FRESH FOCUS

Community-Based Mental Health and Substance Use Services for People Leaving Prison: Equity and Inclusion Strengths and Limitations in Specialized Service Inventory Development

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Abstract

Community reentry from prison is a challenging process, especially for persons with lived and living experience of mental health concerns. Access to appropriate community-based care for those leaving prison is a key part of improving health equity for this population. Our work to develop a cross-Canada inventory of active community mental health and substance use services for criminal justice-involved persons represents a valuable example for others hoping to conduct projects that are similar in nature and scope. We describe the strengths and limitations of our health equity-informed, multi-pronged approach to service inventory development, highlighting the importance of considering and addressing search- and stakeholder-related biases. Investment of time and resources is critical to ensuring comprehensive and inclusive identification of community-based mental health services and meaningful resource development.

Keywords Mental health services · Community-based services · Prisons · Substance use · Community reentry · Canada

Background

Release from prison is generally marked by structural and personal challenges in access to housing, employment, and health and social services (e.g., Harding et al., 2014; Hu et al., 2020; van Dooren et al., 2011; Visher & Travis, 2003). The period soon after release is also associated with increased risk of health-related harms, including suicide and overdose (Farrell & Marsden, 2008; Merrall et al., 2010; Kouyoumdjian et al., 2016). For people with lived and living experience of mental health and/or substance use concerns, community reentry is often extra challenging given specialized support needs, inadequate system planning for community care or continuity of care, and discrimination or reluctance to provide care on the part of health and social service providers (Barrenger et al., 2017; Dean et al., 2013; Denton et al., 2017; Hu et al., 2020; Human Services and Justice Coordinating Committee, 2020; Kirwan et al., 2019; van Olphen et al., 2009; Walker et al., 2018; Wilton & Stewart, 2017). Provision of appropriate community-based health services helps to meet these challenges and is associated with better reentry outcomes for people released from prison, such as reduced likelihood to re-encounter the criminal justice system (e.g., Kouyoumdjian et al., 2015; Stewart et al., 2017). Accessible community-based care for those leaving prison is therefore an essential component of achieving greater health equity with this population (see McLeod et al., 2020), especially in view of the overrepresentation of people living with mental health and substance use concerns in prisons across the world (e.g., Beaudette & Stewart, 2016; Fazel & Seewald, 2012).

In Canada, where our work is situated, specialized community-based health and social services available to people who are reentering the community from prison vary according to factors such as whether a person is under provincial/territorial correctional jurisdiction, geographic location,

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and post-release needs and plans (Hu et al., 2020). For instance, someone who is transitioning to the community from a federal prison may be able to access therapeutic residential facilities that provide programming for substance use and other needs, overseen by the Correctional Service of Canada (2021). A person under provincial jurisdiction and community supervision in Ontario, as another example, may be referred by their probation or parole office to various types of rehabilitative and educational programs that promote positive community reentry (Government of Ontario, 2021). Such community-located services that are connected to the correctional system are generally time-limited; once a person has completed their sentence, including applicable parole or probation time, they can typically access other community-based supports that are available to the general population. Given the significant variation in programs available by correctional jurisdiction and region, the number and scope of community-based services specifically designed to meet the reentry needs of people leaving prison have been uncertain.

The Mental Health Commission of Canada (MHCC)—a national non-profit organization focused on improving mental health—recognizes an urgent need to enhance supports for criminal justice-involved persons living with mental health concerns or mental illness (see https://mentalhealthcommission.ca/what-we-do/mental-health-and-the-justice-system/). This need has only become more urgent during the global COVID-19 pandemic which is disproportionately affecting the health of people who are incarcerated (MHCC, 2021; Mukherjee & El-Bassel, 2020). In 2020, MHCC launched a project to develop an inventory of community-based services specific to or promising for people transitioning from criminal justice settings to the community. We designed this project, overseen by and in collaboration with MHCC, to focus the inventory on mental health and substance use services that are available across Canada and relevant for people reentering the community. Although other kinds of services are vital for this population (e.g., affordable housing, financial, employment, and legal assistance, family and child care), we closely adhered to the noted service scope to ensure creation of a unique and cohesive inventory. We considered a varied audience for this national resource—including service providers who directly offer supports to persons reentering the community from prison—with aims to enhance multi-sector stakeholder awareness of and ability to provide connections to specialized community health services. Our work represents a valuable case example for other projects that may seek to identify active community-based services and construct useable, inclusive program directories. We recently published key lessons learned from developing the national inventory for the MHCC (see Watson et al., 2022). In the present article, we contribute new information to the community mental health literature based on additional experiences during the development of this service inventory that spans different regions. We outline the methodology used to create the inventory and how we attempted to adopt a health equity approach, and suggest areas for improvement in future resource development.

