crosscurrents
The Journal of Addiction and Mental Health
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# Healing justice

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Striking a delicate balance in a forensic hospital

## Betting on time
Why don't prisons offer gambling treatment?

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Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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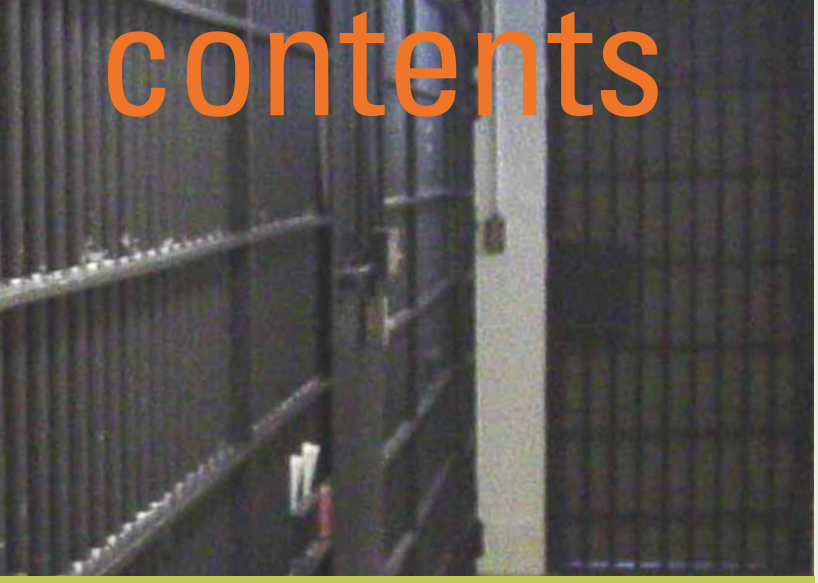

## Focus:

# Healing justice



*Home Away from Home – Psych Ward,* Jai Wax, oil on canvas, 28" x 32"

Jai displays his painting through Workman Arts in Toronto (www.workmanarts.com). Of his inpsiration, he says, "Originality, daring and pathos are practical qualities I can sublimate from the destructive energies of schizophrenia to my art."


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## In Every Issue




camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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#4453

# note from the editor

"Canadian penitentiaries are becoming the largest psychiatric facilities in the country," according to a 2010 report from the Office of the Correctional Investigator. But these facilities don't provide adequate mental health services, so inmates who need care are simply being warehoused in prisons, where the environment itself can exacerbate existing problems.

Between 10 and 12 per cent of offenders entering the federal prison system have a mental health problem, according to the report. Some also have substance use problems. They've ended up in prison because the criminal justice system doesn't recognize the complex nature of their needs. Instead, we criminalize people with mental health and substance use problems.

Yet these people are often the victims of crime, not the perpetrators. Early this year, a man targeted and attacked people with mental health issues in Parkdale, a Toronto neighbourhood with a high consumer population. One beating victim died.

The stories in this issue call for rehabilitation, not punishment. We examine steps along the pathways to care and justice, from diversion programs like drug treatment court to specialized inpatient forensic services to aftercare. We also cover police training, prison gambling and FASD in the criminal justice system.

As always, I invite you to send us comments and ideas so that we can continue to cover the issues that interest you.

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# a view from CAMH

I have been a psychiatrist for more than 20 years. In that time, we have come a long way in how we think about and offer services for people with mental health problems who come into contact with police and the legal system. When I started psychiatry, there were few court diversion programs; forensic psychiatry was not considered a specialty and poorly trained and monitored doctors offered treatment in Dickensian conditions.

We have come a long way, but not far enough. A new report, which was published just before we went to press, reveals some humbling findings. The study, prepared for the Mental Health Commission of Canada, underlined the significant role the police play in the mental health system. The study found that 40 per cent of people with mental illness have been arrested in their lifetime, and 30 per cent have had police involved in their care pathway. One in seven referrals to emergency psychiatric inpatient services involves the police, and five per cent of police dispatches or encounters involve people with mental health problems. Police initiate about 25 per cent of contacts; 15 per cent are made by the person and 20 per cent by family.

Half of these encounters lead to mental health services. In 40 per cent of cases, the encounter is resolved informally. The use of force is rare, but people with mental illness are over-represented in police shooting, stun gun incidents and fatalities. People with mental illness who are suspected of committing a criminal offence are also more likely to be arrested than people without mental illness.

Consumers and service providers, who were interviewed as part of the study, recommend better training of police officers, information sharing between mental health services and police and closer relationships between police and the mental health sector, for example, by ensuring that mental health services are involved in mental health emergency calls that police attend.

This issue of *CrossCurrents* shows how much work is already underway at the intersection between mental illness, addiction and the law. But a recent study has shown that most people with mental health problems who commit offences and end up in the legal and mental health systems are existing clients of mental health services. The worry is that failing to establish good mental health and support services leads to the criminalization of clients.

On a bit of a tangent, the open access journal *PLoS Biology* presents an interesting piece of research that identifies a centre in the brain that deals with justice (http://bit.ly/iGi6b5). It seems that ideas of right and wrong and fairness are hardwired.

**Kwame McKenzie**, MD, MRCPSYCH (UK)
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# More than just business behind bars

Astrid Van Den Broek

If you were to visit the Free Spirit Affirmative Business, you'd find canvases being stretched out, ready to paint. Old jeans being ripped apart and cut into pieces. A window display shows off the workshop's wares. You would also notice the men working in the shop. One might be sitting in a rocking chair, soothed by the rhythm as he works. Another might only be able to handle 10 minutes stretches of work and then have to take a break.

This isn't just any workshop. It's the only business in Canada run and managed by federal inmates with mental illness. Offered through the Ontario Regional Treatment Centre (RTC(O)) at the maximum security Kingston Penitentiary, Free Spirit is about more than making saleable products like dog jackets and tote bags; it provides much needed structure in a setting that may not offer many constructive activities, and even more important, it reinforces the relationship between meaningful work and recovery.

It's a relationship that is clear to Tracy Davidson, the brainchild behind the business. Davidson, then an occupational therapist with RTC(O), discovered that inmates with mental illness weren't permitted to work with CORCAN, the Correctional Service of Canada program that provides employment training within federal institutions. "It was like an endless sea of time—Mondays and Sundays were the same," says Davidson, who is now manager of Community Rehabilitation Services for Providence Care Mental Health Services in Kingston. She made the case that launching a business for inmates with mental illness would boost their well-being and promote recovery. Supported employment would also help them master basic skills that they could then carry into the outside world when they were released.

But with this stigmatized population, it's not surprising that one big challenge at the outset was scepticism on the part of prison staff—and the inmates themselves, many of whom lacked the confidence that they could do the work.

Now, 12 years later, more than 100 men have been involved in the business, which is admired in the community and beyond as a unique example of supported employment.

Starting up involved a lot of creativity, literally. "We started in the hobby craft area and used what we knew," says Davidson. "I have a fine arts studio degree, so I could teach participants how to stretch canvases. They would do a lot of paintings together."

With a meagre $500 launch budget, Davidson and the business associates, as the men are called, had to use what they could find to make saleable products. That included prison blue jeans and old correctional officer uniforms. Meanwhile, the inmates came up with the business name and determined how to price products and distribute the profits. They decided that 60 per cent of the profits would be split among themselves, 15 per cent would be donated to charity and 25 per cent would go towards capital and operation costs.

Running the workshop sessions requires creativity and flexibility. "There's a lot of workplace accommodation," says Davidson. "One man was quite paranoid, so I would meet him in his unit and escort him to the workshop, where I made sure he could sit with his back against the wall and next to a friend he trusted. Another man had anxiety and constantly rocked, so I found an old rocking chair that he could sit in while he worked."

Sometimes two-hour stretches of work seemed unthinkable and would put stress on the men, in which case they broke down tasks into 10-minute stretches interspersed with breaks. The business also tends to avoid projects with tight deadlines because the pressure can be too stressful. Instead, companies that approach Free Spirit with rush requests for products to sell are referred to the existing inventory from which to select.

Inmates with mental illness make environmentally friendly products through the Free Spirit Affirmative Business.

Of the nine current associates, some have been involved with Free Spirit since it began, while others have just recently joined, and others have been participating for a year or two. Men who enjoy their involvement can stay for the duration of their time at the RTC(O). If they experience a mental health problem that interferes with their ability to participate, they temporarily leave the business, but can return when they are ready.

starts to grow," she says. "They tell me they like to work on something that turns into a finished product because it provides a sense of accomplishment, and that feeds their motivation to keep working." The men also say they enjoy the structure and routine the workshop provides. "When we're not open due to operational issues, it can have a negative impact on their mental health because it disrupts their routine," says Dennis.

Free Spirit, the only business in Canada run and managed by federal inmates with mental illness, promotes the relationship between meaningful work, well-being and recovery.

With the right support and structure, participants learn problem-solving and patience, says Lyndsey Dennis, an occupational therapist with RTC(O) who oversees Free Spirit. "The men also develop a sense of personal worth, and their self-esteem

But what the men learn from their very participation in Free Spirit can translate into stronger coping skills. "The men are motivated to start using their coping strategies for their illnesses," says Davidson. "They find ways to work around their disabilities, building on their strengths, and they start using some of those strategies when they need support." Davidson and Dennis both say that the business also helps the men build a sense of camaraderie and community.

In fact, that sense of community spills over beyond the prison walls into the local community, where most of Free Spirit's products are sold in local stores, the penitentiary museum and the Kingston tourism office. One pet store frequently requests orders for coats and collars to be used for show dogs. A customer was so thrilled with the dog coat she bought that she sent the men a photo of her dog sporting the jacket they made. "Customers support the philosophy behind the business," says Dennis. "They're interested in having something that supports the inmates' psychosocial rehabilitation. Vendors tell us they often hear customers saying, 'This is so unique!', "What a great idea!' The men appreciate this feedback because it gives them motivation to continue."

In the words of one associate to Davidson, "By helping the business, I was able to help myself."

# Fighting myths about youth violence

Angela Pirisi

Dr. Jodi Viljoen, an assistant professor in clinical and forensic psychology and Michael Smith Foundation for Health Research Scholar at Simon Fraser University in Vancouver, studies adolescent offenders. Here she addresses myths about youth violence.

