CRISIS RESPONSE TO PERSONS WITH MENTAL ILLNESS: UNDERSTANDING RESPONDER CAPACITY

by

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ABSTRACT

The issue of responding to and meeting the needs of persons experiencing crises relating to mental illness has been increasingly demanding attention in the media and in our communities. Literature suggests that the criminal justice and health systems have become intricately involved as a consequence of deinstitutionalization, and policing authorities have become informally designated as first responders to persons experiencing a mental health crisis. This effect is occurring in many developed countries prompting an examination of these subsystems independently and as they interact together. Further to this, emerging joint initiatives that are considered best practice demand collaboration between these systems and with local communities that has not existed in the past.

My practicum placement experience allowed for an understanding of how these entities cope with and respond to these new demands specifically in the community of Prince George. The learning acquired is consistent with that found in the literature and suggests a deeper understanding of the value of an ecological perspective that requires advanced social work skills in the practice of boundary spanning.

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CHAPTER ONE: INTRODUCTION & DESCRIPTION OF PRACTICUM

The focus of this chapter is to provide a description of the practicum objectives and the agency that served as my learning environment, to outline the learning goals that guided my practicum, and to offer a theoretical synthesis tying together my practice philosophy, the practicum agency, and the value of my learning for advanced social work in the field of mental health.

Practicum Objective

An increase in attention to the crisis interactions between persons with mental illness (MI) and the first responders to them, specifically policing authorities, alongside a personal interest and professional involvement in the field of mental health has provoked a critical inquiry into the preparedness of first responders to adequately and competently respond to persons experiencing a mental health crisis. The Prince George branch of the Canadian Mental Health Association (CMHA-PG) is aligned with the 'Building Capacity: Mental Health and Police Project' (BC:MHPP) which has been designed to examine and where possible improve responses to individuals who are experiencing a mental health crisis. This alliance has resulted in the development of a Mental Health and Police Project (MHPP) Committee in Prince George. The work of this committee has led to the development and delivery of two specific educative initiatives targeted at increasing the capacity of responders to persons experiencing a mental health crisis.

Crisis Intervention Team (CIT) training is a widely used best practice training model for improving interactions between first responders and persons experiencing a mental health crisis. It involves forty hours of education and training that focusses on increasing awareness of mental illness and building community coalitions for supporting individuals with mental

illness in crisis (Watson & Fulambarker, 2012). Mental Health Crisis Response Training (MHCRT) is a unique adaptation of CIT training developed by the Prince George MHPP Committee in response to challenges associated with full participation in a forty hour training program. MHCRT is an eight hour single day training program that strives for similar outcomes as CIT training. CMHA-PG has been regularly providing these trainings since 2009 and remains the only BC community to do so (M.L. Spagrud, personal communication, March 4, 2015).

My practicum placement with CMHA-PG consisted of five hundred and sixty hours and was supervised and informed by professionals in the practice field of social work and mental health. It was meant to enhance what I have learned through previous practice experience and alongside my current research. The learning goals were developed to facilitate an examination of the committee's work, to guide an analysis of the MHCRT and CIT Trainings, to explore how the training is experienced by designated first responders and community partners, and to determine the need for additional or enhanced training in the future.

Practicum Placement

The practicum placement location was chosen because of its rich history as a socially conscious organization, its current practices that reflect social work values such as inclusion, equity, and self-efficacy, and a future orientation that seeks to create communities free of stigma and equitable in power and resources. It has a specific and intense focus on the provision of mental health education and awareness raising initiatives. The Canadian Mental Health Association (CMHA), founded in 1918, is the oldest national mental health charity in Canada; it serves over one hundred thousand people each year and has established branches

in one hundred and thirty five Canadian communities (http://www.cmha.ca). The Prince George branch of the Canadian Mental Health Association (CMHA-PG) has been in operation since 1962 (http://www.princegeorge.cmha.bc.ca). It utilizes the services of a combined one hundred individuals, in both paid and volunteer positions, to maintain operations which stretch from the central interior of BC to the Yukon and Northwest Territories border and from Haida Gwaii to the Alberta border (M.L. Spagrud, personal communication, March 4, 2015).

CMHA-PG serves individuals and families in Prince George and the surrounding area by providing support services which involve psycho-education, life skills, access to resources, housing, as well as both professional and consumer run recreational and vocational programs. It serves the community through advocacy in public policy and through the development and delivery of specialized education and training that is structured to meet the needs of individuals, caregivers, employers, service providers, and communities (http://www.princegeorge.cmha.bc.ca).

CMHA-PG is the only branch that has an established Manager of Education and Projects to oversee the delivery of education, assess need, and evaluate outcomes. Direct practical supervision and direction during my practicum was provided by the Manager of Education and Projects and overseen by the Executive Director who holds a Master's degree in Counselling Psychology and has an established history of both clinical and crisis intervention practice. Regular contact with a consultant who holds a Master's degree in Social Work, is registered with the British Columbia College of Social Workers, and has extensive mental health practice experience supported the synthesis of this learning with

social work theory and philosophy and its integration with advanced social work practice in the field.

Learning Goals

My practicum placement was guided by three learning goals; these goals and associated activities were detailed in the learning contract (Appendix One). The first goal was to acquire knowledge about the training and education, specifically related to and directed toward increasing the capacity for first response to persons experiencing mental health crisis, offered by CMHA-PG and to develop a clear understanding of the joint partnerships and committee work that influenced and supported the development of it. The fulfillment of this goal required a comprehensive review of materials associated with the development of both the MHPP Committee and the subsequent trainings, ongoing consultation with the Manager of Education and Projects, and participation in the local delivery of CIT training.

The second goal was to identify the first responders and relevant community partners in the area served by CMHA-PG and to gain an understanding of how they experience the training available to them and how it shapes their knowledge and understanding of mental illness and mental health crisis response. This was achieved by attending committee and relevant interagency meetings, reviewing training participant feedback evaluations, and through face to face meetings and discussions with key stakeholders.

The third learning goal was to explore future directions for CMHA-PG's work toward increasing the capacities for communities to meet the needs of persons experiencing mental health crisis. Specifically, it meant to determine the need for, and identify potential

components of, additional or enhanced training in addition to identifying community partnerships that might require further development. This goal was accomplished through a comprehensive review of all training feedback evaluations and exploratory discussions with past training participants and committee members, that sought to identify the gaps in understanding they had identified as they utilized their training in the field. These sources of information provided consistent and clear responses regarding future work for the MHPP Committee and for CMHA-PG.

Theoretical Orientation

Responses to persons with severe and persistent mental illness continue to be guided by social understandings influenced by an evolution of theories striving to account for both social and physical aspects of health and illness (Bourgeault, 2010). Establishing a succinct conception of mental illness is not straightforward and this ambiguous understanding remains at the core of contemporary service provision issues, including those that involve crisis response. Medical sociology offers a history of theoretical accounts in the study of health, illness, and healthcare (Bourgeault, 2010) which parallels the process in which mental disorders came to be recognized as mental illness (MI). These influences continue to underlie assumptions about MI and its relationship with social structures, institutions, experiences, and interactions (Bourgeault, 2010). Mental health policy and the evolution of this understanding began around the middle of the twentieth century (Sussman, 2003).

The onset of the sociological study of health was dominated by a structural functionalist paradigm which theorizes that human conditions and experiences reflect the specific social roles that are purposeful, consensual, and interconnected with one another (Bourgeault, 2010). According to Talcott Parsons' notion of the sick role, illness is an

aversion from the normal, or the well, and therefore both biologically and socially deviant. The sick person however, is absolved from responsibility for their illness and from normal social role responsibilities for the period of the illness because they are assumed to desire normalcy (Bourgeault, 2010). This desire drives them to seek and adhere to treatment until such time that they become well. Within this paradigm there is the complimentary role of the healer who identifies, legitimizes, and treats the sick person. The medical practitioner's skill and the altruistic nature of the practice allows for a sanctioned authority and power differential that is not considered problematic (Bourgeault, 2010).

Structural functionalist theory is bound with the operational changes that were occurring in the field of medicine at the time. First, the notion of absolved responsibility for supposed deviance, as described by Bourgeault (2010), is consistent with the renewed humanitarian and subsequent treatment philosophy of the mentally disordered at the time and the resultant shifts in policy that focused on a raised standard of care for them (Sussman, 2003). Secondly, the 1950s marked the introduction of psychiatric epidemiology (Sands, 2001a). Biological studies began producing scientific research that supported the presence of brain differences in persons suffering from MI, specifically schizophrenia, bipolar disorder, and major depressions (Sands, 2001c). As a result, first generation psychotropic medications were developed and recognized for their usefulness in managing some of the symptoms of MI (Sands, 2001b). These advancements legitimized an organic basis for mental disorders and afforded the medical community the sanctioned power and authority that later became identified sociologically as an instrument of social control (Bourgeault, 2010).

In response to some of the identified weaknesses and gaps in structural functionalism, namely the inability of this theory to appropriately account for chronic medical conditions or

enduring disabilities and the vast variability in the observed behavior of patients and physicians, the 1960s brought about a new school of thought (Bourgeault, 2010). Symbolic Interactionism focused its attention on the meaning of social interactions and the subjective aspects of social experiences (Bourgeault, 2010). According to Bourgeault, Erving Goffman endorsed what became known as labelling theory to account for the behavior of both the sick and those who interact with them. Labelling theory posits that individuals who are labelled as ill come to identify as such; the label becomes the defining way in which they are treated by others objectively, which both reflects and reinforces their subjective experience of illness. Further to this, the individual's future behavior is vulnerable to being viewed and interpreted through the lens of their illness. Mental health patients adopt, what Goffman describes as, 'a patienthood' as their way of life which becomes impervious to change (Bourgeault, 2010).

