April 15, 2015

Community Support Services and Mental Health:
An Evaluation of the Effectiveness of Turning Leaf Services Inc.

Submitted by:

Megan Campbell - 7722033

Pamela Parker - 7694521

SOC 3100 - Practicum in Criminological/Sociological Research

University of Manitoba

Acknowledgments

We would like to thank Barkley Engel for his help and guidance over the course of our research. We would also like to thank Ashley Field for all the extra work she did for us and for helping get our surveys sent out. We are very appreciative of the Case Workers, Jon Bickle-Tapper, Alana Chegus, Alex Lysenko and Marina Wilderspin, who provided us their client monthly goal sheets to analyse, as well as the Support Workers who helped with distribution and completion of the client surveys. We would like to express our gratitude to all the clients and staff of Turning Leaf who participated in our research. Finally, thanks to Professor Frank Cormier for all his help and support this year.

Contents

1 Abstract 5

2 Introduction 6

3 Literature Review 7

3.1 Background 7

3.2 Known Causes of Mental Illness and Intellectual Challenges 7

3.3 Statistics on Mental Illness and Intellectual Challenges: 8

3.4 Effects of Mental Illness and Intellectual Challenges on a Personal Level 14

3.5 Housing 15

3.6 Effects of Stigma and Labelling 16

3.7 Health Care 17

3.8 Social Effects of Mental Illness and Intellectual Challenges 18

3.9 Employment 19

3.10 Justice System 21

3.11 Effects of Community Based Programs 22

3.12 Conclusion 24

4 Methodology 25

5 Findings 28

5.1 Client Survey Questionnaire Results 28

5.2 Staff Survey Questionnaire Results 31

5.3 Results of Client File Examination 36

5.4 Program Costs 40

5.5 Average Costs of Turning Leaf and its Alternatives 41

6 Discussion and Conclusions 45

6.1 Analysis of the Community Support Program 45

6.2 Client File Analysis 47
6.3 Analysis of the Residential Support Program 50
6.4 Cost Analysis 51
6.5 Analysis and Comparison of Turning Leaf and its Alternatives 54
6.6 Overall Evaluation of Turning Leaf 57
6.7 Limitations 59
6.8 Conclusion 59
7 References 61
8 Appendices 66
8.1 Client Survey 66
8.2 Staff Survey 72
8.3 Monthly Goal Sheet Template 78
8.4 Monthly Goal Sheets Coding Categories 81
8.5 Ethics Approval 84

1 Abstract

In regard to supporting persons with mental illnesses or intellectual challenges, it has been found that community-based programs are becoming preferred as an alternate approach to incarceration and hospitalization. However, considering that all community-based programs are unique, their individual level of effectiveness still needs to be evaluated. The literature demonstrates that programs which include reinforcing social relations, promoting healthy life changes, and community reintegration have higher recovery rates, but information is lacking in regard to the effectiveness of Winnipeg's, non-profit, community-based program: Turning Leaf Services Incorporated. This report introduces a quantitative, summative evaluation of the effectiveness of Turning Leaf. The evaluation comprises results from client and staff opinion surveys, client file analysis of a random sample, along with a cost analysis. The findings suggest that Turning Leaf is effective in most areas studied. The opinions of clients and staff, as shown by the questionnaires, are mostly positive. There are definite improvements that can be made in terms of the number of goals clients are achieving with the help of Turning Leaf but results show that the more time spent utilizing Turning Leaf's services, the higher the percent of goals accomplished. The cost analysis shows that Turning Leaf is an economical alternative to incarceration and hospitalization for persons with a mental illness. This research is expected to help determine how effective Turning Leaf is in offering its services to its clientele, reveal the areas that require improvement, and, in turn, help ensure that clients are receiving quality service.

2 Introduction

In Canada, as many as one in five people are likely to experience a diagnosable mental illness (Mental Health Resource Guide for Winnipeg, 2015). People with mental illnesses or intellectual challenges have to overcome many societal barriers in their lifetime including stigma, increased chances of homelessness, unemployment and incarceration. Community based services can be an effective way to support people to overcome such barriers as they focus on helping people make connections and lifestyle changes that contribute to recovery. Turning Leaf Services Incorporated (Turning Leaf) is an example of such a service. Turning Leaf provides support to youth and adults living with mental illnesses or intellectual challenges by offering many different programs.

After a review of the existing literature was complete, an evaluation was done on the programs offered by Turning Leaf to determine whether the agency was effective in delivering programs to clients. The evaluation focused on the Community Support Program, the Residential Program and the agency's overall effectiveness. Effectiveness was determined based on an analysis of survey questionnaires completed by staff and clients that represent their opinions on Turning Leaf's effectiveness. As well, an analysis of 11 clients' monthly goal sheets was done to determine whether the agency was effective in helping clients meet goals. Finally, a cost-benefit analysis of Turning Leaf's individual programs, specifically the Community Support Program and the Residential Support Program, was completed.

3 Literature Review

3.1 Background

Mental health, according to the Public Health Agency of Canada (2006), is the capacity of persons to feel, think and act in ways that enhance their ability to enjoy life and deal with the challenges they face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity. In contrast to mental well-being, mental illness is associated with impaired functioning along with significant levels of distress. Mental illnesses can create alterations in thought, mood or behaviour, or a combination of these things (Public Health Agency of Canada, 2006).

3.2 Known Causes of Mental Illness and Intellectual Challenges

Most mental illnesses are found to be more common among close family members, suggesting a genetic basis of disorders (Public Health Agency of Canada, 2006). Mental illness researchers have noticed a residual or baseline level in their studies which supports the notion that genetic and biological effects function autonomously of the immediate social and economic environment (Hudson, 2005). Though genetic relations vary with different types of mental illnesses, further research is necessary in finding the direct implication of genes in the development of a mental illness.

In terms of environmental factors, the family environment seemed to hold the greatest impact on mental health. It was discovered that single-parent families, in particular, were strongly associated with psychological distress among children (Hudson, 2005). Rende et al.

(1993) discovered that genetic influence was not significant compared to shared environmental influences on extreme depression symptoms (Cicchetti & Toth, 1998).

The home environment also proves influential on a person's mental health. In a long term study, results showed that approximately eighty percent of young adults who had been abused had at least one psychiatric disorder by 21 years of age (Public Health Agency of Canada, 2006). The disorders included depression, anxiety disorders, eating disorders, and suicide.

Moreover, inmates in correctional facilities are more likely than the general population to have present or past mental illnesses. In fact, over ninety percent of inmates are diagnosed with a mood, anxiety, or psychotic disorder or a combination of the three (Public Health Agency of Canada, 2006). Correctional facilities have been known to create symptoms of anxiety and depression due to the nature of the environment and the fact that some mental illnesses are highly associated with participation in illegal acts, such as theft or violence, which in turn results in their incarceration (Public Health Agency of Canada, 2006).

3.3 Statistics on Mental Illness and Intellectual Challenges:

3.3.1 Who is affected by Mental Illness and/or Intellectual Challenges in Canada?

In contrast to public belief, mental illness can affect anyone regardless of intelligence, social class or income level. In fact, one in five Canadians today are likely to experience a diagnosable mental illness (Mental Health Resource Guide for Winnipeg, 2015). Although anyone is susceptible to mental illness, certain demographic characteristics can demonstrate a higher risk of mental illness.

3.3.2 Sex

Although biological sex factors differentiating males and females are not clearly identifiable as causes for mental illness, some sex differences are apparent in certain mental illnesses. Research indicates that women are more prone to mood and anxiety disorders, including depression and Major Depression Disorder (MDD). In fact, women are 1.5 times likelier to meet the criteria for a mood or anxiety disorder (Public Health Agency of Canada, 2006). Despite the fact that prevalence rates of anxiety disorders among young boys and girls are relatively equal, the ratio of female predominance transforms into a 3:1 ratio by adolescence (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). In cases of MDD, the ratio rises as high as 4:1 for teenage girls (Culbertson, 1997). While information is lacking about the reasons behind these ratio differences, a few possible explanations exist. First, it is found that women are more willing to seek help in cases of mental illness, therefore elevating recorded numbers of cases of depression in women (Dagani, Purcell, de Girolamo, Cocchi & McGorry, 2012). Second, it is argued that the difference in ratio could be based on biological differences. Lastly, research suggests that a woman's psychosocial opportunities and position in the world might put her at a higher risk for depression (Culbertson, 1997). The latter suggesting that a woman's risk of mental illness is consequently socially determined.

In contrast to women, men are reported to be 2.6 times more likely to meet criteria for substance dependence (Public Health Agency of Canada, 2006). In addition to having a higher risk of substance abuse, men also have a significantly greater risk of impulse control disorders (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005).

Moreover, findings demonstrate that since the 1950's, rates for males committing suicide have become three times higher than the female rates (Cutcliffe, 2005). By 1990, males became

four times likelier to commit suicide compared to females, and as of 1998, suicide became the leading cause of death of Canadian males aged between 25-29 and 40-44 years of age (Cutcliffe, 2005). Theories suggest this is because males tend to use more lethal methods in suicide attempts than females (Cannetto & Sakinofsky, 1998). Females are three times more likely to report suicidal ideation and nonfatal suicide behaviour than males however; low-lethality methods chosen by females, such as poison could result in failed attempts (Cannetto & Sakinofsky, 1998). It is important to note that studies show the method used to commit suicide is not the best measure of intent to commit suicide (Cannetto & Sakinofsky, 1998).

3.3.3 Age

The first onset of a mental disorder will usually occur in childhood or adolescence. It is important to note that mental illness is distinct from chronic illnesses in the sense that they have a stronger foothold in youth. Early age of onset is also strongly associated with a longer duration of untreated illness (Dagani, Purcell, de Girolamo, Cocchi & McGorry, 2012). Individuals who have matured out of the high-risk age ranges for disorders have a substantially lower risk of mental illness (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005). Disorders vary in common ages of onset. Behaviour and specific anxiety disorders have a tendency to develop in childhood (Dagani, Purcell, de Girolamo, Cocchi & McGorry, 2012). However, mood disorders continue to develop during each stage of life (Public Health Agency of Canada, 2006).

One in five Canadians between 15-64 years of age report symptoms related to mental illness (Public Health Agency of Canada, 2006). The following are the respective percentages of reported symptoms by age groups:

- 19.8 percent of individuals aged between 15-24 years of age report symptoms of mental illness;

- 22.7 percent of individuals aged between 25-44 years of age report symptoms of mental illness;
- 23.4 percent of individuals aged between 45-64 years of age report symptoms of mental illness;
- 10.3 percent of individuals aged 65 years of age or more report symptoms of mental illness.

It is estimated that eighty to ninety percent of seniors, individuals aged 65 years of age or more, that are residents in a long term care facility have some type of mental disorder (Public Health Agency of Canada, 2006). However, as previously marked, only 10.3 percent of individuals aged 65 years of age or more did report symptoms of mental illness.

Half of all "lifetime" cases of mental illness start at approximately the age of fourteen, and three quarters start by age 24 (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005). The 15-24 age group demonstrates a higher occurrence of mood disorders, anxiety disorders, or substance dependence (Public Health Agency of Canada, 2006). In a study on early age onset, Kessler, Berglund, Demler, Jin, Merikangas and Walters (2005) discovered that the median age of onset for anxiety and impulse control disorders was 11 years of age. The median age for substance dependence was 20 years of age. Males with schizophrenia showed a median onset age in their late twenties, while females with schizophrenia showed a median onset age in their mid thirties.

Although the onset of most mental disorders usually occurs during the first three decades of life, effective treatment is typically not initiated until a number of years later (Dagani, Purcell, de Girolamo, Cocchi & McGorry, 2012). Adolescence and early adulthood includes a high number of developmental changes which likely contribute to the development of mental illnesses (Public Health Agency of Canada, 2006). Early onset paired with early intervention and

treatment has shown significantly fewer symptoms of mental illness in addition to superior functioning on measures assessing global, social, occupational, and community functioning in comparison to patients with an onset occurring later in adulthood which was equally treated (Dagani, Purcell, de Girolamo, Cocchi & McGorry, 2012).

3.3.4 Culture & Ethnicity

Waxler (1974) states that societies do not cause different rates of mental illness nor tolerate different degrees of deviance, instead they respond differently to psychiatric illness once it occurs. It appears that higher ethnic identification may be more influential to well-being among male ethnic minorities compared to females (Bombay, Matheson & Anisman, 2010). In a study by Bombay, Matheson, and Anisman (2010), the researchers discovered that feelings of ethnic pride and belonging were not linked to depressive symptoms among female African American adolescents, but were associated with diminished symptoms among males. The reason for gender differences among ethnicities needs to be further explored.

Aboriginal people in Canada experience a higher risk of mental or physical disorders than their non-Aboriginal counterparts (Bombay, Matheson & Anisman, 2010). Aboriginal people who regarded Aboriginal identity as central to their self-concepts may be particularly likely to experience greater despair and depressive symptoms when faced with cultural discrimination (Bombay, Matheson & Anisman, 2010). In addition, Native American populations have a higher risk of committing suicide on "reserves" in Canada where traditional cultural practices have faded (Cicchetti & Toth, 1998).

3.3.5 Socioeconomic Status

Socio-economic status (SES) has a great impact on mental health. SES has been shown to impact the development of mental illness directly, as well as indirectly through its association with unfavourable, economically stressful conditions among lower income groups (Hudson, 2005). Higher levels of mental illness are present in low-income and low-SES groups compared to more privileged groups (Belle, 1990). Studies show that SES is inversely related to the development of mental illness; the lower the SES, the higher the risk of developing a mental disorder, and vice-versa (Public Health Agency of Canada, 2006).

