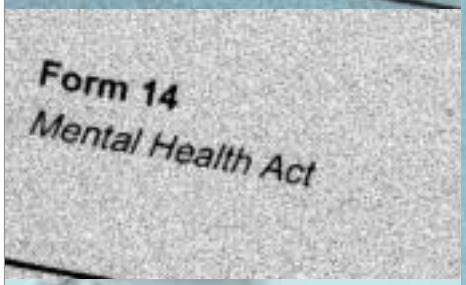
FACES OF JUSTICE IN COURTROOM 102:

1. THE HONOURABLE MR. JUSTICE EDWARD F. ORMSTON
2. LOWELL SMIKLE, COURT ADMINISTRATIVE LIAISON
3. DAVID TAYLOR, DUTY COUNSEL, LEGAL AID ONTARIO
4. BERNADETTE SAAD (RIGHT), DUTY COUNSEL, LEGAL AID ONTARIO
5. THE HONOURABLE MR. JUSTICE RICHARD D. SCHNEIDER
6. MARGARET CREAL, ASSISTANT CROWN ATTORNEY



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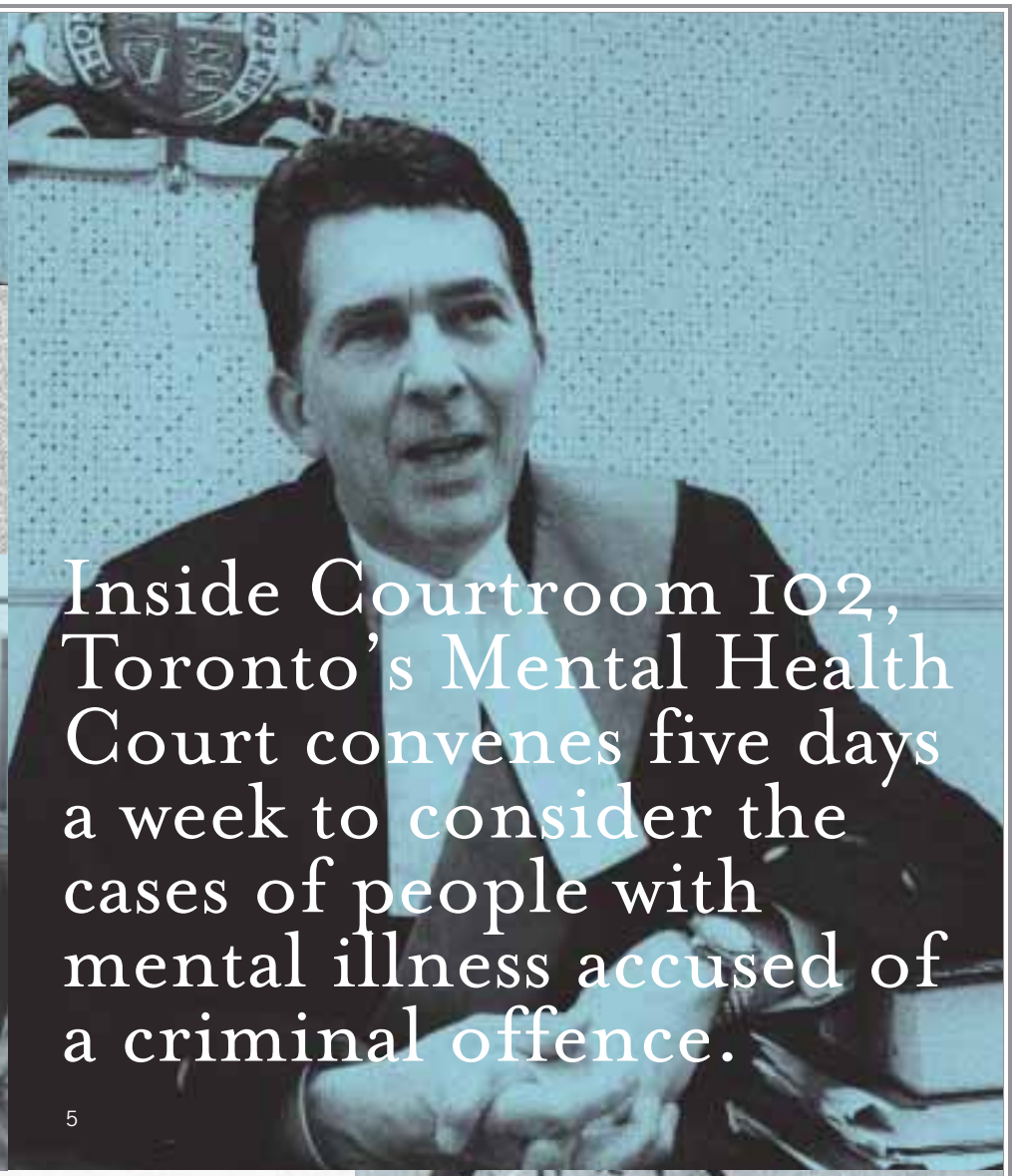