During the 1960s the effect of pharmacological treatments, on both quality of life and functioning of institutionalized individuals with moderate to severe MI, could no longer be denied. Institutionalization, which had been the dominant intervention and management system for mentally disordered individuals for over a century (Durbin, Goering, Streiner, & Pink, 2006), was questioned and recovery from MI was considered possible (Sands, 2001a). Patienthood, as understood by symbolic interactionists, was the equivalent of what otherwise became known, by the medical community, as institutionalization. Both terms are used to describe the process of having one's own self-identity and image stripped and replaced with one that reflects the agenda of the large institution in which all aspects of life are controlled and pre-determined (Bourgeault, 2010). The recognition of this phenomenon, along with advancing pharmacological success, influenced the drive toward deinstitutionalization and

the subsequent movement toward community care that gained popularity during this time (Sands, 2001a).

The growth of advancements in psychiatric understanding and knowledge led to increased attention to diagnosis as well as establishing diagnostic criteria. According to the American Psychiatric Association Diagnostic Manual of Mental Disorders Fifth Edition (2013) diagnosis of MI continues to be rooted in reports of subjective experience and observation of behavior rather than biomedical evidence. The reliance on both objective and subjective social processes, for diagnosis, provided support for critics who suggested that it was inappropriate to medically label conditions for which there were no evidence of medical pathology (Sands, 2001a); despite previous research supporting the biomedical perspective, the debate over the medicalization of MI persisted.

Consistent with a focus on evidence and a growing criticism of the biomedical framing of MI and the practice of psychiatry, a new theoretical paradigm emerged. Social constructionism questions the acquisition of knowledge and suggests that knowledge itself is produced by individuals and then oriented toward specific issues or problems (Bourgeault, 2010). According to Bourgeault, medical sociology was particularly invested in this perspective, perhaps due to the intense restructuring of the health and mental health systems at the time which included the pending end to the institutionalization that had dominated the previous one hundred years (Feldberg, Vipond, & Bryant, 2010). The social construction of illness perspective asserts that disease, as a label, is socially constructed and assigned to specific states and that this process serves to reinforce existing social structures essentially recognizing “medicine as an institution of social control” (Zola as cited in Bouregault, 2010, p. 45).

The social constructionist paradigm took hold and paralleled the deinstitutionalization movement (Bourgeault, 2010). Changes in Canada's mental health legislation in the 1970s focused on protecting the rights of those who had been involuntarily institutionalized and decreasing the number of people involuntarily confined and treated (Cotton & Coleman, 2010). This movement criticized the separation of individuals from their families and communities and subscribed to psychosocial based models of care that focused on environments and the social processes that are associated with MI (Sealy, 2012). This fueled the ongoing debate between social constructionists and the medical community; the medicalization of social processes continues to be at the forefront of sociological study today (Bourgeault, 2010).

Post-modern theorists continue to rely on the experience of subjectivism and multiple truths; they subscribe to an understanding of MI as a social construct that permits the use of medicalization to assert social control (Bouregault, 2010). This social constructionist perspective criticizes medical model assessment, diagnosis, and treatment and has become increasingly aligned with strength based models of MI intervention (Taylor, 2006). Paradoxically, as the medical model of understanding MI emerged and provided the thrust toward deinstitutionalization and the movement to community care for individuals, it has increasingly relied on psychosocial interventions which are also aligned with strengths based philosophy (Sands, 2001c). While strengths based approaches that recognize and promote individual rights and capacities have become increasingly utilized in mental health practice, the paradigm from which these approaches stem is not easily discernable yet is arguably instrumental in how these approaches are developed, delivered, and received (Taylor, 2006).

There are two distinct and competing paradigms whose interaction could either weaken or strengthen efficacious mental health treatment and mental health crisis response today (Taylor, 2006). The medical model of understanding MI is supported by evidence and although psychopharmacological interventions have been proven highly effective they do little to address the social factors and forces that influence the development, presentation, and progression of MI as well as the recovery of those affected (Bowers, 2000). The prevailing paradigms of social constructionism and post-modernism recognize these social and structural forces through the utilization of labelling and deviancy theories that confront labelling effects, stigma, and inequity (Taylor, 2006). Unfortunately, these perspectives are also aligned with critics who discredit biology indirectly through exclusion and directly by framing MI as an expression of unchecked emotion, deep unhappiness, and negative self-talk, or worse as a learned state of mind or a personal choice (Taylor , 2006). Both the medical model and the social constructionist model strive for response modalities that recognize individual rights, freedoms, and choice which reflect strengths based philosophy (Bowers, 2000); however, strengths based approaches based solely in either model, dismissing the influence of biology or the impact of social context, threaten to inadvertently place responsibility for MI directly onto the individual (Taylor, 2006).

Theory guiding Interventions

The Canadian Mental Health Association strives to increase understanding of MI as both biologically and socially influenced. CMHA-PG is grounded in a value system which reflects respectful, inclusive, client centered care that strives for proactive rather than reactive service provision. The organization relies on a strengths based perspective that acknowledges the biopsychosocial nature of MI, the impact of structural inequity, and the capacity for

recovery from mental illness (MI). These values underlie a mission statement that promotes "mentally healthy people in a healthy society" (http://www.princegeorge.cmha.bc.ca) and guides the delivery of services in a way that supports individuals' resiliency and recovery.

Recovery focused perspectives have led to the examination of common service delivery practice and challenged long held beliefs of both professionals and the public, including beliefs around the capacity of individuals to manage their mental health and increase their quality of life (Kidd et al., 2011). Recovery oriented practice places the individual first and embraces their full participation in their care; recovery plans focus on renewed hope and commitment to wellness while encouraging the individual to redefine themselves, acknowledge their illness, and manage the symptoms. Individuals are assumed capable of being involved in meaningful activity, exercising their citizenship, overcoming effects of discrimination, and being supported by others (Kidd et al., 2011). CMHA-PG articulates a vision that involves: the provision of individual services that are received in the spirit of dignity and that support caregivers, families, and natural support systems; advocacy for the fair allocation of resources within public policy that serve to reduce the stigma associated with MI; and creating communities that seek to strive for experiences of equity and that value both physical and mental health and wellness (http://www.princegeorge.cmha.bc.ca).

Theoretical Synthesis

Attempts at understanding and evaluating current responses to individuals experiencing a mental health crisis demand recognizing which philosophy or paradigm first responders are operating from. Kerson, McCoyd, and Chimchirian (2005) describe what they identify as an "ecological reinterpretation and enrichment of social work practice in health

and mental health systems" (p. 23) as boundary spanning. While boundary spanning acknowledges the value of an ecological perspective, it moves beyond applying it to the relationship between individuals and environments to applying it in a broader context. It relies on principles of systems theory to rationalize the relationship between and amongst macro, mezzo, and micro systems in terms of both influence and resistance to change (Kerson et al., 2005). Utilizing this framework, an analysis of the crisis interactions between individuals with MI and first responder's moves beyond the actions or capacities of the individuals involved. It requires an evaluation of individual's responses in the context of the organization they represent, of the organization in the context of funding and delegation, of funding and delegation in the context of policy and law, and policy and law in the context of national and international interests (Kerson, et al., 2005).

As a structural social worker practicing in the field of mental health I recognize the impact of environmental inequity and acknowledge the legitimacy of neurobiology; I choose to consolidate this understanding through a bioecological perspective. Taylor (2006) describes bioecological practice as one that relies on an expanded understanding of biological influence to include external entities such as pollutants and culturally influenced experiences and an expanded understanding of the social context to include the interaction between one's environment and their development. From this perspective "human behavior can seldom be understood from a single theoretical framework" (Taylor, 2006, p. 4). From this perspective effective assessments of social interaction rely on an understanding of exchanges at and between micro, mezzo, and macro system levels. (Taylor, 2006). The opportunity to integrate my theoretical knowledge into my practical learning, through direct observation, consultation, collaboration, and participation was invaluable in understanding the systemic

challenges to initiating meaningful change in the interactions between first responders and persons with MI.

Summary

My practicum learning experience allowed for an opportunity to explore how the BC: MHPP, MHCRT, and CIT training are experienced within the community of Prince George and outlying regions covered by CMHA-PG. The learning that occurred was interpreted through a social work lens that recognizes the influence of structural power and authority and utilizes a systems approach to make sense of how the criminal justice system and health system navigate the shared responsibility for improving crisis response to individuals with MI. This interpretation along with an enriched literature review comprises a learning experience and final practicum report that provides social work with a broader scope of understanding and a greater intervention and response latitude for supporting individuals, families, communities, and organizations within the mental health field.

CHAPTER TWO: LITERATURE REVIEW

The writings examined and included in the literature review are consistent with the topic of crisis response to individuals with moderate to severe mental illness (MI). They were chosen from the large amount of recent material available that examines the subject area through the disciplines of law, psychiatry, nursing, and social work as well as research specific to mental health, police practice, and community development. The literature consistently identifies policing authorities as first responders to persons with MI who are experiencing a mental health crisis in the community and explores the nature of their preparedness and capacity in doing so.

Cotton and Coleman (2010) refer to the inevitable confluence of the mental health system and criminal justice system that was created by the deinstitutionalization movement; they suggest a systems approach to understanding these independent systems as subsystems of a larger social service system that requires shifting. Deinstitutionalization as a catalyst to the pending criminalization of MI is further identified and examined in much of the literature prompting an analysis of the intersecting and influencing nature of both the mental health and criminal justice systems. The amount of literature available allowed for an analysis specific to a Canadian context. It reveals a focused attention directed at resolving this dilemma and developing models of crisis response that reflect person centered service that rely on the cooperation of and collaboration between mental health, policing, and the communities within which they operate.

Police as First Responders

The deinstitutionalization movement, which meant to replace inpatient psychiatric care with community based care, has resulted in an unintended gap in services for individuals

with moderate to severe MI. Current outpatient services have not equaled previous inpatient services and those that do exist remain fragmented with limited ability to meet the needs of persons with MI and in particular those in crisis (Adelman, 2003). Consequently, nearly one third of persons with serious MI come into contact with police during their first attempt at accessing crisis mental health support (Adelman, 2003). The realities of structural issues such as inadequate social assistance rates and lack of affordable housing were not anticipated nor well planned for and have exacerbated difficult circumstances for persons with MI who are at increased risk of experiencing poverty and homelessness (Parent, 2011). The resulting marginalization increases the likelihood of involvement with the criminal justice system through increased police interaction (Stanyon, Goodman, & Whitehouse, 2014).