A study in 1998 found that poverty and unemployment served to increase the duration of episodes but not the likelihood of their initial occurrence (Hudson, 2005). In addition, lower SES has the potential to worsen mental disorders (Dagani, Purcell, de Girolamo, Cocchi & McGorry, 2012). Culbertson (1997) found that poverty was in fact a "pathway to depression". Living in poverty may lead to a lack of opportunity and consequently to hopelessness, anger, and despair. When combined with a genetic predisposition, poverty can contribute to the development of mental illnesses (Public Health Agency of Canada, 2006). However, it is important to note that most people who are poor do not have mental illnesses. In addition, income level is not a predictive factor of mental illness (Belle, 1990).

The likelihood that those with a mental illness may drift into poverty as they have difficulty achieving and maintaining regular employment is one mental illness hypothesis proposed by the Public Health Agency of Canada (2006). This indirect association between poverty and mental illness may be mitigated by the "class" effect, whereby the networks of support around people in higher socio-economic classes prevent their drift into poverty. The idea

that the impact of SES on mental illnesses is mediated by economic stress received the strongest support by data (Hudson, 2005).

3.4 Effects of Mental Illness and Intellectual Challenges on a Personal Level

3.4.1 Primary Effects

Mental disorders have proven to affect relationships, social and work functioning. In extreme cases, it has also brought people in contact with the law (Public Health Agency of Canada, 2006). Persons with an anxiety disorder experience significant impairment in psychosocial functioning (Koerner, Dugas, Savard & Marchand, 2004). Though in comparison to physical conditions, impairments caused by anxiety disorders impair functioning more subtly. Koerner, Dugas, Savard and Marchand (2004) discovered that anxiety disorders are associated with decreased quality of life, impairment in interpersonal relationships, as well as in social and occupational domains.

3.4.2 Secondary Effects

Mental illness has a major impact on interpersonal relationships; therefore it greatly affects both individuals and their families (Public Health Agency of Canada, 2006). Families face difficult decisions regarding treatment, hospitalization and housing amongst a multitude of other things when a family member displays symptoms of mental illness. In addition, families are faced with a financial burden as a result of purchasing medications, requesting time off work and searching for extra support. When asked in a survey conducted by the Public Health Agency of Canada (2006), 86 percent of persons interviewed on mental illness believed that it was a family responsibility to care for a family member with a mental illness. Respondents found that

58 percent of the time, no one else could take the role of caregiver other than themselves. An observation was made that the majority (70 percent) of caregivers are female.

Families of a person diagnosed with schizophrenia are especially affected, both psychologically and economically, due to the chronic course and early onset of the disorder (Knapp, Mangalore & Simon, 2004). In the case of bipolar disorder, the aftermath of a manic episode can be devastating for both individuals and for their families and loved ones (Public Health Agency of Canada, 2006). The Public Health Agency of Canada (2006) explains that the heavy demands associated with caring for a person with mental illness can lead to "burnouts" on behalf of the caretaker, and create anxiety due to an uncertain future.

3.5 Housing

People with mental illnesses are more likely to experience chronic homelessness or a lack of safe, affordable housing (Drake & Whitley, 2014). There are an estimated 150,000–300,000 homeless people in Canada (Roos et al., 2013). A study of two North American cities showed that approximately 50 percent of the beds within homeless shelters were used by the mentally ill (Goering, Macnaughton & Nelson, 2013). Research shows that having safe and secure housing provides psychological benefits that are fundamental to recovery from mental illness (Drake & Whitley, 2014). There seems to be a gap between the services research suggests mentally ill people should receive, and the reality of those individuals receiving those services (Goering, Macnaughton & Nelson, 2013). Goering et al. (2013) believe that it is the change in responsibility for social housing from federal and provincial legislation to municipal, which results in a lack of funding for social housing projects.

3.6 Effects of Stigma and Labelling

Symptoms of mental illness are often coupled with irrational fears of potential violence by the general population. In fact, very few persons with a mental illness are violent (Public Health Agency of Canada, 2006). Such stereotyping and discrimination often leads to limited and reduced social interactions. The latter results in both anger and avoidance behaviours by persons who are mentally ill.

In a study on mental illness, 53.5 percent of respondents said that they were embarrassed by their diagnosis (Public Health Agency of Canada, 2006). This study also showed that 54.3 percent of respondents faced discrimination due to their mental illness. Stigma often causes them to delay seeking health care, avoid following through with recommended treatment, and avoid sharing their concerns with family, friends, co-workers, employers, health service providers and others in the community. The isolating outcome of stigma sometimes leads to cases of suicide among the mentally ill population (Public Health Agency of Canada, 2006).

Societal attitudes can directly affect the availability of resources and supports as well as the likelihood that treatment will be sought. In addition, societal attitudes can have a great impact on how a disorder develops as well as on how it is addressed when it is present (Cicchetti & Toth, 1998). A study among Aboriginals indicated that perceived discrimination was associated with various negative health and social outcomes, including depressive symptoms (Bombay, Matheson & Anisman, 2010). This demonstrates how discriminatory experiences may serve as stressors that result in reduced well-being (Bombay, Matheson & Anisman, 2010).

3.7 Health Care

3.7.1 Hospitalization of Persons with Mental Illness and/or Intellectual Challenges

In a Canadian survey on mental illness carried out in 2002, 4.9 percent of persons with a mental illness reported being hospitalized in the past twelve months (Public Health Agency of Canada, 2006). Female individuals ranging from 15-24 years of age were twice as likely to report being hospitalized compared to their male counterparts.

Knapp, Mangalore and Simon (p. 283, 2004) explain that "patients presenting themselves for the first time often show acute psychotic symptoms that require hospitalization, while treatment for people with repeated relapses is also still predominantly hospital-based across much of the world". Inpatient admission is the single largest contributor to the direct costs of treating disorders, such as schizophrenia. During the 1994-2000 period, there was a median of twenty new individuals hospitalized in an acute psychiatric unit for every 10,000 individuals in the total population (Hudson, 2005).

Persons with affective disorders are more frequently hospitalized. Their rate of hospitalization is 16 per 10,000 population, and those with schizophrenia, hold a rate of 2.2 per 10,000 population (Hudson, 2005). Schizophrenia is a chronic illness, and so its costs tend to persist. The average total cost of inpatient services per schizophrenic patient per year is $11,312 (Knapp, Mangalore & Simon, 2004).

3.7.2 Treatment

Stigmatization often causes individuals with mental illness to delay seeking health care, avoid following through with recommended treatment, and avoid sharing their concerns with their social network (Public Health Agency of Canada, 2006). Young people tend not to seek

professional help for mental health problems. In addition, access to treatment is highest among older patients, with people ages 18-30 years old being the minority (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005).

Patients with a panic disorder are more likely to get evaluations for cardiological symptoms than symptoms of Generalized Anxiety Disorder (GAD) due to the fact that panic attacks are often mistaken for signs of a heart attack (Koerner, Dugas, Savard & Marchand, 2004). Approximately half of panic disorder and GAD patients consult a physician for "heart problems" (Koerner, Dugas, Savard & Marchand, 2004). The latter stresses the importance of improving the awareness of general practitioners of the symptoms of mental disorders.

3.8 Social Effects of Mental Illness and Intellectual Challenges

3.8.1 Social Relations

> "While hospitalization provides important short term respite and care, prolonged periods of hospitalization can remove the individual from their normal environment and weaken social connections, making re-integration into community living more challenging" (Public Health Agency of Canada, p.11, 2006).

Re-integration into the community, whether it is following hospitalization or incarceration, poses many difficulties for persons with mental health issues. As discussed earlier, the negative stigma and labelling associated with persons who have a mental illnesses can lead such individuals to isolate themselves from their community. By doing so, their social ties diminish, and in some cases disappear completely. A social network has been identified as being beneficial for the support and treatment of a mental disorder. Due to stigmatization, labelling, discrimination, hospitalization, and incarceration of the mentally ill, individuals with a mental disorder are robbed of their social ties.

3.9 Employment

People with mental illness or intellectual challenges find it harder than most to get or maintain a job. According to the Canadian Mental Health Association Ontario and Centre for Addiction and Mental Health (2010), employment has a direct link to health and quality of life. Research suggests employment can be essential to people who are trying to recover from a mental health issue and should be a central component to any mental health recovery program (Barlow et al., 2011). There are many benefits that come from being employed including increased self-esteem, decreased social isolation, improved quality of life, financial gain, personal growth and improved mental health (Barlow et al., 2011).

There are currently disincentives for those with mental health issues to find employment. Financial support from the government or family members can act as a deterrent to find work (Bond et al. 2011). Employment programs that aim to help people return to work need to make employment seem both feasible and attractive (Canadian Mental Health Association, 2010).

The unemployment rate for those with mental health problems is higher than any other disability group (Barlow et al., 2011). For those with the most severe mental disorders, or with no previous job experience, unemployment rates range between 70 to 90 percent and for those with less severe mental illnesses such as depression or anxiety, unemployment rates can be over 30 percent (Canadian Mental Health Association, 2010). Those who are lucky enough to be employed can expect an average tenure of 6 months (Barlow et al., 2011). Individuals with mental illnesses are often consigned to minimum-wage jobs with non-standard types of work, reduced benefits or limited advancement opportunities. These types of jobs are vulnerable to fluctuations in the economy (Canadian Mental Health Association, 2010). The stress that is associated with this type of employment can actually lead to decreased mental health.

An important factor in understanding why the unemployment rate for those with mental illness is so high is identifying the barriers that keep them from being employed. A United States study of employers shows that approximately 70 percent of employers are reluctant to hire someone with a history of mental illness (Barlow et al., 2011). Assumptions made about those with mental illnesses or intellectual challenges can arise from a lack of education among employers. These assumptions include the idea of incompetence, a perception that the person is dangerous or unpredictable, the belief that mental illness is not a legitimate illness, the idea that working is unhealthy for those with mental disorders and the thought that employing someone with a mental illness represents an act of charity (Barlow et al., 2011) . Individual barriers that people with mental illness or intellectual challenges have to face can include stigma or discrimination from co-workers, poor educational achievements and policy disincentives (Barlow et al., 2011). These perceived barriers can affect the behaviour, self-efficacy, self-esteem, motivation and job acquisition of mentally ill or intellectually challenged people (Bond et al. 2011).

Suggestions to improve employment rates of mentally ill or the intellectually challenged include more employment programs or services that can help place people with a job (Barlow et al., 2011). For the employment programs that already exist, research suggests more focus should be placed on social encouragement to obtain work, personal motivation and self-esteem, as well as job search behaviours (Bond et al. 2011). Currently there are no workplace accommodations or a list of best practice approaches that employers can use when hiring someone with a mental health issue or intellectual challenge (Barlow et al., 2011). To encourage employers to hire more people with mental illness, employer incentives have been suggested with penalties for not hiring a diverse workforce (Canadian Mental Health Association, 2010).

3.10 Justice System

Many people who suffer from mental illness or intellectual challenges end up incarcerated (World Health Organization, 2005). Manitoba had the highest rate of incarceration among Canadian provinces at 213 per 100,000 adult population in 2010-2011 which is more than double the average of 90 for the rest of Canada (Statistics Canada, 2012). A large number of mentally ill people end up criminalized due to the misconception that people with mental disorders are a danger to the public (World Health Organization, 2005). People with mental illnesses who have committed a minor offence are often sent to prison because it is an easier alternative than providing treatment for the disorder (World Health Organization, 2005). Incarceration limits the potential for rehabilitative services and interventions targeted to a person's specific needs. Research suggests people with mental disorders should not be incarcerated since "the criminal justice system emphasizes deterrence and punishment rather than treatment and care" (World Health Organization, 2005: 3). Incarceration can have especially damaging effects on those who already have a mental disorder and can decrease the likelihood of a successful outcome (Lambie & Randell, 2013). Mental health problems are often not acknowledged while incarcerated but addressing the needs of people with mental disorders can reduce recidivism and increase the chance of successfully readjusting to the community (World Health Organization, 2005). Lambie and Randell (2013) argue that there is a disconnection between correctional services and community based services which could lead to reoffending or a lack of treatment upon release.

Early treatment programs that allow the mentally ill to stay out of the hospital or the criminal justice system can be more cost effective (Mental Health Commission of Canada, 2013). Mental health problems and illnesses cost the Canadian economy nearly $50 billion per

year providing treatment, care and support services (Mental Health Commission of Canada, 2013). The Mental Health Commission of Canada (2013) makes the case that better intervention in the form of policy initiatives could save Canada an estimated $4 billion annually on mental health care costs. Meanwhile, the cost of crime is rising along with increased requirements of the justice system. In 2010-2011 Canada spent about $4.1 billion on federal adult corrections with an average of $357 spent per inmate per day (Statistics Canada, 2012). High costs are incurred by the criminal justice system because people with mental health problems are not receiving proper treatment which could be addressed by placing more importance on early treatment programs (Mental Health Commission of Canada, 2013).

3.11 Effects of Community Based Programs

Many community-based services that focus on mental illness consider recovery as an objective of their program. Recovery is routinely considered a process rather than an outcome and is related to a specific client's life aspirations. Research that was conducted on 19 American recovery programs for those with serious mental illness included "employment, independent living, community participation and formation of mutually supportive interpersonal relationships" as measures that define a successful road to recovery (Drake, Strickler, & Whitley, 201l: 547). Community programs that aim to make a difference in the lives of people with mental illness should encourage patient choice, agency, and financial, residential and personal independence (Drake & Whitley, 2014). There are still barriers for those with mental health problems to access community services including a shortage of resources to meet the magnitude of unmet needs. Drake and Whitley (2014) argue that "integrating social and medical services would be humane, cost-effective, and truly recovery-oriented" (Drake & Whitley, 2014: 238).

