A Turning Leaf on Mental Illness:

A Formative Evaluation of a Community-Based Response

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Abstract

The paper will discuss the literature on mental illness, the stigmatization of mental illness, mental illness and crime, the responses to mental illness and crime (including medicalization, incarceration, and community-based responses), and the logic model as a way of evaluating community-based responses. Following the literature review, the paper will introduce the research issue, methodologies used in collecting data, the findings of the study, and a discussion of the findings, as well as recommendations for future research.

Introduction

Mental illness and crime are not only heavily studied areas in academia, but also common topics of discussion within society; similarly, the stigmatization of mental illness is gaining momentum in the public eye. The following paper will discuss these issues, as well as common responses to mental illness and crime, such as medicalization and incarceration. This paper will then highlight community-based responses as a supplement to medicalization and as a possible alternative to incarceration. Drawing on this discussion, the paper will focus on one agency that works with people who suffer from mental illness and may have come in contact with the law: Turning Leaf.

Literature Review

Mental Illness

Mental illness refers to a range of thoughts, emotions, and behaviours that result in an individual experiencing distress or impairment. Distress or impairment due to mental illness can manifest itself in areas such as school or work, in social relationships or family interactions, or in the ability to live independently. The term “mental illness” is a broad term because it encompasses a wide range of mental health problems and because symptoms, duration, recurrence, and intensity vary widely among individuals (Mental Health Commission of Canada, 2013).

Literature on mental illness points to a wide range of casual factors. To understand mental illness, a complex interaction of psychological, biological, genetic, personal, social, economic, and environmental factors must be considered. Research on mental illness illustrates a connection between mental health and overall health. It has been found that factors which contribute to the development of mental illness also contribute to overall poor health (Mental

Health Commission of Canada, 2013). Similarly, research shows that the social determinants of physical health (such as social support, education, and poverty) also influence mental health (Bourget Management Consulting, 2007).

As the following national statistics from the Mental Health Commission of Canada (2013) show, mental illness in Canada is prevalent:

- In any given year, 1 in 5 Canadians experience mental illness
- More than 6.7 million Canadians are living with mental illness today
- More than 28% of Canadians aged 20-29 experience mental illness
- By the time Canadians reach the age of 40, 1 in 2 will have had or have a mental illness
- If Canadians reach 90 years of age or older, about 65% of men and almost 70% of women will have or have had a mental illness

These numbers are striking, especially considering that by comparison 2.2 million Canadians (1 in 15) have Type 2 diabetes and 1.4 million Canadians (1 in 25) have heart disease (Mental Health Commission of Canada, 2013). Similarly, on a worldwide scale, mental disorders account for four of the ten leading causes of disability and are therefore the single most disabling group of disorders (Bourget Management Consulting, 2007; Canadian Mental Health Association, 2013). Mental illness indirectly affects all people at some point in their lives either by personal experience, though a family member, through a friend or colleague, or as a caregiver (Canadian Mental Health Association, 2013).

<u>**The Effects of Mental Illness**</u>

Mental Illness and Stigma

Stigma refers to negative attitudes which result in discriminating behaviours, negative stereotypes, social rejection, and prejudice. Mental illness is often subject to stigma and therefore those who suffer from mental illness are stigmatized (or suffer stigmatization) (Bourget Management Consulting, 2007). The stigmatization of the mentally ill is evident within Canadian society and has resulted in internalized stigma for many people who suffer from mental illness and in negative attitudes towards help-seeking for mental illness problems (Jagdeo et al, 2009; Livingston & Boyd, 2010).

The stigmatization of mental illness creates a two-fold problem for people who suffer from mental illness. Firstly, the individual must cope with the symptoms of the mental illness itself which, depending on the case, may involve mood swings, anxiety, depression, delusions, or even hallucinations. These symptoms alone present significant barriers. Secondly, people who suffer from mental illness must cope with the stigma surrounding their condition. This creates a double disadvantage as an individual must deal with both their illness and society's negative reaction (Rüsch et al, 2005).

Society's negative reaction towards mental illness creates an "out-group" of those who experience mental illness. An out-group develops when society adopts an "us vs. them" mentality which forces the undesirable group into social exclusion (Martin et al, 2000). This

stigmatization leads to discrimination which manifests itself in all areas of life; for example, individuals who suffer from mental illness have reported discrimination in the workplace and from landlords. Many employers refuse to hire an individual who suffers from a mental illness or if a mental illness is disclosed, career advancement is undermined. Similarly, individuals may be denied rental housing due to mental illness. It has been suggested that the media have influenced stigmatization of those who suffer from mental illness by use of negative images, news stories, and through fiction (Bourget Management Consulting, 2007).

These factors can often result in internalized stigma, which occurs when an individual internalizes society's perceptions of them (Livingston & Boyd, 2010). This notion is similar to the sociological concept of labeling which occurs when an individual is labeled by society and then comes to accept the label as valid (Becker, 2008). Accepting the label of "mentally ill", or internalizing the negative stigma, results in individuals limiting their social interactions. In addition, individuals experience lower levels of life satisfaction, self-esteem, self-confidence, hope, and empowerment, as well as increased symptoms of anxiety, depression, and fear (Bourget Management Consulting, 2007; Livingston & Boyd, 2010; Rüsch et al, 2005). These findings are echoed when those directly affected by mental illness are asked to comment on their lived experiences; reoccurring themes include suffering, frustration, helplessness, shame, self-loathing, alienation, confinement, and lack of control (Zolnierek, 2011). For these reasons,

internalized stigma can be one of the largest barriers faced by a person who experiences mental illness (Shrivastava, 2013).

Stigma is also relevant to help-seeking for mental health problems. Fear of social rejection and discrimination often results in increase of symptoms, as well as reluctance to disclose mental health problems, seek help, and adhere to treatment (Bourget Management Consulting, 2007). This then contributes to a higher risk of relapse, further disability, discrimination, and isolation. Potential complications include suicide, violence, and harm to others, as well as deterioration in general health and the ability to live independently. Due to this, stigma has been identified as a clinical risk factor (Shrivastava, 2013).

Unfortunately, it would appear that negative attitudes towards mental health help-seeking are prevalent. A study conducted in the United States and Ontario illuminated the general trend towards avoiding help in North America. Of participants aged 15-54 years of age, 15% of those in Ontario and 20% of those in the United States of America stated that they would not seek treatment for a serious emotional problem. Similarly, approximately half of participants in both surveys confirmed that they would be embarrassed if their friends knew that they used mental health services. Negative attitudes towards help-seeking were highest among individuals who were young, single, less educated, of lower socioeconomic status, and using or dependent on

substances (Jagdeo et al, 2009). Similarly, on a global scale, studies show that 70% of those with mental illness issues do not receive any mental health intervention (Henderson et al, 2013).

Help-seeking may also be hindered by stigma generated among mental health professionals. Research illustrates that the attitudes of mental health professionals are similar to those found in the general public. In relation to this finding, the study indicated that professionals do show discrimination towards individuals who suffer from mental illness and that medical training (psychiatric training included) rarely directly addresses the issue of stigma (Bourget Management Consulting, 2007).