**Myth: Youth violence is growing.**
**Fact:** There was an increase in crime among both youth and adults in the 1990s, but it isn't certain whether the increase was real or whether zero-tolerance policies flagged more offenses. Youth crime has stabilized and actually appears to have decreased. Statistics Canada data from 2007 to 2009 reported a four per cent decrease in overall and violent crime, and a five per cent decrease in property crime. Still, the popular public perception is that youth violence is growing. The 2008 National Justice Survey in Canada found that there is always a significant proportion of the population that believes crime is increasing, regardless of what official records say.

**Myth: Youth violence is about criminal behaviour, not mental health issues.**
**Fact:** Over the past decade, awareness has grown that rates of mental disorders in adolescent offenders are high. U.S. studies show that about 60 per cent of male and 70 per cent of female adolescent offenders meet criteria for a psychiatric disorder, even after excluding a conduct disorder. Major depression, post-traumatic stress disorder, attention-deficit hyperactivity disorder (ADHD) and substance use disorders are particularly common. But mental illness doesn't account for most youth crime, and most adolescents with mental illness aren't violent. However, mental illness may contribute to offending. Some disorders and symptoms increase risk, others decrease risk and others have no effect. Substance abuse and ADHD have the most established relationship to offending. But the relationship between mental health and offending isn't simple. For example, studies trying to determine whether a link exists between depression and offending show inconsistent, even conflicting, results.

**Myth: Most young offenders end up reoffending.**
**Fact:** Not necessarily. Many adolescents engage in some illegal behaviour. However, considerable research indicates that offending and aggression decline with age. Many, if not most, youth who offend don't become adult offenders. This pattern of decline is true even among youth who are serious violent offenders. These declines in offending are likely linked to maturation. As adolescents age, they become less impulsive, less sensation-seeking and more resistant to negative peer influences. These developmental changes contribute to the decrease in offending.

**Myth: Most future violent offenders can be identified in early childhood.**
**Fact:** Uncontrolled behaviour or being diagnosed with conduct disorder as a child doesn't predetermine later violence. Many violent adolescents weren't highly aggressive or "out of control" in early childhood. Most children with mental and behavioural disorders don't become violent adolescents. Aggressive behaviour first develops from nine to 48 months, peaks at age 6 and then typically declines, even in youth who exhibit fairly serious aggression early. There have been many efforts to identify which children will become offenders and to develop various risk-assessment tools. We have even seen the extension of the idea of psychopaths to adolescent offenders, even children. Psychopathy is an adult personality disorder that many consider to be a strong predictor of offending. However, one study found that most youth identified as psychopaths in adolescence didn't become adult psychopaths. There are significant limitations to our ability to predict violence. Childhood and adolescence are periods of enormous developmental change, so aggressive behaviour may be less stable in children and adolescents than adults.

**Myth: Youth sexual offending behaviour is the same as adult sex offending.**
**Fact:** It's hard to draw comparisons, since we don't know as much about sexual offending among youth as we do about adult sexual offending. Rates of sexual reoffending by youth may be lower than among adult offenders; a meta-analysis found that about eight per cent of youth reoffended within eight years. Some experts suggest that sex offending by youth may be related to their own experiences of abuse; 40 to 60 per cent of juvenile sex offenders have been victims of sexual abuse, but most abused children don't become sex offenders. Compared to adult sex offenses, youth sex offenses are less likely to include aggression or violence. Risk and protective factors may also differ, and some hypotheses posit that these factors may fluctuate and change considerably during adolescence.

**Myth: Prevention and treatment of youth violence doesn't work.**
**Fact:** The widely held belief that nothing works has been proved wrong. There is strong evidence for different strategies at different developmental periods. These include home visit programs where nurses visit at-risk pregnant women before and after birth. The visits focus on caregiving, linking mothers to services and helping them bond with the child. A 15-year follow-up study found that this type of program resulted in 70 per cent fewer convictions among youth, and lowered child abuse rates by 50 per cent.

Approaches that seem to work with adolescents include multi-systemic therapy (MST), functional family care and Oregon multidimensional treatment foster care. Evidence, mostly from the United States, shows that MST, which focuses on family, peer systems and community, results in reduced offending and drug use, increased school attendance and decreased mental health problems. These programs don't just focus on changing youth; they focus on the systems in which youth are embedded, particularly families. They also work because they are based in the community, not in the justice system. In contrast, a considerable body of research suggests that some "get tough" approaches, such as giving adolescents very punitive sentences, do not prevent reoffending.

# Therapeutic jurisprudence: justice and care or justice versus care?

Barbara Russell

Our beliefs about the interactions of judges and lawyers and the operations of courts can be heavily influenced by media portrayals. For instance, court procedures are often described as adversarial because only one party wins, usually at the expense of the other party, and the courtroom atmosphere is painted as hostile. However, various procedural rules or checks and balances exist to try to preserve fairness and deflect the influence of power and human shortcomings, such as dishonesty or malice.

Yet the law's psycho-emotional impact is not limited to winning or losing, and it does not need to be accidental or unimportant, according to law professors David Wexler and Bruce Winick at the University of Arizona and the University of Miami, respectively. In the late 1980s, they developed the concept of therapeutic jurisprudence, which they describe as "an interdisciplinary method of legal scholarship that aims to reform the law in an effort to [intentionally] improve the psychological and emotional well being of those affected by the legal process" (*International Journal of Law and Psychiatry*, 2010).

The concept of therapeutic jurisprudence often underlies the creation of mental health and drug treatment courts, where "care" comes in the guise of psychiatric and psychological treatment. Therapeutic jurisprudence, however, seems to have generated quite a bit of debate about its validity and usefulness, not just for mental health and drug treatment courts, but also for family and criminal courts, and even for coroners' work. As I read about the concept, it became increasingly clear that part of this ongoing debate involves important ethical questions about when justice and caring are appropriate, by whom and towards whom, and how and when they are inappropriate.

Health care workers, too, face situations in which care and justice co-exist nicely, and in which they do not. In a highly cited chapter in the 2000 book *Margin of Error*, ethicists George Webster and Françoise Baylis explain moral distress, which has garnered considerable attention in the nursing literature. In medicine, the term "burnout" refers to a similar and well-known experience. Webster and Baylis hold that moral distress occurs when what one believes to be right does not match what one does or what ultimately happens. This incongruence can occur when a health care worker's care of a particular client must be curtailed so that she can care for the other clients waiting to see her—in other words, care versus justice. Moral distress results, too, in a paradigmatic case of clashing values, namely when a client chooses to forego recommended treatment: the clinician is torn between caring about the person's recovery and respecting the person's exercise of a legal and moral right.

In the 1960s and '70s, psychologist Lawrence Kohlberg concluded that boys' moral reasoning tended to be more advanced and nuanced than that of girls. In later studies of young girls, psychologist Carol Gilligan found that girls' insights and reasoning reflected a relational ethic of care in contrast to boys' reliance on an ethic of abstract rules or principles. Gilligan concluded that what these studies revealed were not superior or inferior moral insight and reflection, but meaningful, gendered differences. Interestingly, many drug courts now offer different programs for women and men. Might this difference be justified, albeit only partially, because men and women have different views about what matters morally?

Gilligan's work helped to launch feminist moral theory and bioethics. Associating women with an ethic of care generated much discussion: is this ethic natural and affirmative of women, or is it socially imposed and oppressive? Another question subsequently arose: can a care ethic, with its focus on actual relationships and people close at hand, and a justice ethic, with its focus on fairness and impartiality, co-exist harmoniously?

Many academics and advocates of feminist moral theory and bioethics believe justice and care can co-exist. Yet an iconic Western image for justice is a blindfolded woman holding a set of scales. The blindfold signifies impartiality. So it is not surprising that many other academics and advocates conclude that either justice or care will ultimately outweigh or trump the other.

Part of the legal debate about therapeutic jurisprudence, I think, taps into the ambiguity of the words "care" and "caring," an ambiguity that has increased the complexity of everyday health care practices. For instance, "taking care of" is not the same as "caring for" or "caring about." Health care workers, especially in a publicly funded health system, can be expected to *take care of* someone when he cannot, due to a medical problem. Nevertheless, *care of* must remain collaborative in terms of the client's or patient's own "role" and preferences and his family's involvement and responsibilities. *Caring about* someone involves paying close attention to both what matters to her and the person she is; therefore, staff work purposefully to support her own efforts. I'd like to suggest that *caring for* someone involves a measure of emotional affection and connection that can lead, unfortunately, to professional boundary concerns. Within health care, the word "care" is also invoked frequently in reference to "standards of care," which tend to focus on techniques or procedures.

At a basic level, therapeutic jurisprudence brings justice and caring closer together. How close the relationship should be is an important ethical discussion, conceptually and practically, not just by the judicial and legal staff associated with different court settings, but also by health care teams and programs associated with these courts.

Do you have a **comment** or **question** for ethicist Barbara Russell?

Visit the Ethics Matters blog at **www.camhcrosscurrents.net/blogs/ethicist** and have your say.

Mark de la Hey

## Supportive policies help nurses tackle substance use problems

Support and treatment are more effective than punitive policies in helping nurses with substance use problems, and in turn provide better protection for those in their care, according to a study from Vanderbilt University in Nashville, Tenn. The study synthesized the results of three previous papers that examined substance abuse policies in the nursing profession. The researchers compared traditional substance abuse policies with alternative-to-discipline (ATD) strategies, which aim to motivate nurses to voluntarily seek assistance for substance use problems. ATD strategies advocate rehabilitation rather than punishment, self-regulation rather than regulatory intervention and professional discipline, and aim to protect public health and welfare by preventing substandard nursing practice. Previous research has shown that ATD programs help to ensure patient safety by removing nurses with substance use problems from practice within a matter of days or weeks, whereas traditional disciplinary procedures can take as many as three years. The evidence also suggests that getting nurses into treatment, rather than focusing on punitive measures, is more effective in helping nurses recover from addiction and remain in the profession. Punitive policies may actually endanger the public by making it difficult for nurses to seek help or for colleagues to report abuse, knowing that the individual might lose their job.

*Journal of Clinical Nursing,* February 2011, v. 20(3–4): 504–509. Todd Monroe and Heidi Kenaga, Vanderbilt University School of Nursing, Nashville, Tenn.