3.11.1 Making Connections

Social relations are an important factor in recovery from mental illness. Programs that focus on allowing the client to feel known, understood and accepted by the staff had a better chance of facilitating recovery (Drake & Whitley, 2014). A great deal of emphasis was placed on the importance of supportive people and helpers on the road to recovery. Teaching family members about mental illness and reducing tensions in the family relationship can reduce the likelihood of relapses (Aschbrenner et al. 2012). Research suggests a link between social environments and healthy behaviours, making active support from the family important (Aschbrenner et al. 2012). Studies also note the importance of "peer support as an aspect of social connectedness" (Drake & Whitley, 2014: 239). However the stigma associated with mental illness can create barriers to the client's desired community integration and social connectedness (Drake & Whitley, 2014).

3.11.2 Healthy Changes

Research suggests people who have mental health problems often struggle with an unhealthy lifestyle including obesity, sedentary lifestyle, poor diet, drugs, alcohol and smoking (Aschbrenner et al. 2012). Smoking is especially prominent with those who have a mental health disorder as statistics suggest 60 to 90 percent smoke (O'Sullivan, Gilbert & Ward, 2006). For those with severe mental illnesses that are considered chronic and incapacitating it can be easy to develop a service-dependent lifestyle and lack autonomy. This is why everyday activities, routines and normal life processes are important in fostering recovery (Drake & Whitley, 2014). Studies indicate that not enough community organizations include healthy lifestyle intervention programs but that they would be critical to recovery (Aschbrenner et al. 2012).

3.11.3 Transitioning back into the Community

Transitioning back into the community after an event such as incarceration or hospitalization can be difficult for those suffering with mental illness or intellectual challenges. According to a United States survey of mental health recovery centres done by Drake et al., (2011), an important step in recovery involves positive transitions in work, social functioning, recreation, spirituality, community participation and education. Time away from the community as well as the stigma that comes with being incarcerated or institutionalized can result in challenges to reintegration (Lambie & Randell, 2013). This transition can be especially difficult for youth as it is often simultaneous with the transition into adulthood. This can put youths at a higher risk for recidivism (Lambie & Randell, 2013). In order to achieve a successful transition, programs are needed not just to provide surveillance but to help maintain pro-social behaviours (Lambie & Randell, 2013). Programs that can address issues "in the months following release, including engagement with community services and community supervision, are keys to successful transition" and can decrease the risk of future contact with the justice system (Lambie & Randell, 2013: 455).

3.12 Conclusion

After providing a background that gives an understanding of what mental health is and why it is important, the causes of mental disorders and intellectual challenges were discussed. Mental illnesses can originate from genetic, biological or environmental factors. Although genetic disposition does have an impact on the development of a mental illness, contrary to public belief, environmental factors proved to have a greater impact. Any member of society is susceptible to a mental illness. It was found that women tend to have higher rates of mental illness, however, a direct link to the sex difference needs further exploring. As discussed, mental

illness is more common in the younger population. Persons aging between 15 to 24 years of age are at a higher risk of developing a mental illness. Studies show that SES is inversely related to the development of mental illness and that a lower SES has the potential to worsen mental disorders. All in all, mental illness has been shown to affect multiple areas of a person's life including their ability to maintain housing, keep a job and retain social relationships.

In treating mental disorders, hospitalization is sometimes used and can lead to stigmatization and weakened social connections. Due to barriers such as stigmatization, people with mental disorders can find it a struggle to become or stay employed. Incarceration can also be a problem for those who are mentally ill as they are often wrongly criminalized due to public fear of their disorder. The high costs of mental health care and incarceration were described with a focus on how preventative community services could lower those costs.

Community based approaches to help those with a mental disorder usually focus on making and maintaining healthy connections with others, making healthy lifestyle changes and readjusting to the community after a period of hospitalization or incarceration. Community based approaches were described as a better option for dealing with mental illness than hospitalization or incarceration as they are better suited to meet the needs of those with a mental disorder.

4 Methodology

A literature review was executed to help the researchers familiarize themselves with the existing data and information concerning mental illness, its effects, and the existing approaches to support persons with mental illnesses or intellectual challenges. Considering the varying approaches, the researchers focused their study on the community-based approach to mental health. To expand their knowledge of community-based approaches, the researchers conducted a

quantitative, summative evaluation of Turning Leaf. Turning Leaf is a community-based organisation located in Winnipeg, Manitoba, which assists persons with mental illnesses and intellectual challenges on a daily basis.

Before conducting their research, the researchers received approval for their project from the Research Ethics Board at the University of Manitoba.

With the goal of evaluating the effectiveness of Turning Leaf's programs, the researchers conducted a survey, which consisted of two separate questionnaires, one by the personnel of Turning Leaf and the other by its clients. The questionnaires were developed by the researchers, then reviewed by the CEO of Turning Leaf, Mr. Barkley Engel. The survey questionnaire for the personnel of Turning Leaf was administered electronically via the internet. Personnel were sent a recruitment e-mail with a link leading them to the questionnaire. Support workers and program coordinators were recruited to distribute and help clients fill out their questionnaire. Assisting support workers were required to sign a confidentiality agreement to adhere to the University of Manitoba Ethics Board requirements. The researchers met with the support workers and program coordinators prior to the distribution of the survey questionnaires to introduce, explain, and answer any questions they had about the study and completion of the questionnaires. Both personnel and clients were given two weeks to complete their questionnaires. Due to a lower than anticipated response rate, the deadline was extended an additional week. The final results of the questionnaires were entered into SPSS, a statistical analysis software package, where frequencies and cross-tabulations were produced for the researchers to analyse.

In addition, the researchers reviewed client files, in particular, client monthly goal sheets, to determine the effectiveness of Turning Leaf in assisting clients to meet goals and determine the category of goals in which the agency was most effective. The files used were randomly

selected by case managers at Turning Leaf. The information from the files was coded using a coding guideline created by the researchers (view appendix 9.4). The main coding categories included key areas of support in: community integration, behavioural concerns, daily living skills, employment and education, shelter and housing, medical and psychiatric, and incidents and legal issues. The coding data were then analysed by category using SPSS. Goal achievement percentages were obtained from the analysis of frequencies and cross-tabulations and subsequently compared to determine the agency's effectiveness.

The client files were also used to compare goal achievement with agency intervention in the form of hours per week the client used Turning Leaf's services. The number of goals achieved or not achieved for each client was tallied and a percent was given which showed how successful the client was in achieving their set goals. The clients were then split into 3 groups depending on how many hours per week they used Turning Leaf's services. The groups consists of clients that attended Turning Leaf 9 hours a week or less, 10 to 19 hours a week and 20 hours a week or more. The percentages of achievement within those groups were then averaged to obtain a final percentage of goals achieved for each group.

A cost-benefit analysis was carried out to evaluate each program offered by Turning Leaf independently. The findings from the survey questionnaires and the client files were used to accomplish the analysis, in addition to financial information provided by Turning Leaf. Furthermore, the costs of Turning Leaf, a community-based approach to mental illness, was compared to the costs of its alternatives, incarceration and hospitalization.

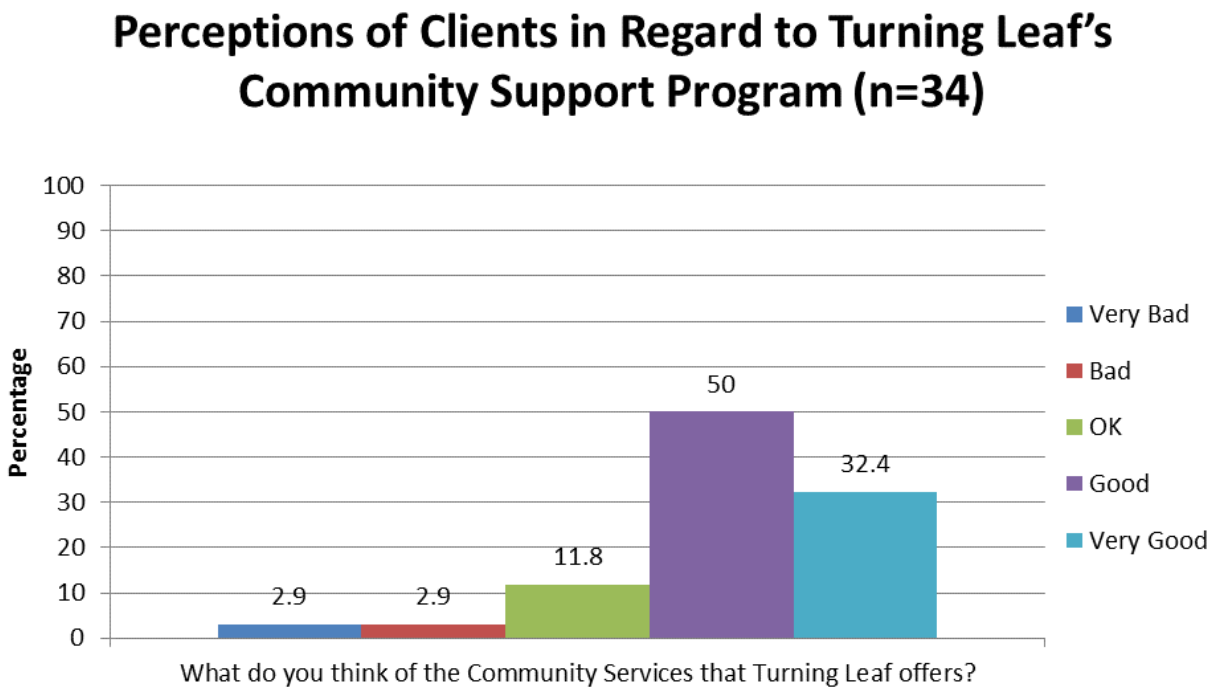
5 Findings

5.1 Client Survey Questionnaire Results

According to the 35 clients who participated in the client survey questionnaire, 97.1% "like going to Turning Leaf" and 100% of the clients agreed that "the people at Turning Leaf help them". The clients were asked questions with the purpose of evaluating Turning Leaf in general and the specific Programs offered.

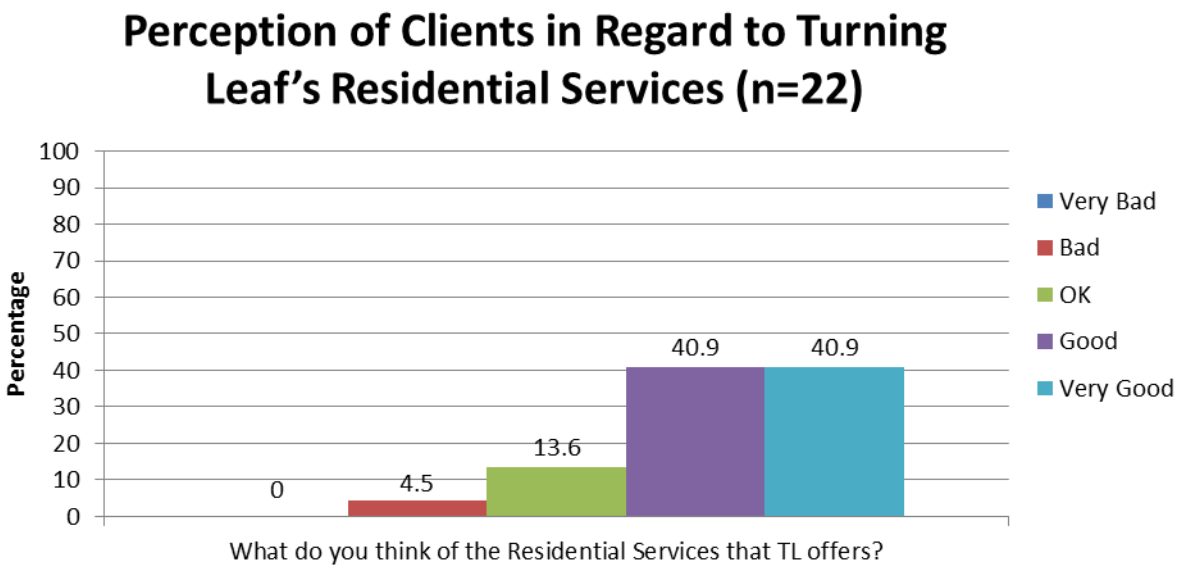
The Community Support Program offered by Turning Leaf focuses on three main goals; including helping the clients to manage risk, overcome challenges and learn to meet their own needs. In terms of managing risk, when asked whether Turning Leaf helped them "develop a safety plan and stick to it", 69.7% indicated that was true. In regard to helping clients deal with challenges in their lives, 54.5% of clients responded that it was "true" and 18.2% responded it was "very true". When asked whether Turning Leaf helped them recognize and meet their own needs 58.1% of clients responded "true". Other questions that aimed to evaluate the Community Support Program include whether Turning Leaf helped clients cope with stress. Of the clients who answered, 56.9% thought it was "true" but 25% were "unsure". In regard to the counselling sessions offered by Turning Leaf, 51.9% of clients thought the individual counselling had helped them but only 31.6% thought that the family counselling sessions were helpful, and 47.4% of clients were "unsure" whether the family counselling sessions were helpful. When asked how Turning Leaf was at helping them meet people in the community, 52.9% of clients thought that Turning Leaf was "good" while 23.5% thought they were "OK" and 23.5% thought they were "very good". When asked whether Turning Leaf helped them learn how to talk to people, 44.1% of clients thought they were "good". When asked, 97.1% of clients thought that "Turning Leaf helped them set good personal goals" and 87.9% thought Turning Leaf would help them if they

were in trouble. Overall, 82.4% of the clients thought the Community Support Program was either “good” or “very good” and only 5.8% thought it was “bad” or “very bad”. The following graph depicts the exact distribution of these responses.