Inside Courtroom 102, Toronto's Mental Health Court convenes five days a week to consider the cases of people with mental illness accused of a criminal offence.

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Fighting Fires

Mental health court support programs in Ontario were created to build bridges between the criminal justice system and community services. Yet the day-to-day job of the mental health court support worker often feels more like fire-fighting than bridge-building. With not enough services available in the community and people not knowing where to turn for help, much of the support worker's time is spent responding to crises.

"I hate to say it, but we're dealing with the fires as they come up rather than looking at the origins, or keeping the fires out," observes Rick Gadde, mental health court support worker for the CMHA Sault Ste. Marie Branch.

Opportunities for prevention do exist. Gadde often works with family members, for example, to help them negotiate the sometimes confusing rules under the Mental Health Act that can be used to get people into treatment and prevent situations from escalating.

But in most cases, by the time the court worker gets connected with a person in need, that person has already been charged with an offence and may already have had several court appearances. "Oftentimes, we get people on their third or fourth appearance," says Courtenay McGlashen, manager of the mental health court support program for the CMHA Peel Region Branch. "They've just been bouncing around because no one really knows what to do with them."

Mental health court support programs currently exist in fewer than 20 communities across the province, usually as a service provided by a local mental health agency. Seventeen CMHA branches in Ontario, including Sault Ste. Marie and Peel Region, run court

support programs, although they vary in size and services offered.

The CMHA Toronto Branch mental health court support program in the Scarborough Courthouse is one of the biggest and best organized in the province. Managed by Frank Sirotich, the program includes two diversion workers and a case manager, as well as two psychiatrists who attend on a regular basis. The Scarborough program is one of five mental health court support programs serving the Toronto area. The others are located in Etobicoke, North York, and downtown Toronto at College Park and Old City Hall.

Both Gadde and McGlashen, on the other hand, work alone and serve communities that span large geographic distances. In addition to the court in Sault Ste. Marie, Gadde says, "There is a need out in the region," in the smaller neighbouring communities of Wawa, Blind River, Elliot Lake and Thessalon. McGlashen admits it's a challenge to cover the region of Peel and that "on any given day I could be in five different courtrooms at the same time." A little relief is in sight, however – CMHA Peel recently received new funding for case management workers, and some of those staff will work with the diversion program.

The position of mental health court support worker is a new one in the field, and Gadde and McGlashen have come to their roles by different routes. McGlashen started his job in Peel on a student placement, and his training consisted of a hands-on "crash course" in the criminal justice system provided by the duty counsel and other court professionals.

Gadde took on the job six weeks after his "retirement" from a previous career that included positions in two provincial ministries, supervising social work students, and being a police officer. To support his current role, he has participated in training from North Bay Psychiatric Hospital on such topics as fitness screening, fetal alcohol spectrum disorder, post-partum depression and concurrent disorders. In return, Gadde offers training to other providers, including suicide intervention.

Court support workers and other professionals with the CMHA Toronto program also benefited from specialized training, including a three-day course on risk assessment provided by the Centre for Addiction and Mental Health. Sirotich says that while formal training is important, court support workers do a lot of "learning on the job," especially in understanding the criteria the court system uses to make a decision on whether or not someone is suitable for diversion or for a bail release from jail.

McGlashen identifies mental health diversion as the "primary function" of the mental health court support program. He defines diversion as "a way of taking someone with criminal charges out of the criminal justice system and steering them towards the mental health system." The Peel program successfully diverted 56 individuals from the criminal justice system into mental health treatment in 2003-2004. Only 3 percent of those individuals have since re-offended.