Mental Illness and Crime

Research shows that there is a connection between poor mental health and crime. In children, mental health factors such as hyperactivity, depression, anxiety, indirect and direct aggression, lack of motivation, and low self-esteem correlate with higher delinquency rates (Canadian Institute for Health Information, 2009). Similarly, there is a prevalence of mental illness in prison populations (Draine et al, 2002). Due to these findings, it has been argued that the evidence supporting a link between mental illness, violence, and crime must be taken seriously (Marzuk, 1996). Further investigation, however, reveals that both children and adults who suffer from mental illness and engage in delinquent or criminal behaviours share other commonalities which make the relationship far more complicated. Commonly, these individuals also face issues such as poverty, lack of education, problems with employment, lack of housing,

substance abuse or dependency, and lack of pro-social attachments. Due to these converging factors, it is crucial to understand mental illness and crime within a broader social context. Typically, individuals are facing a multitude of factors which contribute to poor mental health and increased likelihood of criminal behaviour. Therefore, although there is a relationship between mental illness and criminal behaviour, it would appear that mental illness does not cause criminal behaviour, but rather that broader social factors contribute to both mental illness and criminality (Draine et al, 2002).

Responses to Mental Illness and Crime

Medicalization

Increased medicalization of mental illness has been a trend over the last decade. The health care costs of mental illness have a major impact on the Canadian economy. It is theorized that mental illness costs Canada over $14.4 billion annually. Therefore, mental illness is a major contributor to hospital costs in Canada. Health statistics from 1999/2000 report that in that year mental illness accounted for 9,022,382 hospital days and 199,308 hospital separations. A hospital separation occurs when a patient or resident leaves due to transfer, sign-out, discharge, or death; separation numbers are most commonly used to measure the utilization of hospital services because information is typically gathered at the time of separation (as opposed to admission) to the hospital. Of those with mental illness hospitalized, the average length of stay was 45 days,

with general hospitals averaging 27 days and psychiatric hospitals averaging 160 days (Public Health Agency of Canada, 2012).

Though medication in extreme cases should not be discounted, there are critiques of over-medicalization. Critics argue that over-medicalization occurs when a society internalizes medical and scientific rhetoric. Commonly, a "biochemical imbalance" is used to explain mental illness and drugs are prescribed to correct or compensate for the imbalance; for example, reductionist biological explanations stress that schizophrenia results from an excess of dopamine in the brain and that depression results from a lack of serotonin. Critics argue that reducing a condition to a biological imperfection situates the mental illness deep within the individual but outside of their control. This can cause distress and decrease feelings of empowerment, as well as potentially mask deeper issues. Over-medicalization also discredits other methods of therapy such as conversation or guidance (Cohen, 2008).

Drawing from previous discussion, it is also important to remember that there is a general trend towards avoiding help and that mental illness often occurs in individuals suffering from poverty and associated stressors. These barriers interfere with the ability to treat mental illness medically. Furthermore, individuals situated within a context of poverty may not view medication and mental health as a top priority and may not be able to afford medication (Bourget Management Consulting, 2007; Draine et al, 2002).

Incarceration

The Canadian criminal justice system is focused on punishment and incarceration (Cousineau & Veevers, 1972). As of 2012, Canada's incarceration rate was 785 women per 100,000 and 3,287 men per 100,000. Incarcerating people places a burden on the Canadian economy. In 2010-2011, expenditures on federal corrections totaled approximately $2.4 billion. An average federal inmate costs $313 a day and $114,364 a year ($111,042 for men and $214,614 for women) (Public Safety Canada, 2012). Looking among the provinces, in 2010/2011, Manitoba reported the highest rate of incarceration; at 213 per 100,000 of the adult population, Manitoba more than doubled the provincial and territorial average of 90 per 100,000 adults (Statistics Canada, 2013).

Due to the relationship between mental illness, poverty, and crime previously discussed, mental illness is typically overrepresented in inmate populations. This is because, within the current system, an offender with mental illness is more likely to be incarcerated than treated; unless the accused is considered not criminally responsible due to mental disorder, the Canadian system considers incarceration, as opposed to treatment, the appropriate response to criminal behaviour. In addition, the staff in correctional facilities typically lack the appropriate training to deal with mental illness issues and inmates with mental illness issues are less likely to be released on bail, are more likely to experience abuse from guards and inmates, and have heightened rates of suicide (Markowitz, 2011). Due to this, mental health professionals are

becoming increasingly concerned about the high numbers of inmates suffering from mental illness (Lamb & Weinberger, 1999).

The harm of incarceration has also been studied extensively. In addition to the national economic burden, scholars point to personal harm, increased risk of reoffending, and harm to the family of the offender. In terms of personal harm, prisoners typically experience physical harm, as well as increased mental health issues and psychological stress. Physical harm can be the result of physical or sexual assault, fighting, or suicide. Mental health issues and psychological stress typically increase due to the removal of the individual from their previous environment, the prison environment itself, increased stress in all areas of life, and disassociation from previous relationships (Dumond, 2000; Walker, 1983).

Furthermore, spending time in prison is a factor that is related to criminal reoffending. The following list outlines some of the key ways in which prison time can worsen factors heavily associated with criminal reoffending:

- Education
    - Education that was taking place prior to incarceration is disrupted
    - Existing skills decline or become outdated during sentence
    - Negative attitudes towards education are reinforced during the sentence
- Employment

    - Employment that was taking place prior to incarceration is disrupted
    - Existing skills decline or become outdated during sentence
    - Prison work reinforces the idea that work is mundane, results in low pay, and has no connection to desirable opportunities
    - Likelihood of employment after the sentence is diminished due to criminal record
- Substance abuse
    - Prisoners may start or increase drug use
    - Sharing needles can result in disease
- Mental health
    - As previously discussed, prison time diminishes mental health
    - When released, prisoners are often faced with chaotic lifestyles and improper follow-up support
- Attitudes
    - Other prisoners and the prison system reinforce negative attitudes towards authority and victims, and positive attitudes towards crime
- Institutionalization
    - If an individual has previous experience in care, prison time can reinforce an institutionalized background

    - When released, lack of the previous heavily structured lifestyle can result in an inability to act and think on one's own, a sudden increase in activities that used to be prohibited, or mental breakdowns
- Housing
    - Housing can be lost upon incarceration
    - Housing is difficult to secure following the sentence due to criminal record or lack of financial resources
    - Increased risk of homelessness
- Debt
    - Existing debt can increase during a prison sentence
    - Upon release, a lack of financial resources can continue to worsen debt situations

When a prisoner is released, the factors outlined may contribute to criminal reoffending (Small et al, 2005; Social Exclusion Unit, 2002).

Prison time also affects the family of the inmate. It is important to remember that inmates are also part of a broader family structure. Inmates are also children, parents, kin, or friends. It is important to remember that when an individual is incarcerated, they are typically leaving behind a family network (Travis & Waul, 2003). Implications of incarceration in this context include the disruption of familial relationships, alterations to familial support networks, damage to positive

links between the prisoner and the family, breaking of stable relationships, financial difficulties, emotional, mental, and physical health problems among family members, and new burdens on governmental services such as schools, foster care, adoption agencies, and youth-serving organizations (Social Exclusion Unit, 2002; Travis et al, 2006). When families of incarcerated individuals were interviewed, they spoke of financial strain, parenting strain, emotional stress, and concern over the loss of involvement with the incarcerated person (Arditti et al, 2003).