Case Example: Implementing a Health Equity-informed, Multi-pronged Approach

MHCC and our team based at the Centre for Addiction and Mental Health share organizational commitments to health equity principles that prioritize reducing health disparities and increasing opportunities for all community members to access quality health services (e.g., Braverman, 2014). These commitments include the position that people involved in the criminal justice system retain their rights to health care, and that individual and group identities can significantly influence the impacts of system contact (MHCC, 2020). Further, it is vital to recognize that prison-to-community transitions for specific populations—including Indigenous communities, Black and racialized communities, and women and gender-diverse people—are often complicated and interrupted by structural marginalization and inequalities that enable disproportionately harmful impacts of the criminal justice system, and by a lack of tailored and culturally safe care services to meet diverse needs (e.g., Khenti, 2014; Fortune et al., 2020; Murdocca, 2020; van der Meulen et al., 2018). We approached national service inventory development with a health equity and inclusion lens (see Centre for Addiction and Mental Health, 2021). As such, we sought to create a new living resource that would improve awareness of a broad range of available community-based mental health and substance use services for people leaving prison, with emphasis on locating community-led and culturally appropriate programs, wherever possible.

Developing a national or multi-jurisdictional inventory of active community-based services is an inherently complicated endeavor when there is wide geographic dispersion of and decentralized public information about the services of interest. This scenario is the case in Canada which has a federal correctional system (overseeing sentences of two years or more), plus 13 provincial/territorial jurisdictions each with its own correctional system (for sentences less than two years in length) and approach to health service provision and community reentry (e.g., McLeod & Martin, 2018). Additionally, when a project team is primarily based in one jurisdiction (which was also the case in our work), constructing an inclusive inventory of services with a national or multi-jurisdictional scope readily turns into a time- and resource-intensive effort, especially with finding smaller and/or community-led local programs. To meet these challenges, we used a multi-pronged approach that enabled us

to triangulate across several sources of information to locate community-based services relevant for the inventory and to identify service gaps and promising practices. Overall, our approach entailed organizational collaboration, outreach to knowledgeable stakeholders across Canada's provincial/territorial jurisdictions, and structured, comprehensive searches of academic and grey literature, online service directories, and program websites. A bilingual knowledge broker supported all of these steps with searches, material, and communications in Canada's other official language, French.

Throughout an approximately 6-month period bridging late 2020 and early 2021, our team met regularly with MHCC to make decisions about inventory scope and structure, literature and service search methods, and presentation of deliverables. An MHCC advisory committee, composed of multi-sector subject matter experts, was consulted throughout the project for their feedback on the inventory and accompanying final report. Our team also built a connection to another national agency—the Canadian Association of Elizabeth Fry Societies (CAEFS), composed of local societies throughout the country—that advocates for prisoner rights, capacity building, and raising public awareness in relation to criminalized women and gender-diverse people. We met regularly with CAEFS leadership to understand their current work on building community capacity to provide community service information needed by criminalized women and gender-diverse people (see http://www.caefs.ca/building-capacity) to ensure we complemented, not duplicated, our respective resource development.

We collaborated with MHCC and CAEFS to compile a list of knowledgeable stakeholders to contact from relevant organizations and sectors across Canada (i.e., non-governmental organizations, provincial/territorial health systems, criminal justice agencies, research institutes, and forensic hospital settings). We sent to approximately 50 stakeholders a brief email survey, consisting of three open-ended questions, to help identify relevant services in each provincial/territorial jurisdiction. We defined "mental health services" for the purposes of our request as a wide range of community-based programs for people in need of mental health supports, inclusive of crisis, inpatient, and/or outpatient services. Similarly, we broadly defined "substance use services" as any community-based program that addresses substance use, inclusive of treatment and harm reduction programs, as well as supports for alcohol and/or other substance use. We also invited stakeholders to identify local service gaps and any additional types of mental health and/or substance use services they would like to see available to assist those who are reentering the community from criminal justice settings.