Simultaneously, changes in law enforcement practice consistent with contemporary models of community policing have emerged. Traditional policing was reactive and grounded in an emphasis on rules and procedures, a tendency to use force, and a devaluing of attention to non-criminal matters (Adelman, 2003). Contemporary community policing is proactive and relies on principles such as client centered service, collaboration and consultation with community, fairness, equity, and outcome focus (Cotton & Coleman, 2010). This philosophical shift demands that police officers respond to the public as collaborative problem-solvers while maintaining the traditional role of ensuring safety, providing protection, and enforcing the law. At the same time changes in mental health services, a rise in homelessness, and the growing availability of illicit drugs have culminated in increased incidents of disturbed behavior and potential violence on the streets (Parent, 2011).

There has been a marked increase in attention to the interactions between persons exhibiting disturbed behavior and the police who respond to them and growing concern about the effects of them (FirstHand, 2016). This has prompted the utilization of inquests and inquires meant to better understand these exchanges. In 2011 the Mental Health Commission of Canada supported the first large scale Canadian study meant to explore the nature of these interactions (Stanyon et al., 2014). It found that three out of every ten people with MI had come into contact with the police; two out of five people with MI had been arrested; and persons with MI were overrepresented in both lethal and non-lethal interactions involving police weapons (Stanyon et al., 2014). Similar findings are reported in American literature which indicates that ten percent of police calls involve emotionally disturbed behavior specifically associated with MI (Watson & Fulambarker, 2012). These interactions are vulnerable to the effects of media sensationalization that reinforces unsubstantiated beliefs that persons with MI are inherently dangerous which in turn influences both the public's perception and police response. The reality is that these interactions can have devastating effects for individuals, families, communities, and the police (FirstHand, 2016).

Challenges for police as first responders

The shift to contemporary policing models, that stress community involvement and focus on immediate and collaborative problem solving, places police officers in a position for which they have not been adequately trained or prepared. Research indicates that police have about the same level of knowledge regarding MI, including similar negative understandings, as the general public (Bonfine, Ritter, & Munetz, 2014). Although basic police training does include components on working with individuals who have a MI, this training is neither consistent nor comprehensive (Cotton & Coleman, 2010). This specialized instruction, which

is generally delivered in a lecture format, ranges from one to twenty four hours with the average involving less than ten hours (Stanyon et al., 2014). Despite this, police in the role of first responders are tasked with triaging at the crisis scene and quickly determining if the cause of an individual's behavior is psychiatric or criminal (Bonfine et al., 2014). Police report a lack of knowledge, skill, and understanding of MI that compromises their confidence in being able to achieve this (Adelman, 2003).

There are complicating risk factors involved with crisis response. An individual experiencing a mental health crisis often appears aggressive and dangerous (Parent, 2011). Public perceptions that reflect this belief influence both the report to police as well as response by them (Bonfine et al., 2014). The requirement that the response and subsequent problem solving be swift and the lack of available collateral information elevates the risk of inaccurate assessment and compromises the understanding of other factors that may be relevant (Parent, 2011). These ambiguous conditions, along with an erroneous presumption of normalcy on the part of responding police officers, can combine and culminate in deadly or disastrous encounters (FirstHand, 2016). An inquiry into thirty specific incidents involving police deadly force in British Columbia revealed that twenty five percent of the individuals involved had an MI (Parent, 2011).

Police report feeling conflicted as they are both obliged to assist individuals experiencing a mental health crisis while also obligated to protect them as well as society from potential harm (Cotton & Coleman, 2010). The individual discretion in response regarding whether to arrest, warn, or do nothing can lead to arrests based on the belief that mental health services are not accessible and the protection of both the individual and society is best served by the arrest (Cotton & Coleman, 2010). This response leads to the

criminalization of MI and has resulted in a prison population where almost fifteen percent of males and thirty one percent of females have an MI (Watson & Fulambarker, 2012). It is estimated that between 15 and 40 percent of those involved with the criminal justice system have an untreated MI (Adelman, 2003).

Police involvement with MI in the community is often viewed as a failure of the mental health system, this exemption of police responsibility reinforces a sense of ambivalence felt by police officers (Cotton & Coleman, 2010). While the frustration over unresponsive mental health service providers persists, 80 percent of officers today agree that first response to mental health crisis is within their role (Cotton & Coleman, 2010). Unfortunately, the hierarchical structure of the police can threaten effective collaboration with both mental health services and the community (Bonfine et al., 2014). Despite reoccurring intersections between police and mental health service providers, relationships between the two are often fractured by a misunderstanding of roles and lack of resources that neither have control over (Watson & Fulambarker, 2012).

The negative effects of this can be felt by individuals, families, and communities, as well as the police. Unprepared, unsupported, under-skilled, and under resourced police response leads to long delays in access to appropriate and effective service, as well as risk for additional trauma, violence, and criminalization for individuals (Adelman, 2003). Interactions that evolve into incidents of harm have prolonged effects for police as well. These include immediate stress and long term physical, emotional, and psychological distress for officers, even in the event that they are exonerated of any wrong doing (Adelman, 2003). Despite this, recipients of crisis response who have been asked about their experiences describe negative and positive experiences with both police and mental health service

providers. They report that these interactions are heavily influenced by the responder's use of effective communication, expression of empathy, and display of authentic concern (Boscarato et al., 2014). The increased attention to problematic interactions between police and individuals with MI has led to the development of models of crisis response meant to bridge the gap in mental health services and stop the criminalization of MI (Watson & Fulambarker, 2012).

The Development of Crisis Response Models

The development of mental health crisis response models relies on the use of systems theory to account for how changes in the mental health system have been realized within the criminal justice system, specifically policing (Cotton & Coleman, 2010). Diversion from the criminal justice system requires the development of mechanisms for accurate on site assessment and disposition, training and tools for dispatch and communication personnel, and specialized crisis response locations other than hospital or jail (Cotton & Coleman, 2010). The perspectives of the police, who act as first responders, are integral in developing efficacious models for increasing their capacity to respond. Current best practice models involve active officer training and practice, not just passive learning, in working with persons with MI (Stanyon et al., 2014). Interactive, practical, and applied training techniques, or simulation, are shown to improve psycho motor skill, enhance retention of knowledge, enhance immediate decision making ability, and increase confidence. They provide an option for immediate feedback, practice, and reinforcement with minimal risk (Stanyon et al., 2014). This perspective is consistent with the belief that a personal familiarity with MI reduces negative views and increases positive views providing support for the development of models involving designated police units that allow specific officers to regularly experience

interactions involving MI and subsequently increase their understanding, confidence, and skill (Bonfine et al., 2014).

The experiences of crisis response interactions by individuals with MI are equally important to understand. While little research has been undertaken in this area in North America, a small scale qualitative study conducted in Australia provides a preliminary look at these experiences (Boscarta et al., 2014). The study was designed to evaluate the components of joint responses involving professionals from both the mental health field and policing. Three pilot project models were utilized in the research; two were based directly in the police force and one was based within mental health services. The police led initiatives involved the use of a specialized Crisis Intervention Team (CIT) model with designated officers and alternately an embedded model involving the employment of mental health professionals, known as civilian officers, directly by the police force. The mental health based initiative was a Ride-Along Model that involved outreach teams made up of a mental health practitioner and a police officer. All of these initiatives are used in North America and considered best practice models (Adelman, 2003).

The responses of the participants revealed negative perceptions of all single resource crisis response including those specifically designed to meet the needs of individuals experiencing a mental health crisis (Boscarato et al., 2014). Five distinct themes emerged as integral to effective crisis intervention and support. *Response speed* as a main theme was described as including both initial response as well as the time taken to identify the crisis as one based in MI and subsequently access the appropriate resource or care. Participants suggested that the longer it took for the responding officers to connect with mental health professionals the greater the escalation of the crisis. An equally important emphasis was

placed on the theme of *humane treatment* which was described as interaction that involved respect for dignity and autonomy as well as listening without judgment. While participants specifically noted that mental health teams provided a level of normalization to their experience that eased their distress, they acknowledged that individual police officers also had the capacity for this effect. Both *threat* and *over reaction of police* were identified as distinct themes and they are both based in the inherent authority of the police that is reinforced by their uniforms, access to weapons, and as a result of prior exchanges involving rough non-lethal force. Lastly, and most importantly the theme of *disjointed response* was discussed. Participants felt that response by supposed dual teams was still so compartmentalized and disorganized that they were subjected to further frustration, chaos, and alienation (Boscarato et al., 2014).

Models of Mental Health Crisis Response

There are specific influences that result in a unique Canadian context. First, the changes in Canada's mental health policy that began in the 1970s and were followed by a National Senate report that "promotes a balanced approach to institutional and community based mental health services" (Sealy, 2012, p.230) are not yet fully realized. The realization of them continues to be threatened by the competing philosophies that drive inpatient and outpatient services (Kidd et al., 2014) and which underlie specific professional practice frameworks and values (Park, Lencucha, Mattingly, Zafran, & Kirmayer, 2015). Secondly, while a National Mental Health Strategy was finally articulated in 2012, the implementation of practices that support this strategy are not yet mandated (Goldbloom, 2012). This process is threatened by the regionalization of authority for their development and delivery that occurs with both healthcare and justice policy (Latimer, 2005). Lastly, Canada is unique in

its geographic and demographic makeup and issues related to geography, climate, population distribution, ethnic diversity, and cultural history indirectly impact persons with MI and their interactions with policing authorities (Cotton & Coleman, 2010). Cotton and Coleman (2010) report that Canadians with MI have over three times as many contacts with police as the general population and are twice as likely to have succeeding interactions. When these interactions result in arrest, persons with MI are more likely to be incarcerated and are more likely to be flagged in the system as dangerous and violent without respect for context (Cotton & Coleman, 2010).