## Expectations mediate connection between impulsivity and marijuana use

It is well known that individuals with high impulsivity are more likely to use marijuana. Now, research from College of the Holy Cross in Worcester, Mass., indicates that this association may be best explained by the acquired preparedness model (APM), which holds that high-risk individuals are more likely to develop certain types of learning, which in turn lead to substance abuse. The study involved 332 women aged 18 to 24 who were recruited as part of a larger study of marijuana use and sexual risk. Impulsivity was significantly related to frequency of marijuana use, the presence of marijuana-related problems and marijuana dependence. These relationships were mediated by positive and negative expectations and by the individual's sense of their ability to refuse marijuana. Positive expectations about marijuana use were associated with more days of marijuana use, whereas negative expectations were associated with fewer days of use and higher levels of marijuana-related problems and marijuana dependence. A person's confidence in their ability to refuse marijuana was associated with fewer marijuana use days and lower levels of marijuana-related problems and dependence. The authors conclude that their results support the APM model, suggesting that, among people with high impulsivity, "those who lack appropriate strategies to resist the temptation to use marijuana are more likely to exhibit more frequent marijuana use and use-related negative consequences."

*Addictive Behaviors,* April 2011, v. 36(4): 389–396. Jumi Hayaki et al., Department of Psychology, College of the Holy Cross, Worcester, Mass.

## Mania and depression may occur simultaneously

Depressive and manic symptoms may not represent opposite ends of a continuum within bipolar disorder, according to new research from the University of California, Berkeley. Researchers followed 236 individuals with bipolar disorder for 18 months, conducting face-to-face interviews every two months to assess depressive and manic symptoms. During the study, 92 per cent of participants reported at least some depressive symptoms, while 70 per cent reported manic symptoms. According to the traditional one-dimensional model of bipolar disorder, depressive and manic symptoms lie on a single continuum. The expectation is that these symptoms should be negatively correlated – a person with manic symptoms would be less likely to exhibit depressive symptoms, and vice versa. However, this study found that correlations between depressive and manic symptoms were extremely low, with no negative relationship, suggesting that these symptoms are independent of each other. The authors see a two-dimensional model as a better fit, with mania and depression fluctuating independently – meaning that manic and depressive symptoms could occur at the same time. They also suggest that the risk factors that increase the likelihood of mania in bipolar disorder may differ from those that increase the risk of depression.

*Acta Psychiatrica Scandinavica*, March 2011, v. 123(3): 206–210. S.L. Johnson et al., Department of Psychology, University of California, Berkeley.

## Stressful life events associated with distinct pattern of OCD

Research from Bellvitge University Hospital in Hospitalet de Llobregat, Spain, indicates that when stressful life events occur close to the onset of obsessive compulsive disorder (OCD), the result is a pattern of symptoms distinct from the pattern found in individuals with OCD that is not associated with a stressful life event. Researchers interviewed 412 outpatients who had experienced OCD symptoms for at least one year. For 154 of the participants, onset occurred within one year of experiencing a stressful life event (SLE). The stressful events most frequently reported were related to family and social relationships, health problems and education and work difficulties. Participants whose OCD was preceded by an SLE tended to develop OCD at a later age, were more likely to be female, more frequently experienced contamination/cleaning symptoms and were less likely to have a family history of OCD. Notably, participants who reported complicated births were 5.5 times more likely to have had an SLE preceding the onset of OCD than those who did not experience obstetric complications. The study's authors see their findings pointing to the possible existence of a life-stress–related subtype of OCD.

*Depression and Anxiety*, February 9, 2011 online, doi: 10.1002/da.20792. Eva Real et al., Psychiatry Department, Hospital Universitari de Bellvitge, Hospitalet de Llobregat, Spain.

## Depression increases with age in women at risk for substance abuse

Women at high risk for substance abuse tend to experience decreases in alcohol problems and antisocial behaviour over time, but their levels of depression increase, according to research from the University of Michigan in Ann Arbor. The study followed 273 women considered to be at high risk for substance abuse over 12 years, looking at how their symptoms were influenced by individual characteristics, family relationships and neighbourhood environment. At baseline, 23 per cent of the women, whose average age was 31, met criteria for alcohol use disorder, 0.4 per cent for antisocial personality disorder and 14 per cent for major depressive disorder. On average, the women's alcohol problems declined, as did antisocial behaviour; however, depression levels increased. Women with a history of alcohol problems or whose partners showed symptoms of alcohol problems were more likely to engage in antisocial behaviour. Externalizing behaviour by the women's children (e.g., acting out, getting into trouble) was associated with higher levels of alcohol abuse and antisocial behaviour in the women, whereas children's internalizing behaviour (e.g., withdrawal, anxiety) was associated with higher levels of depression. Women with more social support had lower levels of depression, while those who lived in unstable neighbourhoods where residents moved frequently were more likely to have alcohol problems and depression. The authors suggest that intervention efforts could assist women by improving social support and training opportunities, providing access to family counselling and improving neighbourhoods.

*Development and Psychopathology*, v. 23(1): 325–337. Anne Buu et al., Department of Psychiatry, University of Michigan, Ann Arbor.

## Predicting treatment engagement among people with concurrent disorder

Health care professionals often find it difficult to engage people with co-occurring mental illness and substance use problems in substance abuse treatment. Now, research from the University of Maryland School of Medicine has identified factors that may predict treatment engagement. Researchers used data on 176 individuals with serious mental illness (SMI) enrolled in a trial of substance abuse treatment. Men were only 46 per cent as likely as women to complete the intake assessment, and participants with schizophrenia were 44 per cent as likely as those with other diagnoses to complete it. After assessment, 110 participants went on to treatment. Those who reported more positive feelings toward their families were more likely to enter treatment. Those with current drug dependence were only 30 per cent as likely as those with recent drug dependence to enter treatment. Individuals who had been arrested in the 90 days before the study began were only 37 per cent as likely to engage in treatment as those who had not been arrested. The authors suggest that concurrent disorders programs "may need to identify incentives such as assistance with legal problems, housing and homelessness, or other issues that can convince men with SMI that substance abuse treatment can be worthwhile."

*Addictive Behaviors*, May 2011, v. 36(5): 439–447. Clayton H. Brown et al., Department of Epidemiology and Public Health, University of Maryland School of Medicine, Baltimore.

## Psychotic symptoms increase risk of suicide

New research from King's College London indicates that, among people with psychotic disorders, suicide risk increases with the number of psychotic symptoms the person exhibits. The study involved 2,132 individuals reporting a first episode of psychosis in London, Dumfries and Galloway and Nottingham. The study followed participants for an average of 13 years. There were 424 deaths over the course of the study, 51 of which were suicides. Males were almost three times more likely than females to commit suicide. Patients with more than four psychotic symptoms were almost seven times as likely as those with four or fewer symptoms to commit suicide. The presence of any manic symptom (e.g., grandiose delusions or reckless activity) in the year following the first episode of psychosis was associated with a twofold increase in suicide risk. Since suicide risk showed a stronger relationship with the number of psychotic symptoms than with the presence of any manic symptom, the authors conclude that suicide risk is increased by a quantitative threshold effect of symptoms rather than the qualitative nature of the symptoms.

*Schizophrenia Research*, March 2011, v. 126(1–3): 11-19. Rina Dutta et al., Department of Psychosis Studies, Institute of Psychiatry, King's College London, United Kingdom.

# Evil or ill?

## Forensic mental health services pave pathway to justice

By Dr. Sandy Simpson

The forensic system exists to help people who have fallen foul of the law get back into care, into health and into their communities. To this end, the Law and Mental Health Program at the Centre for Addiction and Mental Health (CAMH) in Toronto provides a range of services: court triage and diversion; 165 inpatient beds for assessment; treatment and recovery programs; an outpatient team; and specialized outpatient services for people with problems of sex offending or abnormal sexual drive.

Why do we have these services? Why are they distinct from other mental health services? And why are they not part of the criminal justice system?

We know only too well that people with serious mental illness are at greater risk of arrest and imprisonment, in part because the nature of their illness gives rise to poverty, substance misuse and homelessness, which may bring them into contact with the law. For others, their illness causes behaviour that results in serious harm to others. The courts and criminal justice system need help determining the right way to respond.

If someone is acutely mentally unwell, they may not be able to understand what is occurring in court or to defend themselves properly. They need to be helped into care to restore their competence so they become fit to stand trial. Our staff in the region's courts provide assessments to the court and arrange treatment in this situation.

Dr. Sandy Simpson's Law and Mental Health Program helps people who have fallen foul of the law get back into care, into health and into their communities.

After a period of treatment, or if the person can enter a plea, the court has two major concerns. First, if the charges are relatively minor and if mental health care is what the person really needs, the court may divert the person into care rather than prosecute through the criminal justice system. These programs, which include mental health court, are provided in part by CAMH, and with community partners.

If the charges are more serious and it is felt that the person has a defence against the charges as being not criminally responsible (NCR) because of mental illness, we can provide expert testimony to help the court make that finding. If the defence is accepted by the court, the person is sent to hospital under the supervision of the Ontario Review Board (ORB) under our clinical care.

Once found NCR or unfit to stand trial and ordered under the ORB, most individuals come to an inpatient bed initially to develop a rehabilitation and recovery plan. The person is under the authority of the ORB, which oversees their pathway through care, balancing their needs with the safety interests of the public. Within the parameters set by the ORB, the person progresses through levels of more secure to less secure care as their wellness improves, their understanding of their need to stay well in the long term grows and the risk to the public decreases.

Individual and group work and developing social and vocational skills are very important, in relation to the person's illness, generally, and in relation to how risk re-emerges in their lives, specifically. Family relationships and supports are also key.

As people progress on this journey, most can return to the community. Our large outpatient service facilitates community reintegration. We support other ACT teams and transitional case management teams that have ORB clients. More than 280 people are cared for by our outpatient follow-up services. When the ORB finds they no longer represent a threat to the public, they cease to be ORB clients and return to care under general mental health services.

**Fast facts**

The Ontario Review Board for 2010–2011 reports:

171 ORB members

1,972 ORB hearings

248 new accused

94 absolute discharges

1,622 accused under jurisdiction of ORB

Unfortunately, most people with serious mental illness coming before the courts do not come to hospital; rather, they go to prison. Between 15 and 20 per cent of inmates have a serious mental illness, and between 70 and 85 per cent have a substance use disorder. In Ontario, mental health care for these people is in the hands of the Ministry of Community Safety and Correctional Services, with contracts with health care staff to provide sessional time. But services are inadequate. The period of imprisonment should be taken as an opportunity to link people to care. Most inmates have short sentences, and developing pathways for follow-up upon release is very important for both individual health and public safety. CAMH does only a small amount of this work, but we are helping to develop good care pathways for inmates with mental illness.