The Residential Support Program is another service offered by Turning Leaf. It is a program designed to assist clients in developing skills that will lead to healthy and successful independent living. Specific questions in the survey questionnaire were aimed at evaluating the Residential Program. These questions mainly focused on personal care. When asked how Turning Leaf was at helping clients learn to take care of themselves, 72.7% thought they were either “good” or “very good”. Of those that responded, 40.6% thought Turning Leaf was “good” at teaching them how to eat healthier while 37.5% thought they were just “OK”. In regard to cleanliness, 78.8% thought Turning Leaf was either “good” or “very good” at teaching them how to keep themselves clean and 64.6% thought Turning Leaf was “good” or “very good” at

teaching them how to keep their house clean. Overall, 81.8% of the clients thought that the Residential Support Program was "good" or "very good". The following graph represents the responses.



Finally the questions aimed at evaluating the Day Services program focused on employment and education. Only 7 clients reported that they had a job. Of that 7, 3 believed Turning Leaf was "very good" at helping them with their job, 3 thought Turning Leaf was "OK" and 1 client said turning leaf was "good". Only 1 client who completed the survey reported that they went to school.

When asked whether Turning Leaf had told them about the other services offered, 74.3% of clients responded that yes, they had been made aware of the other services that could help them. Overall, 80% of clients rated Turning Leaf as "good" or "very good" and only 2.9% rated Turning Leaf as "very bad".

5.2 Staff Survey Questionnaire Results

The online survey questionnaire for the staff of Turning Leaf reported that amongst all of the participants (n=35), the majority had worked for Turning Leaf between 2 and 5 years (61.8%). Those who had worked for Turning Leaf for a period of time less than 2 years represented 23.5% of the sample, and those who worked for Turning Leaf over 5 years represented 14.7% of the sample.

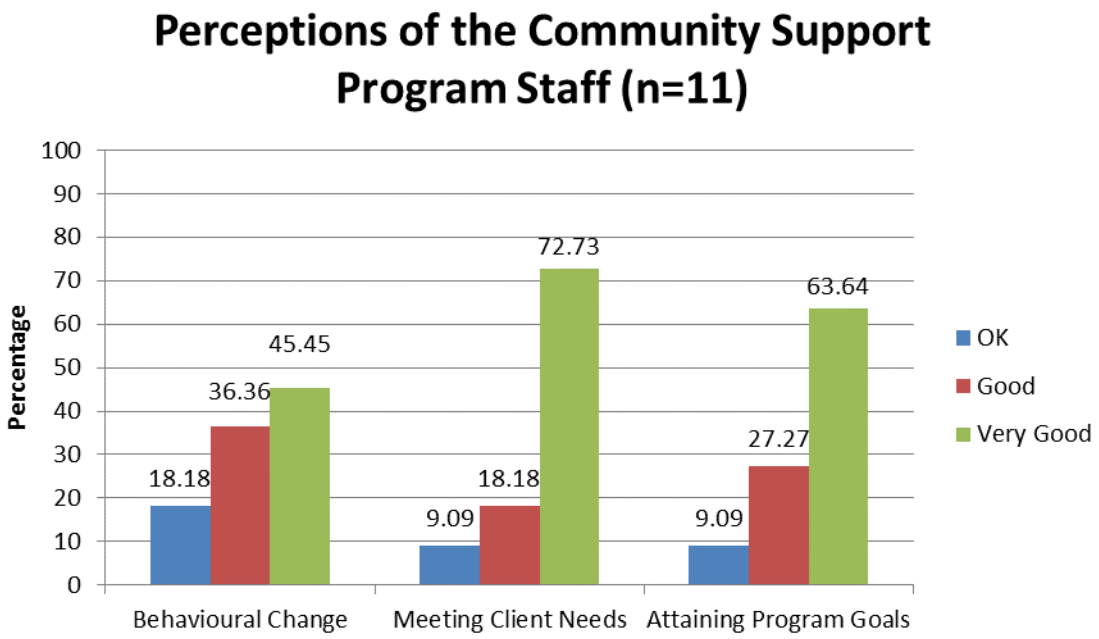
Of the same sample, 34.3% of the respondents work for the Community Support Program, 46.8% work for the Residential Support Program, 9.3% work for the Day Services, and 9.3% work in other sectors which includes the Crisis Team, intake, and administration.

Participants were asked a series of questions which focused on the mission statement of the Community Support Program. The main goals of the program are to help clients manage risk, overcome challenges, and to learn how to meet their own needs. In regard to helping clients manage risks, 76.4% of the staff agreed or strongly agreed that Turning Leaf was successful. When asked if they found that the majority of clients who had received assistance from Turning Leaf followed the safety plan they had created with Turning Leaf, 69.7% agreed on some level. In terms of making safer choices, 70.6% of the staff agreed on some level that clients were capable of making safer choices if they had received assistance from Turning Leaf. Also, 79.4% of the staff agreed on some level that clients of Turning Leaf reached out for assistance as soon as possible in times of crisis.

A second goal of the Community Support Program is to help client overcome challenges. When asked if Turning Leaf was successful in teaching clients to overcome challenges in their daily lives, 88.2% of the staff agreed on some level with the statement. When asked their level of

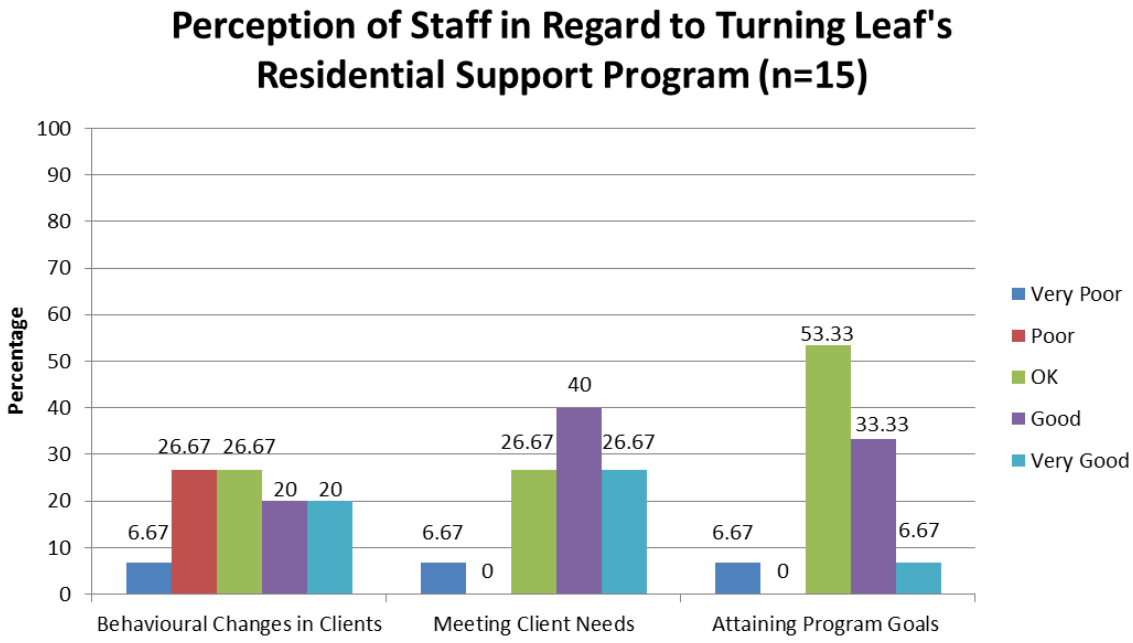
agreement with the success rate of Turning Leaf in teaching clients how to cope with stress, 79.5% of the staff agreed on some level that Turning Leaf was successful.

The final goal of the Community Support Program is to help clients learn how to meet their own needs. One of the program's approaches is to aid clients in developing good interpersonal skills, which in return can help them effectively communicate their needs. The majority of the staff surveyed (82.4%) agreed that Turning Leaf is doing well in helping clients develop good interpersonal skills. The graph on the following page represents the responses to the questions from the staff opinion survey questionnaire referring to the Community Support Program's main goals.



As mentioned earlier, 46.8% of the surveyed sample work for the Residential Support Program. The Residential Support Program provides a variety of services tailored to individuals. In particular, the program focuses on delivering programs that will help clients develop skills that promote healthy and independent living. When asked whether Turning Leaf was successful

in getting participants to engage in activities that promote healthy residential living, 73.5% agreed on some level that they were successful. In regard to teaching clients how to appropriately care for themselves, 88.2% agreed, on some level, that Turning Leaf was successful in attaining this goal. Staff perceptions demonstrated that 61.8% agreed, on some level, that clients who received assistance from Turning Leaf successfully make healthy decisions. On the other hand, 29.4% reported that Turning Leaf was average at attaining this goal. The following graph represents the responses to the questions referring to the program's main goals.



The survey questionnaire distributed to the staff also contained questions which evaluated Turning Leaf as a whole. Staff members were asked whether they found that clients, on average, seemed like they wanted to be at Turning Leaf when they were there. Results showed that 79.5% of staff members agreed on some level that clients seemed to want to be at Turning Leaf.

In regard to the initial assessment process when clients are first introduced to Turning Leaf, staff members agreed at a rate of 78.1% that the process was effectively identifying the

needs of the clients. Also, 60.6% of the staff strongly agreed and 27.3% agreed, making that a total of 87.9% in agreement, that meeting the client's personal needs is a top priority at Turning Leaf.

Considering that Turning Leaf offers a great variety of services, staff were asked if they found that clients seemed to be aware of the variety of services available at Turning Leaf. Results showed that 45.5% of staff members agreed, and 24.2% strongly agreed to the latter statement, which totals to 69.7% in agreement. Also in this regard, staff were asked whether they found that Turning Leaf was effective in referring clients to other programs within the organization, such as the Day Services Program, SET, and Guided Living. Staff answered 62.5% in agreement, and 28.1% remained neutral on the topic.

As for delivering the services to their clients, staff were asked questions concerning the training they had received, providing the services, and the results of the services. The majority of the respondents (87.9%) agreed that the training they received from Turning Leaf provided them with the proper tools and knowledge to effectively perform their work duties. In addition, staff agreed in majority (72.8%) that Turning Leaf is successfully providing all planned services to its clientele. In regard to receiving expected results from its programs, 43.8% of the respondents agreed, 28.1% strongly agreed, and 21.9% remained neutral. Making that 71.9% in agreement that Turning Leaf is receiving expected results from its programs according to the staff members surveyed.

The staff were given 3 open-ended questions to answer at the end of the questionnaire that allowed them to respond, in their own words, about the effectiveness of Turning Leaf and any challenges they encounter in delivering services to clients. Staff (n=24) were asked whether any new client needs had arisen since they started at Turning Leaf and how they are being

addressed. The responses fit into several broad categories. The most common response to this question was that client needs are met by the staff as they arise and are adapted to help each individual. Many staff members expressed the need for more programs including Aboriginal services, a work placement program and addictions programming as well as an introduction to the Employment and Income Assistance (EIA) process. One staff member suggested a type of day program specifically for the clients in the residential program so that clients can have something to look forward to and have the opportunity to develop new skills. Housing was also an issue that was brought up by staff members as the need for housing has increased. Housing difficulties include waitlists for subsidized housing, bedbug infestations, and landlords who do not accept renters on EIA. Finally one staff member asserted the need for "bigger space" either through renovations or finding a new building.

The second open-ended question asked the staff (n=23) whether there were any ways in which Turning Leaf could be more effective. The most common response was that more training and resources were needed for the staff. Suggestions for training include familiarizing staff with the justice system and other such services that can have an effect on clients such as Child and Family Services. An increase in wages to attract more qualified staff was also suggested. An increase in the effectiveness of communication between staffing locations was mentioned by several people. One staff member reported that more funding was needed in order to be more effective in providing assistance to those in need. Some staff members mentioned that management could be more understanding and consistent in decision making. A lack of consistency and the need for more structure were issues that came up multiple times and it was suggested that Turning Leaf could be more effective at meeting its mandate. Many staff

members responded that there should be more observations of clients before accepting a referral. Full risk assessments and review of case files should precede service delivery.

The third and final open-ended question asked the staff (n=25) whether there are any challenges in delivering programs to clients. The challenge that came up the most often was a lack of funding, but many staff member also responded that Turning Leaf was understaffed and under trained. Many people mentioned that the staff was burnt out or overworked which can affect the level of care provided. Inconsistency from the management can also create challenges according to some staff members. The latter includes too much paperwork, structural disorganization and files with missing information due to system gaps. Another challenge that was mentioned by many staff members was the client's reluctance to accept the support offered either due to lack of motivation or desire for help. Other challenges mentioned by respondents include waitlists or lack of appropriate resources, opposition from community members, negative influences in the lives of clients, and not enough time spent with the clients.

5.3 Results of Client File Examination

Client files (n=11) from the Community Support Program were analysed to determine how effective the agency is in helping clients meet their monthly goals. Each goal was analysed according to the key areas of support which includes community integration, behavioural concerns, daily living skills, employment and education, shelter and housing, medical and psychiatric, as well as incidents and legal issues.