With this in mind the models utilized in Canada fall within two categories, those that are based in the authority of policing and those based in the authority of the mental health system. The emerging approaches and responses acknowledge and attempt to account for system shifts that must occur as a result of changes in Canadian mental health services (Grant & Westhues, 2011). The most predominant model currently relied on involves the use of a mental health mobile crisis team (Cotton & Coleman, 2010). There are many variations of this model and while all involve collaboration with the local police force, the teams are generally developed within the health system (Adelman, 2003). These teams are comprised of health professionals such as psychiatric nurses, social workers, and mental health practitioners in addition to a police officer. While the design of these teams varies, the goals are the same. They are meant to provide a quick response with both the safety afforded by the police and the knowledge afforded by the mental health professional (Cotton & Coleman, 2010).

Variations of this approach include those where the police and mental health practitioner travel in a single unmarked police car, such as in the Car 87 project which

originated in Vancouver British Columbia and has since been utilized in several other cities throughout Canada (Adelman, 2003) including Prince George where the Car 60 program has been in operation since 2015 (CKPG News, 2016). Other variations involve teams co-responding in separate vehicles and then determining the need on scene with either the mental health team or police assuming control and the other providing support. Some of these teams have connected or joint dispatch systems and others have protocols set out for communication between the parties (Cotton & Coleman, 2010). The benefits of these approaches include quick response time, safety, and service that is informed about MI. In many cases the team is known by the individuals and ideally, the mental health practitioner has the ability to seamlessly link or transition the individual to the appropriate follow up or wrap around service (Cotton & Coleman, 2010). These approaches however, are challenged by limitations in availability, in terms of capacity to attend to more than one call at a time (Adelman, 2003), by the lack of appropriate holding or assessment centers which can result in persons being held in jail and further traumatized and criminalized (James, 2008), and by a lack of coordinated and integrated mental health services in general (Kirst, et al., 2015).

Many police departments have developed internal initiatives to meet the increased demands for crisis interactions with emotionally or behaviorally disturbed individuals. The designation of specific officers for individual case management and/or liaison between the mental health and correction systems is effective when the community size allows for identification of individuals with MI as frequent service users (Cotton & Coleman, 2010). Recruiting and directly employing mental health professionals as civilian officers, while proven to be expensive, can ensure the availability of staff experienced in issues related to MI (Adelman, 2003). An equally expensive alternative is the utilization of a comprehensive

advanced police response, which is achieved by ensuring all officers receive advanced mental health training (Cotton & Coleman, 2010). Finally, the most widely and successfully used strategy, not only in Canada but around the world is the implementation of Crisis Intervention Team (CIT) training (Cotton & Coleman, 2010).

Crisis Intervention Team (CIT) Training

While CIT training is not yet designated as an evidence-based practice, it is considered a best practice model approach around the world (Watson & Fulambarker, 2012). It is noted to be the most readily accepted and adopted training approach utilized by police organizations who have been historically impervious to change and resistant to easily adopting new programs and initiatives (Morabito, Watson, & Draine, 2013). As with most major organizational changes, the thrust toward development of this model arose out of the attention to a critical incident of harm between police and an individual with MI that occurred in Memphis USA in 1988. The community collaboration that followed identified a high level of frustration and mistrust between the police force, the mental health system, and individuals with MI as well as their families (Watson & Fulambarker, 2012). The primary goals of the program are to provide training to those acting in the role of first responders to a mental health crisis, that addresses issues of safety and diverts individuals from a criminal justice response to a health based response (Watson & Fulambarker, 2012). The impetus however is not to provide abstract education and training rather to facilitate structural shifts by changing understanding, attitudes, and subsequently behavior (Watson & Fulambarker, 2012).

The original CIT training was designed to increase the capacity of first responders to identify and recognize the signs and symptoms present in a person with MI, gain a working

knowledge of psychiatric treatment protocols, appreciate the complexities inherent to co-occurring disorders, develop a confident understanding of the legal requirements associated with individual rights and apprehension, and develop advanced skills in verbal de-escalation (Watson & Fulambarker, 2012). As CIT training has become increasingly recognized as a best practice, it has evolved to include components specific to persons with developmental disability and aging issues, trauma and excited delirium effects, individual and family perspectives, as well as community resource access and availability (Watson & Fulambarker, 2012). It relies on a standard forty hours of training (Watson & Fulambarker, 2012) and is particularly valuable, in its flexibility, to be structured or organized to meet the specific needs of the communities and by the communities in which it is being utilized (Bonfine, Ritter, & Munetz, 2014). Coleman and Cotton (2014) recognize the enhanced CIT training developments occurring in the Province of British Columbia (BC) through collaboration of the Canadian Mental Health Association BC Division and RCMP E Division which strive to extend this training to emergency dispatchers, hospital emergency room attendants, and corrections, parole, and probation officers.

There are two distinct principles upon which CIT training rests. The first is a belief that not all officers are well suited to adopting the philosophy that underlies the CIT training model and therefore relies on volunteerism to identify those that are (Watson & Fulambarker, 2012). The CIT training model utilizes screening procedures, for individual personality cohesiveness with the program, seeking officers with the characteristics most suited to the unique nature of crisis work (Bonfine et al., 2014). These personal characteristics are identified as a high level of self-awareness and ability to maintain self-control, quick mental reflexes, creativity and flexibility, resiliency, objectivity, and optimism (James, 2008). It is

suggested that a minimum of twenty-five percent of a force's officers be designated as CIT trained in order to achieve a twenty four hour, seven day a week, response ability; it emphasizes however that quality of training is more critical than quantity (Watson & Fulambarker, 2012). The second integral principle is a belief in the value of collaboration. This is a collaboration that moves beyond the mental health and justice systems to validate, include, and conceptualize the community concerns and perspectives in the training as well and to make that collaboration a fluid process with ongoing evaluation (Bonfine et al., 2014).

Research suggests that CIT training improves intervention outcomes for individuals with MI who are experiencing a crisis, the police who act as first responders to them, the public, and most importantly it appears to lead to a greater sense of community cohesion (Bonfine et al., 2014). While preliminary data cannot yet be generalized, due to challenges associated with accurately tracking encounters and outcomes, it does suggest a correlation between CIT training and successful diversion from the criminal justice system (Watson & Fulambarker, 2012). Canada, Angell, and Watson (2012) point out that initial encounters between individuals with MI in crisis and first responders have significant influence on if and how individuals go on to engage with and utilize mental health services. CIT trained officers appear to possess a broader understanding of crisis behaviors, a wider skill set in exploring problems, and more flexibility in identifying solutions (Canada et al., 2012). Most importantly, it appears that the quality of interaction between police and persons with MI, as well as the general public, are greatly enhanced by CIT training (Bonfine et al., 2014).

Officers with CIT training are more likely to make referrals to the mental health system and more inclined to problem solve and seek resource alternatives; this inclination increases proportionally with increases in resource accessibility (Bonfine et al., 2014). While

the overall success of CIT training appears to increase along with increases in available mental health resources (Canada, Angell, & Watson, 2010) officers' satisfaction with the training as capacity enhancing was not diminished in low resource areas (Morabito, Watson, & Draine, 2013). These officers also use less force and rely less on subduing weapons or tools so interactions are less harmful (Bonfine et al., 2014) and departments report a lower use of high intensity response mechanisms and SWAT teams (Watson & Fulambarker, 2012). Further to this, research in the area of officer perceptions reveals a marked increase in individual confidence as well as belief in the department's capacity which results in reduced apathy and ambivalence (Watson & Fulambarker, 2012). Police report that they are better able to ensure safety for themselves as well as the public (Watson & Fulambarker, 2012), have a greater recognition of the power of their presence as an authority, and have a greater ability to slow down interactions and engage in active listening. This is contrary to the command and control response that has been relied on in the past (Bonfine et al., 2014). Finally, officers report that the training has enhanced their performance overall, that they regularly utilize the tools and techniques in all their interactions, and that the philosophy is supported by and reinforced within the department. This suggests that CIT has the capacity to reshape interpretations of police and lead to communities that seek a police presence (Bonfine et al., 2014).

CIT training is not without criticism. Some of the crucial components have been found difficult to implement which threaten to significantly compromise the integrity of the program. Central or shared dispatch systems, which are informed through CIT training, are not commonly achieved (Watson & Fulambarker, 2012). Information transmission systems serve as the impetus for responsible effective coordination of the appropriate responders,

without this, interactions that rely on quick fluid response, are threatened (Parent, 2011). Designated assessment centers or sites that facilitate the transfer of individuals from police custody to the appropriate health based resource are also not easily achievable and currently exist in less than thirty percent of established CIT training programs (Watson & Fulambarker, 2012). The absence of this component increases the risk of both continued criminalization and heightened crisis, as apprehended individuals are held in police cells awaiting service coordination. Remediation of this requires additional collaboration with acute care resources, which are generally separated from mental health services, or mutually and informally agreed upon memorandums of understanding between local police and mental health service providers (Watson & Fulambarker, 2012). Lastly, some critics of CIT training suggest that forty hours of training is grossly insufficient to enact any real system change (Boscarato et al., 2014).

Despite these challenges and acknowledging the lack of current research, CIT training is emerging as a valid response to the current issues surrounding interactions between first responders and individuals experiencing a mental health crisis. Individuals with MI who have experienced interactions with CIT trained police believe that it does lead to attitude and understanding shifts (Watson & Fulambarker, 2012) and it has been associated with increases in police competency specifically related to symptomology and de-escalation skills (Boscarato et al., 2014).

Summary of Literature Review

The common features of Canadian response models include community-based liaison committees that involve key stakeholders such as: mental health practitioners, police, firefighter and ambulance paramedics, housing agencies, representatives of the criminal

justice system, and most importantly individuals with MI and their informal supports (Cotton & Coleman, 2010). Despite wide recognition of the need for specialized responses, at the turn of the century only 42 of the 350 police services in Canada had any specialized strategies in place (Cotton & Coleman, 2010). In 2007 the mental health commission of Canada advised that the development of a national strategy to address the convergence between mental health and the law was a top priority. Despite this, as of 2010 the proportion of calls related to mental health but still being diverted directly to police is as high as 49 percent in some areas of Canada (Cotton & Coleman, 2010). While Canada's mental health strategy reflects recovery philosophy, practices in the field of mental health reflect a recovery philosophy that remains incomplete and requires system shifts in all entities (Grant & Westhues, 2011).