Community-Based Responses

Community-based responses are often created as an alternative to incarceration and a supplement to medical care. Oftentimes, community-based responses for those who experience mental illness and have come in contact with the law work to establish integration into the community and mental well-being. Evaluations seem to suggest that community-based responses result in integration and therefore limit reoffending. Community-based responses also cost substantially less than incarceration (an average budget of $31,148 annually versus $114,364) (Public Safety Canada, 2012). Currently however, there is a lack of community-based groups and, where they do exist, there is fragmented care. This is an area that needs to be developed and evaluated further (Davydov et al, 2010; Kopelowicz & Liberma, 2003; Latimer, 2005).

Community-based responses typically foster integration into the community by focusing on learning skills. Evidence-based practices such as community involvement, supported

employment, social skills training, family education, integrated programs for individuals with multiple diagnoses, and combined treatment and rehabilitation have proven successful (Kopelowicz & Liberma, 2003; Latimer, 2005).

Community responses also often focus on mental well-being. Professionals in the field typically agree that mental health is a necessary component of overall health. It is important to note that mental health is not simply an absence of mental illness. Mental health is a state of well-being that allows individuals to realize their potential, cope with life stresses, work productively, and make contributions to their community. It is noted that positive mental health acts as a buffer from stress and therefore helps to reduce the risk of mental illness. This buffering effect is often termed “resilience” by professionals. Resilience is considered a protective factor which allows individuals to thrive even in the face of adversity. This means that, even if an individual is dealing with a mental illness, he or she can still maintain resilience and positive mental health. Resilience and positive mental health contribute to a successful journey to recovery. It is important to note that within community-based organizations, “recovery” does not always imply “a cure”. Recovery is often considered the ability to live a satisfying and meaningful life. To foster recovery, community-based organizations often focus on goal oriented improvement (Davydov, 2010; Mental Health Commission of Canada, 2013).

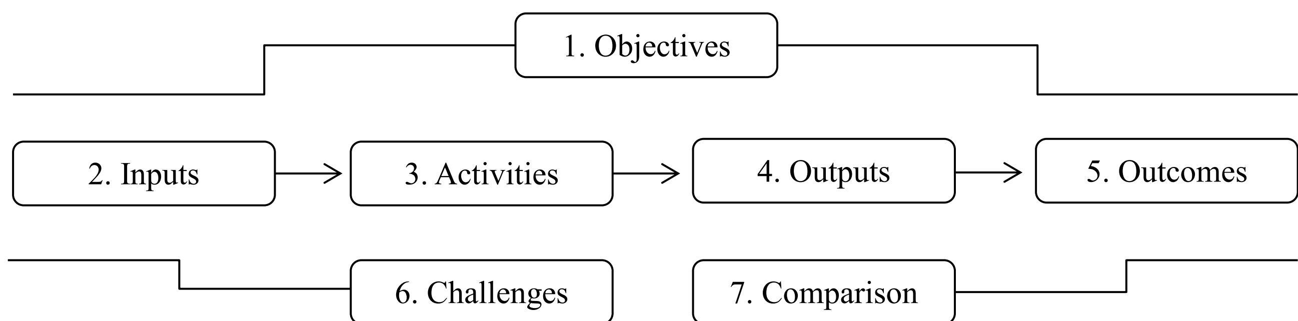
Unfortunately, though a wide range of community-based support organizations have been developed in Canada, resources are still needed and existing care is often fragmented. Studies show that community-based resources are lacking in most provinces and that when supports do exist, programs are often fragmented which means that individuals are often left vulnerable. Fragmentation can occur when programs do not address the full range of an individual's needs or when programs do not follow an individual until they are able to function independently (Latimer, 2005).

Taking these problems into consideration, there are organizations which attempt to offer a range of services and continued support. One such organization that exists locally in Winnipeg is Turning Leaf. Turning Leaf's main clientele are individuals who suffer from mental illness, are at risk of coming in contact with the law, or have come in contact with the law. Turning Leaf offers a community support program, residential support program, day services, guided living, family outreach, individual counselling, family counselling, community outreach, and crisis stabilization. These programs touch on all of the factors previously discussed. Turning Leaf also prides itself on continued care and does not leave participants until they are able to live independently. The general consensus among the staff and participants is that this organization and its programs are effective, however no formal evaluation has been done (Turning Leaf, 2013).

Evaluation

When the high prevalence of mental illness, the likelihood of incarceration, and the possible responses to these issues are considered, evidence suggests that community-based responses (as opposed to strict medicalization or incarceration) offer the most promise. This can be seen in the benefits of community-based responses to the individual and the family and friends of the individual, as well as in the reduced cost in national economic spending. This being stated, further evaluations of community-based responses are still needed (Latimer, 2005).

A widely used framework of evaluation is the logic model. The logic model identifies and connects a program's objective, inputs, activities, outputs, and outcomes; a comparison can then be made between the program in question and other pre-existing alternatives. The logic model is a tool that is a very useful starting point for evaluation. The components of the logic model are illustrated in the table to follow:



The components can be conceptualized by asking the following questions: 1. Objectives: What is the program trying to accomplish? (Often the objective is found in the form of a mission statement) 2. Inputs: What is the program "putting in" in order to achieve the desired result?

(Inputs typically include financial and human resources) 3. Activities: What is the program producing or providing in terms of programming? 4. Outputs: What is the program producing or providing in terms of administrative information? 5. Outcomes: Have the objectives been achieved? (Can be broken down into immediate, intermediate, and ultimate outcomes) 6. Challenges: What are challenges faced by the agency? 7. Comparison: What are the possible alternatives to the program? Typically, overall program evaluations seek to uncover the level of effectiveness in producing or providing the desired results and the cost effectiveness in doing so (Cooksy et al, 2001; Cormier, 2013; McLaughlin & Jordan, 1999). As we look to the future, the logic model may provide a useful tool in conducting further evaluations to solidify the best practices for individuals who are suffering from mental illness and have come in contact with the law.

Turning Leaf

In 2004, Barkley J. Engel, current Executive Director at Turning Leaf, led a group of professionals from the fields of developmental disability services, victim advocacy, justice, and family systems therapy in a formal dialogue regarding their experiences in working with intellectually challenged adults residing in the community. This dialogue voiced a number of shared interests and concerns around the available services working with intellectually challenged adults. In particular, the group identified three basic concerns:

1. A lack of special transitional services available to the intellectually challenged adult population during transition from institutional and familial settings to adult, independent living settings
2. A lack of resources specifically designed to meet the diverse needs of the intellectually challenged and mentally ill adult population

3. A lack of supports available to those that demonstrate problematic behaviors such as addictions, homelessness, family conflict, or behaviours that place them in contact with the criminal justice system

Following this discussion, a committee was formed, an appropriate name for the organization was developed, and concentrated plans were drafted to develop a service designed to meet the support needs of intellectually challenged adults residing or wishing to reside independently in the community. Since its official commencement in January 2005, Turning Leaf has operated as a private, non-profit, incorporated organization dedicated to the development and delivery of community-based services specifically designed to assist and empower adults residing in the community who are intellectually challenged or who are living with mental illness (Turning Leaf, 2014).