Most of the people who are diverted from jail to the mental health system have been charged with non-violent crimes, known as "class one" offences. Examples of these include public disturbances, such as yelling at people in public, breach of probation, and mischief charges. More serious offences, such as "uttering threats," can also be diverted, depending on the circumstances.

Gadde provides an example of "one of the simpler situations" – a woman with no criminal history who was charged with "simple assault" after she "grabbed hold of somebody." At the time of the assault, the woman was changing her medications, a process that can significantly affect the person's behaviour. Based on this and other factors, Gadde recommended that her case be diverted, with conditions that included writing a letter of apology to the victim, performing community service and keeping the peace. The Crown accepted the recommendation and set a date two months later to follow up with the woman to make sure she had met all the conditions.

Diversion is only one part of the day-to-day work of a mental health court support worker. In cases where diversion is not appropriate and people proceed through the criminal justice process, the court worker can help the court understand the psychiatric treatment needs of the accused. They also provide support to prisoners with mental illness, by helping them adjust to jail, for example, or helping them create a plan to come back to the community after they serve their sentence.

One key to the success of court support programs is the linkages they have developed with other players in the system. A wide range of criminal justice professionals can be involved with each individual before the court, such as Crown officers, defence or duty counsel, judges, and cell supervisors, as well as workers from the John Howard Society who provide supervision for people on bail. "We have excellent buy-in from these people," says Gadde.

> Mental health court support workers offer their clients who qualify for diversion an opportunity to develop a plan that will not only satisfy the requirements of the legal system, but also help the person deal with getting and keeping healthy.

In addition to accessing the case management, clubhouse, counselling, vocational, peer and group support, and other services offered by their local

CMHA, both Gadde and McGlashen also refer people to services elsewhere in the community – inpatient assessment and treatment, counselling for abuse and addiction, income support programs (such as Ontario Works and the Ontario Disability Support Program), and homeless shelters. "You name it, we use whatever we've got," says McGlashen.

Forging links across sectors becomes easier when court support programs are able to demonstrate the effectiveness of their work. Before the program existed in Sault Ste. Marie, people who required an assessment to see if they were fit to stand trial had to be sent to North Bay Psychiatric Hospital, a process that required two police officers driving the individual five hours each way. According to Gadde, "80 percent of the people being shipped there were just being turned around and sent back because they were found to be fit."

RICK GADDE, MENTAL HEALTH COURT SUPPORT WORKER, CMHA SAULT ST. MARIE BRANCH.

With the court support program available in their home community, the long trip to North Bay is no longer necessary. People with mental illness are being better served, police time is freed up, and the psychiatric beds that were being used to assess people are now available for other patients.

The clients that Gadde and McGlashen work with run the entire age spectrum, from a 16-year-old boy experiencing his first psychiatric crisis and causing a public disturbance, to a senior in her 70s, suffering depression and loneliness from the loss of her family and caught shoplifting for the first time in her life. Beyond the shared fact that they all have a mental illness and are involved, or at risk of becoming involved, with the criminal justice system, each person is unique.

Getting to know the person – who they are and what's going on in their life that has led them into trouble with the law – is a key task for the mental health court support worker. "What I try to do is provide the court with a picture of who this person is," says Gadde. He reviews the person's background, talks with the police and court workers, and consults with the family, if possible.

"We get great information from families on what some of the issues are," agrees McGlashen. "Families are usually the first contact we have with the individual. They would alert us that their loved one is in custody and needs some help."

> Getting to know the person — who they are and what's going on in their life that has led them into trouble with the law — is a key task for the mental health court support worker.

The family members suffer through the process as well. They are often in "dire straights themselves," says Gadde. "They're barely holding on as a care provider." Finding help for family members is part of the court support worker's role. McGlashen often refers people to the Family Association for Mental Health Everywhere (FAME), a local family support group with whom he has developed a good relationship.

Mental health court support workers offer their clients who qualify for diversion an opportunity to develop a plan that will not only satisfy the requirements of the legal system, but also help the person deal with the many issues involved in getting and keeping healthy.