Although individuals with MI who have been given a voice report that they would not initiate a police response to their crisis (Boscarato et al., 2014), research indicates that specialized and comprehensive training does increase the capacity of police officers to meet the needs specifically cited by them. These needs include quick response, humane treatment, and a reduction of threat and force (Boscarato et al., 2014). At the same time, this training facilitates the necessary structural shifts within the police force itself (Cotton & Coleman 2010). Where approaches that advocate for comprehensive mental health training for all officers are considered too expensive, CIT training is emerging as a viable alternative. Initial evaluations of the CIT training approach indicate that it improves individual police officers confidence and capacity and creates a culture of optimism within police organizations that utilize it (Bonfine et al., 2014). CIT trained officers are better able to meet the crisis needs of individuals with MI, have better results aligning individuals with the appropriate mental

health services, and utilize these skills more often in interactions with the public (Boscarato et al, 2014). These results are consistent with contemporary policing philosophy and objectives suggesting that CIT training has the potential to improve relationships and lead to more cohesive communities where perceptions of individuals experiencing a mental health crisis begin to shift.

CHAPTER THREE: THE PRACTICUM LEARNING EXPERIENCE

This chapter describes my practicum learning goals and the activities that guided my learning experience. It offers a discussion about the development of my skills in the area of community development and organizational social work and the enhancement of my skills in clinical social work and case management. It outlines the knowledge I gained from the perspective of the questions that guided my learning, in relation to that acquired through the literature review, and in the context of social work in the field of mental health.

Learning Goals and Questions Guiding Practicum Placement

I completed a 560 hour practicum placement at the Prince George branch of the Canadian Mental Health Association (CMHA-PG). My learning experience was supervised by professionals in a variety of disciplines relevant to and reflective of social work in the field of mental health; they included recreational therapy, counselling education, and social work. The main purpose and central objective of the practicum placement was to gain an understanding of how police and other community professionals, who act as first responders in Prince George and other regions covered by CMHA-PG, are prepared to meet the needs of individuals who are experiencing a mental health crisis.

The practicum involved meeting the following learning goals: (1) gain a comprehensive knowledge of the education and training offered to first responders in the community and an understanding of how these initiatives were realized, (2) identify the first responders and relevant community partners and explore how they experience the training available to them, (3) evaluate the need for, and identify components of, additional or enhanced training while exploring future directions for the ongoing work of the Mental Health and Police Project (MHPP) Committee. This analysis was guided by several distinct

questions: What is Crisis Intervention Team (CIT) training and how is CMHA-PG utilizing this model to facilitate greater understanding of mental illness (MI) and support the increased capacity of first responders? Who are the community professionals and first responders accessing this training and how is it experienced by them? What are the needs for supplemental or enhanced training and how can this training be tailored to meet the unique needs of the region served by CMHA-PG?

Community Development and Organizational Social Work

I was involved in a number of activities that served to increase my understanding of, and level of skill in, community development and organizational social work. Community development and organizational social work are realized through interventions at multiple structural levels. The activities that I engaged in and the learning acquired is presented within this framework and consistent with the principles of systems theory and an ecological perspective that recognizes the reciprocal relationship between individual agency or organizational interventions, collective community movements, and larger societal or structural change (Kerson et al., 2005).

Micro Level Interventions: The Agency

In an effort to fully and completely engage in an analysis of the training offered by CMHA-PG, it was necessary for me to gain a competent knowledge of how the need for these trainings was identified and how the agency worked to develop them. This coordination of activities meant to achieve the agency's goals is a key component of organizational social work (www.facetsofsocialwork). I spent a significant amount of time exploring the history, philosophy, and vast scope of practices that form CMHA-PG, with a specific focus on those

that are aligned with the goals of increasing awareness, reducing stigma, and providing advocacy. I gained a valuable understanding of the agency philosophy, vision, and mandate; I increased my awareness of the agency's historical and current presence in the community, and I gained an excellent knowledge of the organizational framework, programs, and services that strive to meet the agency goals. I was able to illustrate this learning through the development of flow charts outlining the current and proposed future CMHA-PG framework and the position of the project that I worked on within it.

My review of the literature and in particular the *Study in Blue And Grey* by Judith Adelman (2003), which prompted the development of the Building Capacities: Mental Health and Police Project at a provincial level, resulted in a meaningful understanding of how CMHA at a local level, provincial level, and national level work together to achieve a national vision while meeting local needs. I have an enhanced appreciation of local and provincial CMHA mandates for service provision that are specifically aligned with advocacy, equity, social responsibility, and justice. I experienced a renewed belief in the capacity for local chapters of national organizations to compel systemic change through innovative responses and unique solutions to global challenges as the BC chapters of CMHA have done and are recognized for in the literature (Coleman & Cotton, 2014).

I collected, reviewed, organized, and itemized all the literature utilized in the development of the MHPP Committee in Prince George; I documented my learning in a visual timeline that outlined this process which spanned from 2006 to 2015. I was able to develop an excellent understanding of how non-profit social service organizations seek out and apply for project funding which is another key component of community development and organizational social work (www.facetsofsocialwork). I learned that the process of

seeking, identifying, and engaging in funding proposal writing creates competition amongst, while demanding collaboration between, community organizations. This process has the potential to threaten or compromise the meaningful professional relationships and collective community work that is necessary for the success of the interventions sought. My learning extends to an awareness of how funding compositions in general have an influence on all levels of service development and delivery and the importance of this awareness when evaluating professional relationships, partnerships, and interventions that communities collectively engage in.

Working within the agency and on this project I was pleased to participate in daily operations that reflected the overarching philosophy of the organization. I worked alongside paid staff, volunteers, students, and service recipients and I observed a respectful and supportive belief in the value of collaboration between them and in the value of our collective expertise and contributions; this renewed my belief in human service facility. The organization of the immense amount of material utilized in this project and the documents I developed for the general use of the agency, allowed me to serve both the interests of the agency and those of the committee as they move forward in their work with the community.

Mezzo Level Interventions: The Community

My practicum placement experience facilitated learning in four distinct aspects of community development work identified as: (1) building and fostering community coalitions (2) supporting communities in defining social problems, (3) supporting communities in mobilizing for an identified cause, (4) supporting the planning, development, and evaluation of new programs meant to meet the needs of people and organizations in the community (www.facetsofsocialwork).

Through regular attendance and participation in the MHPP Committee meetings I was able to identify and build relationships with current committee members and key community stakeholders that would prove to be invaluable in producing meaningful and genuine project outcomes. I strengthened my professional communication skills through my exploratory discussions with these community members and I developed an enthusiastic interest in the process of boundary spanning as a means of understanding individual service providers in the context of the organization they represent, organizations in the context of their regulatory parameters, and that regulation in the context of larger social philosophy and policy. The direct evaluative feedback I received reflects the coalition building skills I demonstrated as it was noted that I was successful in gaining valuable insight and information in a professional and approachable manner by displaying a willingness to listen, to seek input, and to respond positively to the suggestions I was provided.

I engaged in a thorough review of the documents related to the development of the MHPP Steering Committee, the community work this committee engaged in, the conclusions they drew, and the final report that reflected their findings. This final report, which was submitted and approved for funding, outlined the themes and recommendations that were specific to the community of Prince George and in the context of the larger provincial movement. I gained an excellent knowledge of the issues that led to the project both provincially and locally, and a comprehensive understanding of how local communities experience, identify, and define the direct effects of larger structural changes. The material review, alongside discussions with my direct supervisor and social work consultant, led to the development of the questions that guided my exploratory discussions with committee

members and community stakeholders. This process serves as an example of a community development activity meant to help identify community specific concerns.

I participated in the 2015 CIT training; the realization of this widely utilized program in Prince George reflects the successful mobilization of action toward improving crisis response to persons with MI. My participation in this forty hour training program allowed me to identify training participants and to become aware of the general level of expertise held by them; it supported my understanding of the materials used and my awareness of the professionals involved in this knowledge sharing event; it allowed me to experience the community collaboration necessary for the successful delivery of the training and the dissemination of learning from it. Reflection on this activity from the perspective of a participant and later as a practicum student researching it has strengthened my feelings around confronting societal apathy and working to induce structural change. I was able to experience the building of relationships and the reciprocal learning about participants professional roles, frameworks, and philosophies that is cited in the literature as integral to effective collaborative response to persons with MI in crisis (Kirst et al., 2015).

My practicum activities meant to consolidate six years of training participant feedback with current responses regarding the immediate, ongoing, and enduring impacts of the Mental Health Crisis Response Training (MHCRT) and CIT training for the participants, the agencies they represent, and the community in which they operate. They meant to explore the need for the development of additional training and to identify the components that might be recommended and to provide a synopsis of the community's experiences of the overall impact and future direction for the MHPP Committee in Prince George. This is the essence of planning, developing, and evaluating programs designed to meet the needs of individuals and

organizations and is a critical piece of community development work (www.facetsofsocialwork).

A large amount of time was spent reviewing, organizing, and itemizing materials associated with the development and ongoing work of the MHPP Committee and the development, delivery, and ongoing evaluation of the MHCRT and CIT training over the past eight years. This information was considered alongside the information I collected directly through discussions with and in the community. I gained first and foremost a keen understanding of the complexities involved in orchestrating a program review and I was provided a preliminary opportunity to engage in thematic analysis of information. The utilization of these skills are endorsed in my final evaluation that confirms the value of the work that I accomplished for the committee and toward their goal of improving crisis response capacity in the community. The overall result was an enhanced understanding of organizational community development activities involving the development, evaluation, and adaptation of interventions and an enhanced appreciation for establishing evidence based practices that can serve as a foundation for guiding and supporting them.