Community integration was a popular area of support with 59 total goals between clients. Breaking down the goals, 50.8% of the goals focused on recreational activities. Goals that had to do with attending Turning Leaf or its workshops made up 22%, while 15.3% of the goals had to

do with relationship building, and 11.9% dealt with conflict resolution. Of the community integration goals, 30.5% were achieved and 30.5% were not achieved while 39% were undetermined which refers to goals that were not specified as being achieved or not. In regard to achievement for each specific goal, no goals were achieved in the area of relationship building or conflict resolution. Of the recreational goals, 37% were achieved and 37% were not achieved. The goal with the highest achievement rate was attending Turning Leaf or its workshops at 54%.

Another key area of support is behavioural concerns which consisted of 27 total goals. The majority of goals in this area were focused on addiction issues at 48.1%. Another popular goal in this area includes interpersonal skills at 44.4% and finally at-risk behaviour which included only two goals. Overall, 48.1% of the goals in this area were achieved and only 11.1% were not achieved making 40.7% undetermined. Interpersonal skills had the best achievement rate at 75%. The two at-risk behaviour goals were not achieved. For the addictions issues goal, 30% were achieved but 70% were undetermined.

By far the most popular area of support which included 145 client goals, is daily living skills. The specific goals included in this area are financial and homeowner responsibilities which made up 25.5% of all goals, home cleanliness and maintenance at 20.7%, health and fitness at 20.7% and hygiene at 17.2%. Smaller goals also included are diet which made up 7.6%, clothing and laundry at 5.5% and finally transportation at 2.8%. Achievement success for this area of support was not optimal. Overall, 37.2% of goals were achieved and 46.2% were not achieved while 16.6% of goals in this area were undetermined. However certain goals had higher achievement rates than others. For example clothing and laundry had an 88% achievement rate. Financial and homeowner responsibilities' achievement rate was 46% and the goals not achieved made up 30%. Successful goals for transportation only was 25%. Achieved goals in home

cleanliness and maintenance was 33.3% whereas unachieved was 53%. Hygiene had similar results with a goal achievement rate of 48% and goals not achieved at 52%. Diet goal achievement was 36%, with 55% of goals unachieved. Health and fitness had the lowest achievement rate at 10%, where 57% of the goals were not achieved and 33% were undetermined.

Employment and education is an area of support that has fewer goals than other key areas with only 24 total client goals. Although this area includes schooling and volunteer placement goals, most of the goals set by clients had to do with employment. There was only one goal each for schooling and volunteering. Overall the achievement rate for this area of specialization was only 20.8% where unachieved goals were 41.7% and undetermined goals made up 37.5%. Employment, which made up 91.7% of the total goals, had a goal achievement rate of 55% leaving 40% of goals not achieved and 40% undetermined.

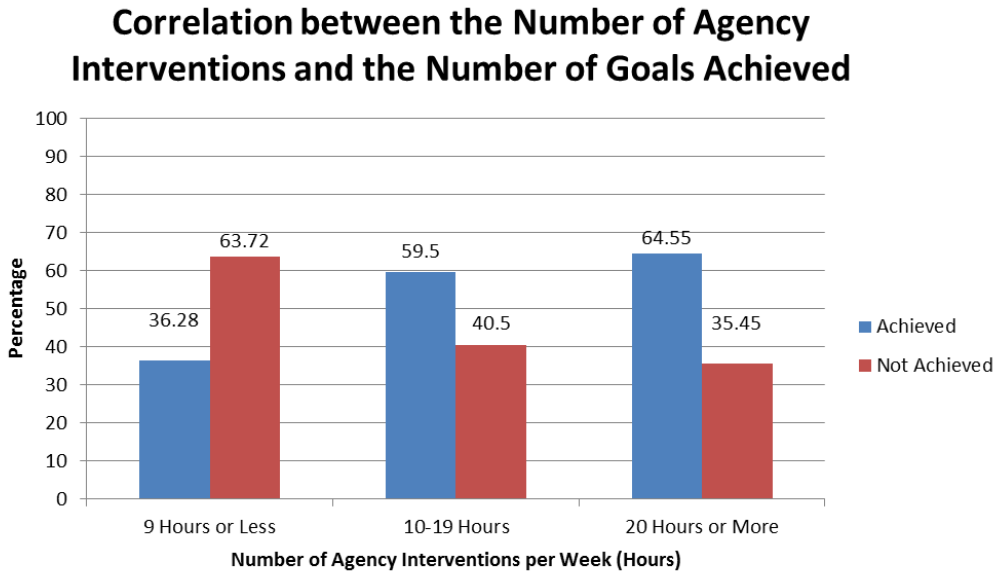
Shelter and housing goals were much less common with only 16 total goals. The most popular goal in this area was affordable housing at 68%. Transient behaviour made up 18.8% and tenant advocacy made up 12.5% respectfully. This was an area of support where goal achievement was fairly good at 62.5% with only 31.3% of goals not achieved. Transient behaviour was best with 100% goal achievement while 64% of affordable housing goals were achieved and 36% of goals were not achieved. Finally 50% of tenant advocacy goals were achieved and 50% were not.

There were 36 total medical and psychiatric goals in the client files analysed. Most of these goals fell into the area of treatment and medication as it made up 47.2%. The next most frequent goal was appointments at 33.3%. Self-care made up 13.9%, and dental and optical made up only 5.6% of all goals in this area of support. This area had also had good achievement as

only 8.3% of the goals were not achieved, 58.3% of goals were achieved and the rest were undetermined. The goal with the highest level of achievement was dental and optical with an achievement of 100%. Appointments also had a high level of achievement as 83% of goals were achieved and only 16% were undetermined. Of treatment goals, 35% were achieved and 59% were undetermined. Finally for self-care goals, 60% were achieved and 40% were not achieved.

There was only 1 goal that dealt with the last key area of support, incidents and legal issues. An accurate achievement rate cannot be determined from this area of support due to lack of data. When combined, there were 308 total client goals analyzed and 40% of those goals were achieved, 34% were not achieved and 26% were undetermined.

The 11 client files analysed were also used to determine a correlation between goals achieved and the amount of intervention from Turning Leaf as measured by how many hours a week the client used Turning Leaf's services. Clients were split into 3 groups depending on their hours per week. Those who had under 9 hours were grouped together, 10 to 19 hours were another group and those with 20 or more hours made up the final group.



The previous graph shows that clients who attended Turning Leaf 9 hours a week or less had a goal achievement rate of only 36.28% while 63.74% of goals were not achieved. For clients with whom Turning Leaf had contact between 10 and 19 hours a week, the level of goal achievement was 59.5% and 40.5% of goals were unachieved. The biggest improvement came when clients spent 20 hours or more using Turning Leaf's services as their goals were achieved 64.55% of the time and not achieved in 35.45%. There appears to be a direct correlation between hours spent receiving services from Turning Leaf and goal achievement.

5.4 Program Costs

In the year 2014, Turning Leaf spent a total of $7,958,123.42 to offer its programs to its clientele. The direct costs of programs, which include salaries and benefits for staff members, supplies and materials required for the programs, rent for the facilities required for the programs, transportation and utilities, make up 79.5% of that total, that being $6,328,123.42 in the year 2014. The indirect costs of offering the programs, which include management staff salaries and benefits, infrastructure costs, licences, marketing and training make up the remaining 20.5% of the year's spending; which equals $1,630,000.00.

The three main programs that Turning Leaf offers are the Residential Support Program, the Community Support Program, and the Day Services program. In 2014, the Residential Support Program represented 53.16%, the Community Support Program represented 19.32%, and the Day Services Program represented 7.04% of the overall organizational budget. This report will mainly focus on the Residential Support Program and the Community Support Program.

5.5 Average Costs of Turning Leaf and its Alternatives

Turning Leaf clients can be divided into three behavioural risk categories: low risk, medium risk, and high risk. The low risk category is comprised of clients which require minimal weekly interventions. These interventions make up of 10 hours or less per week. The medium risk category consists of clients which require intermediate weekly interventions. The interventions range between 11 to 20 hours per week. Lastly, the high risk category encompasses clients which require elevated amounts of weekly interventions. The intervention rate in this category is 21 hours or more per week.

Table 1 - Comparison of Costs of the Behavioural Risk Categories of Turning Leaf Clients

TURNING LEAF SERVICES INC.					
	Average Goal Achievement Rate (Percentage)	**Average Daily Cost**	**Average Weekly Cost**	**Average Monthly Cost**	**Average Yearly Cost**
Low Risk *(10 Hours or Less per Week)*	39.34%	$43.99	$219.95	$879.80	$7,918.20
Medium Risk *(11-20 Hours per Week)*	37.02%	$104.16	$520.79	$2,083.17	$18,748.44
High Risk *(21 Hours or More per Week)*	80.65%	$326.19	$1,630.94	$6,523.76	$78,285.20

As noticeable in Table 1 on the previous page, the low risk category, with the intervention of Turning Leaf, has an average goal achievement rate of 39.3%. The medium risk category has an average goal achievement rate of 37%, and the high risk category has an average goal achievement rate of 80.6%.

Furthermore, Table 1 demonstrates that the average yearly costs of the low risk category equals $7,918.20, the medium category equals $18,748.44, and the high risk category equals $78,285.20. When comparing the low risk category and the medium risk category a difference of $10,830.24 is apparent. The medium risk category and the high risk category hold a greater difference of $59,536.76. The polarizing categories, low and high risk, have an average yearly cost difference of $70,367.00.

Table 2 - Comparison of Costs for Incarceration and Hospitalization in Canada

ALTERNATIVES TO THE COMMUNITY-BASED APPROACH					
		Average Daily Cost	**Average Weekly Cost**	**Average Monthly Cost**	**Average Yearly Cost**
Incarceration	***Federal Inmate***	$357.00	$2,499.00	$9,996.00	$119,952.00
	Provincial or Territorial Inmate	$171.00	$1,197.00	$4,788.00	$57,456.00
Hospitalization	***Mood Disorders***	$525.37	-	-	-
	Schizophrenia/ Schizoaffective Disorder	$599.37	-	-	-
	Total Daily Average	$562.37	-	-	-

*Hospitalization costs can only be calculated at a daily level due to varying lengths of stays per patient (Note that the *average* length of a stay for mood disorders and schizophrenia are less than a month)

Sources: Statistics Canada and the Canadian Institute for Health Information (2012-2013)

Table 2 on the previous page, demonstrates the costs of alternate approaches to mental illness, incarceration and hospitalization. In a Canadian federal correctional institution, the average daily cost of an inmate is $357 which equals an average yearly cost of $11,995. In a provincial correctional institution, the average daily cost of an inmate is $171 which equals an average yearly cost of $57,456. There is a daily cost difference of $186 between federal and provincial institutions, and a yearly cost difference of $62,496.

In regard to the costs of hospitalization of people who are mentally ill, the average daily cost of a person with a mood disorder in Manitoba is approximately $525.37. The average daily cost of a person with schizophrenia or a schizoaffective disorder in Manitoba is approximately $599.37. The latter averages to a daily hospitalization rate of $562.37.

The daily average difference between hospitalization and a federal correctional institution is $205.37, and the difference between hospitalization and a provincial correctional institution is $391.37.

Table 3 on the following page, illustrates the estimated average cost of a stay in a Manitoban hospital in accordance to a selection of mental illnesses. The table also demonstrates the average length of stay (in days) and the approximate daily cost for every mental illness listed.

The subsequent table, Table 4, compares the average length and cost of a stay in a Manitoba hospital of both mood disorders and schizophrenia or schizoaffective disorders, as well as the approximate daily cost. For comparative purposes, total averages were calculated using this data to provide an approximate daily cost of hospitalization for mental illness in Manitoba.

Table 3 - Costs of Hospitalization in Manitoba for the Age Group of 18-59 Years of Age (Disorder Specific)

	Estimated Average Cost of Stay	Average Length of Stay (Days)	Approximate Daily Cost
Eating Disorder	$16,313.00	46.2	$353.10
Personality Disorder	$4,429.00	6.6	$671.06
Anxiety Disorder	$5,135.00	5.0	$1,027.00
Bipolar Disorder and Severe Depression	$10,463.00	20.6	$507.91
Substance Abuse with Acute Intoxication	$1,756.00	1.7	$1032.94
Schizophrenia/Schizoaffective Disorder	$13,306.00	22.2	$599.37
Childhood/Adolescent Developmental Disorder	$12,760.00	10.2	$1,250.98

Source: Canadian Institute for Health Information (2012-2013)

Table 4 - Costs of Hospitalization in Manitoba for the Age Group of 18-59 Years of Age (Specific to Mood Disorders and Schizophrenia/Schizoaffective Disorder)

	Estimated Average Cost of Stay	Average Length of Stay (Days)	Approximate Daily Cost
Mood Disorder	$5,674.00	10.8	$525.37
Schizophrenia/Schizoaffective Disorder	$13,306.00	22.2	$599.37
Average Totals:	$9,490.00	16.5	$562.37

Source: Canadian Institute for Health Information (2012-2013)

6 Discussion and Conclusions

6.1 Analysis of the Community Support Program

To understand at a larger scale the effectiveness of the Community Support Program, the results from both the staff and client surveys will be compared and analysed. As stated earlier, the Community Support Program's main goals are to help clients manage risk, overcome challenges, and learn how to meet their own needs.