**Dr. Sandy Simpson** is clinical director of the Law and Mental Health Program at the Centre for Addiction and Mental Health, and associate professor in the Law and Mental Health Program at the University of Toronto.

# Custody and caring

## Striking a delicate balance in a forensic hospital

By Linda Hossie

Social worker Nancy Lynk loves her job. "What I enjoy most in working with patients is finding out how they got to this point, learning their life story," she says with an infectious smile. "If I won a million dollars, I would still be here."

But "here" is the maximum security mental health hospital that is part of Waypoint Centre for Mental Health Care in Penetanguishene, Ont. It treats some of the most misunderstood people in society with the severest behaviours associated with mental illness.

The time I spent with Lynk and two nurses at Waypoint (formerly the Mental Health Centre Penetanguishene), painted a vivid picture of the dual role they play, reflecting a delicate balance between caring and custody.

Forensic hospitals are defined by the requirement to treat and care for psychiatric patients who are also offenders. For the clinical staff working there, that means connecting with patients, even when they evoke strong, negative emotions: some have committed frightening crimes, some are threatening or dangerous, some regard those charged with their care as enforcers of their confinement.

Lynk's patients come to hospital through courts or penal institutions, but the offences with which they are charged vary from lesser offences that could result in harm to themselves or others to sexual assault or murder. Lynk, who has worked at the all-male facility for five years, says slightly more than half of the offences involve assault.

Lynk does court-ordered psychosocial assessments to determine whether the person understood what they were doing when they committed the offence. She also works with the families of patients, explaining the hospital process and helping them sort their way through the day-to-day realities. Many have been trying to get help for their children for years. Lynk explains to them that although the place looks like a prison, it is a hospital, and the purpose of her unit is to assess mental illness, not criminality. (In fact, the government recently approved a $471 million redevelopment project to replace the old facility with a new one designed as a hospital.)

Lynk has an office at one end of a narrow hall, along which are strung meeting rooms, a kitchen, a nursing station and patient rooms that do, in fact, resemble prison cells. The locked rooms have steel doors and thick metal grids over windows opening onto the hall. Each contains a bed, a toilet and a sink, although desks can be added for patients who want one and who are stable. Exterior windows are barred with what look almost like louvers.

On the day I visit, one patient is at the window in one of the rooms, bellowing, and the patients in other rooms sit or recline on the beds. Lynk waves a cheery hello to one of the men as she passes.

Verbal and physical abuse and threats toward staff sometimes happen. But part of the hospital's work is to minimize the opportunity for harm to patients and staff. Lynk says the structure of the ward's routine can be helpful to people whose lives have been chaotic.

**Waypoint fast facts (2010–2011)**

Provincial Forensic Programs (maximum security)

160 beds
219 admissions
216 discharges
All men

Regional Forensic Services Program (medium security)

20 beds
40 admissions
39 discharges
14 men, 6 women

**Forensic mental health resources**

- **American Academy of Psychiatry and the Law**
  www.aapl.org
- **American Psychological Association – Criminal Justice Section**
  www.apa.org/divisions/div18/cjpsych
- **Canadian Academy of Psychiatry and the Law**
  http://caplca.org/
- **Canadian Psychological Association – Criminal Justice Section**
  www.cpa.ca/aboutcpa/cpasections/criminaljusticepsychology
- **International Academy of Law and Mental Health**
  www.ialmh.org
- **International Association of Forensic Mental Health Services**
  www.iafmhs.org

Down the hill from Oak Ridge, as the maximum security hospital used to be called, is the Regional Forensic Services Program, a 20-bed medium security unit for men and women. It's clearly more relaxed. Patients lounge in a common room, and on the wards, some are napping in chairs. But patients can arrive at both hospitals handcuffed and accompanied by police. Both places provide seclusion for patients who are volatile, and both use physical restraints, but only as a last resort, says Sarah Morgan, a nurse at the program. Learning how to assess and manage violence risk is necessary because the potential for violence among this population is ever present.

Morgan describes how important the relationships between nurses and patients are in creating a secure environment for everyone. "It's a priority for nurses to build trust with patients," she says. "It's a matter of keeping us functioning as a family because that's what we are." That means getting to know patients as individuals, which includes learning their triggers for anger and other emotions.

Forging therapeutic relationships can be a challenging, slow process because some patients view nurses as being part of the system of detention. Many of Morgan's patients, all of whom are referred by a judge, claim to have been wrongfully accused, and some are defensive because they've been in jail. Morgan says that for patients, hearing that the staff are "here to help them" goes a long way to building trust.

But when feelings of natural caring are distorted—and it can happen, given the nature of some of the offences—staff must find a way to respond through ethical caring. Peter Helleman, who has been a nurse at the maximum security hospital for 16 years, says that nurses are obligated through their professional code of ethics to develop a non-judgmental attitude. "You have to tune out the more heinous things and deal with the person," he says. "You deal with the immediate person, and you deal with signs and symptoms of major mental illness."

Morgan agrees, saying that as a nurse working with forensic patients "you have to be aware of your own personal beliefs and not bring them to work. You need to keep an open mind and check your beliefs at the door more than anyone [working outside forensic psychiatry]."

Helleman remembers a patient with schizophrenia who saw snakes coming out of Helleman's eyes. "He wanted to get those snakes," Helleman says, and under the circumstances, it seemed like a reasonable reaction. Helleman worked for nine years at Oak Ridge before he had to cope with an actual assault by a patient, and even in that case, he was able to de-escalate the situation quickly. But the potential for violence is one reason to keep communication open with patients, he says, and to let them know exactly what the nurse's role is and what the patients should do in their own best interests. "It's like a marriage," he says. "You have to compromise."

**Navigating the forensic system**

Want to see a simple map of pathways through the forensic system in Ontario? *Network* magazine, published by the Ontario branch of the Canadian Mental Health Association, provides an excellent guide that illustrates the points of intersection between criminal justice and mental health care. Visit www.ontario.cmha.ca/network.asp. Under "Back Issues," find the winter 2009 issue and read "Navigating the forensic system."

It's a relationship in which Helleman gets to know many of his patients as very intelligent people, and as being able to maintain a sense of humour, even in the middle of terrible difficulties. A sign of that is visible on the wall of the quiet room, where patients go when they need to de-escalate. It's an austere room that contains nothing but a toilet and sink. Over the sink, someone has written a bit of graffiti: "Please sign our guest book."

One of the strengths of the programs at the maximum security hospital, in Helleman's view, is that staff mix with patients. Depending on the level of activity patients are allowed, they may be confined to their room or they may be able to enter common areas, taking advantage of recreation and other facilities with various levels of supervision. There are gym and pool facilities, as well as television and recreations rooms.

"We get people who are 'career criminals' and we still give them privileges and play pool with them and play catch in the yard," says Helleman. Some nurses and patients watch hockey games on the television together and nurses take that as an opportunity to reinforce positive behaviour. "A nurse might say to a patient, 'You're not just watching TV, you're modelling pro-social behaviour,'" says Helleman.

For Morgan, such interactions go beyond therapeutic. She says of the patients: "They're people. They like communicating and having interaction like anybody else."

And like anybody else, they enjoy simple pleasures. Both Helleman and Lynk mention the patient kitchen in their respective units, where two patients at a time are allowed to cook a meal of their choice. The patients prepare a list of ingredients and a staff member does the shopping. The menu might be an ethnic food that a patient has been missing, or it could be a steak dinner.

Forensic hospitals are beloved of murder-mystery writers and horror-film makers, but one aspect of life there that is often overlooked is that patients who have committed crimes while ill can feel terrible remorse as they recover. Some may have killed a person, possibly even a family member, and have difficulty coping with the enormity of that.

Lynk tries to help her patients cope with these feelings. She tells them, "What you did, it wasn't you; it was the illness." She refers some of them to the hospital's chaplain for help. "In society there is such a lack of understanding of mental illness," she says. "When people hear 'murder,' they automatically think 'criminal,' and they can't get past that, no matter what. People don't consider that maybe the person is ill, that it was the symptoms of their illness that led to the offence, and that they are actually a kind, loving, person who would not have done such a thing had they not been inflicted with mental illness."

As for how they themselves cope, Helleman and Lynk respond in different ways. Helleman says of the nature of the crimes some patients have committed, "You just get used to it."

For Lynk, "It's a safe place to work. I don't ever come in here afraid." But she does admit that work can spill over into her life outside. If she is in a store, for example, and the public address system comes on, her first reaction is to think it's a code white, and the adrenalin starts rushing. "But then I shake it off and laugh at myself," she says.

If there is any part of the job that Lynk dislikes, it's that patients leave the forensic hospital and she may never know how they're getting along in the outside world. "I hate not knowing," she says. "I just want to know, are they doing well?" She gives departing patients her card, and hopes they'll get in touch, but it's up to them.

One former patient did contact Lynk two years after he left. He had continued to take his medication, found a job and returned to university. It's not how every story ends, but it brings a smile of satisfaction to Lynk's face. CC

Social worker Nancy Lynk assesses mental illness, not criminality.

The potential for violence is one reason to keep communication open with patients, says Peter Helleman.

For Sarah Morgan, the relationships between nurses and patients are crucial in creating a secure environment for everyone.

# Wrong place, wrong time

## One man's crusade to keep people with FASD out of jail

By Anne Ptasznik

Joseph Cloutier, 52, from the Ojibway First Nations, still recalls the doors of the Kingston Penitentiary closing behind him. "It was scary," he says, with a nervous laugh. Forced to leave behind all his possessions and enter the prison with nothing but the clothes on his back, Cloutier remembers feeling intimidated by the guards with their guns. Fortunately for Cloutier, he was at the maximum-security prison only as a visitor to share his story with Aboriginal inmates, particularly his experience of having fetal alcohol spectrum disorder (FASD).

FASD, a broad term describing birth defects and conditions in people who were exposed to alcohol during pregnancy, carries various physical, mental, behavioural and learning problems. These include misunderstanding cause and effect, difficulty learning from past experience and a tendency toward impulsive behaviours—all of which can lead to conflict with the law. According to the John Howard Society of Ontario, 60 per cent of people with FASD over age 12 have been charged with or convicted of a crime. Estimates place the rate of FASD inside Canadian prisons at 10 times higher than in the general population.

While Aboriginal people are also overrepresented in the criminal justice system, initial research indicating that FASD is higher among Aboriginals is now in dispute. A 2003 review published by the Aboriginal Healing Foundation suggested that disruptive, challenging behaviours attributed to FASD may be caused by other traumatic life experiences to which Aboriginal people have been subjected, particularly the legacy of the residential schools.