"The court is only really concerned with supervision as a whole – are they getting their meds, are they seeing their doctor," says McGlashen. But once the plan is accepted by the court, he "works with the individual to empower them to get where they want to go in life."

Without the option of diversion, people suffer greatly when their mental illness is treated as a crime. "We've had people who had suicide attempts every time they had to come to court," says McGlashen.

A key part of the job is helping people cope with the "huge intimidation factor" of being in the court, by "ensuring that clients and their support networks understand the court process entirely," says Gadde. "One of the greatest rewards I have is the fact that people don't feel alone."

Gadde and McGlashen both describe their work as extremely rewarding. "I really feel that I'm doing good work," says McGlashen, "because the criminal justice system is no place for somebody who is mentally ill. Having a chance to help somebody get out of the system, that's great."

Editor's Note: On January 12, 2005, the Ministry of Health and Long-Term Care announced $27.5 million in new funding for community mental health services in Ontario to help people with mental illness stay out of the criminal justice system. The investment is intended to expand services in five key areas: crisis outreach and response, short-term residential crisis support beds, intensive case management, supportive housing services, and court support services.

For more information about mental health court support and other services provided by CMHA branches in Ontario, visit www.ontario.cmha.ca/branches.

Partnering with Police

HELP TEAM MEMBERS CONSTABLE CHERYL MCVICAR AND MENTAL HEALTH WORKER DARREN SIMS FROM CMHA CHATHAM-KENT ASSIST A DESPONDENT PERSON.

Police and mental health workers in Chatham-Kent agree that strong partnerships, clear protocols, and specialized training are effective strategies to reduce tragic consequences when police interact with the mentally ill. A few years ago, cops and care providers in this largely rural community in southwestern Ontario came together to create the Chatham-Kent HELP Team to respond to people in psychiatric crisis. By all accounts, their collaboration has been a success.

HELP Team members are available 24/7 to intervene in situations involving the mentally ill, by assisting the investigating officer or making referrals to the proper mental health service provider. The team maintains a database of client information and has developed protocols for information sharing among the partners. Their approach is to proactively build relationships with people who repeatedly come into contact with the law, and to consider alternative measures, including informal diversion, for mentally ill offenders.

Modelled on the well-known Crisis Intervention Team in Memphis, the HELP Team strategy involves four days of additional training for selected front-line patrol officers, provided by mental health professionals. "We've developed a training program for police that covers everything from crisis intervention, to psychiatrists speaking to them about mental illness, to knowledge of psychotropic medications," explains Len Caro, executive director of the Canadian Mental Health Association (CMHA), Chatham-Kent Branch.

While training may not make the police experts in mental illness, adds Inspector Clare Wiersma of the Chatham-Kent Police Service, "sometimes the information can be used as a bridge to connect with the person in crisis. Anyone who deals with people struggling with mental illness, for example, knows the harsh side-effects of many of the medications. Sometimes the officer can ask, 'What medications are you on?' and say, 'Oh yeah, I understand it might have this side-effect and are you having problems with that?' The interaction may create just enough of a bridge that the mentally ill person now feels a connection with the police officer and may be more likely to listen to his advice. It can help de-escalate the incident."

Job shadowing has also proven to be a helpful supplement to formal training. "Our crisis nurses have gone out into the community and spent a normal shift with police officers," says Paula Reaume-Zimmer, director of mental health services at the Chatham-Kent Health Alliance, another HELP Team partner. "It helps them recognize what police officers are confronted with, and the frustrations the police may have with mental health clients."

Understanding and respecting each other's role has helped to improve communications among the partners. "Where before, problems would fester, now we very quickly can call and say something didn't go right on this particular case and ask what we can do to improve it," says Wiersma. "Instead of finger-pointing back and forth, the agencies are putting their heads together and coming up with solutions."

Kathleen Hartford of the Lawson Health Research Institute in London, Ontario, has identified the Chatham-Kent HELP Team as a best practice model. And the team's own informal satisfaction survey, conducted among CMHA staff, consumers, family members, crisis nurses and Assertive Community Treatment team members, resulted in a very high approval rating. Almost all respondents who had contact with HELP Team officers felt they were more able than other police officers to assist the mentally ill (only 3 percent disagreed), and they suggested that all officers should get the same specialized training.