Clients and staff were both questioned about their opinion of the effectiveness of the safety plans created for clients with the help of the staff in the Community Support Program in hopes to meet the program's goal of helping clients manage risk. Staff agreed at a rate of 69.7% that clients who received assistance from Turning Leaf followed their safety plans created with the help of the Community Support Program. A similar response is apparent in the results of the client survey. Client results showed that 69.7% agreed and 12.1% strongly agreed (total agreement of 81.8%) that they followed through with the safety plans they had created with the help of the Community Support Program. It can be concluded that the Community Support Program is doing well in terms of meeting the program goal of helping clients manage risk in their daily lives with the help of safety plans. However, it is interesting to note that though both groups responded positively, there is still a difference of 12.1% between the two groups.

In regard to the second goal, helping clients overcome challenges, staff and clients have comparable responses when asked directly whether Turning Leaf helps with overcoming challenges. The majority of the staff members surveyed (88.2%) agreed on some level that the Community Support Program assisted clients in overcoming challenges. The majority of clients also agreed in the statement at 72.7%. Nonetheless, a slight difference is evident between the

staff and client opinions when asked how effective the Community Support Program is with helping clients cope with stress. Staff members indicated 79.5% agreement with the statement that the program helps clients cope with stress, while 65.7% of clients state that the program has helped them cope with stress. Though the result seem fairly close, it is interesting to note that 25.0% of client respondents were uncertain of how effective the Community Support Program was in helping them cope with stress, and that there is a 13.8% difference between the staff and client rating.

As discussed in the findings section, the final goal of the Community Support Program is to help clients learn how to meet their own needs. Doing so includes helping clients to develop good interpersonal skills, which in turn can help them effectively communicate their needs. In order to appropriately analyse the effectiveness of the Community Support Program in attaining this goal, the responses of one of the questions from the staff survey questionnaires was compared to the responses to two questions from the client survey questionnaire.

The majority of the staff surveyed (82.4%) agreed that Turning Leaf is doing well in helping clients develop good interpersonal skills, which as discussed, helps clients meet their needs. In the client opinion survey, clients were asked to evaluate both how the program was at helping them meet people in the community and how the program was at helping them learn how to talk to people. The client respondents answered in majority (76.5%) that the Community Support Program was in fact doing well in helping them meet people in the community. The remaining 23.5% reported the program as doing "OK", therefore, there were no negative responses to this question. As for the second question, 44.1% of the client respondents found that the Community Support Program was good at helping them learn how to effectively talk to others. The "OK" and "Very Good" options each gathered 23.5% of the responses. Once again,

few negative responses were collected. Therefore, it can be concluded that the Community Support Program is doing well in terms of meeting the program goal of helping clients meet their needs in terms of helping them develop good interpersonal skills, meet people in the community and teaching clients how to effectively talk to others.

In addition, for this goal clients and staff were asked to rate the Community Support Program's overall effectiveness in meeting clients' needs. Clients were asked to rate how the program was in terms of helping them recognise and meet their own needs, and staff were asked their opinion on how well they thought their program was regarding meeting client needs. The majority of clients (58.1%) responded that it was "true" that the Community Support Program helped them recognise and meet their own personal needs. Another 19.4% of client responded that the statement was "very true", which totals to a 77.5% rate of agreement. It is important to note that only 3.2% of clients found that the statement was "hardly true" and the remaining 19.4% were "not sure" whether Turning Leaf helped them recognise and meet their needs. Staff survey results were equally positive in regard to this program goal. The Community Support Program staff answered, in majority (72.7%), that the program was "Very Good" in terms of meeting client needs, and 18.2% responded that they thought the program was "Good". Thus, 90.9% of the Community Support Program staff thought that the program was doing well in terms of meeting this particular program goal. Again, the staff rated the effectiveness at a higher level with a difference of 13.4% from the clients.

6.2 Client File Analysis

The analysis of the client files from the Community Support Program was able to provide a clear picture of how the agency is doing in regard to helping their clients achieve their personal

goals. The analysis highlights the areas in which Turning Leaf can make improvements, which could hopefully result in more clients achieving their goals.

Many clients had goals that fell into the community integration category so this could be an area where Turning Leaf might want to focus their attention. Only 30.5% of the community integration goals were achieved. Relationship building and conflict resolution were areas that did not have any goal achievement according to the client files examined. Behavioural concerns was another area where only 48% of the goals were achieved. Clients seemed to be fairly successful at achieving goals related to interpersonal skills but there were very low achievement rates for both at-risk behaviour and addiction issues goals. The area of support that had the most goals by far was daily living. This is an important area for Turning Leaf to pay attention to as most clients analysed seem to have goals in this category but the achievement rate was only 37.2%. Health and fitness as well as hygiene are two areas that require attention as they are common goals among clients but the success rates are fairly low. Employment and education is an area with only 20.8% of goals achieved and could therefore use the attention of Turning Leaf. It is important to note that most of the goals in this category fell under employment. Shelter and housing was one area of support where the achievement rate was comparatively good at 62.5%. Finally, medical and psychiatric goals had an achievement rate of 58.3%. Most of these goals fell under the category of treatment or medication.

To develop a clearer picture of achievement rates, Turning Leaf may want to focus on defining goals as achieved or not instead of using the category “undetermined”. Providing the case-managers with a precise definition of what an achieved goal consists of, as well as what an unachieved goal consists of, may help clear up any confusion. Turning Leaf could use the category “in progress” in the future to provide more useful information as leaving a goal

achievement level as “undetermined” or “somewhat achieved” could potentially result in the goal being overlooked. Therefore, creating a precise and inclusive definition for these two categories could likely result in a higher rate of goal completion due to case-managers being able to better assist and guide clients with achieving their personal, monthly goals.

Results show that there is a positive correlation between goal achievement and intervention from Turning Leaf. As the number of hours per week spent receiving help from Turning Leaf increases, the number of goals achieved also increases. Similarly, as the number of hours decrease, the number of goals achieved also decreases. It is important to note that correlation does not equal causation. While there is a relationship between the number of hours per week spent receiving help from Turning Leaf and the number of personal goals achieved, one does not necessarily cause a change in the other.

On the whole, it can be concluded that the Community Support Program is performing well in the opinions of both the staff and clients of Turning Leaf in terms of meeting its program goals. It is interesting to note, however, that in the majority of cases, the staff rated the performance levels of the program at a higher rate than the clients. With an overall goal achievement rate of 40% in the client’s monthly goal assessments, it would appear that Turning Leaf’s Community Support Program could be more effective in helping their clients achieve their personal goals. It is important to note however, that client participation can have a lot to do with the likelihood of achieving goals. Turning Leaf does not have control over a client who is unwilling to put in the time and effort it takes to accomplish a goal. Results also show that the more hours a client spends utilizing Turning Leaf’s services, the more likely they are to achieve their goals. Therefore, clients who spend less time receiving intervention from Turning Leaf are

less likely to accomplish their goals. Without spending more time with each client, Turning Leaf may not be as effective as they would hope, at helping clients accomplish their goals.

Future research to uncover the average length of time it takes a client to achieve a goal could be done to further analyse client achievement patterns and its relation with Turning Leaf's involvement. Future research would also be required to distinguish why a difference exists between the staff and client opinions about the Community Support Program.

6.3 Analysis of the Residential Support Program

To determine the effectiveness of the Residential Support program, the applicable results from the staff and client surveys will be compared and analysed. Clients and staff were asked about the success of activities that promote healthy residential living. Overall, 73.5% of staff agreed on some level that Turning Leaf was successful at providing activities that promote healthy living. Client questions focused on the individual activities that make up healthy living. For example, 58.4% of clients thought Turning Leaf was “good” or “very good” at teaching them how to eat healthier and 64.6% of clients responded with “good” or “very good” when asked how Turning Leaf was at teaching them to keep their house clean. There is a slight discrepancy between the staff and the clients in the perception Turning Leaf’s success in promoting healthy residential living. The staff report more success than the clients do. There could be improvements made in helping clients learn how to live a more healthy lifestyle by eating healthy and maintaining a clean living environment.

Another aspect of the Residential Support Program focuses on teaching clients how to care for themselves. A majority of staff at 88.2% agreed some level that Turning Leaf was successful at teaching clients to care for themselves. When clients were asked how well Turning

Leaf was doing in teaching them to care for themselves, 72.7% of clients responded with “good” or “very good”. Clients were also asked how Turning Leaf was doing in teaching them to keep themselves clean and 78.8% of clients said they were “good” or “very good”. There is less of a discrepancy between staff and client opinions in this area however the staff still report higher rates of success than shown by client responses. The difference could be due to improved hygiene being more noticeable to others than it is to oneself.

Overall, 81.8% of the clients agree that the Residential Program offered by Turning is “good” or “very good”. Whereas only 33.3% of the staff who work for the Residential Support Program responded that client feedback for the program is good and no staff member responded that feedback was “very good”. This highlights a huge discrepancy between staff and client opinion on the program.

After comparing the opinions from the client and staff surveys, it is clear that Turning Leaf’s Residential Support Program is effective. There are some inconsistencies between client and staff opinions of the program, however for the most part the opinions were positive. Both clients and staff felt that the Residential Support program is successful in providing help to clients.

6.4 Cost Analysis

The Community Support Program made up 24.3% of the budget spending for programs at Turning Leaf in 2014. When the clients were asked to rate on a scale ranging from "Very Bad" to "Very Good" the services that make up the Community Support Program, 50.0% rated them as "Good" and 32.4% rated them as "Very Good", making up a total of 82.4% of the overall responses for the question. The staff who reported working for the Community Support Program

(n=11), reported that the program was noticing good or very good behavioural changes (81.8%) in their clients. Also, 90.9% of the Community Support Program staff reported that the program was doing well in terms of meeting the client's needs, attaining its program goals, and that the client feedback was positive for the program. Thus, considering that the program is obtaining good-quality results, it can be concluded that the program holds beneficial worth to the clients and cost-effective value to the organization.

In 2014, the Residential Support Program made up 66.85% of the budget for programs at Turning Leaf. When the clients were asked to rate on a scale ranging from "Very Bad" to "Very Good" the services offered by the Residential Support Program, 40.9% rated them as "Good" and 40.9% rated them as "Very Good" making up a total of 81.8% of the overall for the question.

Of the staff who reported working for the Residential Support Program (n=15) in the survey, 40.0% reported that the program was noticing “good” or “very good” behavioural changes in its clients, 26.6% reported an “OK” change, and 33.3% reported “poor” or “very poor” amounts of behavioural change in the clients of the Residential Support Program.

In regard to the Residential Support Program meeting the client's needs, 66.7% of the staff working for the program rated it as “good” or “very good”, and 26.7% rated it as “OK” at meeting the client's needs. When the staff of the Residential Support Program were asked to rate the program in terms of attaining its program goals, 53.3% thought that the Residential Support Program was “OK” at attaining its goals, 39.9% thought they were “good” or “very good”.

In terms of the client feedback, 46.7% of the Residential Support Program reported the feedback they received from clients was poor or very poor, while 20% reported it was “OK”, and 33.3% reported the program was “good” or “very good”.

Considering that the Residential Support Program makes up 66.8% of the budget for the programs offered at Turning Leaf and that the client and staff opinions vary on certain aspects, a minor re-evaluation of the program is required. An area that requires attention, based on the staff responses, is the program's capability of producing positive behavioural changes in clients. Though the program is creating positive behavioural changes (40.0% responded "good" or "very good", and 26.6% responded "OK"), an anomaly in the results presented itself when 33.3% of the staff members found that the program was producing either "poor" or "very poor" behavioural changes in its clients. It is be noted that 33.3% certainly does not represent the majority, however, considering that the number is larger than in most other areas evaluated, it cannot be overlooked. Further exploration in why staff may hold this opinion is required to better understand this anomaly in the results. Another area that requires attention is apparent in the results from the staff survey where 46.7% of the staff members who participated in the survey stated that the client feedback was "poor" or "very poor". Once again, this result is an anomaly in the findings which suggests further exploration on the subject is needed. Therefore, considering that there are some anomalies in the findings for this program and that it encompasses the majority (66.85%) of the budget for the offering of programs at Turning Leaf, it is strongly suggested that Turning Leaf re-evaluates the above mentioned areas that demonstrated anomalies to ensure that the program remains cost-effective to the organization and produces expected benefits for its clients.

6.5 Analysis and Comparison of Turning Leaf and its Alternatives

As discussed earlier and displayed in Table 1 (based on the client file analysis) the low risk category has an average goal achievement rate of 39.3%, the medium risk category has an average goal achievement rate of 37%, and the high risk category has an average goal achievement rate of 80.6%. It is interesting to note that the average goal achievement rate for the medium risk category is lower, though not by much (a difference of 2.3%), than that of the low risk category. Considering that the medium risk category consists of more interventions from Turning Leaf and costs $1,203.37 more monthly than the low risk category, further research is required. Exploration is required to identify why the category scores lower and does not reflect the pattern observed in the analysis of the monthly goal sheets that suggests that the more interventions that Turning Leaf has with a client, the more the goal achievement rate will be higher.

The average goal achievement rate (80.6%) of the high risk category holds a notable difference of 43.6% from the preceding grouping, the medium risk category. Therefore, this finding does reflect the same pattern discovered in the analysis of the monthly goal sheets. The difference between goal achievement percentages are quite drastic with this category. One can once again conclude that the larger the amount of interventions with Turning Leaf, the better the outcome regarding goal achievement.

In Table 2, costs of incarceration and hospitalization were compared. It was discovered that the average daily cost of a federal inmate was $357.00 and that of a provincial inmate was $171.00. Also, the average daily cost of hospitalization was $562.37. It may seem like hospitalization is costlier than incarceration, however, it has to be noted that hospital stays are generally much shorter than a prison sentence, therefore, it is generally less expensive.