What is clear, however, is that Aboriginal people with FASD make up a disproportionate percentage of people in prison. It's a situation that Cloutier is fighting to change.

Growing up, Cloutier, whose handsome features include an ever present impish smile, faced many learning challenges in school. "I had a hard time communicating from my head to my hand," he says. The teacher would be erasing the blackboard by the time he had copied the first sentence. When he was about 7, physicians labeled him "mentally challenged," for which his schoolmates teased him. Cloutier never got an official diagnosis of FASD, but he recalls being told that he had a brain disorder, explained as malfunctioning brain circuits, which stemmed from his mother having an alcohol problem.

Cloutier was adopted and raised in Sudbury as a little girl until he was 5, when he discovered he was actually a boy. He was mentally, physically and sexually abused by his adoptive father. When he finished high school, his parents placed him in a group home. But Cloutier felt he didn't fit in with the other residents, who had developmental disabilities, so he left and went to live on the streets for about 10 years, first in Toronto, then across the United States. He started breaking into homes and stealing jewellery and money, which he saw as gifts that would help him make friends. "I was easily led

**FASD and criminal justice resources**

- Canadian FASD Training Online Database www.ccsa.ca
- FASD ONE Justice Committee www.fasdjustice.on.ca
- Fetal Alcohol Spectrum Disorder and the Criminal Justice System: A Poor Fit www.johnhoward.on.ca
- Fetal Alcohol Spectrum Disorder and the Youth Criminal Justice System www.justice.gc.ca
- Fetal Alcohol Syndrome among Aboriginal People in Canada: Review and Analysis of the Intergenerational Links to Residential Schools. www.ahf.ca/downloads/fetal-alcohol-syndrome.pdf
- Government of Alberta FASD website www.fasd-cmc.alberta.ca
- SAMHSA: FASD Centre for Excellence www.fascenter.samhsa.gov

into doing things like breaking into a car to get a car stereo," he says. But one day he was caught.

That's when Cloutier learned to use the labels he had been given growing up to his advantage. "I told them I had a sickness, that I was mentally disturbed," he says. The police accepted his story, and he never ended up with a criminal record.

The close calls were the impetus Cloutier needed to return to Sudbury and turn his life around. He learned that he was from the Sagamok Anishnawbek Reserve in Massey, Ont. There he met some family members, learned that he was Ojibway and discovered the identity of his mother, but nothing about his birth father. He received support for his FASD–related challenges, including reading and writing, as well as counselling for sexual abuse. He also began to accept himself as two-spirited.

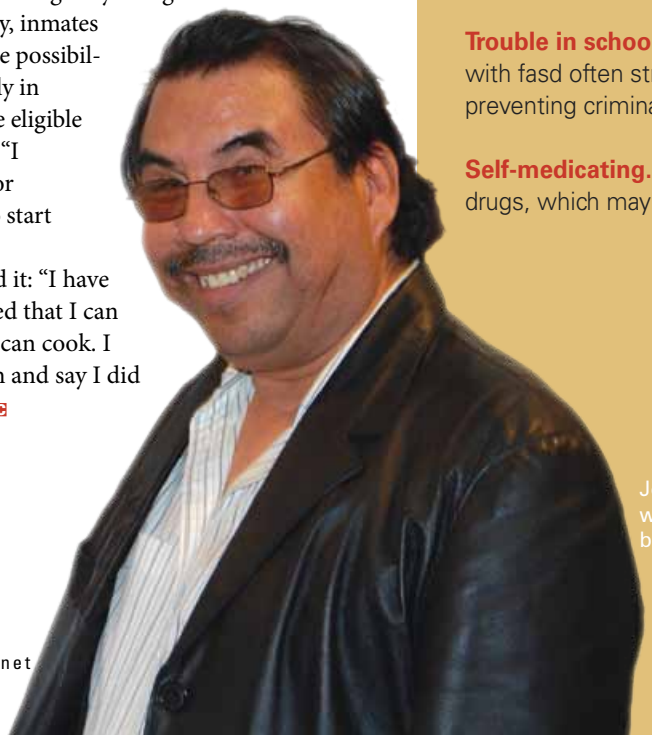
It was around that time that Cloutier began volunteering with charitable organizations to raise awareness about FASD. He has visited inmates at medium- and maximum-security prisons across Ontario. Recently, Cloutier spoke at a justice conference in Winnipeg, for which he received a standing ovation.

He has seen improvements in how FASD is dealt with in the justice system. The justice workers he meets are eager to learn about the disorder and how to support people who have it. Cloutier also speaks at schools in the hope that awareness of FASD may get students the help they need early and steer them away from criminal involvement.

The neurological and behavioural effects of FASD create challenges throughout the criminal justice process for those affected by it. Cloutier hears one concern over and over from inmates: "The consensus is that things are being said and done too quickly for them to grasp what is really going on," he says. Inmates tell him that they need someone to sit down with them and clearly explain their rights, the implications of what is happening and any documents they are asked to sign. Otherwise, says Cloutier, "they could be charged with murder, even though they never murdered anybody and they're penalized without understanding what's going on."

Cloutier wants people living with FASD to know that they can lead good lives. "Just through my being there and sharing my story, inmates have expressed hope in the possibility of functioning normally in society when they become eligible for release," says Cloutier. "I encourage them to look for services to enable them to start a new positive life."

After all, Cloutier did it: "I have a lovely wife, a home, a bed that I can sleep in and a meal that I can cook. I can hold my head up high and say I did something good today."



Joseph Cloutier visits Canadian prisons to talk with inmates about FASD and spread hope about building better lives.

### A poor fit between FASD and the criminal justice system

People with FASD face challenges at all stages of the criminal justice system. The John Howard Society of Ontario explains why:

**Trouble with assessment, judgment and reasoning.** This makes it hard to make good choices and to consider long-term goals. People with FASD are more vulnerable to manipulation and coercion, which puts them at higher risk of giving false confessions.

**Poor memory.** Poor memory can make a person vulnerable when trying to recall events during a criminal investigation. People with fasd may be at risk of incriminating themselves during a police interrogation or court hearing.

**Misunderstanding cause and effect.** Connecting cause and effect is key to the concept of deterrence. This means that punishment is unlikely to prevent similar behaviour in the future. If a person with FASD commits a crime and is later convicted, they may not be able to connect the two events.

**Inability to generalize.** Connecting similar but separate events requires being able to apply knowledge gained from one situation to a new situation. For example, a person with fasd may learn that they will go to jail for cocaine possession, but may not understand that they will also go to jail for heroin possession.

**Inability to think abstractly.** Individuals with fasd often struggle to understand basic concepts in math, money and time, as well as rules and laws. This difficulty with abstraction means that many people with fasd cannot imagine or consider the future. This places them at risk during plea bargaining, sentencing and parole hearings.

**Difficulty planning.** Planning requires the ability to envision the future and achieve goals through a series of complex steps. Difficulty doing this can lead to impulsive behaviour. It also makes it difficult for people with fasd to be deterred from committing a crime, so recidivism rates are high.

**Trouble in school.** Due to no diagnosis or misdiagnosis, people with fasd often struggle in school. Education is strongly linked with preventing criminal behaviour and recidivism.

**Self-medicating.** Some people with fasd self-medicate with illegal drugs, which may lead to addiction and conflict with the law.

# Betting on time

## Why don't prisons offer gambling treatment?

By Astrid Van Den Broek

If you ask Chris Myers what prison gambling looks like, he paints a clear picture: while it's actually forbidden, it's a popular activity, especially card games like poker. And "any day you can put down as much as you want on a sports pool," says Myers. Even backgammon or bridge is available at $10 a corner, and that currency consists of anything you can buy from cigarettes to canteen items to illegal phones that can be wired in. And since prisons are relatively monotonous places to be, where structure rules, the thrill of illicit gambling holds definite allure.

As the problem gambling co-coordinator and counsellor for the Options for Change Addictions Team at Frontenac Community Mental Health Services in Kingston, Ont., Myers sees it all. At about 40 per cent, the prevalence of gambling within Canadian correctional facilities is lower than in the general population, but criminal offenders have the highest rate of problem gambling of any population. About 30 per cent meet criteria for problem gambling, and approximately 50 per cent of crime by these individuals is committed to support gambling.

Yet for its widespread prevalence in prisons across Canada, problem gambling is targeted by few, if any, treatment programs for inmates, either inside or after they've been released.

This might reflect what's going on beyond prison walls, where problem gambling in general isn't considered to be as serious of an issue as substance abuse or sex offending, for example, says Myers. In fact, as Myers points out, the culture of gambling is glamorized with televised tournaments and poker celebrities. Gambling opportunities have also increased, particularly via the Internet, and with Pro-Line sports betting at many corner stores. "For some people, this increased availability and accessibility increase the 'need' to gamble," says Myers.

With such accessibility to general gambling venues, it means that problem gambling can lead to consequences such as incarceration. In a 2009 study published in the *Journal of Gambling Studies*," of the 254 male offenders who were studied at the maximum-security federal Milhaven Institution in Bath, Ont., about 10 per cent scored in the pathological gambler range before incarceration. In a more recent study awaiting publication, the figure landed at about nine per cent. "We asked people about the relationship between their criminal behaviour and gambling, and about 65 per cent of pathological gamblers told us their gambling led to crime," says Nigel Turner, a research scientist with the Social Epidemiological Research Department at the Centre for Addiction and Mental Health in Toronto, who led the two studies. "They gambled, lost money, got in debt and engaged in criminal activities to pay those debts. As one man said, 'Around it goes.'"

Despite the connection between gambling and crime, attitudes toward gambling in prison vary within the correctional system. It seems to depend on the facility, says Myers. Some institutions welcome help to address the problem, but others see it differently. "Some institutions think it keeps inmates quiet; it keeps them out of trouble," says Myers.

Gambling's popularity in prison may be attributed in part to the lack of recreation options, says D.J. Williams, a former researcher at the University of Lethbridge in Alberta, who is now with the Department of Sociology, Social Work and Criminal Justice at Idaho State University. "Passing the time" was a common response when he asked inmates why they gambled.

What isn't common are treatment options for pathological gambling. Myers is trying to address the need with a pathological gambling program that he runs in three Ontario institutions. The 15-week, three-hour weekly psycho-education program focuses on life balance and relapse prevention. Myers also works with inmates released into the Kingston area and connects parolees with gambling programs in the areas they're being released into.