Presentations from consumers themselves are a key element of that training. "Officers who have attended the training have indicated that it's probably the most impactful part," says Wiersma, "to hear from somebody who was a highly functioning member of society, with a good career, et cetera, and was then struck by a mental illness. The person has learned to cope with their illness, but in many cases they've lost their career, have to deal with stigma, and so on. It certainly helps the officers to get a real understanding of the issues involved with mental illness, and the challenges that people face. It raises their level of empathy."

For more information about police and mental health issues, including links to related resources, visit www.ontario.cmha.ca/network.

Busting the Stigma

PHOTO BY LAURENCE ACLAND

Four years ago, after 17 years on the force, police officer Bill Anderson (not his real name) began to notice changes in his mood and responses to situations. He felt overwhelming frustration and confusion, he withdrew from family and friends, he hated going to work, he began to smoke very heavily, he committed minor crimes in order to get caught, and he planned his suicide. He became a different person – angry and fearful. Eventually, after a major crisis, he went to a psychiatrist his wife knew, and he was diagnosed with clinical depression.

Anderson remembers how he used to think about people with mental illness. "They were the opposite of us as police officers. We were strong and resilient, they were weak and flawed. We called them 'nutbars.'" Now he was one of the nutbars.

Anderson knows his situation is not unique, yet nobody at work talks openly about having a mental illness, he says, and many pretend that mental illness doesn't happen to police officers. Police officers in Canada face a daily balancing act, trying to protect their emotional and psychological health while maintaining effectiveness in their ever-increasing role as service-oriented, helping professionals.

The job of police officer can be extremely stressful. There are many risk factors, not found in most occupations, for developing addiction and mental health problems. While the police experience many of the same stresses as other workers – long hours, dwindling resources, and managers who sometimes have less than adequate skills – they also experience unique daily challenges to maintaining a healthy mental balance: the witnessing of horrific human tragedies; the danger of physical and psychological abuse; a heavily structured, hierarchical work environment; constant public exposure and scrutiny; and personal liability and accountability for all actions.

Two seemingly opposite character traits are required to do the job. A police officer must be tough and dispassionate ("Just the facts, ma'am") when confronted with dangerous, emotionally charged or horrific situations. At the same time, the officer cannot be cold and callous, but must maintain an open mind and a compassionate heart.

Dr. Dorothy Cotton, a psychologist at Correctional Service Canada and Queen's University, and co-chair of the Canadian National Committee for Police/Mental Health Liaison, is well-acquainted with the contradictions of police psychology. Her recent study of police attitudes toward people with mental illness revealed that police officers show more understanding and compassion than the average Canadian. Most of the 150 Canadian officers who

participated in the study believe that people with mental illness deserve more societal tolerance and should not be denied their individual rights.

According to Officer Anderson, this attitude of tolerance and advocacy for human rights does not extend to a fellow officer experiencing a mental health problem. "If you break your leg on the job, everybody rallies around. But if you have depression because of the job, they see you permanently as a nutbar and they don't want to know you. Policing has a very tight and unforgiving subculture that does not support disclosure of mental illness."

Terry Coleman, chief of Moose Jaw Police for seven years, and co-chair of the Canadian National Committee for Police/Mental Health Liaison, says that when he began policing more than 30 years ago, emotional problems were taboo on any police force. Yet despite the current workplace climate that continues to discourage personal disclosure of mental health problems, Coleman is encouraged by what he sees as an evolution of understanding among officers.

"The culture is so different from 1969 when I first joined the force in Calgary, when any discussion of the emotional impact of the job was thought of as wussy crap." Coleman believes that officers are increasingly seeking professional help through their Employee and Family Assistance Programs (EFAPs). He also sees an increase in requests for critical incident and stress debriefings, indicating a growing awareness of the impact of the job on the mental health of officers. And he believes that in private conversations police officers do try to steer their colleagues to get help.

Yet the stigma remains, and support services may be inadequate or poorly promoted within the organization. Anderson says that officers are suspicious of critical incident debriefing sessions because statements they make could be used against them. Another barrier to treatment may be lack of awareness of assessment and referral services available through EFAPs. Even when a police officer is referred to a psychiatrist, the officer may worry that people will find out or that somehow confidentiality might be breached. The lack of trust reinforces the stigma, and the silence continues.