Table 5 - Cost Comparisons between Different Approaches to Mental Illness in Canada

	Turning Leaf Services Inc.			**Incarceration**		**Hospitalization**
	Low Risk	***Medium Risk***	***High Risk***	***Provincial***	***Federal***	**-**
Average Daily Cost	$43.99	$104.16	$326.19	$171.00	$357.00	$562.37
Average Weekly Cost	$219.95	$520.79	$1,630.94	$1,197.00	$2,499.00	-
Average Monthly Cost	$879.80	$2,038.17	$6,523.76	$4,788.00	$9,996.00	-
Average Yearly Cost	$7,918.20	$18,748.44	$78,285.20	$57,456.00	$119,952.00	-

*Hospitalization costs can only be calculated at a daily level due to varying lengths of stays per patient (Note that the average length of stays are less than a month)

Sources: Statistics Canada and the Canadian Institute for Health Information (2012-2013)

Table 5 is a compilation of the cost comparisons of the various approaches to dealing with mental illness in Canada. When comparing the low risk group to the alternatives, cost differences are evident. The daily average cost at Turning Leaf for the low risk category is approximately $43.99. In comparison to the incarceration alternative, the low risk group shows to be $127.01 less expensive per day, and $49,537.80 less expensive per year than an inmate in a provincial correctional institution. The low risk group is $313.01 less expensive per day, and $112,033.80 less expensive per year than an inmate in a federal correctional institution. In comparison to the hospitalization alternative, the low risk group is $518.38 less expensive per day. A yearly

comparison cannot be tabulated for the reason that the majority of patients hospitalized for a mental illness do not stay in care for up to a year.

The medium risk group has daily average cost at Turning Leaf of approximately $104.16. In comparison to the incarceration alternative, the medium risk category shows to be $66.84 less expensive per day, and $38,707.56 less expensive per year than an inmate in a provincial correctional institution. The medium risk category is $252.84 less expensive per day, and $101,203.56 less expensive per year than an inmate in a federal correctional institution. In comparison to the hospitalization alternative, the medium risk category is $458.21 less expensive per day. Again, a yearly comparison cannot be tabulated.

Lastly, the high risk category has daily average cost at Turning Leaf of approximately $326.19. Conversely from the two latter categories, in comparison to the incarceration alternative, the high risk category shows to be $155.19 more expensive per day, and $20,829.20 more expensive per year than an inmate in a provincial correctional institution. However, the high risk category is $30.81 less expensive per day, and $41,666.80 less expensive per year than an inmate in a federal correctional institution. In comparison to the hospitalization alternative, the high risk category is $236.18 less expensive per day. Once more, a yearly comparison cannot be tabulated.

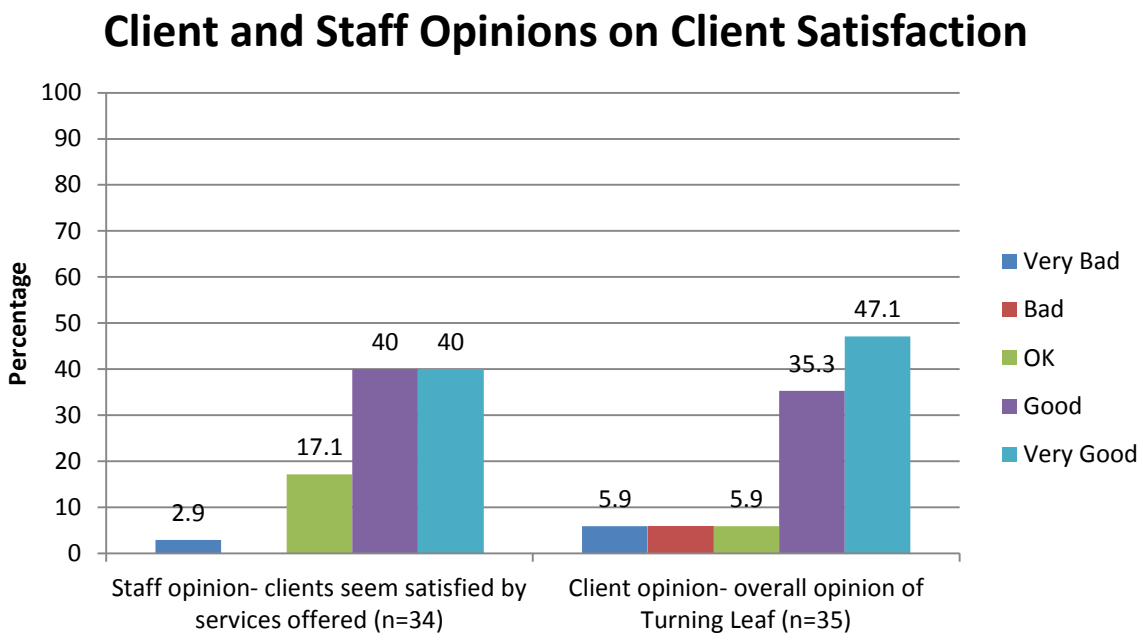
Though the high risk category demonstrated to be more expensive than an inmate in a provincial correctional institution, it cannot be concluded that incarceration is a better alternative for high risk clients. As discussed in the literature review, incarceration has a variety of negative impacts on mental health, and should not be considered as treatment for mental illness.

6.6 Overall Evaluation of Turning Leaf

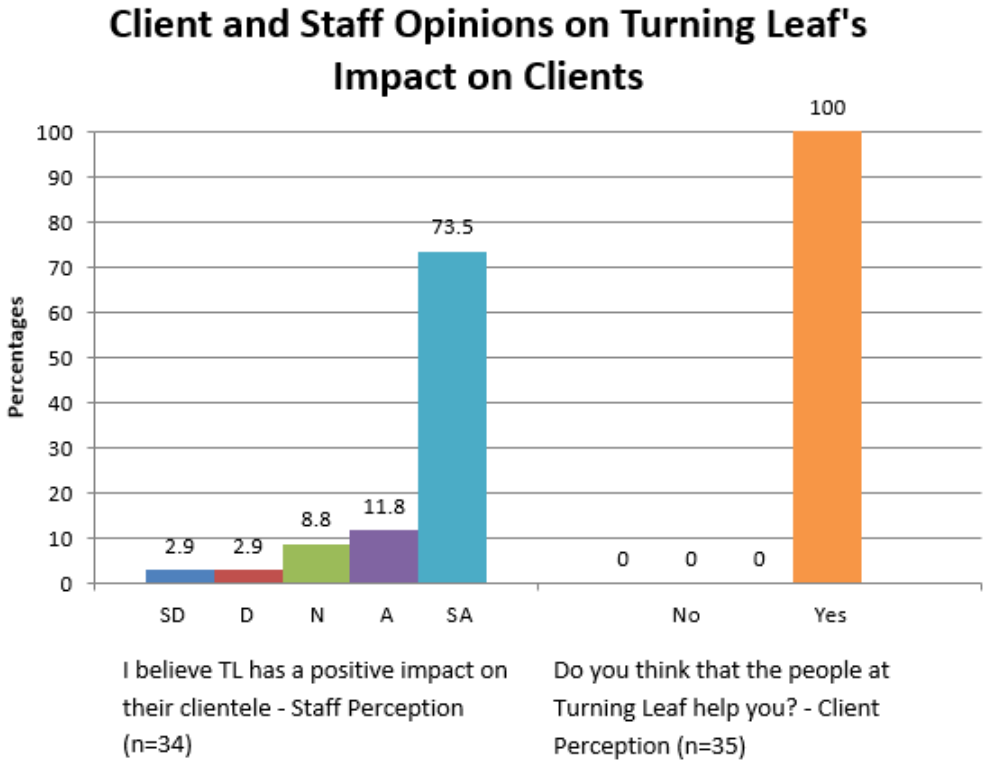
Client and staff perceptions of Turning Leaf were generally very positive as 97.1% of clients enjoy going to Turning Leaf and an impressive 100% think it helps them. Comparatively, when staff were asked whether clients seemed like they wanted to be there, 79.5% agreed on some level. This would suggest clients enjoy attending Turning Leaf more than the staff believe. An important question in the client survey was rating the truthfulness of this statement, "I feel that Turning Leaf would help me if I were in trouble". The findings showed that 87.9% of clients believed the statement to be true or very true. This implies clients have trust in the staff and the ability of Turning Leaf's services to provide help. When staff were asked whether they believed clients would reach out to them in a crisis, 79.4% of staff had some level of agreement. This would suggest the clients trust and rely on the agency more than the staff believe. On average, staff had an 82.4% level of agreement that clients are satisfied by Turning Leaf's services whereas 80% of clients rated their overall experience with Turning Leaf as either "good" or "very good".

The graphs that follow display the distribution of staff and client opinions tabulated from the opinion survey questionnaires. Graph 1 depicts opinions on the overall client satisfaction with Turning Leaf. Graph 2 displays the opinions on the impact Turning Leaf has on its clients overall. As discussed, it is noticeable that the majority of responses are positive in both graphs.

Graph 1



Graph 2



An area in which Turning Leaf could improve would be informing their clients of the variety of services offered. On some level 69.7% of staff respondents agreed that clients knew about the other services offered but 25.7% of clients responded that they had not been told about other services that could be of help.

6.7 Limitations

There were definite limitations to the client file analysis. The data was generated from a year's worth of monthly goal sheets for only 11 client files that were selected at random. The latter may result in the findings not properly representing the population of clients of Turning Leaf. In addition, due to the fact that the data from the client file analysis was used to compare Turning Leaf to its alternatives, the three behavioural categories were limited to the small sample of the client files. In particular, the high risk category was limited to only one client, which in result, poorly reflects the population of that category. With more time and resources, a larger number of client files could be analyzed to provide more accurate results. Another limitation of this study includes the narrow time frame to conduct the research. Furthermore, considering that the research consisted of a small, non-probability sample, the findings hold poor external validity, meaning that they cannot be generalized to other organisations or populations. In addition, the sample used cannot be classified as an accurate representation of the clients or staff of Turning Leaf. Lastly, causal claims cannot be made with the correlational data due to the possibility that confounding variables might be affecting the behaviours.

6.8 Conclusion

The overall findings suggest that Turning Leaf is effective in most areas studied. The opinions of clients and staff, as shown by the questionnaires, are mostly positive. There are definite improvements that can be made in terms of the number of goals clients are achieving

with the help of Turning Leaf, but results show that the more time spent utilizing Turning Leaf's services, the higher the percentage of goals accomplished. Finally the cost analysis showed that even though each program offered by Turning Leaf costs hundreds of thousands, even millions of dollars to run, clients and staff rated the programs as very effective which makes them worth the money spent. Additionally, Turning Leaf proves to be an economical alternative to treating mental illness in comparison to incarceration and hospitalization.

7 References

Aschbrenner, Kelly., Bartels, Stephen., Mueser, Kim., Carpenter-Song, Elizabeth., & Kinney, Allison. (2012). Consumer Perspectives on Involving Family and Significant Others in a Healthy Lifestyle Intervention, *Health & Social Work, 37 (4)*, 207-215.

Barlow, Constance A., Khalema, Ernest., & Shankar, Janki. (2011). Work, Employment, and Mental Illness: Expanding the Domain of Canadian Social Work, *Journal of Social Work in Disability & Rehabilitation, 10 (4)*, 268-283.

Belle, D. (1990). Poverty and Women's Mental Health. *American Psychologist*, 45(3), 385-389.

Bombay, A., Matheson K., & Anisman H. (2010). Decomposing Identity: Differential Relationships Between Several Aspects of Ethnic Identity and the Negative Effects of Perceived Discrimination Among First Nations Adults in Canada. *Cultural Diversity and Ethnic Minority Psychology*, 16(4), 507-515.

Bond, Gary., Corbière, Marc., Gilles, Pierre-Yves., Goldner, Elliot., Lecomte, Tania., Lesage, Alain., & Zaniboni, Sara. (2011). Job Acquisition for People with Severe Mental Illness Enrolled in Supported Employment Programs: A Theoretically Grounded Empirical Study, *Journal of Occupational Rehabilitation, 21(3)*, 342-354.

Canadian Institute for Health Information (2015). Patient Cost Estimator, 2012-2013. Retrieved from: http://www.cihi.ca/cihi-ext-portal/internet/en/documentfull/spending+and+health+workforce/spending/pce_application#

Canadian Mental Health Association Ontario and Centre for Addiction and Mental Health. (2010). Employment and Education for People with Mental Illness. Retrieved from:

https://knowledgex.camh.net/policy_health/social_determinants/Documents/CAMH_CMHA_Ont_Employment_Discussion_2010.pdf

Canetto, Silva Sara., & Sakinofsky, Isaac. (1998). The Gender Paradox in Suicide, *Suicide and Life Threatening Behaviour,* 28(1), 1-23.

Cicchetti, D. & Toth, S. L. (1998). The Development of Depression in Children and Adolescents. *American Psychologist*, 53(2), 221-237.

Culbertson, F. M. (1997). Depression and Gender. *American Psychologist*, 52(1), 25-31.

Cutcliffe, J. R. (2005). Toward an Understanding of Suicide in First-Nation Canadians. *Crisis*, 26(3), 141-145.

Dagani, R., Purcell, A., de Girolamo, G., Cocchi A., & McGorry P. D. (2012). Age of Onset of Mental Disorders and Use of Mental Health Services: Needs, Oppotunities and Obstacles. *Epidemiology and Psychiatris Sciences*, 21, 47-57.