Macro Level Interventions: Society

Latimer (2005) highlights the need to recognize the influence of global, international, and national legislation on fragmented local healthcare and justice system delivery. The entirety of my learning experience at CMHA-PG provided me with an appreciation for the value of monitoring, analyzing, and evaluating public and social policies while advocating for the specific needs of a community. The culmination of my literature review, materials review during my practicum, interactions with supervising professionals, and engagements in and with the community of Prince George provided me with a comprehensive knowledge of

how larger social issues are realized and responded to in local communities. Cotton and Coleman (2010) suggest that the development of models to support efficacious crisis response to persons with MI relies on a systems theory interpretation to understand the shift in responsibility between systems. My experience provided me with a deeper appreciation for the complexities that underlie any significant shift in social policy and in particular for the time it takes to balance the pendulum of change from the institutionalization of MI to the community inclusion of persons with MI.

Clinical Social Work and Case Management

While the bulk of my activities served to support the development of my skills in community development and organizational social work; my learning also served to enhance the skills I currently possess in the area of clinical social work and case management practice. This learning will be directly realized in the following aspects of my future practice, they include: (1) providing access to, allocating, monitoring, and evaluating services and resources while providing appropriate referrals; (2) interfacing with other professionals and reducing the fragmentation of services; (3) engaging in a range of tasks that support and enhance the systems clients face; (4) and contributing to the development of social policy (www.facetsofsocialwork). My learning occurred both through the process of my practicum learning exploration and the final product of it.

The Process of Exploration

My clinical social work and case management practice has been enhanced by the process of my exploration into the work of the MHPP Committee through an increased awareness of how local non-profit agencies are linked with each other and with government

organizations. This linkage occurs through competitive funding practices and policies and paradoxically through shared interests and collective movements such as special interest committees. This understanding provides me with a more informed approach when making referrals and navigating the challenges associated with serving individuals involved with multiple service providers.

The MHPP Committee action plan, delivered in 2007 by CMHA-PG, cited specific challenges to improving crisis response to persons with MI. It recommended implementing standardized training and education protocols, improving community collaboration and collective movement toward reducing stigma and improving conditions for persons with MI, and expanding specialized mental health services. These recommendations are reflected in the literature as integral to improving the outcomes of interactions between persons with MI in crisis and the police who respond to them (Watson & Fulambarker, 2012). My work on this project, my research, my review of materials, and my discussions with community partners indicate that these components continue to need collective attention from individual professionals, agencies and organizations, and service users who can offer a variety of insights, experiences, and expertise.

I gained insight into the value of independent service providers remaining open and active in a variety of collective activities beyond those directed exclusively at individual clients and to accepting a shared responsibility for improving the system of services that clients face. I identified challenges in the community that are consistent with those in the literature that suggest professionals have low levels of understanding about other professional roles despite experiencing high levels of service intersection (Watson & Fulambarker, 2012). I approached this project with a belief in the desire of human service

providers, in the field of mental health, to facilitate recovery oriented practices in the spirit of community collaboration and despite the bureaucratic challenges; I learned that interfacing with other professionals responsibly requires first a knowledge of and second an acceptance and respect for the differences in professional philosophies, scopes, and service mandates that individual service providers represent.

The Product of Exploration

The conclusions I drew from the information collected are invaluable to my current clinical and case management practice involving persons with MI. The presentation of this learning occurred in the form of a final report for the use of the agency and a presentation to the members of the MHPP Committee. The report and presentation highlighted the themes that emerged through my discussions and alongside my review of training feedback evaluations from both MHCRT and CIT training. Discussions with community partners, committee members, and key stakeholders involved a variety of professionals from community agencies, uniformed responders from both the Royal Canadian Mounted Police (RCMP) and British Columbia Ambulance Service (BCAS), representatives from the health authority, and service users themselves. They responded to the following questions: What is your understanding of the issues that prompted the committee development in PG? What is your understanding of how the committee has worked to address these issues and how would you describe the value of that work? How would you describe the value of the committee's continued collaboration? Do you have any independent comments or observations that you feel would benefit the purpose of the project and inquiry?

I learned that while a general lack of knowledge and pervasive stigma about MI compromises effective crisis response for persons with MI, this lack of capacity is

exacerbated by mistrust and misunderstanding between and amongst service providers. Kirst et al. (2015) recognize role philosophy and professional culture differences as a significant threat to effective mental health crisis response. The discussions revealed that service providers themselves recognized a distinct lack of service provider cohesion that could otherwise lead to professionals being better equipped and supported in their service provision. This lack of cohesion within mental health services is directly observed by professionals, reported to them by the persons that they serve, and evidenced by their direct acknowledgement of historical blame assigning for service breakdowns. There was a consensus that the committee's work had resulted in significantly improved professional understanding, communication, and collaboration; it had facilitated increased knowledge of community services, resources, and professional roles, and it had subsequently improved experiences for persons with MI and with uniformed responders specifically, in the community.

Responses however also overwhelmingly reflected an ongoing need for improvements in relationships between service providers. Feedback from local service providers and key stakeholders reflected a lack of knowledge about other service provider's capacity, a lack of awareness about potential organizational challenges, and an absence of tolerance for perceived limitations. Fractured relationships between service providers is cited in the literature as an ongoing challenge that leads to negative consequences for not only individuals with MI but for service providers as well (Adleman, 2003). Despite a consistent acknowledgement that how a person with MI experiences independent services depends on the performance of the system as a whole, discussions revealed that ownership of intervention initiatives exists in a way that is not conducive to reducing the fragmentation of

services. This phenomena, perhaps sanctioned by funding compositions and power, requires individual professionals to boundary span beyond their discipline and the organization they represent. This boundary spanning is understood as the ability to locate and identify the boundaries that limit or restrict the capacities of partner organizations and our own, to assess the capacity to effectively navigate them, and to develop skills to bridge them in an effort to improve conditions at all levels of intervention (Kerson et al., 2005). In doing so we address the challenges associated with ongoing fragmentation that threatens collaborative responses and results in further negative consequences for individuals with MI (Boscarato et al., 2014).

A significant portion of my practicum activity focused specifically on the MHCRT and CIT training and was guided by the questions that reflected my learning goals. Interestingly, the work of the MHPP Committee itself was often aligned exclusively with the development and delivery of these two trainings. Community partners did not easily distinguish between the committee work and the training as the origin of the positive outcomes they identified; the outcomes were attributed to committee work and training interchangeably throughout my discussions.

I reviewed training feedback evaluations from both MHCRT and CIT training from 2009 to 2015. I examined the sylabus, outlines, and agendas as well as the participant logs. While I was not able to connect with the number of past participants I had hoped to or planned for, I was able to engage in discussions with representatives of the uniformed responders who consistently attended and participated in the trainings offered. The collection of information I received provided a large breadth of responses from which I drew my conclusions; these conclusions will positively impact my professional capacity in clinical social work and case management practice.

What is Crisis Intervention Team (CIT) Training and how is CMHA-PG utilizing this model to facilitate greater understanding of mental illness and support the increased capacity of first responders?

CIT training is a universally used best practice model developed to guide the interactions between police and persons experiencing a mental health crisis (Watson & Fulambarker, 2012). It is distinct from other models due to its unique structure that encompasses not only policing and health authority perspectives but those of the entire community in an effort to provide training that is reflective of that particular community's needs and reaches all first responders (Bonfine et al., 2014). It recognizes the shift in responsibility, for persons with MI, from the health system to the criminal justice system that has occurred as a result of deinstitutionalization and validates the need for police input into solutions (Stanyon et al., 2014). Preliminary evaluations of CIT training suggest it is successful in redirecting individuals with MI in crisis from criminal to health based responses (Watson & Fulambarker, 2012). The MHPP Committee recognized the capacity for this training to address the challenges associated with improving crisis response in the community, specifically those related to the need for standardized training and education protocols and the need for improved community collaboration and collective movement toward improving conditions for persons with MI. The committee was successful in obtaining the necessary resources and preliminary training supports to develop and subsequently deliver CIT training in the community of Prince George in 2009, 2011, 2013, and 2015.

A central guiding principle of CIT training philosophy is a belief in the value of community collaboration that moves beyond the health and justice systems and involves the

community (Bonfine et al., 2014). The MHPP Committee has emulated this guiding principle in the development and delivery of the CIT training in the community and the surrounding areas served by CMHA-PG. The committee strives to utilize local services and resources in the delivery of this training, it relies on the volunteerism of presenting professionals and organizing persons, and it depends on donations which include the donation of the training venue. It engages in comprehensive ongoing evaluation in an effort to ensure the continued relevance and success of the training and encourages the highest degree of community involvement. The MHPP Committee expanded on this principle by developing the MHCRT in response to recognized challenges associated with participants gaining employer support to attend the full forty hour CIT program. MHCRT is unique in that it was developed by the committee and is exclusively delivered in the region covered by CMHA-PG. Despite criticism that the MHCRT might reduce the integrity and possibly the success of CIT training by providing an easier alternative, it has proven to be both successful on its own and complimentary to the CIT training, it has been offered by CMHA-PG three times annually since 2009.

CIT training is designed to increase overall awareness of MI and the experiences of those living with MI; the success of this model relies on its flexibility to adapt to community specific challenges, needs, services, and resources (Watson & Fulambarker, 2012). The MHPP Committee has worked to ensure the training delivered in Prince George is relevant to the community through ongoing consultation. Topics specific to Prince George that have been introduced include Fetal Alcohol Spectrum Disorders, Aboriginal Understandings, Street Spirits Role Play, and a local Service User Panel. Not surprisingly, training participants consistently rated these topics as those that provided the highest level of

satisfaction. Consultation during the training and with the committee strives to monitor the level of participant satisfaction with current topics, seeks suggestions for future topics, and assess the level of engagement between participants and presenters.