But as Turner points out, whether or not there's a program available can largely depend on external prison circumstances. "A lot depends on having a local treatment service provider who is able and willing to go into the institution and provide the services for that community," he says.

If gambling programs aren't available, some inmates enter other programs, such as those for substance use problems. "The treatment programs in institutions tend to deal with these other issues, not gambling," says Williams. "So the gambling piece is missed, and when we do see the link between gambling and crime, it's assumed that the other form of treatment will spill over and address the gambling issue." He adds, "That might be the case, or it might not; we don't really know."

Even when services are available in prisons, logistics challenges can stand in the way. The higher the security level of the institution, the more limited the movement and availability of inmates. Or if there's something going on in the institution such as an incident, service providers may not be able to get in that day.

Then there are resource and educational challenges. "I see my job partly as educating management, workers and program staff," says Myers. "They need to understand that if people with gambling problems aren't treated in prison, they'll go back onto the street and do the same things."

Myers would like to see more and better screening of new inmates for pathological gambling. "One of my goals is to actually start asking questions about gambling," says Myers. "When inmates come into Millhaven, for example, mostly for three to six months of imprisonment, an assessment is done. But unless gambling is part of their charge and is stated on their charge, are they asked, How much do you gamble? What do you do in your spare time?"

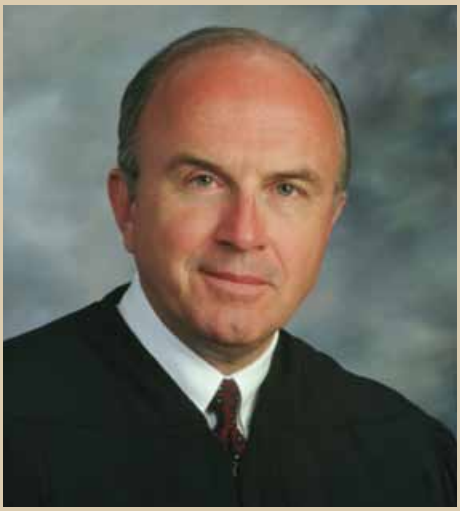
Spare time—and there's plenty in prison—is an opportunity to provide recreational programs with a prevention or treatment component, says Williams. "Here in the United States—but I think it's impacted the Canadian system to some degree—there's been a 'tough on crime' approach since the mid-'90s, and a lot of recreational programs have been cut because they're considered a luxury." Although a causal link between reduced recreation opportunities and increased gambling in prisons hasn't been established, for Williams, it's common sense: "If you don't have adequate recreation opportunities and leisure time, you're going to turn to gambling and other means that may not be healthy."

### Gambling treatment court stresses help, not punishment

The New York Gambling Treatment Court in Amherst, N.Y., is the only program in the world that diverts people who have committed gambling-related crimes from prison and into treatment. "Our goal is to get people into treatment so that they don't turn back to crime to support their addiction," says Justice Mark G. Farrell, who presides over the court.

Farrell recognized the need for a gambling treatment court after seeing defendants in traditional courts who appeared to have "out-of-control gambling problems." To deal with them, Farrell in 2001 created a separate court modeled on the drug courts in which he has worked that focuses on rehabilitation, not punishment.

As with drugs courts, defendants must plead guilty, which gives Farrell discretion to defer punishment for up to a year and dismiss charges for those who complete the program. Defendants who pass a screening process sign a contract agreeing to participate in the program and abide by its rules. They then begin a treatment program that includes individual and group therapy, debt counselling and regular check-ins with the court. The program takes a little over a year to complete.



Justice Mark G. Farrell presides over the world's first gambling treatment court.

With an estimated 10 per cent increase in convictions coming through his court every year, Farrell would welcome more courts like his. The approach is indeed attracting attention, as gaming jurisdictions around the world investigate new ways to help problem gamblers.

To find out how many people have gone through the court and how well they do, access this story at www.camhcrosscurrents.net and read the "Gambling treatment court by the numbers" sidebar.

Get a glimpse into the life of a drug treatment court counsellor by visiting **www.camhcrosscurrents.net.** Read the story called "Stopping the revolving door"

# "I believe in second chances"

## Female offenders make strides towards community reintegration

By Avril Roberts

The first time Missie* was released from prison on parole, she lasted six months. "I was involved with drugs, so to get out and give up all my friends and have nothing was hard," says Missie. "I didn't have any positive community contacts, people on the outside who could help me with resources and good social surroundings. I ended up relapsing and going back."

But since completing her sentence in December 2009, Missie has stayed out of prison and stayed clean. She credits Stride, an innovative community reintegration program of Community Justice Initiatives (CJI), which works with the federal Grand Valley Institution for Women (GVI) in Kitchener, Ont. "My Stride Circle supported me emotionally, giving me the courage to go through with what I needed to do, instead of getting nervous and backing out. I felt more secure the second time."

That sense of security in re-entering the community is crucial for incarcerated women with mental health and addiction problems. Many of them have lost everything—homes, jobs, possessions, family connections and children—unlike men, who often have a woman—mother, wife or girlfriend—tending things at home. These women have few supported housing options, and those that exist are often not in the communities where they plan to move. "The priority for many women is to get their children back and create a home," says Julie Thompson, program director for CJI, a leader in providing restorative practices.

Stigma and social isolation are the biggest challenges to community reintegration. Stereotypes make people reluctant to offer women offenders housing and employment or social and financial support. Self-stigma prevents many women from asking for help. "We fear that we won't be accepted," says Marlene, who has served two-thirds of her five-year sentence.

Thompson understands that fear: "For women pushed to the margins by mental health, abuse or addiction issues prior to incarceration, and further isolated from society during incarceration, understanding how they're supposed to fit back into society in a meaningful way is overwhelming," she says.

Easing the transition is what Stride Circles have been doing for 13 years. They operate like a network of friends and family to assist women with the nitty-gritty of settling into new lives. At the heart of each Circle is the woman, supported by a CJI facilitator, and three community volunteers who make a commitment to support her leading up to and after her release. A Circle usually lasts three to four years.

In Missie's Circle, one volunteer accompanied her to children's aid meetings, as Missie fought to regain custody of her children; another attended Alcoholics Anonymous meetings with her; the third, her "Christian mentor," introduced her to members of her church. "Instead of there just being the four of us, the Circle broadened my connections to the community and to supports," says Missie.

The Circle tried to help Missie access emergency housing, but it was ultimately family and friends who helped her secure an apartment for herself and her two teenagers. Completing GVI's horticultural program gave Missie a head start on seasonal landscaping work. Her former Circle members are now her friends.

The women at GVI meet the volunteers initially at Stride Night, a weekly social gathering where CJI brings community members into the prison to join the women in crafts, games, music and other recreation. An Early Years Centre delivers workshops on parenting and play a few times a year.

Stride Nights unite women from the federal penitentiary with volunteers for activities and support that help the women build new lives after they leave prison.

"The purpose of Stride Night is to create a community inside the institution where the women and volunteers connect and build relationships," says Thompson. "The volunteers meet the women, hear their stories and see them as individuals with potential. And the women hear what kinds of struggles volunteers themselves have in their daily lives. It humanizes the situation, showing that we have more in common than what keeps us apart." Participation in Stride is voluntary and has no bearing on a woman's eligibility for parole.

Michelle was drawn to Stride Night because there was nothing else to do on a Tuesday evening at the prison. Wary of "these do-gooders," she was gradually won over when she realized, "It didn't matter if I just went for cookies or if I wanted to stay longer; these people were always happy to see me."

Michelle says that throughout the year leading up to her release and in the two years since, the Circle has offered her love and caring without judgment. "They have accepted me regardless of the worst things I have done." They kept in touch when Michelle was released to a halfway house and welcomed her arrival at a new community, helping her find and furnish an apartment and accompanying her on outings as one of the conditions of her release.

For this young woman starting her life over, the Circle was initially the only source of friends. Now, with mixed emotions, Michelle is beginning to transition away from her Circle, as she slowly develops friendships among her peers at university and at her part-time job. Loneliness is still a factor because she feels vulnerable when meeting new people. "If people ask me about my past, I never know what to say, but I'm getting better at it," she says.

Through the university's counselling services, Michelle feels she is finally receiving counselling appropriate for someone with "serious issues with drug and alcohol abuse" and undiagnosed depression and anxiety. In prison, she had seen five different psychologists with different therapeutic approaches.

Now, Michelle credits the Stride Circle with giving her "a brand-new shot at life. The Circle gave me an opportunity to be around healthy people. It's so easy to take that for granted if your life is together, but if it's not, that's life-changing in itself."

Michelle is on a path that Marlene hopes to follow. Newly released from prison on statutory release, having served 40 months of her five-year sentence, Marlene is going through the most difficult time—the first year after release. Her Circle is helping her manage the stress. "They're there for me to talk to, to call, to e-mail," she says. "If I'm having a stressful day, we can sometimes go for supper or shop for things I need."

As with many women coming out of prison, transportation is a problem, so Marlene often asks Circle members to drive her to out-of-town appointments, such as the random urinalysis that is a parole condition. She attends Alcoholics Anonymous and Celebrate Recovery meetings, sometimes up to four times a week, to work on her alcohol and gambling issues. She is "tickled pink" by the positive reception she gets from people like her new landlord, who, on hearing her story, said, "I believe in second chances."

Marlene's Stride experience has encouraged her to help women get off the streets. She wants to start a sewing and alteration business, showing women how to repair, recycle and repurpose clothing, much as the Stride program helps women reconstruct their lives. "I'm taking one day at a time, but I know I'm not going back to GVI," says Marlene. "There's nothing in my bones that says I need to mess this up."

Communities must play their part, too, says Thompson. "We focus a lot on individuals who are marginalized, expecting them to make changes, to get their act together and become productive members of society; but as a society, we need to pull together and create safer, more compassionate communities for people to be successful in."

*all Stride participant names have been changed

For more information about Stride visit **www.cjiwr.com**.