Chief Coleman has never had an officer disclose a mental illness to him in his seven years as chief, nor has he heard of any officer anywhere disclosing a mental illness. He has had officers disclose substance abuse, and he has experienced the suicide of one of his officers, but he says that nobody talks openly at work about having a mental illness.

Twenty thousand men and women are members of the Police Association of Ontario. Health Canada statistics indicate that one in five Canadians will experience a mental health problem in their lifetime, usually during their adult working years. The laws of probability, coupled with the elevated risk factors of a high-stress job, suggest that roughly 4,000 of Ontario's police officers will experience a mental health problem at some point, most likely during their time in the service. What happens when no one wants to hear about it?

The stigma of mental illness prevents officers from seeking appropriate treatment, according to Officer Anderson. Police officers suffer in silence. They self-medicate with alcohol, engage in crime, and some end their lives by suicide. But the culture responds with denial. "The culture says that we don't have alcoholism, we don't have suicide, we don't have officers calling out for help by committing crimes," says Anderson. "The family is often told that an officer died while cleaning his weapon. But we all know that you can't shoot yourself while cleaning your gun."

Culturally, police services are similar to the military, where there is a high premium on toughness, according to psychologist Dr. Dorothy Cotton. She says police officers may believe that any hope of advancement would be curtailed if they sought psychological help. Fellow officers may perceive it as a sign of weakness.

Officer Anderson agrees. "You can't say, 'Listen, I have depression,' because police officers have a very narrow view of mental illness. As soon as you say that you have a mental health problem, you're a 'nutbar', and you're finished." Anderson has told colleagues he trusts about his experience, but does not feel safe speaking openly about it, even though he feels his experience has made him a better officer, enhancing his skills and ability to help people. He says he is not a risk to his fellow officers, and feels he is liked, trusted and respected by the officers he works closely with.

Anderson believes that change in the culture will only happen with education, particularly for senior officers for whom mental illness among police is a "new" phenomenon. He says that supervisors need training to be aware of the early signs and symptoms of depression, and need to develop the knowledge and skills to offer appropriate help rather than automatically initiating discipline when there is a problem.

> Nobody at work talks openly about having a mental illness, and many pretend that mental illness doesn't happen to police officers.

Today Officer Anderson loves his job in uniform patrol, and enjoys a healthy work/life balance. His personal journey has been difficult and painful. He credits his recovery to incredible support from his wife, his family and friends, and his good fortune in having access to a psychiatrist whom he could trust. He willingly speaks privately to fellow officers who approach him unofficially, in obvious need of psychiatric assistance. His hope is that some day these officers will be able to say out loud, "I am depressed and I need help."

YOUTH JUSTICE

Keeping kids out of jail is a full-time job for Natalie St. John. She's a youth court worker at the Newmarket Provincial Court, where young offenders are sent from all over York Region. She's also the assistant coordinator of the Youth Court Action Planning Program (YCAPP) in York Region, a Legal Aid Ontario pilot project that's helping young people stay out of custody by connecting them with community resources.

Delivered in partnership with Operation Springboard, YCAPP serves youth between the ages of 12 and 17 who are eligible for legal aid. While other diversion programs are available for first-time, non-violent offenders, YCAPP's diversion component is for young people who don't fit that category – a boy who gets into a schoolyard fight and gives someone a bloody nose, for example, and is charged with assault causing bodily harm.

"When defence counsel has someone they think would benefit from YCAPP's services, they refer the youth to me," explains St. John. "I complete an assessment on the youth to determine if they're a manageable risk for a community-based plan, or if a diversion plan would make sense in the circumstances. I then link the youth up with community agencies by making referrals and appointments for them." The program is voluntary, and each young person who is accepted into YCAPP gets a detailed, individualized plan.

"Defence counsel would then present this plan to the Crown Attorney, and if it's accepted, the youth would be diverted out of the court system, or the plan may serve as an alternative to a proposed detention order or custodial sentence. With respect to diversion plans, the youth always has to come back to court to prove that they've done what they said they were going to do." At that point, the proceedings may be stayed, the charges withdrawn, or a peace bond issued.