Methodology

With the information from the literature review in mind, the researchers sought to investigate further the rationale behind community-based responses by using a logic model framework. To do so, the researchers worked closely with Turning Leaf. To follow is a description of the Turning Leaf clientele, a logic model of the Turning Leaf agency, a logic model of one of Turning Leaf's programs: Community Support Services, and a breakdown of typical costs to assist clients. Data used to collect the following findings included the literature review, agency documents, and in-depth interviews with agency employees. For more information, key agency documents can be found in the appendix. In-depth interviews were conducted with Barkley Engels (Executive Director), Zach Dixon (Community Crisis Supervisor), Marina Wilderspin (Community Support Case Manager), Nikki Keizer (Residential

Licensing Coordinator), Alex Lysenko (Community Support Case Manager), and Alana Cheques (Community Support Case Manager). These individuals were chosen due to their knowledge of the Turning Leaf program and participants. The methodology for the project was primarily qualitative in focus with consultations with the aforementioned staff members providing the majority of the data. Limitations of the study include limited time and expertise in evaluation. It is important to note that the study is based on a preliminary investigation of Turning Leaf and that further research is needed to determine the effectiveness of the program. In addition, limitations of the data include lack of access to alternative agencies to accurately compare Turning Leaf to existing alternatives.

Findings

Turning Leaf Clientele

The clients that Turning Leaf assists can be categorized into three risk levels: low risk, medium risk, high risk.

1. A low risk client is characterized by:
    - Absence of harm to self and others
    - High independent living skills
    - Adequate coping mechanisms
    - Presence of a positive social support network (for example, family, friends, or church)
    - Managed mental health treatment and medication
2. A medium risk client is characterized by:
    - Some risk to self and others
    - Moderate independent living skills
    - Compromised coping mechanisms

- Intermittent positive supports
- Undiagnosed or unmanaged mental health and medication

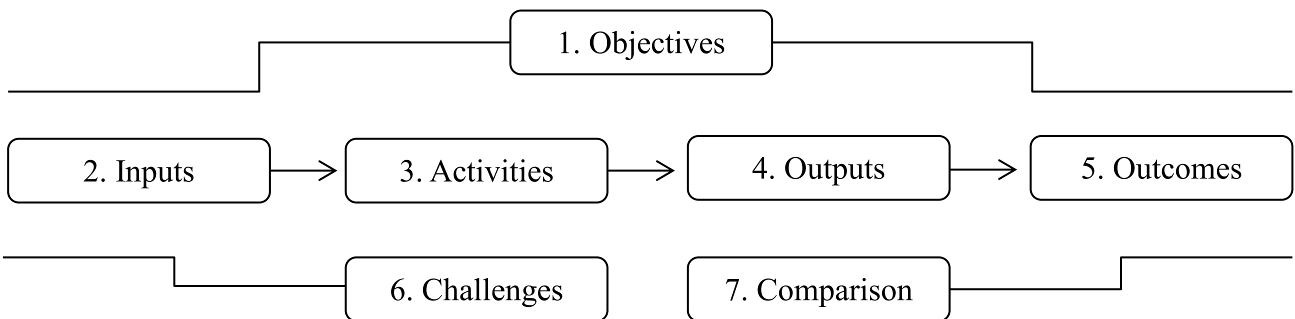
3. A high risk client is characterized by:

- Active and immediate risk to self and others
- Presence of mental health crisis
- Decompensate independent living skills
- Inadequate or comprised coping mechanisms
- Absence of positive social supports or social networks
- Minimum access to support

(Turning Leaf, 2014)

Turning Leaf Logic Model

With this clientele in mind, recall the logic model framework:



At Turning Leaf, the sections of the logic model are as follows:

1. Objectives: What is the program trying to accomplish?
    1. Making connections: To make personal supportive connections with the clients
    2. Supporting healthy change: To collaborate with the clients to promote positive changes in their personal life

    3. Sharing hope: To give clients who are experiencing crisis or detrimental living conditions an opportunity to improve and stabilize their lifestyles in the future

2. Inputs: What is the program "putting in" in order to achieve the desired result?
    1. Personnel: Staff, volunteers, 200 clients at the time of the report (4 in Clinical Services, 130 in Community Support Program, 42 in Residential Program, 24 in Day Services)
    2. Equipment: Items which supplement staff and client needs
    3. Monetary allocation: $6,084,015.99 total (98.41% provincial funding, 1.3% federal funding, .29% private funding)
    4. Client referrals: From Child and Family Services, Community Living Disability Services, families, justice officials (for example Probation Services), courts, Forensic Psychological Services, Provincial Special Needs, Winnipeg Regional Health Authority, and psychiatrists
3. Activities: What is the program producing or providing in terms of programming?
    1. Admission interviews: Qualitative interviews with the clients and case managers to find out if Turning Leaf is the right service for the client
    2. Clinical Services: Life skill assessments and high risk behaviour assessments
    3. Community Support Services: Access to treatment and support throughout the community
    4. Crisis Intervention: Management of crisis scenarios 24 hours a day
    5. Residential Services: 24 hour in-home supported living environment
    6. Day Services: Life-skill building, social skill building, vocational skills training, volunteer opportunities, and recreational options

4. Outputs: What is the program producing or providing in terms of administrative information?
    1. Staff training regimes: Turning Leaf requires that staff members complete a two-week training process, have their first aid certificate, have a clear criminal record check, child abuse registry checks, and satisfactory references (please see Appendix A: Staff Training Regime for more information)
    2. Incident reports: Write-ups that occur whenever there is an incident with the clients
    3. Monthly goal sheets: The clients' monthly goal progression (please see Appendix B: Monthly Goal Sheet for more information)
    4. Time sheets: The cumulative time a worker has spent with the clients
    5. Shift log: Logs used to document what staff accomplished with the clients during a given work-shift
    6. Goal acquisition process: A collaborative process to help the clients to achieve stated goals and interest inventories (a list of activities the clients enjoy doing which help to reinforce positive developments in the clients' behaviour)
    7. Systems involvement: Working with other agencies or institutions such as Child and Family Services, Addictions Foundation of Manitoba, Forensic Psychological Services, Community Living Disability Services, Child and Family Services, Probations Services, Provincial Special Needs, Winnipeg Regional Health Authority, Community Mental Health, and the courts
5. Outcomes: Have the objectives been achieved?
    1. Immediate Outcomes: Short-term outcomes

1. Develop rapport: Getting to know the clients on a personal level and making sure the clients are comfortable with the workers that are trying to help them
2. Determine the clients' needs: Discussion with the clients about what goals and skills the clients would prefer to work on or what areas of their life they would like to be different
3. Raise clients' awareness of risky behaviour: Through developing rapport, the clients will identify problem areas which staff can then identify as goals to be worked on in the future
4. Assess the clients' problem behaviour: Assessments provided by Clinical Service within Turning Leaf or by an external system involvement (for example an external psychiatrist, psychologist, or doctor)
5. Identify goals: Specific goal identity and goal strategies to meet the clients' goals

2. Intermediate Outcomes: Medium-term outcomes
    1. Positive behaviour change: The clients experience an increase in positive behaviour change (for example, management of stress, emotions, body, and/or mind, as well as increase in social skills) which typically aids in goal achievement
    2. Form supportive relationship of trust: The clients develop trusting relationships with the staff
    3. Continue goal acquisition process: Continuation of goal achievement, enhancement of goals, and new goals once previous goals have been met

3. Ultimate Outcomes: Long-term outcomes

    1. Client independence: Absolute autonomy of the clients
    2. Eliminate recidivism: Keep the clients from coming in contact with the criminal justice system or reduce the severity of sentences
    3. Eliminate problem behaviour: Eliminate the clients problem behaviour and recognize and affirm progress
    4. Experience healthy and stable connections: The clients will experience positive connections with their communities and develop supportive networks