### Getting out and staying out

A new study published online in the *American Journal of Public Health* has found that aftercare helps female offenders stay out of prison. The study, conducted by researchers from St. Michael's Hospital in Toronto and the Correctional Service of Canada (CSC), evaluated the effectiveness of the CSC Community Relapse Prevention and Maintenance (CRPM) program, which assists female offenders with addiction. Among the findings:

- Women prisoners with substance use problems who did not participate in an aftercare program were 10 times more likely to return to custody within one year after release than women who participated.
- More than one-third returned to prison within the first six months, mainly for violating release conditions.
- Women who violated a condition of abstinence were almost twice as likely to return to custody as women who did not violate conditions.
- Women who were unemployed while on parole were more than twice as likely to return to custody as women who worked.
- By six months, 26% of women with no exposure to CRPM had returned to custody.
- Most women who returned to custody had not completed high school or were unemployed during their release.

To find out how programs like Stride offer value for money, access this story online and read the **"Reintegration programs make $ense"** sidebar at www.camhcrosscurrents.net.

# Psychiatrists in blue

## Improving police responses to people with mental illness

By Ned Morgan

Police interactions with people with mental health problems have garnered a lot of attention over the last decade, thanks in large part to the work of psychologist Dr. Dorothy Cotton and retired Moose Jaw, Sask.–police chief Terry Coleman. Cotton and Coleman spearheaded the Police/Mental Health Liaison website (www.pmhl.ca), a project of the Canadian Association of Chiefs of Police. They also serve as consultant researchers for the Police Project of the Mental Health Commission of Canada, which will develop guidelines for police training across Canada with the aim of improving interactions between police and individuals with mental health problems. *CrossCurrents* asked Cotton and Coleman about progress in this area.

Psychologist Dorothy Cotton and retired police chief Terry Coleman help police to improve their response to people with mental health problems.

### Why are police interacting more with people with mental health problems?

Cotton spent 25 years working at a provincial psychiatric hospital, starting in the mid-1970's. Towards the end of her tenure, she noticed how much time police were spending with patients. "A lot of people had been released into the community and didn't have much in the way of supports," she says. Cotton sees another reason besides de-institutionalization for increased police involvement: "We've seen a shift in social focus towards the right; we're more of a law-and-order society. Society in some ways has become less tolerant. When people don't know what to do, they phone the police."

### When do police interact with people with mental health issues?

Media usually focus on police apprehensions under mental health acts, but the far more common interactions involve police serving in more nuanced roles, says Coleman. The shortage of community mental health services means that police often intervene in non-criminal situations to provide assistance and social support.

"Police get called when someone is acting strangely, not necessarily violently," says Coleman. "Some people are uncomfortable when they see someone dressed strangely, talking to themselves or sounding irrational, even if they're not threatening anybody."

Cotton points to the "huge range of functions" assumed by police, from apprehensions—"probably less than 10 per cent of interactions with people who are mentally ill"—to responding to calls from families, co-workers, friends and neighbours. "One role that is overlooked is that of providing informal social supports to people with mental illness. Often it is police who check up on them, give them a buck for a coffee and help them to find a place where they might get food," says Cotton.

### How do mental health consumers perceive police?

In the general population, attitudes toward police are often fear driven. "None of us like to have the police appear on our doorstep," says Cotton. "It's frightening for any person, particularly if you are acutely ill, feeling uneasy, maybe paranoid. It's also very stigmatizing."

As part of the MHCC's Police Project, Cotton and Coleman were involved in a newly released study of consumer experiences with and attitudes towards police in British Columbia. "Consumer attitudes are generally positive, although somewhat less positive than those of society as a whole," says Coleman. He adds that most people feel that police were helpful, that they had an overall beneficial effect on their lives, and that the police treated them fairly and with respect. "I don't want to paint an unduly rosy picture, because there were also those who think interactions could have been better," says Coleman. "But particularly for more seriously mentally ill people, the police are the best friends they have. You can't just phone a mental health worker and get them to come out and see you. They don't wander by you on the street to check and see if you're okay. Police do."

### Do traditional models of policing meet the needs of people with mental illness?

"Traditional policing was incident-driven," says Cotton. "An incredible amount of time spent at hospitals, usually in emergency wards, looking after the person they'd transported, waiting for various people in the health system to attend and take over. I think that was a very practical impetus for police to look for a better way."

Coleman started in policing in Calgary in 1969, during the traditional era of policing. "I can't remember any training that prepared me to deal with people with mental illness, never mind someone in crisis," he says. Coleman frequently encountered individuals with mental illness, many of them homeless and with addiction. "Back then, we had to 'wing it'; some of us got it right, some didn't. But when a new chief came along in the early '70s, there was an attempt to make referrals to mental health and addiction services." Coleman says that today, law enforcement is just one tool the police use. "The rest is the social services aspect of the work."

### Are police training and education making a difference?

As part of the Police Project, Coleman and Cotton researched how police basic-training programs across Canada prepare future police officers to respond to people with mental health problems and found quite a range of approaches. "One of the best programs we found was the Royal Newfoundland Constabulary in association with Memorial University in St. John's," says Coleman. "At 30-odd hours, it's a good program. Other police academies and colleges might only dedicate half a day."

Cotton and Coleman's work with the Police Project includes a proposed training model called TEMPO (Training and Education about Mental Illness for Police Officers). "TEMPO addresses all levels of training, not just officers on the street, but people working the front desk, the call takers, the dispatchers, anybody interacting with the public," says Cotton. "Training won't fix everything, but it is a necessary prerequisite. And because it's included in basic training, it sends a clear message to police that this is important work."

Coleman says education must tackle stigma: "Police are better educated, but the public and many police officers still equate mental illness with violence. We've discussed stigma with the MHCC to determine how we can introduce this into a program for police personnel." The TEMPO model is a start.

### What are the key components of a police approach to people with mental illness?

Officers must use their own judgment, which is why training and education are so important, says Coleman. "Police by nature are action-oriented; they like to get the job done and move on to the next call. But in some circumstances, a conversation could resolve a situation. Education and training can impress upon police officers that this is an alternative, so they can understand what they're witnessing and hearing." Coleman adds that police must be prepared to take their time, and verbal and de-escalation skills are critical.

### What barriers do police face in working with the mental health system?

"The biggest problem police have is the biggest problem the rest of us have—lack of access," says Cotton. "Police may see someone in need of immediate care and treatment, but they don't have magic ways of accessing help any more than the rest of us do. The only option open to police, aside from informal encouragement, is to determine whether the person meets criteria of the Mental Health Act, and if they think they do, take them to an emergency room, where they might spend hours."

This is where joint-response teams can be extremely helpful because they facilitate, as much as possible, gaining access to the system," says Cotton. As an example, Cotton points to joint-response programs like COAST (Crisis Outreach and Support Team) in Hamilton, Ont., which consists of child and youth crisis workers, mental health workers, nurses and plain-clothes police officers. "The officer is there in case there is a risk of danger or harm to anyone," says Cotton. "Very often these models result in less involvement of the criminal justice system and a quicker way to access services and supports."

## Cops and compassion

- **Canadian Police/Mental Health Liaison website.** Includes guidelines for working with the mental health system www.pmhl.ca
- Mental Health Commission of Canada **Police Project.** Search www.mentalhealthcommission.ca
- **Not just another call … Police response to people with mental illnesses in Ontario.** A practical guide for frontline officers offered by the Ontario Police College www.opconline.ca/res/MentalHealth/index.html
- **Police and mental health: A critical review of joint police and mental health collaborations in Ontario.** Issues and solutions presented by the Provincial Human Services and Justice Coordinating Committee www.ofcmhap.on.ca/node/501
- **Police and mental illness.** Practical U.S. and Canadian resources compiled by the Ontario branch of the Canadian Mental Health Association www.ontario.cmha.ca/justice.asp?cID=5441

# Do community treatment orders work?

Ann-Marie O'Brien

Community treatment orders (CTOs) are part of a complex landscape of law, policy and practice. Defining and measuring their effectiveness depends on who you ask; policy makers, practitioners and the people who fall under CTOs all present different perspectives. CTOs do not exist in a vacuum. Many factors affect how, when and with whom they are used, including the availability and willingness of physicians and the mental health infrastructure to support them. Ten years after the introduction of CTOs in Ontario, there exists only a handful of studies to inform opinions on their usefulness. Many important questions remain unanswered.

The purpose of CTOs as defined in the Ontario legislation is to provide a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric hospital. They are meant to provide the support people need to maintain wellness outside of institutional care, thus reducing use of inpatient services. It seems reasonable, then, to gauge the effectiveness of CTOs by measuring their impact on hospitalization rates. Every Canadian study that has used this measure has found CTOs to reduce use of hospital inpatient beds. However, some critics note the limitation of this measure. They argue that within the context of ever decreasing hospital inpatient resources, staying out of hospital does not in itself indicate wellness. Simply closing hospital beds will decrease their use.

There is another possible way to measure success. CTO legislation is developed within unique cultural and socioeconomic contexts. In Ontario, like in many other jurisdictions, the legislation was motivated by an act of violence by a person whose symptoms of illness were untreated. Given the association of this legislation with random acts of violence committed by people with untreated mental disorders, it would be reasonable to evaluate CTOs by measuring their impact on violence. This question has yet to be examined in Ontario.

CTOs knit together the minimal presumed necessities for mental health and well-being of individuals with serious mental disorder: treatment (usually and sometimes exclusively medication) and medical supervision. CTOs in Ontario, unlike in other jurisdictions, are physician directed, not court ordered. One challenge of determining whether CTOs work is distinguishing between the effectiveness of the CTO and the effectiveness of the treatment. One measure of effectiveness would be the impact of CTOs on compliance. All studies that have examined compliance have found a positive association between CTOs and compliance.

The introduction of CTOs has affected agencies such as the Psychiatric Patient Advocate Office (PPAO) and the Office of the Public Guardian and Trustee. In 2009, the PPAO reported having received 2,198 requests for rights advice for CTOs—a six-fold increase since 2002. It would be interesting to know what additional funding these agencies have received to keep up with the increased demand for services. What is the impact of this funding—or lack of funding—on individuals subject to CTOs? To what extent have recent changes in legislation been driven by increased demands for rights advice and diminished resources to keep up with those demands?

Historically, mental health services have been divided between inpatients (voluntary and involuntary) and outpatients. Once outside the institution, people were more or less on their own. The introduction of CTOs has created a new set of mental health service users—involuntary outpatients. The PPAO, in its 2009 annual report, reported that almost 70 per cent of CTOs were consented to by substitute decision makers. How have our practices been adapted to serve involuntary outpatients? Many community-based practitioners are unprepared for this new reality. When CTO legislation was passed, significant funds were channeled to community-based mental health agencies to hire case managers to provide services to people on CTOs. Currently, the number of people on CTOs has far surpassed the number of case managers originally funded to serve involuntary outpatients. From a practice perspective, what lessons have been learned from the past 10 years?