Launched in July 2002 in anticipation of the new Youth Criminal Justice Act (YCJA), the YCAPP program has three objectives: to reduce the number of youth going through the court process by increasing diversion, to increase opportunities for release at the bail hearing stage, and to reduce the over-reliance on custody as a response to youth crime.

ILLUSTRATIONS BY SAM HARDAKER

Asked to provide a case example, St. John tells the story of a young woman living in a group home, who was diagnosed with a mental illness and on medication. "She had an episode one night, and threw shampoo and nail polish all over the walls of the group home. She was charged with mischief and actually held in custody. I called the Children's Aid Society and got them to come and have her released into their care. She was already involved with a psychiatrist, but I was able to get the psychiatrist to see her on a more regular basis. What was happening, in fact, was that her medication was being altered at the time, and that was causing some imbalances, causing her to have certain behaviours."

In the plan she presented to the court, St. John recommended that the girl's case be put over for about three or four months, while the medication was worked out with her doctor. She then brought in a letter from the psychiatrist, confirming that things were back on track and explaining the medication issue. The young woman also performed some community service hours. In the end, her charges were withdrawn.

YCAPP began in Toronto at the 311 Jarvis court, then moved to two other Toronto courts, and finally to the Newmarket court in January 2003. As of November 30, 2004, there have been 1232 referrals to the four courts combined, resulting in 887 plans completed, with 796 accepted by the court – a 90 percent success rate.

Improving the youth justice system was identified as a key priority for the Department of Justice Canada, which funded the YCAPP program for the first two years. Canada has the highest youth incarceration rate in the Western world, and a review of the Young Offenders Act (YOA) in 1996 revealed that the courts were over-used for minor cases that are better dealt with outside the courts. The YCJA, which replaced the YOA as of April 1, 2003, puts special emphasis on rehabilitation and reintegration, as well as timely intervention. Among other changes, courts are now prohibited from using pre-trial detention "as a substitute for appropriate child protection, mental health or other social measures" (Section 29).

"YCAPP is building on the principles of the Youth Criminal Justice Act. I think it's been really successful, because I haven't seen many of the youth I have assisted coming back before the courts."

– NATALIE ST. JOHN

For diversion plans to be effective, however, adequate community services must exist and be properly funded. "What in fact is happening on occasion, although it's not supposed to," says St. John, is that young people are held in custody for mental health reasons because "there's nobody to bail them out and/or there's no facility that will accept them in a timely manner due to waiting lists."

Even court-ordered assessments take time. "There is quite an extensive wait period for Section 34 assessments under the Youth Criminal Justice Act, which are psychological or psychiatric assessments," explains St. John. "In York Region, it's about six to eight weeks for a psychological assessment, and it's about three months for a psychiatric assessment."

Among the many agencies that St. John partners with for support is the Canadian Mental Health Association (CMHA), York Region Branch, which runs the mental health court support program at the Newmarket courthouse. "The community resources I'm most familiar with are in the adult stream," says CMHA support worker Jonathan King. "Natalie is much more familiar with children's services. That's her bailiwick. When we collaborate, I rely on her expertise about what's available out there in the youth sector, and what kind of supports make sense."

Although the CMHA program deals mostly with adults, it does assist young offenders as well, according to King. "One case we're working on right now that Natalie brought forward is a young man who was charged with uttering threats. He suffers from a mood disorder, and our involvement in supporting the diversion plan is making sure that he follows through on the requirements, which basically means continuing to see his doctor and taking medications."

King notes that diversion is voluntary – clients must give consent and agree to the treatment plan. But clients must first meet the requirements for diversion, and the recommended plan must be approved by the Crown.

Partnerships with other sectors, including mental health, are a key element of the new approach taken by the YCJA. The youth program in Newmarket is a good example of how those new principles are being enacted.

"In my view, YCAPP has been extremely effective," concludes St. John. "Of course, I would like better access to services, and more services to be available, especially for children with mental health issues. But we're able to put plans in place, usually at the first or second court appearance, so that our kids are only coming to court two or three times, rather than eight or nine times going through the traditional court process. And it is making them aware of consequences, and making them be accountable for their actions. So I think it's building on the principles of the Youth Criminal Justice Act. I think it's been really successful, because I haven't seen many of the youth I have assisted coming back before the courts."