6. Challenges: What are challenges faced by the agency?

    1. Internal challenges:

        1. Lack of funding (provincial, federal, and community donations)
        2. Difficulty attracting skilled employees who have the credentials and experience in this line of work
        3. Employee turn-over
        4. Finding appropriate housing for services and clients (for example, municipal and provincial restrictions which limit the amount of clients living in a residential household or occupancy permits)
        5. Unhealthy of problematic lifestyle factors in clients (for example, family relations, sex-trade involvement, or gang involvement)
        6. Making sure the agency is up to date with employee training and quality insurance: Training regimes must be preparing workers to service the clients' needs

2. Externally challenges:

    1. Society's stigmatization and discrimination of Turning Leaf clients

    2. Lack of government funding: The need for more federal and provincial donations

    3. Lack of community awareness and donations: The community may not be aware of the service and the need for this service in Winnipeg

    4. Provincial and residential licensing issues

    5. Provincial zoning issues limit the amount of housing Turning Leaf can utilize in one area

    6. Occupancy permits

    7. Client withdrawal.

7. Alternatives: What are the possible alternatives to the program?

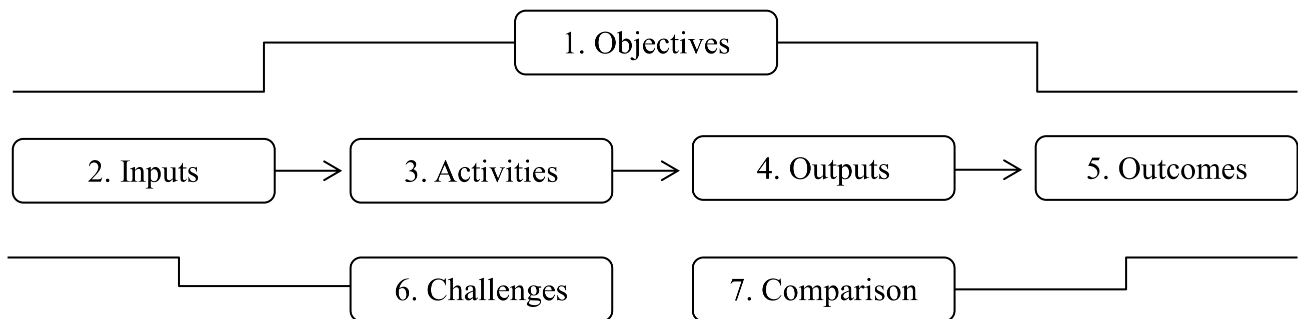
    1. Hospitalization

    2. Incarceration

(Turning Leaf, 2014)

Community Support Services Logic Model

Recall the logic model framework:



For Community Support Services, the sections of the logic model are as follows:

1. Objectives: What is the program trying to accomplish?
    1. Risk management: Individualized set of interventions which the clients use on a daily basis to halt arousal, minimize risk, and substitute healthy coping strategies
    2. Advocacy: Providing assistance and a voice for the clients
    3. Secure relationships: Professional support to build a supportive network for the client and promote client independence
2. Inputs: What is the program "putting in" in order to achieve the desired result?
    1. 130 clients (at the time of the report)
    2. 43 support staff (at the time of the report)
    3. 1 director (at the time of the report)
    4. 5 case managers (at the time of the report)
    5. Funding: For the year of 2013, $2,639,678.30 funded the Community Support Program
    6. Referrals from systems involvement: Working with other agencies or institutions such as Child and Family Services, Addictions Foundation of Manitoba, Forensic Psychological Services, Community Living Disability Services, Child and Family Services, Probation Services, Provincial Special Needs, Winnipeg Regional Health Authority, Community Mental Health, and courts
    7. Equipment: Documentation of the clients, recording tools for the worker, shift logs (please see Appendix C: Shift Log for more information), daily goal sheets, eco-passes for the clients, staff gas mileage program, and client medication
3. Activities: What is the program producing or providing in terms of programming?

    1. Life skills support: Aids the clients in developing life skills through one-on-one support with a community support worker (for example, healthy meal planning, grocery shopping, meal preparation, apartment cleanliness, money management, time management, impression management, management of health, and management of medical needs (monitoring their medication) (Turning Leaf, 2013)
    2. Social skills support: Social skill building activities (for example, practical skills such as how to socialize with grocery clerks or bank tellers, how to connect with a waiter at a restaurant to give their order, and how to create a positive social network for themselves, as well as positive peer involvement, relationship building, boundary recognition, problem solving, appropriate and healthy coping skills, community orientation and access, and recreational interests and involvement (Turning Leaf, 2013)
    3. Interest inventory: A list of activities or things the clients enjoy doing
    4. Risk management: Person-centered risk management process which includes the identification of risk, boundary recognition, safety planning, behaviour planning, treatment contracts, signs of hazard, understanding emotional triggers, and systemic and environmental controls (Turning Leaf, 2013)
    5. Crisis intervention supports: A unique service provided by Turning Leaf which provides the clients with 24 hours access to care from trained community crisis intervention workers (Turning Leaf, 2013)

4. Outputs: What is the program producing or providing in terms of administrative information?
    1. Staff training regimes: Two-week training process, first aid certificate, clear criminal record check, child abuse registry checks, and satisfactory references, as well as an

understanding of “seen surveys” (or the hazardous things to look out for before entering the clients’ household) and boundary recognition (how to identify if a client is under the influence of substances, potential threats in the area such as gang members or abusive family members, and knowing what can trigger a client’s emotional arousal) (please see Appendix A: Staff Training Regime for more information)

  2. Interest inventory: List of the clients’ interests (paired with the goal acquisition process)
  3. Rapport with client: Getting to know the client on a personal level and making sure the client is comfortable with the workers that are trying to help them (for example, a worker will go for a coffee to get a better sense of what real issues the client needs to work on)
  4. Goal acquisition process: A collaborative process of a worker and one case manager who works with a client to achieve stated goals (goals are most often intertwined with other areas and problems that can be improved upon before reaching the desired goals)
  5. Systems involvement: Case managers will transport clients to other agencies or institutions to gain more insight into the clients’ condition and to aid in the goal acquisition process

5. Outcomes: Have the objectives been achieved?
  1. Immediate Outcomes – these are a sample of the short-term outcomes of the community support program in servicing clients.

1. Begin to develop rapport with client: Developing a secure connection between each other
2. Buy-ins from client: The clients' willingness to cooperate and work with the agency to promote healthy change
3. Interest inventory participation: Internal document that lists the clients' interests and is paired with the goal acquisition process and community support activities (for example, if the client enjoys going to the gym and would like a membership, the client will first need a job to pay for the membership – this allows a community support worker to work with the client in finding employment so they are able to pay for a gym membership)
4. Begin goal acquisition process: Developing goals (often a complicated and changing step-by-step process of achieving smaller goals to reach larger goals)

2. Intermediate Outcomes these are a sample of the medium-term outcomes of the community support program in servicing clients.
   1. Introduce the clients to alternate resources that are in proximity: Introducing the clients to resources in their neighbourhood to build upon skill generalization and independency (for example, a worker will introduce a client to a nearby inner-city recreational facility which the client is able to go to when they feel unsafe or unsecure)
   2. Understanding what community can offer the client: Similar to introducing the clients to alternate resources that are in proximity but achieved when the clients internalize an understanding of where they can obtain resources when a community

support worker is not available (for example, a client will understand where to go in their community to obtain free laundry, a shelter, and free food)

3. Supportive relationship of trust: Facilitating a trusting relationship between the clients and staff

Building awareness for negative stimuli: Building the clients' perception and awareness of negative situations or environments (for example, a client who was previously in a gang would be able to identify gang members in their area as negative stimuli)

4. Positive behaviour change and skill generalization: Positive changes in behaviour and beginning to generalize the activities that they succeed at into their daily living

3. Ultimate Outcomes - these are a sample of the long-term outcomes of the community support program in servicing clients.