My examination of the development and delivery of this training suggests that it has been structured and is experienced in ways that are consistent with those in the literature. Stanyon et al. (2014) talk about the high value typically attached to simulation and interactive training modalities. Responses from local CIT training participants place a high level of satisfaction on the opportunity to actively practice the skills that are being taught; they designated the highest satisfaction ratings consistently to the topics that incorporate role playing, active participation, and live interaction. CIT training participants specifically cite Street Spirits role play, crisis communication demonstrations, and interaction with the service user panel as particularly valuable. Responses from the MHCRT participants identified these same components as those that they desired to have more of.

Watson and Fulambarker (2012) recognize that CIT training facilitates police perceptions of an increased capacity to respond to persons with MI in crisis both more effectively and more empathetically. Bonfine et al (2014) points out that these police perceptions include an enhancement in their overall performance and a regular utilization of the specific tools and techniques learned, in all interactions with the public. Similar outcomes are recognized by the participants in the local delivery of MHCRT and CIT training. Responses identify the most valuable aspect of the training as the service user panel which is credited for bringing emotion back into the profession. Participants commented that this component offered an opportunity to seek direction from those who are directly affected by the services provided and that listening to their experiences and advice is the best way for

first responders to learn a better approach. The Service User Panel was identified as the most valuable component nearly twice as much as any other single component. A significant proportion of responses referenced the training's success as a tool that confronts stigma and poor attitudes and recommended future topics that reflect a desire for an increased understanding of marginalizing experiences associated with vulnerable populations, cultural perspectives, and legal involvements.

While the primary goal of CIT training is to increase the capacity of first responders to recognize mental health crises and respond appropriately, the overarching philosophy is to move beyond the delivery of abstract education and to motivate structural shifts through increased global understanding (Watson & Fulambaeker, 2012). This theme emerged throughout my discussions with local training participants. The filtration of knowledge and shift in thinking from individual participant to the organization they represent was described as a positive outcome. It led to a wider interest in, and acceptance of, shifts in attitude toward persons with MI and subsequently increased direct support for the individual responding to these crises. This outcome is consistent with that in the literature which suggests CIT training increases the ability of the individual responder and enhances the overall capacity of the organization they represent (Watson & Fulambarker, 2012).

Who are the community professionals and first responders accessing this training and how is it experienced by them?

Literature consistently identifies policing authorities as first responders to crisis involving persons with MI and reveals that one third of persons with MI come into contact with police during their first attempt at accessing mental health support (Adleman, 2003). Police acknowledge the shift in health and criminal justice philosophies that have resulted in

their roles being extended in this direction (Cotton & Coleman, 2010) and have become the main target and recipients of interventions meant to improve these crisis interactions. While the Prince George members of the RCMP are no exception and make up a high percentage of both MHCRT and CIT training participants, they are equaled by participants from Prince George Fire Rescue (PGFR) and they are closely followed by members of the BCAS.

I reviewed training participant attendance logs kept by CMHA-PG which provided both participant names and their sponsoring organization from MHCRT and CIT trainings since 2009. The MHPP Committee appears to be reaching a wider more community inclusive audience by utilizing MHCRT in conjunction with CIT training. Examination of participant logs and training feedback indicates that the MHCRT and CIT training is being accessed by different compositions of these three uniformed responder groups. While PGFR and BCAS make up a significant proportion of total participants in both trainings, PGFR have a significantly higher presence in the CIT training and BCAS have a significantly higher presence in the MHCRT. RCMP account for one third of the total participants in both MHCRT and CIT training; it is noteworthy that the MHCRT is also capturing a significant number of emergency dispatch operators that have been identified as a critical audience in the literature (Watson & Fulambarker, 2012). The remaining participants are a collection of individuals from local community agencies, the health authority, post secondary institutions, and the general population. Participant responses reflect a high level of satisfaction with both the MHCRT and CIT training and the topics which have been developed to reflect the unique and specific conditions of the areas covered by CMHA-PG.

The exploration into how the training is experienced by the participants involved my review of training participant evaluations and feedback received though my discussions with

community members, it revealed two distinct themes. These themes were consistent between the two trainings and with the literature that shows CIT training has the potential to benefit the individual in crisis and the responder, but more importantly leads to greater community cohesion (Bonfine et al., 2014). Participant responses from MHCRT and CIT training reflect the same themes, namely; significantly enhanced community collaboration and an increased capacity for both individual and collective response that honors the persons being served. CIT training participants appear to experience the highest degree of satisfaction from the community connections that occur during and as a result of the training, while MHCRT participants appear to experience the highest degree of satisfaction from the enhancement of independent response skill. This may be reflective of the different audiences they attract, or the structural differences in the trainings, such as the duration of training time, which influences the amount of opportunity for participant interaction and engagement.

Training participants expressed an appreciation for the increase in service provider connection, collaboration, and role understanding with each other. This was evidenced by comments that overwhelmingly identified this professional collaboration, both through the interactive nature of the training and the building of sustained relationships following it, as the most positive outcome of the training. Participants recognized the value of understanding how professionals and community service providers respond to a mental health crisis absent police involvement and validated the importance of cohesion between other entities specifically citing medical response, dispatch systems, and corrections protocols.

This theme was also evidenced by recommendations from training participants that overwhelmingly recognized the need for a greater diversity and representation of professional participants in the training and the dissemination of more community specific

information. This community specific information included a greater knowledge of services and resources and a greater understanding of the patient journey from emergency response through immediate follow up to long term support. Participants identified these as critical to the success of an initial crisis intervention. While changes in thinking described as increased understanding, awareness, and insight and changes in feeling identified as increased empathy and compassion were commonly recognized as positive outcomes, responses regarding the value of professional collaboration unequivocally exceeded them.

The second consistent theme that emerged through this exploration was an increase in individual response capacity which was described as both practice skill and confidence in using it. Participant responses acknowledged that the presentation of educative materials specific to mental health disorders, complicating factors such as substance abuse and processes of marginalization, and social policy and legal influences, led to personal shifts in thinking and feeling. These shifts resulted in a greater recognition of the influence of power differentials; this enhanced insight, awareness, and compassion alongside the acquired skill in crisis interactions and verbal de-escalation, facilitated better individual performance in the field. This individual capacity is cited in the literature as an integral component to effective crisis response (Watson & Fulambarker, 2012) and individuals with MI report that their immediate experiences are impacted more by this factor than by the professional designation or intervention mechanism the responder represents (Boscarato et al., 2014). Participants routinely commented on the value of incorporating educative material with an opportunity to practice new skills through simulation exercises and role playing opportunities. They suggested that this allowed for the synthesis of the learning that occurred and increased their confidence. The increased ability to recognize, understand, and respond to a mental health

crisis was routinely cited by participants as one of the most satisfying outcomes of the training.

What are the needs for supplemental or enhanced training and how can this training be tailored to meet the unique needs of the region served by CMHA-PG?

Past participants of the MHCRT and CIT training were asked to provide feedback regarding the need for alternate topics and/or enhanced material. I consolidated participant responses collected from training evaluations completed immediately following training sessions from 2009-2016 and those collected through my discussions with representatives of the RCMP, BCAS, and PGFR. Responses did not reflect a need or desire for more advanced material, rather overwhelmingly recommended ongoing training that facilitates a more confident understanding of the basics and reinforces the skills already acquired. Participants placed a high value on observing the practical utilization of acquired knowledge and skills through the viewing of video clips and participation in mock scenarios. Participant responses suggested that while the compilation of educative material was necessary for a comprehensive understanding, the specific knowledge and skills gained required immediate and ongoing utilization; in the absence of this, those skills were at risk of becoming lost. There was a recognition that specific professionals incorporate specific pieces of the training into practice and that refresher training should *refresh* that which isn't regularly used. Participants attached value to the opportunity to apply newly learned skills in their professional practice and returning to a training venue to discuss those experiences while relearning the components they may not have regularly utilized. This is consistent with literature that recognizes the significance of practically applying new skills in developing the confidence needed to fully utilize them (Stanyon et al., 2014).

Other noteworthy responses included the need for wider dissemination of the training. Participants indicated that CIT training should be made available to all front line staff and emerging professionals in the field of mental health. While most participants who completed CIT training did so with the support of their employers, it was noted during discussions that many organizations are not supporting staff in attending this training perhaps due to its length. While the MHCRT does provide an alternative, participants in both trainings speculated that greater organizational support would yield a broader audience of participants and subsequently a more consistent standard response to persons with MI. Responses also reflected disappointment that the training was inaccessible for professionals stationed in the smaller outlying communities serviced by Prince George resources. While participants recognized the time commitment required to participate in the forty hours of training, recommendations to reduce it were not made.

Lastly, participants indicated that the training was an appropriate venue for the provision of current and updated information on community specific services and resources directed at and relevant to mental health service provision. Participant responses clearly indicate a desire for a forum that provides up to date information on new research regarding MI as well as community specific service and resource information and flow of service contacts that are accurate. There was an acknowledgement that the movement of professionals within the services and ongoing service reorganization in Prince George rendered this a complex task.

Summary of the Practicum Learning Experience

The learning that occurred includes a competent understanding of who the key stakeholders in the field of mental health are, how they work independently to meet the needs

of persons with MI, how they collaborate with one another, and how they define the challenges to those collaborations. While current participation in the MHPP Committee has declined, largely due to the attainment of many of its original goals, the resultant trainings continue to provide an avenue for achieving greater social awareness of the needs of persons with MI and a greater capacity for meeting those needs. Both MHCRT and CIT training are recognized as mechanisms that support community development and collaboration amongst key stakeholders through a shared language, philosophy, and framework.

I developed an excellent understanding of the MHCRT and CIT training, their original development, and their applicability for and presence in my community. The community wide enhancement in skill and capacity for managing crisis interactions involving a person with MI is achieved through increased knowledge and awareness of MI but more importantly, a significant improvement in service provider communication and collaboration, and an increased appreciation of the community's services and resources. These positive outcomes have occurred as a result of the work of the MHPP Committee and continues through the ongoing delivery of the MHCRT and CIT training.

My learning experience has increased my ability to evaluate resources and services and facilitate access to them for the persons I serve. It has increased my capacity for interfacing authentically and meaningfully with other professionals while recognizing the limits and potentials to those interactions. I have an increased confidence in and commitment to engaging in a wide range of activities in the spirit of improving the systems that effect persons with MI. These skills will be realized in my professional practice involving clinical social work and case management.