Systematic searches of academic and grey literature (e.g., documents and content authored by governments and community agencies, including Internet publications and resources) comprised another primary strategy to identify community-based mental health and substance use services for criminal justice-involved persons in Canada. We engaged librarian assistance at our organization to develop comprehensive, structured search strategies for both types of literature, including customized Google searches in English and French designed to locate relevant service information in each province and territory. Initial Google searches readily captured reports and (albeit less commonly) policy documents authored by governments and larger non-governmental agencies and institutes. Based on librarian recommendations, we supplemented these searches with searching a series of online directories of regional health and social services (e.g., http://211.ca), and not-for-profit and charity organizations. We ran these searches to help find material from a wider cross-section of agencies, including smaller organizations, and, ultimately, the types of specialized programs of that could be included in the national inventory. Google and supplemental searches of directories entailed using a set of keywords (e.g., "post-release", "reentry", and "reintegration") to specify the population of interest.

Notably, our searches were also lagging in picking up information on services designed for and/or led by specific populations. In response to MHCC advisory committee member feedback, we added more Google searches employing terms such as "healing", "traditional", and "cultural safety" to improve our ability to locate services led by and designed for, in particular, First Nations, Inuit, and Métis populations across Canada. Advisory committee feedback also provided several examples of programs that were missed by our methods and warranted inventory inclusion as low-barrier services that provide culturally appropriate and safe health and wellness supports to Indigenous people.

Overall, our online searches led to a deeper browsing of numerous publicly available program websites that came up as search hits. An important tension in our methods that should be highlighted here was that the use of more inclusive search strategies, including use of broader terms (i.e., "healing", "traditional"), generated many hits about services that were not necessarily specific to the aim of identifying reentry or post-correctional release programs. It required taking additional steps (i.e., website visits and reviewing information) to determine if program sites contained enough information to clarify service inclusion in the inventory. If a service was deemed relevant as an inventory entry, we collected and recorded its details such as, contact information, geographic focus, program description and objectives, and specific supports offered.

Our health equity-informed, multi-pronged approach led to the creation of a living resource that has since seen national dissemination (see http://mentalhealthcommission.ca/resource/national-inventory-of-mental-health-and-substance-use-services-and-supports/). We learned much from this work, including the significant gaps that exist in

community-based mental health and substance use services in Canada. First, there appears to be a dearth of such services specific to the needs of criminal justice-involved persons. Second, where there are such services, they often do not (or, at least, there is little to no publicly available information on how they) address the needs of specific populations such as Indigenous communities, Black and racialized communities, and women and gender-diverse people (see again Watson et al., 2022), for more detail on those lessons learned and general recommendations that emerged from this work). Next, we outline notable limitations with our methods. Explicitly acknowledging these limitations in the community mental health literature will hopefully lead to greater equity and inclusivity in future service inventory and related resource development.

Search Biases

When searching grey literature for evidence reviews and syntheses, and for information to populate a service inventory or resource, we suggest there is a need for more reflection on the basic technologies and algorithms we tend to use in our work. Using a set of complementary search strategies is a well-known recommendation for such endeavors, to effectively help reduce omission of relevant sources and information (e.g., Godin et al., 2015). This knowledge informed our multi-pronged approach. Nonetheless, any primary reliance on large online search engines, such as Google, can introduce certain biases and, in our case, exclusions by design. As described above, we modified and supplemented our Google searches upon noticing key limitations with the searches, particularly in helping us find smaller and community-driven programs of interest for the inventory. While these limited results are commonly experienced when running web-based searches for grey literature, such searches remain a valuable add-on to or even substitute for academic literature searches, depending on the nature of the work or topic (Godin et al., 2015; Pappas & Williams, 2011). That said, it is important to acknowledge that in much research and resource development, the use of online search engines often goes uncritiqued and/or unsupplemented with other data- or information-gathering strategies.