Your Responsibilities Under the Personal Health Information Protection Act

On November 1, 2004, the Personal Health Information Protection Act, 2004 (PHIPA) came into effect in Ontario. The act creates consistent rules for the collection, use and sharing of personal health information by doctors, pharmacists and other healthcare providers, known as "health information custodians" under this legislation.

To whom does PHIPA apply?
PHIPA applies to individuals and organizations involved in the delivery of healthcare services. Under the act, they are referred to as "health information custodians." They include:

- healthcare practitioners such as doctors, nurses, dentists, psychologists and optometrists
- hospitals
- long-term care homes and homes for special care
- Community Care Access Centres
- pharmacies
- medical laboratories
- local medical officers of health
- ambulance services
- community mental health programs
- the Ministry of Health and Long-Term Care.

What will Health Information Custodians be required to do?

- Collect only the information they need to do their jobs;
- Take steps to safeguard personal health information;
- Take reasonable steps to ensure records are accurate and complete for the work they do;
- Designate a contact person responsible for answering questions about personal health information and for making corrections to personal health records;
- Provide a written description of the practices they use to protect patient information and the name of the contact person.

PHIPA will also give the Information and Privacy Commissioner/Ontario, an independent body, responsibility for ensuring that health information custodians comply with PHIPA.

For more information:
Call our INFOline at **1-800-461-2036** or TTY **1-800-387-5559**
Visit: **www.health.gov.on.ca**

Ontario

CALENDAR

January-June 2005
Metamorphosis Festival. A new cross-disciplinary festival celebrating transformation and the arts, including artworks commissioned by the Workman Theatre Project in partnership with the Centre for Addiction and Mental Health. Toronto, Ontario. www.metamorphosisfestival.ca.

February 3-4, 2005
CMHA BC Division's 3rd Annual Bottom Line Conference on Depression, Anxiety and Addictions in the Workplace. Vancouver Conference and Exhibition Centre, Vancouver, BC. 604-688-3234, rfried@cmha-bc.org, www.bottomlineconference.ca.

February 6-12, 2005
Eating Disorder Awareness Week. 1-866-633-4220, www.nedic.ca.

February 23-27, 2005
Sixth annual Shadows of the Mind Film Festival. Galaxy Cinemas, Sault Ste. Marie, Ontario. 705-256-2226, info@ shadowsfilmfest.com, www.shadowsfilmfest.com.

February 24-26, 2005
Innovation through Collaboration: Building an Agenda for Psychology. Ontario Psychological Association 2005 Convention. Toronto Marriott Eaton Centre Hotel, Toronto, Ontario. 416-961-5552, opa@psych.on.ca, www.psych.on.ca.

May 2-8, 2005
Mental Health Week. A Canadian Mental Health Association national event to increase awareness of the importance of good mental health. 416-484-7750, info@cmha.ca, www.cmha.ca.

May 5-7, 2005
Family Matters: Families and Treatment, Partners in Recovery. Mood Disorders Association of Ontario and Schizophrenia Society of Ontario. Niagara Falls, Ontario. 416-486-8046 or 416-449-6830, www.mooddisorders.on.ca or www.schizophrenia.on.ca.

May 17-20, 2005
Canadian Conference on Homelessness: Stories, Research, Solutions. York University, Toronto, Ontario. 416-736-2100 ext. 40025, cch@edu.yorku.ca, www.homelessconference.ca.

May 31-June 2, 2005
Setting Our Course for Recovery: What Works and Why? PSR-RPS Canada National Conference. Halifax, Nova Scotia. 902-460-7346, www.psrrpscanada.ca.

September 21-24, 2005
Make Mental Health Matter. National conference of the Canadian Mental Health Association and the Edmonton Schizophrenia Conference Committee. Edmonton, Alberta. 780-414-1663, marketwhys@compusmart.ab.ca, www.cmha-edmonton.ab.ca.

October 23-26, 2005
Making Gains in Mental Health and Addictions: Transformation — Challenges and Opportunities. Third annual joint conference of Addictions Ontario, Canadian Mental Health Association, Ontario, Centre for Addiction and Mental Health, and Ontario Federation of Community Mental Health and Addiction Programs. London, Ontario. 705-454-8107, rachel@haliburtonhighlands.com, www.makinggains.ca.

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