CHAPTER FOUR: IMPLICATIONS FOR PROFESSIONAL PRACTICE AND CONCLUSIONS

Implications for Social Work Practice

As a result of my practicum learning opportunity I gained extensive knowledge and awareness of the community specific interventions that are aimed at improving crisis interactions between persons with MI and first responders in the area covered by CMHA-PG. I determined that local experiences reflect those found in the literature and that innovative responses to some of the challenges are being explored and developed right in my own community. I learned that social work has a large breadth of intervention capacity from direct specific service work with individuals to universal policy development and that individual social workers can initiate structural change regardless of where their practice is situated on that continuum.

The learning that occurred provided me with an appreciation for and renewed commitment to structural social work practice that is aligned with systems theory and an ecological approach. This perspective aids in making sense of how independent entities are impacted, empowered, or restricted by the systems within which they exist. It is clear that social work in the context of clinical and case management practice cannot be exclusively therapeutic for the client; rather it is meant to provide individual support, aid in the recognition of structural influences to individual's experiences, and confront them in a way that supports individual needs while facilitating greater inclusion and equity in society. This is the essence of social work as I understand and embrace it. An ecological approach extends the scope of individual intervention outward and influences the structures that impact these experiences and that individual clients may not even be aware of. This reinforces the

appropriateness of my choice to advance my practice in clinical case work by pursuing a master's degree in social work rather than a psychologically exclusive discipline.

Structural social work has an important role to play in the field of mental health and the practice of boundary spanning, which is particularly well suited for social workers, supports that role (Kerson et al., 2005). An inquiry into how MI is understood and how that understanding is or might be shifted provides insight into what might underlie current assumptions within organizations that are attempting to develop appropriate models of crisis response. An inquiry that involves multiple organizations and disciplines seeks to understand those intersections, linkages, and patterns of authority and responsibility (Kerson et al., 2005). The nature of social work as flexible and holistic render it a natural fit for utilizing this understanding to reframe individual problems and intervene at higher levels and for advocating for more functional policies that improve conditions for client populations. Social work relies on relationship building and communication but must be informed by high levels of skill and knowledge in order to interpret law, policy, and organizational interests while promoting social justice, equity, and autonomy for, and with, those it is meant to serve.

Conclusions

I completed a 560 hour supervised practicum placement at the Prince George branch of the Canadian Mental Health Association and surpassed the expectations for learning that I articulated in my learning goals and anticipated through the activities I engaged in. I developed a greater knowledge of a wide range of community development practices and enhanced my current skills in clinical social work. I increased my capacity for informed practice in my community through an increased understanding of the nature of intersecting and competing services and resources and I developed coalitions with a wide array of

community members. I developed an enthusiastic interest in boundary spanning and a renewed commitment to practice that incorporates this skill and this philosophy to make sense of the barriers that professionals in the field of human service work encounter in their daily work and which threaten to diminish both their passion and their capacity.

Discussions with the key stakeholders and committee members, which involved a good variety of service representatives with distinct and differing ideological foundations, indicate that the work of the MHPP Committee over the past eight years is highly valued. That value is not diminished by the acknowledgement that the attainment of the original goals necessitates a redefinition of purpose. I determined that the value of the MHPP Committee's future work, as described by its members, is aligned with the MHCRT and CIT training. The association of the training itself with the ultimate goals of the committee suggests that the specific grounding of these trainings as core components of work within the mental health system in Prince George, may be a worthy direction for the committee to explore.

While the totality of feedback on the trainings was positive and encouraging this intervention is not without some criticism. Training participants identified deficits in dispatching and information systems as well as an absence of appropriate assessment sites as contributing factors to fragmented mental health service delivery that are inevitable and particularly difficult to navigate. Despite research that suggests forty hours of CIT training is grossly insufficient and simplifies response capacity to a complex problem (Boscarato et al., 2014) responses specific to training experiences in Prince George indicate that forty hours of training is in and of itself a barrier to wider dissemination of a valuable mechanism in the

effort to improve these interactions. The absence of employer support for participation in a 40 hour program limits the range of professionals who are able to access it.

Committee member responses and training participant responses reflect the same value for enhanced community capacity to meet the needs of persons with MI both in and out of crisis through increased awareness of mental health and illness, improved service provider collaboration, and improved resource knowledge and linkage. Training participants placed a high value on ongoing and refresher training that elevates and maintains a certain standard of practice and level of professional skill. Both MHCRT and CIT training appear to offer an excellent avenue for establishing a shared and respectful understanding of mental health services as a system and subsequently for the development of system responses to the challenges they face.

My experience at CMHA-PG has provided me with an increased knowledge of the community in which I practice and the professionals with whom I practice. It has increased my understanding of how communities are connected both by social problems and through resource development and it provided opportunities for professional relationship building and boundary spanning skill development. I have a greater understanding of the level of awareness regarding the challenges facing the individuals I serve and an appreciation for the power associated with my position. I have an increased capacity to access and effectively utilize the services and resources available in my work, to engage in practice that supports community development, and to interact with other professionals and service providers in a way that builds respect for the work that all professionals in the field of mental health engage in and that honors the people we serve.

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Appendices

Appendix One: Learning Contract

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

***School of Social Work*, College of Arts, Social and Health Sciences**

Field Education Learning Contract

(This contract serves as a guide for the student's learning objectives. The learning contract should be completed by the second week of placement. It should be developed collaboratively by the student and the agency supervisor).

Agency's Name: Canadian Mental Health Association – Prince George Branch

Program: Community Development, Education, and Training

Address: 1152 3rd Avenue, Prince George BC, V2L 3E5

Phone: 250-564-8644

Agency Supervisor: Maureen Davis Educational Degrees: M.Ed.

Phone: 250-564-8644 Email: Maureendavis@cmhapg.ca

MSW Supervision: **Glenn Beach** Educational Degrees: MSW

Phone: 250-301-6475 Email: beachg@cnc.bc.ca

Field Direction: Mary Lu Spagrud Educational Degrees: BRS

Phone: 250-564-8644 ext 207 Email: marylu@cmhapg.ca

Student Name: Kelly Bumby Educational Degrees: BSW

Phone: 250-565-8599 Email: bumby@unbc.ca

Faculty Field Instructor: Heather Peters Educational Degrees: MSW, PhD

Phone: 250-991-7540 Email: Heather.Peters@unbc.ca

Administrative Arrangements

Practicum Start Date: April 7, 2015 **End Date:** August 21, 2015

Weekdays and Hours of practicum: Monday-Friday, 0830-1700 hours until July 14, 2015, then Monday and Tuesday, 0830-1700 hours until August 21, 2015

Supervision schedule: Bi-weekly meetings with Field Director/Agency Supervisor; monthly meetings with MSW Supervisor and Faculty Field Instructor.

Office space: On site office space at CMHA

Administrative support: None

Transportation: N/A

Learning Contract Practicum Activities

The following activities are derived from the practicum learning goals:

1. Learning goal: To gain a comprehensive knowledge of the training and education, with a particular focus on Crisis Intervention Team (CIT) Training, being offered directly through CMHA-PG as well that which is available through joint partnerships and committee work.

a) Orient myself and my work within the organization by talking with staff in the various programs in order to acquire a competent knowledge of the services provided by, and the overall organizational framework of, the PG branch of CMHA.

a) Review organization history and vision with respect to education and awareness raising mandates; review relevant and associated agency policy and procedural manuals.

b) Review materials associated with the Mental Health Policing Project.

c) Review materials relied on in the development of funding proposals for CIT training and other associated training.

d) Review resources utilized in the development of CIT training outlines and syllabus'.

e) Participate in annual CIT training.

The learning that occurs will be documented; an organizational flow chart will be completed as well as a timeline that describes the initial development and ongoing process in the delivery of CIT training. Achievement of this goal will be evidenced by the completion of these documents.

2. Learning goal: To identify who the first responders and community partners are in the area served by CMHA-PG, how they experience the training available to them, and how it shapes their knowledge and understanding of mental illness and mental health crisis response.

a) Attend Mental Health and Policing Project (MHPP) committee meetings.

b) Consult with Manager of Education and Projects; review previous (MHPP) committee meeting minutes to identify key stakeholders and historical interests.

c) Review and interpret CIT training feedback and evaluations.

d) Meet with identified stakeholders, community partners, and participants to discuss their experiences with the Crisis Intervention Team (CIT) training.

The learning that occurs will be documented and represented in a visual format that allows for a comparison of experiences between participants; achievement of this goal will be evidenced by the development of this document.

3. Learning goal: To determine the need for supplemental or additional training and identify the components of that training & to evaluate the delivery of trainings associated with the MHPP throughout the region covered by CHMA-PG which spans the northern half of British Columbia and includes several rural and remote communities.

a) Meet with identified stakeholders, community partners, and participants to discuss recommendations for a second level or refresher training associated with the goals of the MHPP and current CIT training.

b) Identify additional potential community partnerships and engage in discussion about the need for CMHA-PG services and partnership, specifically related to the MHPP and CIT training.

b) Review research specific to Prince George and other northern and remote Canadian communities.

c) Review current and emerging research, as per Manager of Education and Projects, regarding developing initiatives happening globally.

d) Review research on curriculum development specifically related to adult learners.

e) Review current research on community development and community capacity building.

d) Develop written summary outlining findings in relation to current literature.

The learning that occurs will result in written recommendations for future or supplemental CIT and MHCRT training and the dissemination of these trainings throughout the region served by CMHA-PG including smaller, rural, and remote communities.

PLAN FOR MEETING GOALS AND OBJECTIVES: Outlined above

By the Mid Term Evaluation

Evidence of successful completion of tasks associated with learning goals 1 and 2

Comments:

By the End Term Evaluation

Evidence of successful completion of tasks associated with learning goal 3

Comments:

Learning Contract Signatures

Student:

Agency Supervisor:

Field Director:

Faculty Field Instructor:

Date: April 27, 2015