Drake, Robert E., Strickler, David., & Whitley, Rob. (2011). Recovery Centers for People with Severe Mental Illness: A Survey of Programs, *Community Mental Health Journal, 48(5)*, 547-556.

Drake, Robert E., & Whitley, Rob. (2014). Recovery and Severe Mental Illness: Description and Analysis, *Canadian Journal of Psychiatry, 59 (5),* 236-242.

Easton, Stephen., Furness, Hilary., and Brantingham, Paul. (2014). Cost of Crime in Canada: 2014 Report. Fraser Institute.

Goering, Paula., Macnaughton, Eric., & Nelson, Geoffrey. (2013). Bringing politics and Evidence Together: Policy Entrepreneurship and the Conception of the At Home/Chez

Soi Housing First Initiative for Addressing Homelessness and Mental Illness in Canada, *Social Sciences and Medicine, 82,* 100-108.

Hudson S. G., (2005). Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses. *American Journal of Orthopsychiatry*, 75 (1), 3-18.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Surver Replication. *Arch Gen Psychiatry*, 62, 593-768.

Knapp, M., Mangalore, R., & Simon, J. (2004). The Global Costs of Schizophrenia. *Schizophrenia Bulletin*, 30(2), 279-293.

Koerner, N., Dugas, M. J., Savard, P., & Marchand, A. (2004). The Economic Burden of Anxiety Disorders in Canada. *Canadian Psychology*, 45(3), 191-201.

Lambie, Ian. & Randell, Isabel. (2013). The Impact of Incarceration on Juvenile Offenders, *Clinical Psychology Review, 33 (3),* 448-459.

Leenaars, A.A., Wenckstern, S., Sakinofsky, I., Dyck, R. J., Kral, M. J., & Bland, R. C. (1998). Suicide in Canada. *University of Toronto Press*, 24, 138-140.

Manion, I. G. (2010). Provoking Evolution in Child and Youth Mental Health in Canada. *Canadian Psychology*, 51(1), 50-57.

Mental Health Commission of Canada. (2013). *Making the Case for Investing in Mental Health in Canada.* Retrieved from:http://www.mentalhealthcommission.ca/English/-system/files/private/document/Investing_in_Mental_Health_FINAL_Version_ENG.pdf.

Mental Health Resource Guide for Winnipeg. (2015). *The Canadian Mental Health Association*, 19, 1-12. Retrieved from: http://winnipeg.cmha.ca/files/2014/10/Mental-Health-Resource-Guide-for-Winnipeg-19th-Edition-2015.pdf

Miranda, JJ., Patel, V. (2005) Achieving the Millennium Development Goals: Does Mental Health Play a Role, *PLoS Medicine, 2 (10),* 962-965.

O'Sllivan, Julie., Gilbert, Jullian., & Ward, Warren. (2006). Addressing the Health and Lifestyle Issues of People with Mental Illness: The Healthy Living Programme, *Australas Psychiatry, 14*, 150-155.

Roos, Leslie E. Distasio, Jino Bolton, Shay-Lee Katz, Laurence Y. Afifi, Tracie O. Isaak, Corinne Goering, Paula Bruce, Lucille Sareen, Jitender. (2014). A History in-care predicts unique Characteristics in a Homeless Population with Mental Illness, *Child Abuse & Neglect, 38(10),* 1618-1627.

Statistics Canada. (2012). Adult Correctional Statistics in Canada, 2010/2011. Retrieved from: http://www.statcan.gc.ca/pub/85-002-x/2012001/article/11715-eng.htm

The Human Face of Mental Health and Mental Illness in Canada. (2006). *Public Health Agency of Canada*. Retrieved from: http://www.phac-aspc.gc.ca/publicat/human-humain06/4-eng.php#tphp.

Waxler, N. E. (1974). Culture and Mental Illness. *The Journal of Nervous and Mental Disease*, 159(6), 379-395.

Wedding, D., Mengel, M. B., Ulione, M., Cook, K., Kohout, J., Ohlemiller, M., Rudeen, K., & Braddock, S. (2007). Psychologists' Knowledge and Attitudes About Fetal Alcohol Syndrome, Fetal Alcohol Sprectrum Disorders, and Alcohol Use During Pregnancy. *Professional Psychology: Research and Practice*, 38(2), 208-213.

World Health Organization. (2001). Mental Health: New Understanding, New Hope, *The World Health Report 2001*. Retrieved from: http://www.who.int/whr/2001/en/.

World Health Organization. (2005). Information Sheet: Mental Health and Prisons. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0007/98989/WHO_ ICRC_InfoSht_ MNH_Prisons.pdf

8 Appendices

8.1 Client Survey

Community Support Services and Mental Health:
An Evaluation of the Effectiveness of
Turning Leaf Services Incorporated

CLIENT OPINION SURVEY

Instructions for Support Workers: Assist clients in filling out the survey. Feel free to give examples that are relevant to the client for each question. Do not apply any pressure to the client to answer the questions. If they want to skip a question quit the survey they can do so at any time without any penalty.

SECTION 1

Please circle the best answer.

1. Do you like going to Turning Leaf?

Yes **No**

2. Do you think that the people at Turning Leaf help you?

Yes **No**

SECTION 2

Please circle the best answer.

3. How is Turning Leaf at helping you meet people in the community?

4. How is Turning Leaf at helping you learn how to talk to other people?

5. How is Turning Leaf at teaching you how to take care of yourself?

6. How is Turning Leaf at teaching you how to eat healthier?

7. How is Turning Leaf at teaching you how to keep yourself clean?

8. How is Turning Leaf at teaching you how to keep your house clean?

9. Do you go to school?

Yes **No**

10. If yes…how is Turning Leaf at helping you with your schooling?

11. Do you have a job?

Yes **No**

12. If yes… how is Turning Leaf at helping you with your job?

SECTION 3 - *Please circle the best answer.*

Turning Leaf has helped me...

13. ...learn how to deal with challenges in my life for example family problems, heath problems, housing etc.

14. ...learn how to cope with stress.

15. 

..learn how to develop a safety plan and stick to it.

16. …recognise and meet my own needs.

17. How true is this: "I feel that Turning Leaf would help me if I were in trouble"?

18. How true is this: "I feel that the individual counselling sessions have helped me"?

19. How true is this: "I feel that the family counselling sessions have helped me and my family"?

SECTION 4

20. Do you think that Turning Leaf helped you make good personal goals?

Yes **No**

21. What do you think of the Community services that Turning Leaf offers?

22. What do you think of the Residential services that Turning Leaf offers?

23. Did Turning Leaf tell you about the services they have that could help you?

Yes **No**

24. How would you rate your overall experience with Turning Leaf?

8.2 Staff Survey

Community Support Services and Mental Health:
An Evaluation of the Effectiveness of
Turning Leaf Services Incorporated
STAFF OPINION SURVEY

SECTION 1

1. How long have you been employed by Turning Leaf?

    a. Less than 6 months

    b. 6 months to 2 years

    c. 2 years to 5 years

    d. 5 years or more

SECTION 2

Please select the most fitting level of your agreement for each statement below.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. On average, I have noticed progress in the clients that I work with in terms of behavioral changes.					
2. On average, clients of Turning Leaf seem like they want to be there.					

3. Turning Leaf is successful in getting participants to engage in activities that promote healthy residential living.					
4. Turning Leaf is successful in teaching clients how to manage risk.					
5. Turning Leaf is successful in teaching clients on how to overcome challenges in their daily lives.					
6. Turning Leaf is successful in teaching clients how to care for their self.					
7. Turning Leaf is successful in aiding clients to develop good interpersonal skills, such as how to effectively communicate with others.					
8. Turning Leaf is successful in teaching clients how to cope with stress.					
9. Clients who receive assistance from Turning Leaf, in majority, follow their safety plans created with the help of Turning Leaf.					
10. Clients who receive assistance from Turning Leaf capably make safer choices.					
11. Clients who receive assistance from Turning Leaf successfully make healthy decisions.					

12. Turning Leaf successfully helps clients make new connections in the community (e.g. positive peer relations, appropriate referrals to other services available, etc.).					
13. Clients reach out for assistance as soon as possible in times of crisis.					
14. On average, clients seem satisfied by the services offered by Turning Leaf.					
15. "I believe there is still a need for Turning Leaf's services"					
16. "I believe Turning Leaf has a positive impact on their clientele"					

SECTION 3

Please select the most fitting level of your agreement for each statement below.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Training has provided me with the proper tools and knowledge to effectively perform my work duties.					
2. The initial assessment process effectively identifies the needs of the clients.					

3. Turning Leaf is effective in referring clients to other programs within the organization (e.g. Day Services, SET, Guided Living, etc.)					
4. Meeting the clients personal needs is a top priority at Turning Leaf.					
5. Clients seem to be aware of the variety of services available at Turning Leaf. (i.e. Clients know of all the services they have access to)					
6. Turning Leaf is successfully providing all planned services.					
7. Turning Leaf is receiving expected results from its programs.					

SECTION 4

1. What program do you provide the most work hours for? In other words, where do you work predominantly at Turning Leaf?
    a. Residential Support
    b. Community Support
    c. Day Services
    d. Crisis Team
    e. Other, please specify _____

2. In regard to the program which you work for predominantly (your previous answer), please rank the following:

	Very Poor	**Poor**	**OK**	**Good**	**Very Good**
Noticeable behavioural change in clients is _____in this program					
The client feedback about this program is _____.					
The program is _____ in terms of meeting client needs.					
The program is _____ at attaining its program goals.					

SECTION 5 - *open ended questions*

1. Are there any new client needs that have risen since you have started working at Turning Leaf? If so, are they being addressed and how?

2. Do you find that Turning Leaf could be more effective in any sense? If yes, please specify what could be improved.

3. Are there any challenges in delivering programs to clients? If yes, please specify.

8.3 Monthly Goal Sheet Template

Monthly Progress Report

Report Information:

Participant:	
Support Worker:	
Case Manager:	
CSW:	
Report Start Date:	
Report End Date:	
Report Completed:	

Service Goal Progress

*Please complete all fields in each of the 3 Key Areas of Support previously specified**

*(*see Participant Profile)*

1. Key Area of Support:	
Short Term Goal:	Mid-Term Goal:
Goal Achieved? Yes* or No	Goal Achieved? Yes* or No
Observed Progress:	Observed Progress:

Further Progress Needed:	Further Progress Needed:
*If Achieved, New Short Term Goal:	*If Achieved, New Mid-Term Goal:
2. Key Area of Support:	
Short Term Goal:	Mid-Term Goal:
Goal Achieved? Yes* or No	Goal Achieved? Yes* or No
Observed Progress:	Observed Progress:
Further Progress Needed:	Further Progress Needed:
*If Achieved, New Short Term Goal:	*If Achieved, New Mid-Term Goal:

3. Key Area of Support:	
Short Term Goal:	Mid-Term Goal:
Goal Achieved? Yes* or No	Goal Achieved? Yes* or No
Observed Progress:	Observed Progress:
Further Progress Needed:	Further Progress Needed:
*If Achieved, New Short Term Goal:	*If Achieved, New Mid-Term Goal:

Additional Comments and Information

8.4 Monthly Goal Sheets Coding Categories

Main Coding Categories: Key Areas of Support

- Community Integration
- Behavioural Concerns
- Daily Living Skills
- Employment and Education
- Shelter and Housing
- Medical and Psychiatric
- Incidents and Legal Issues

Coding Sub-Categories: Short Term Goals within Key Areas of Support

Community Integration

1: Recreational Activities

2: Attending Turning Leaf Workshops

- ➢ includes any type of interactions with Turning Leaf staff

3: Conflict Resolution

4: Cultural/Spiritual

5: Relationship Building

Behavioural Concerns

7: At-risk Behaviours

8: Interpersonal Skills

9: Addiction Issues

Daily Living Skills

10: Financial and Homeowner Responsibilities

- ➢ includes independent living skills

11: Transportation

12: Home Cleanliness/Maintenance

- ➢ includes household chores and household upkeep tasks (e.g. painting the home)

13: Personal Hygiene

14: Diet

15: Clothing and Laundry

16: Health and Fitness

Employment and Education

17: Schooling

18: Volunteer/Placement

19: Employment

Shelter and Housing

20: Transient Behaviour

21: Affordable Housing

- ➢ includes finding housing and holding on to current home

22: Tenant Advocacy

- ➢ includes prepping and subletting apartment, and finding a successful tenant for such

Medical and Psychiatric

23: Treatment

- ➢ includes taking medicine and following health care recommendations

24: Self-Care

- ➢ includes journaling

25: Appointments

26: Dental/Optical

Incidents and Legal Issues

27: Illegal Activity/Disclosure

28: Justice System

29: Hospitalization

Coding Categories: Goal Achievement

1: Yes (Achieved)

2: No (Not Achieved)

3: Undetermined

8.5 Ethics Approval

UNIVERSITY OF MANITOBA | Research Ethics and Compliance
Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Fax +204-269-7173

APPROVAL CERTIFICATE

February 12, 2015

TO: **Pamela Parker** (Instructor F. Cormier)
Megan Campbell
Principal Investigators

FROM: **Jacquie Vorauer, Chair**
Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2015:015**
Community Support Services and Mental Health: An Evaluation of the Effectiveness of Turning Leaf Services Inc."

Please be advised that your above-referenced protocol has received human ethics approval by the **Psychology/Sociology Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). It is the researcher's responsibility to comply with any copyright requirements. **This approval is valid for one year only**.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, please mail/e-mail/fax (261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM Project Number: http://umanitoba.ca/research/ors/mrt-faq.html#pr0)**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba Ethics of Research Involving Humans.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**