The most fundamental question is, How do CTOs affect the lives of the individuals who are subjected to them? These people are a challenging population to engage for scientific enquiry. Beyond meeting the very broadly defined legal criteria for CTOs, these individuals have different clinical presentations, and diverse socioeconomic realities. Their perceptions of CTOs are as varied as they themselves are as individuals. Some are completely indifferent to the CTO; they are resigned to the lack of power they have over their illness and reluctantly comply with the CTO. They make no connection between treatment compliance, symptom reduction and improved quality of life in the form of stable housing and meaningful employment. Others feel persecuted by the requirements of the CTO. They express feelings of powerlessness, oppression, hopelessness and, often, anger. They deeply resent having to comply with treatment because they, too, don't see the connection between treatment compliance, symptom reduction and improved quality of life. These people frequently engage the Consent and Capacity Board in their pursuit of justice. Another group of people have remarkable stories of recovery that began with involuntary treatment. Some regain capacity to make treatment decisions, and some make the connection between compliance and improved quality of life. What we still need to better understand is the combination of factors that contribute to these positive outcomes.

**Ann-Marie O'Brien** is a CTO coordinator at the Royal Ottawa Mental Health Centre. She is adjunct faculty at the Carleton University School of Social Work.


## CANADA

**Harm Reduction Canada Conference**
July 13–15, Ottawa, Ontario
tel 705 749-6145
e-mail gt@cast-canada.ca
http://cast-canada.ca/HR2011-Main.html

**International Conference on Mindfulness with Youth**
July 15–17, Banff, Alberta
tel 780 919-0693
e-mail catherine@mindfulnessinstitute.ca
www.mindfulnessinstitute.ca

**2nd International Copwatch Conference**
July 22–24, Winnipeg, Manitoba
tel 204 942-1588
e-mail wpgcopwatch@gmail.com
http://conference.winnipegcopwatch.org/

**Canadian Mental Health Association National Conference**
September 14–16, Kelowna, British Columbia
tel 250 861-3644
e-mail nationalconference2011@cmha.bc.ca
http://cmhakelowna.wordpress.com/

**2011 International Conference of Residency Education**
September 22–24, Quebec City, Quebec
tel 613 260-4176
toll-free 800 668-3740, ext. 176
e-mail icre@royalcollege.ca
http://rcpsc.medical.org/icre/

**Royal Ottawa Health Care Group Schizophrenia Conference**
September 23, Ottawa, Ontario
tel 613 722-6521, ext. 6811
e-mail Lucie.Moore@rohcg.on.ca
http://www.rohcg.on.ca/education/events-e.cfm

**1st Canadian Conference on Family Group Conferencing**
September 25–27, Toronto, Ontario
tel 416 987-7725
toll-free 800 227-4645
e-mail fgdm@americanhumane.org
www.oacas.org/circle/

**Psychological Rehabilitation Canada Annual Conference**
September 26–29, Cape Breton, Nova Scotia
toll-free tel 866 655-8548
e-mail support@psrrpscanada.ca
http://psrrpscanada.ca

**Royal Ottawa Health Care Group Forensics Conference: "Mental Health in Corrections"**
September 29–30, Ottawa, Ontario
tel 613 722-6521, ext. 6811
e-mail Lucie.Moore@rohcg.on.ca
www.rohcg.on.ca/education/events-e.cfm

**Canadian Association for Suicide Prevention National Conference**
October 3–5, Vancouver, British Columbia
tel 604 822-7524
e-mail ipad@interchange.ubc.ca
www.casp2011.ca

**Royal Ottawa Health Care Group CBT Workshop: "CBT of Psychosis, PTSD and Dissociation"**
October 13–14, Ottawa, Ontario
tel 613 722-6521, ext. 6811
e-mail Lucie.Moore@rohcg.on.ca
www.rohcg.on.ca/education/events-e.cfm

**Canadian Psychiatric Association 61st Annual Conference**
October 13–15, Vancouver, British Columbia
tel 613 234-2815
e-mail conference@cpa-apc.org
www.cpa-apc.org

**American Academy of Child and Adolescent Psychiatry 58th Annual Meeting**
October 18–23, Toronto, Ontario
tel 202 966-7300
e-mail meetings@aacap.org
www.aacap.org

**Prévenir et intervenir en dépendances : INTERAGIR**
October 23–26, Trois Rivières, Québec
tel 450 646-3271
e-mail secretariat@aitq.com
http://aitq.com/activites/colloque.htm

**6th Education Conference on Mental Health**
October 28, Toronto, Ontario
tel 416 444 8455
e-mail info@careconferences.com
www.careconferences.com

**Association for the Treatment of Sexual Abusers 30th Annual Conference**
November 2–5, Toronto, Ontario
tel 503 643-1023
e-mail atsa@atsa.com
www.atsa.com/conf.html

**Canadian Society of Addiction Medicine Annual Meeting and Scientific Conference**
November 3–6, Vancouver, British Columbia
tel 403 813-7217
e-mail admin@csam.org
www.csam.org

**Issues of Substance 2011 (Canadian Centre on Substance Abuse National Conference)**
November 6–9, Vancouver, British Columbia
tel 613 235-4048
e-mail ios@ccsa.ca
www.issuesofsubstance.ca

**Association for Behavioral and Cognitive Therapies 45th Annual Convention**
November 10–13, Toronto, Ontario
tel 212 647-1890
e-mail tchilders@abct.org
www.abct.org/Conv2011

**Ontario Human Services and Justice Coordinating Committee Conference**
November 21–23, Toronto, Ontario
www.hsjcc.on.ca

## UNITED STATES

**2nd World Congress on Positive Psychology**
July 23–26, Philadelphia, Pennsylvania
tel 856 423-2862
e-mail info@ippanetwork.org
http://community.ippanetwork.org

**119th Annual Convention of the American Psychological Association**
August 4–7, Washington, DC
tel 202 336-6020
e-mail convention@apa.org
www.apa.org/convention/index.aspx

**1st Global Conference on Music and Mental Health**
August 5–7, St. Louis, Missouri
e-mail mmh2011@globalresearchstudies.com
www.hastac.org/events

**American Psychological Association 119th Annual Convention**
August 7–10, San Diego, California
tel 202 336-6020
e-mail convention@apa.org
www.apa.org/convention/index.aspx

**International Nurses Society on Addictions National Educational Conference**
September 10–13, Tucson, Arizona
toll-free tel 1 877 646-8672
e-mail intnsa@intnsa.org
www.intnsa.org/events.php

**National Conference on Addiction Disorders**
September 17–21, San Diego, California
tel 702 944-8753
e-mail info@vendomegrp.com
www.nationalconferenceonaddictiondisorders.com

**2nd International Research Conference on Community Inclusion of Individuals with Psychiatric Disabilities**
September 19–21, Philadelphia, Pennsylvania
tel 215 204-6779
e-mail katy.kaplan@temple.edu
www.tucollaborative.org

**24th Annual National Prevention Network Research Conference**
September 20–23, Atlanta, Georgia
tel 405 325-1439
e-mail npnconference@ou.edu
http://swpc.ou.edu/npn/

**American Psychotherapy Association National Conference**
October 13–14, Branson, Missouri
toll-free tel 800 423-9737, ext. 168
e-mail conference@americanpsychotherapy.com
www.americanpsychotherapy.com/conference/

**25th Annual Conference of the American Psychiatric Nurses Association**
October 19–22, Anaheim, California
tel 703 243-2443
toll-free 866 243-2443
e-mail info@apna.org
www.apna.org

**13th Annual Conference of the Collaborative Family Healthcare Association**
October 27–29, Philadelphia, Pennsylvania
tel 720 940-4880
e-mail CFHA@ascentmeetings.com
www.cfha.net//pages/Conference/

**American Psychiatric Association Institute on Psychiatric Services**
October 27–30, San Francisco, California
toll-free tel 888 357-7924
e-mail: apa@psych.org
www.psych.org

**42nd Annual Meeting of the American Academy of Psychiatry and the Law**
October 27–31, Boston, Massachusetts
tel 860 242-5450
e-mail execoff@aapl.org
www.aapl.org/meetings.htm

**American Public Health Association 139th Annual Convention**
October 29–November 2, Washington, DC
tel 202 777-2521
e-mail natalie.sorkin@apha.org
www.apha.org/meetings

**24th Annual U.S. Psychiatric and Mental Health Congress**
November 7–10, Las Vegas, Nevada
tel 951 219-2881
e-mail brian.bales@cmellc.com
www.psychcongress.com

**Neuroscience Education Institute 2011 Psychopharmacology Congress**
November 10–13, Colorado Springs, Colorado
tel 760 931-8857
toll-free 888 535-5600
e-mail customerservice@neiglobal.com
www.neiglobal.com/Default.aspx?tabid=123

**Society for Neuroscience 41st Annual Meeting**
November 12–16, Washington, DC
tel 202 962-4000
e-mail info@sfn.org
www.sfn.org/am2011

## ABROAD

**World Council for Psychotherapy 6th World Congress**
August 24–28, Sydney, Australia
tel 61 2 9265 0700
e-mail wcp2011@arinex.com.au
www.wcp2011.org

**International Association for Suicide Prevention 26th World Congress**
September 13–17, Beijing, China
e-mail office@iasp.info
www.iasp.info/congresses.php

**World Psychiatric Association 15th World Congress**
September 18–22, Buenos Aires, Argentina
tel 54 11 5252 9801
e-mail wpa-argentina2011@mci-group.com
www.wpa-argentina2011.com.ar

**Global Addiction 2011 Conference**
September 21–23, Lisbon, Portugal
tel 44 20 8878 8289
e-mail info@globaladdiction.org
www.eaat.org/cnf-prog.php?confId=1

**2nd International Congress on Dual Pathology, Addictive Behaviors and Other Mental Disorders**
October 5–8, Barcelona, Spain
tel 34 91 361 2600
e-mail secretariat@cipd2011.com
www.cipd2011.com

**World Congress of the World Federation for Mental Health**
October 17–21, Cape Town, South Africa
tel 27 21 914 2751
e-mail info@wmhc2011.com
www.wmhc2011.com

**7th European Congress on Violence in Clinical Psychiatry**
October 19–22, Prague, Czech Republic
tel 31 20 409 0368
e-mail conference.management@freeler.nl
www.oudconsultancy.nl/prague_cfa

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