   1. Client independence: Skill generalization and absolute autonomy
   2. Client empowerment: The clients' confidence to deal with future challenges in their life
   3. Recognition and affirmation of progress: The clients' ability to recognize their own progress from their initial meeting with Turning Leaf to the developments they have achieved
   4. Skill generalization in daily living: Clients' ability to generalize all the skills they have worked on with Turning Leaf into their daily lives
   5. Eliminate recidivism or problem behaviour: Eliminating transgression of the law and to reduce the severity of sentences

6. Challenges: What are challenges faced by the agency?

1. Lack of funding: federal, provincial, and community donations
2. Client buy-ins: When clients are not willing to change their behaviour
3. Client withdrawal: When clients are not ready for a process of change
4. Justification to system involvement the rates of pay for current progress: For example, a probation officer may want a client to work to getting a job but before that can be accomplished the client needs to control their emotional behaviour
5. Substance abuse or relapse
6. Neglect of medication
7. Abusive family relations
8. Gang involvement
9. Sex-trade involvement
10. Stigma and discrimination from society
11. Partial interference with system involvement: When Turning Leaf and system involvements have different opinions of what is best for the client

7. Alternatives: What are the possible alternatives to the program?
    1. Hospitalization
    2. Incarceration

(Turning Leaf, 2014)

Typical Costs To Provide Turning Leaf Services

With these logic models in mind, the following table illustrates an estimation of the typical cost of servicing clients at each of the aforementioned risk levels as calculated by the staff at Turning Leaf (Turning Leaf, 2014):

Typical Cost per Client per Risk Level			
Risk Level	Hours per Week	Cost per Week	Cost per Day
LOW	10	$285.60	$40.80
MEDIUM	20	$604.80	$86.40
HIGH	40	$1176.00	$168.00

Cost Comparison

The following table illustrates the cost savings of Turning Leaf as opposed to federal corrections (Public Safety Canada, 2012; Turning Leaf 2014):

Average Costs: Federal Corrections Versus Turning Leaf						
Risk Level	**2010-2011 Federal Corrections**		**Turning Leaf**		**Difference**	
	Per Day	**Per Year**	**Per Day**	**Per Year**	**Per Day**	**Per Year**
LOW	$313.00	$114,245	$40.80	$14,892	*$272,20*	*$99,353*
MEDIUM	$313.00	$114,245	$86.40	$31,536	*$22.6.60*	*$61,320*
HIGH	$313.00	$114,245	$168.00	$61,320	*$145.00*	*$52,925*

Discussion

Two Case Studies

The following case studies have been adapted from in-depth interviews with Turning Leaf staff about their clients.

Low Risk

One Turning Leaf client wished to take control of her diabetes and become healthy because her diabetes was affecting her life and her family. Although the way she was living was not healthy, it was comfortable and to change required her stepping out of her comfort zone. It took a long time and the changes were very scary for her. The first step occurred when she

bought a cookbook tailored to diabetic needs for the first time. This was huge for her. The staff was great at acknowledging that this was a big deal for her and didn't attempt to rush her; they let her guide the process. The second step occurred when she agreed to attend a diabetes clinic. On the first visit, she refused to get out of the car. The staff focused on the success of just attempting to get to the clinic. A few weeks later, she got into the clinic. From then on, it was a snowball effect. She started meal planning, grocery shopping, eating breakfast, and curing her addiction to soda. Once she realized she could do it, she felt good, it wasn't scary anymore. Now, she is managing her diabetes, meal planning, goal setting, and active. She is a completely different person than she was before. The process of change was very empowering for her (Turning Leaf, 2014).

Medium Risk

One client at Turning Leaf started in a safe house. She had been involved with the criminal justice system, had youth charges, and had just had a baby. When Turning Leaf began providing services, the baby was just over a year old. The client wanted to find an apartment and wanted to go back to high school. When Turning Leaf found a school she could enroll in, she started to cry; no one in her family had ever graduated high school before. After a few trials and errors, the client secured an apartment. Unfortunately, at this point, the client started seeing a past boyfriend with a violent history. Turning Leaf helped the client come up with safety planning and the client successfully stuck with the safety plans. Unfortunately, after a violent incident, Child and Family Services became involved. Turning Leaf advocated for the client. At this point, the client was removed from her apartment, moved to a hotel, began doing poorly in school, and became pregnant again. Turning Leaf advocated for the client to be allowed to stay in the school and was fortunately successful. Through school, the client was then introduced to

more resources and met other young mothers through the school's parenting program. Now, she is proudly the first ever mature student to graduate from the school, has a new healthy baby girl, has safety planning in place, has a secure place of residence, is connected with her family, and has been free of substance abuse for three years (Turning Leaf, 2014).

Turning Leaf Quotes

Success

"I think it's always important to keep in mind that success has a very broad definition. Success for one person is not a success for another person. Our definition of success is really a lot different than if you ask someone on the street what their definition of success is. What might look like a small success for one person might be really huge." - Nikki Keizer (Turning Leaf, 2014)

Making Connections

"We're so successful because we all feel. We're all feelers. We all want the best for people. We want to support. So there is huge focus on building relationships." – Nikki Keizer (Turning Leaf, 2014)

"We try to connect people. I say, 'Hey, do you have a brother, do you have a sister, do you have a mom, do you have a dad, do you have a cousin, aunt, uncle, a pet dog?' And they're like 'Yeah.' 'Well when's the last time you talked to them? Sometimes its weeks. Sometimes it years." – Zach Dixon (Turning Leaf, 2014)

"Many of our clients haven't had anyone who just wanted to be with them because they are them. They are so used to being used and being tossed away when they have nothing else to give. We build relationships. Sometimes, it's not always about goals… I mean those are very

important and that's a huge aspect of what we do but it's also just letting them know that we're here for you." – Nikki Keizer (Turning Leaf, 2014)

"I go to meetings and sit with big wigs, little wigs, whatever wigs, sideways wigs… and they're like 'How do you guys do it?' It's nothing special; we just sit down and listen." – Zach Dixon (Turning Leaf, 2014)

Supporting Healthy Change

"There's so much need out there" – Nikki Keizer (Turning Leaf, 2014)

"We do it all man, everything: Eye doctors, dentists, food banking, housing, advocating in the legal system, bed bugs, clothing, checkups, keeping people from going off the deep end, connecting people with family..." – Zach Dixon (Turning Leaf, 2014)

"Whatever the need is, we meet the need." – Zach Dixon (Turning Leaf, 2014)

High Risk Clients

"For some people, Turning Leaf is the difference between life and death. Literally." – Zach Dixon (Turning Leaf, 2014)

"Two of the young ladies, that were probably two of the highest risk people I've worked with in terms of substance abuse, homelessness, involvement with criminal history, both were connected to manslaughter charges, and involvement in the sex trade… and they both have been able to conquer their addictions and get healthy and aren't in need of services anymore." – Marina Wilderspin (Turning Leaf, 2014)

"It was a good day because he agreed to put coke in his whiskey, instead of drinking it straight. *That* was a success; it goes back to, what is your definition of success?" – Nikki Keizer (Turning Leaf, 2014)

"When I met him, I went to his house and he had smashed out every window in the house. He crushed his hand on his brother's face – shattered his hand doing it. He attacked his brother, his mom, a cop. Now, he hasn't had an assault in three years and he's cut down on drug use." – Zach Dixon (Turning Leaf, 2014)

"There were stabbings, paranoia, he was in and out of jail, he stabbed a gang member… He wouldn't have lasted a month. Now he's living in residential." – Zach Dixon (Turning Leaf, 2014)

Funding and Pro-Bono Cases

"While in the hospital, she was remembering a conversation she had with BJ (Barkley J. Engel) two years earlier when he visited her in the remand centre and did exactly what BJ does: Talked about hope, talked about change, talked about wanting to help her, and to serve… because that's what it's all about. We went through all the avenues we could think of to get funding because in my opinion and in her opinion visits 3, 4, 5 times a week, she would utilize them. There's so much that she needs, it's an overwhelming amount, and right now she's getting services from us and we're not getting funded for it. It's only about once a week that we're able to see her. I think that if we were able to provide more support we would be able to direct more energy to ensuring that she could be in a safer housing situation than she is right now, we would have been able to advocate for her to be seen by a wider variety of mental health professionals… She's declined a lot and we really really worry about her." – Marina Wilderspin (Turning Leaf, 2014)

“When we get a referral and we see that there is a need, we want to help. We want to be able to provide services. There are some pro-bono cases that are a lot of work and they need so much more support than we are able to give them because it’s hard to put it out there when we aren’t receiving funding for it. I hate that sometimes it has to fall on that business aspect, because I would do everything for free if I could, but there is a money piece that goes along with it. It’s difficult when you see that there’s someone who needs us and needs support and needs advocacy but they aren’t able to get it because of the black and white of the system.” – Nikki Keizer (Turning Leaf, 2014)

Conclusion: Looking To The Future

By drawing on the information from the literature review and findings, the researchers believe that Turning Leaf is a rational program that leads to positive outcomes for its clients. This being said, future research is still needed to accurately gauge the success of Turning Leaf. The researchers suggest continuing the evaluation of Turning Leaf and engaging in a more thorough comparison of Turning Leaf to alternative community-based programs to determine if Turning Leaf is effective and efficient in meeting its goals. This research could include identifying the services that other community-based services provide and comparing them to Turning Leaf, identifying and detailing the innovative services that Turning Leaf provides, and engaging in cost comparison. To aid in this endeavour, an evaluation framework can be found in Appendix D: Evaluation Framework. The researchers are optimistic about the future of this research, as well as the future of Turning Leaf.

References

Arditti, J. A., Lambert-Shute, J., & Joest, K. (2003). Saturday Morning at the Jail: Implications of Incarceration for Families and Children. *Family Relations*,*52*(3), 195-204.

Becker, H. S. (2008). *Outsiders*.

Bourget Management Consulting. (2007). Mental Health Literacy: A Review of the Literature. Ottawa, Canada: Canadian Alliance on Mental Illness and Mental Health.

Canadian Institute for Health Information. (2009). Improving the Health of Canadians: Exploring Positive Mental Health. Ottawa: Canadian Institute for Health Information.

Canadian Mental Health Association. (2013). Fast Facts about Mental Illness.

Cohen, D. (2008). Needed: Critical Thinking About Psychiatric Medications. *Social Work in Mental Health.* 7(1-3), 42-61.

Cooksy, L. J., Gill, P., & Kelly, P. A. (2001). The Program Logic Model as an Integrative Framework for a Multimethod Evaluation. *Evaluation and Program Planning*, *24*(2), 119-128.

Cormier, F. (2013). The Logic Model. *SOC 3100: Practicum in Criminological/Sociological Research.*

Cousineau, D. F., & Veevers, J. E. (1972). Incarceration as a Response to Crime: The Utilization of Canadian Prisons. *Canadian J. Criminology & Corrections*, *14*, 10.

Davydov, D. M., Stewart, R., Ritchie, K., & Chaudieu, I. (2010). Resilience and Mental Health. *Clinical Psychology Review*, *30*(5), 479-495.

Draine, J., Salzer, M. S., Culhane, D. P., & Hadley, T. R. (2002). Role of Social Disadvantage in Crime, Joblessness, and Homelessness among Persons with Serious Mental Illness. *Psychiatric Services*, *53*(5), 565-573.

Dumond, R. W. (2000). Inmate Sexual Assault: The Plague That Persists. *The Prison Journal*, *80*(4), 407-414.

Henderson, C., Lack-Evans, S., Thornicroft, G., (2013). Mental Illness Stigma, Help Seeking, and Public Health Programs. American Journal of Public Health, 103(5), 777-780.

Jagdeo, A., Cox, B.J., Stein, M.B., & Sareen, J. (2009). Negative Attitudes Toward Help Seeking for Mental Illness in 2 Population-Based Surveys From the United States and Canada. Canadian Journal of Psychiatry, 54(11), 757-766.

Kopelowicz, A., & Liberman, R. P. (2003). Integration of Care: Integrating Treatment with Rehabilitation for Persons with Major Mental Illnesses. *Psychiatric Services*, *54*(11), 1491-1498.

Lamb, H. R., & Weinberger, L. E. (1999). Persons with Severe Mental Illness in Jails and Prisons: A Review. *Issues in Community Treatment of Severe Mental Illness: A Compendium of Articles from Psychiatric Services*, 8.

Latimer, E. (2005). Community-Based Care for People with Severe Mental Illness in Canada. *International Journal of Law and Psychiatry*, *28*(5), 561-573.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and Consequences of Internalized Stigma for People Living with Mental Illness: A Systematic Review and Meta-Analysis. *Social Science & Medicine*, *71*(12), 2150-2161.

Markowitz, F. (2011). Mental Illness, Crime, and Violence: Risk, Context, and Social Control. *Aggression and Violent Behaviour*, 16(1) 36-44.

Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of Fear and Loathing: The Role of "Disturbing Behaviour," Labels, and Causal Attributions in Shaping Public Attitudes Toward People with Mental Illness. *Journal of Health and Social Behavior*, 208-223.

Marzuk, P. M. (1996). Violence, Crime, and Mental Illness: How Strong a Link?.

McLaughlin, J. A., & Jordan, G. B. (1999). Logic Models: A Tool for Telling Your Program's Performance Story. *Evaluation and Program Planning*, *22*(1), 65-72.

Mental Health Commission of Canada. (2013). Making the Case for Investing in Mental Health in Canada. Ottawa: Mental Health Commission of Canada.

Public Health Agency of Canada. (2012). A Report on Mental Illnesses in Canada. Government of Canada.

Public Safety Canada (2012). 2012 Corrections and Conditional Release Statistical Overview. Government of Canada.

Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental Illness Stigma: Concepts, Consequences, and Initiatives to Reduce Stigma. *European Psychiatry*, *20*(8), 529-539.

Shrivastava, A., Bureau, Y., Rewari, N., & Johnston, M. (2013). Clinical Risk of Stigma and Discrimination of Mental Illnesses: Need for Objective Assessment and Quantification. *Indian Journal of Psychiatry*, *55*(2), 178.

Social Exclusion Unit. (2002). Reducing Re-Offending by Ex-Prisoners. *London: Social Exclusion Unit*, *9*.

Small, W., Kain, S., Laliberte, N., Schechter, M. T., O'Shaughnessy, M. V., & Spittal, P. M. (2005). Incarceration, Addiction and Harm Reduction: Inmates Experience Injecting Drugs in Prison. *Substance Use & Misuse*, *40*(6), 831-843.

Statistics Canada. (2013). Manitoba Reports Highest Incarceration Rate Among The Provinces. *Government of Canada.* Available online: http://www.statcan.gc.ca/pub/85-002-x/2012001/article/11715-eng.htm#a4

Travis, J., & Waul, M. (Eds.). (2003). *Prisoners Once Removed: The Impact of Incarceration and Reentry on Children, Families, and Communities*. The Urban Insitute.

Travis, J. (2006). Families Left Behind: The Hidden Costs of Incarceration and Reentry.

Turning Leaf. (2013). Our Services. Available online at: http://www.turningleafservices.com/services.html

Turning Leaf (2014). Internal Communications.

Walker, N. (1983). Side-Effects of Incarceration. *Brit. J. Criminology*, *23*, 61.

Zolnierek, C. D. (2011). Exploring Lived Experiences of Persons with Severe Mental Illness: A Review of the Literature. *Issues in Mental Health Nursing*, *32*(1), 46-72.

Appendix

Appendix A: Staff Training Regime

Staffing Requirements/Training/Supervision

To provide the aforementioned services, Turning Leaf (Inc.) will assign a residential support team to work with the systems team. The residential support team – consisting of a case manager, front line support worker(s) – will have accomplished, at minimum, the following:

1. NVCI (or alternative suitable program) training
2. First Aid, Clear Criminal Record Check, Child Abuse Registry Checks and satisfactory references
3. Completed a 2 week training process with Turning Leaf (Inc.) including:
    1. Orientation to the Turning Leaf (Inc.) Mission statement and philosophy on helping
    2. Personnel Policy Manual
    3. Professionalism
    4. Financial Accountability
    5. Person Centred Theory and Planning
    6. Understanding Mental Illness module
    7. Understanding and working with low-medium risk behaviour module
    8. Identifying and intervening around high risk behaviour module
    9. Emergency Procedures
    10. Documentation and reporting
    11. Training to Individualized Support Plans for each resident
    12. Abuse Reporting Policy

13. Introduction to the Vulnerable Persons Act
14. Been informed of expectations of confidentiality and signed confidentiality agreement
15. 12 days of one-on-one job shadowing

4. Complete and pass a Support worker/Residential worker exam (written)
5. HIGH RISK: Complete an Orientation to Offending Interventions training which addresses the following content:
    1. The intellectually challenged sexual offender: definitions of offender and offense
    2. Victim impact
    3. Cycle of Offending
    4. Cycle of Abuse
    5. Indicators For Offending Behaviors
    6. Relapse prevention for the intellectually challenged sexual offender
    7. The design and role of a Residential Treatment facility
    8. Red Flag Situations
    9. Control Plans
    10. Systemic controls / external controls / internalized controls
    11. Disclosures
    12. Reporting Offenses
    13. Safety in the Community: Assessing risk / Minimizing risk
    14. Participant centered risk management: Least restrictive environment / Levels of Supervision according to risk/engaging participant in self-motivated risk assessment and intervention

Appendix B: Monthly Goal Sheet

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

Appendix C: Shift Log

**If 0 Total Hrs of Direct Service (Participant No-Show) please describe your attempts to connect and utilization for remainder of shift (if you connected with another participant, complete an additional log). If Direct Service hours are less than scheduled shift hrs, or if the shift times are different than the scheduled shift times, please explain.*

____

Please report detailed specifics of the shift in each applicable box only:

Incidents and Legal Issues: -illegal activity/disclosure -justice system -hospitalization	____________________ ____________________ ____________________ ____________________
Behavioural Concerns: -at-risk behaviours -interpersonal skills -addiction issues	____________________ ____________________ ____________________ ____________________

Medical/Psychiatric: -treatment and self care -appointments -dental/optical	________________ ________________ ________________ ________________
Shelter/Housing: -transient behaviour -affordable housing -tenant advocacy	________________ ________________ ________________ ________________
Educational/Vocational: -school -volunteer/placement -employment	________________ ________________ ________________ ________________
Community Integration: -cultural/spiritual -family contact/friends -recreation and leisure	________________ ________________ ________________ ________________
Daily Living Skills: -financial/transportation -home cleanliness/hygiene -diet/clothing/laundry	________________ ________________ ________________ ________________

Additional Comments and Information

IMPORTANT: If applicable, please attach an Appointment/Meeting Summary Form

Appendix D: Evaluation Framework

Issues	Questions to Consider	Indicators	Data Sources
Rationale and Relevance of Turning Leaf	1. What is the need for this service? 2. What should be the future direction of treating mental health and recently incarcerated individuals?	Information regarding social services and community support services Perceptions of the public regarding the prevalence mental illness Perceptions of recently incarcerated individuals needing supportive networks Increased awareness of mental illness through media outlets	Literature review Statistics of the prevalence of mental illness in Canada Statistics of the prevalence of recidivism in Canada Criminal Justice Statistics of incarcerated populations Consultations with health care and criminal justice officials Statistics Canada data
Design and Implementation of Turning Leaf and the services provided	1. What type of treatment model is Turning Leaf based on? 2. How does the program function? (Has there been any changes occurred to program delivery? – Why?)	Perceptions of current Turning Leaf clientele Perceptions of current Turning Leaf staff Information regarding the quantity of clients served Changes to Turning Leaf policies	In-depth interviews with current clientele and staff members Review of agency documentation and policies

	3. What is the managerial structure or Turning Leaf? 4. Is the program implemented as planned?		
Successfulness of Turning Leaf in attaining their objectives and goals with clients	1. How does Turning Leaf ensure that its client's needs are met? 2. What are the challenges/obstacles in delivering these programs to clients? (In your opinion which is the pivotal issue Turning Leaf faces in delivering their programs to clients?) 3. How effective has Turning Leaf been in achieving their desired goals with recent clients? (Is there any empirical data to show they have achieved their goals with specific clients?) 4. What resources does Turning Leaf need in order to increase chances of success with their clients? (How can these resources help clients achieve their goals?)	Perceptions of previous and current Turning Leaf clientele Perceptions of current Turning Leaf staff members Increased community awareness of Turning Leaf Increased funding Perceptions of Turning Leaf systems involvement	Survey of a clients' satisfaction of the program In-depth interviews with clientele about their satisfaction of the program Creation of a summative evaluation of Turning Leaf In-depth interviews or administer a survey to a clients' family members or supportive network Review agency documentation and data Case studies of Turning Leaf clientele
Alternatives in servicing clients within Turning Leaf	1. How does Turning Leaf differentiate itself from alternative	Alternate and unique services that Turning Leaf provides	Key informant interviews with alternative community

	services? 2. What services are unique to Turning Leaf? 3. Are there more cost-effective ways of helping clients? 4. What could happen to a current client if Turning Leaf did not exist? 5. How does Turning Leaf work with other agencies and supportive groups in servicing clients? 6. In the future, what sectors or services could be added to Turning Leaf?	Recent changes to Turning Leaf policies and services Perceptions of Turning Leaf staff and clientele in regard to these changes	service programs In-depth interviews with Turning Leaf's systems involvement In-depth interviews or surveys of Turning Leaf staff members In-depth interviews or surveys of Turning Leaf clientele Key informant interviews with provincial health and criminal justice representatives