In developing the national service inventory, our team became acutely aware of the ways in which content from certain institutions are "favored" in Google algorithms and the associated impacts of this favoring on locating a wide cross-section of community-based services. In general, automatic relevance rankings that occur within Google search engines are highly important functions to help reduce the often overwhelming amount of information that is returned from a search and to narrow results to, for instance, specific subject areas or websites (Godin et al., 2015). However, biases can be introduced via processes such as search engine optimization (SEO) whereby search engine algorithms involved in webpage crawling, indexing, and sorting, for example, keep returning the top results of a search (Almukhtar et al., 2021; Ziakis et al., 2019). In practice, effective SEO improves the visibility and, in turn, traffic to a webpage, and SEO services exist to help organizations and businesses raise the ranking of their websites on prominent search engines like Google (Almukhtar et al., 2021). Many community-led services, especially smaller programs and/or those in rural and remote regions, are likely not well set up or resourced for SEO. In addition, some agencies and services may not consistently tag or format their web-based literature nor have the capacity to maintain an archive of their documents and content on the Internet (see again Godin et al., 2015). (A couple of programs we learned of via stakeholder feedback that operate in far northern regions had little to no online information available; we called these programs to confirm their service details.) For these technical reasons, many community-based services and supports—including some that may be most meaningful and accessible for members of specific and local communities—will get excluded from even the most comprehensive searches. Also notably, any absence of consistently formatted content and online archives of program information renders it difficult to reproduce or verify search results at later points in time, creating challenges when it comes to updating community-based service inventories.

Stakeholder Biases

We did employ another important technique to collect information on community-based services of interest across Canada— that is, contacted "content experts" from relevant disciplines and organizations, spanning geographical areas (Godin et al., 2015)—by emailing a short, open-ended-question survey to nearly 50 personnel at organizations known by our collaborative teams and suggested through our networks. We strived to ensure that there was representation of stakeholders from each province/territory and from organizations that, in particular, advocate for and work directly with specific communities disproportionately affected by the criminal justice system, including Indigenous communities, Black and racialized communities, and women and gender-diverse people. Despite these efforts and our commitment to health equity, we must acknowledge that biases also emerged in the stakeholder knowledge realm.

While many respondents provided helpful information (in some cases, lengthy lists of potentially relevant local programs that we searched for, individually, on the Internet), some replied that they were unaware of the kinds of specialized community-based mental health and substance use services we were asking about in their jurisdiction. In reply

to our question about local service gaps, some respondents explicitly noted a lack of programming designed by and/or for Indigenous communities and other specific populations. These findings correspond with our online searches and may also reflect, like those other searches, systemic biases in stakeholder awareness of certain community-led services. A number of organizations on our contact list were larger and/or national in scope, increasing the likelihood that they would share information about other large institutions rather than about smaller and localized services. Any and all additional outreach to a broader range of organizations that work in criminal justice, the general mental health and addictions sectors, and/or with communities most affected by criminal justice involvement would have enhanced this stakeholder-outreach prong of our approach. In particular, more concentrated, participatory collaboration with Indigenous programs would have been so valuable in identifying services that are led by and culturally safe for First Nations, Métis and Inuit communities. More direct engagement with people with lived and living experience of incarceration would have also helped us to identify and build understanding of local supports and forms of service delivery that are especially meaningful for additional specific communities. These types of engagement would have strengthened the health equity commitment of our work, by in part better addressing the continued underrepresentation of specific populations in resource development. This engagement would have also helped us in refining our online searches with more culturally-relevant terms. Indeed, we should also concede that our supplemental search terms, as well as the broad definitions of mental health and substance use services we used in the project, may not well align with different cultural understandings and framings of community supports needed to address mental health and substance use concerns. Advisory committee member feedback underscored this point, as a number of Indigenous program examples they suggested for inventory inclusion emphasized holistic approaches to health and wellness, rather than explicitly using the terms "mental health" and "substance use" (e.g., see Harfield et al., 2018; Lavallee & Poole, 2010; Stewart, 2008).

Effectively Resource Community-Based Service Inventories to Increase Equity and Inclusion

The number of subject matter experts and key stakeholders engaged, as well as the ability to run numerous literature searches, in any project is constrained by funding and timelines (see again Godin et al., 2015). Indeed, developing our contact list and reaching out to stakeholders across Canada was itself an intensive component of the time-limited project we have described here. Our experience with developing a national inventory of community-based mental health and substance use services underscores the need to have a truly national team. This means investment in resources, including commitment from funders, to ensure that appropriately knowledgeable point-persons—people with knowledge of local community-based service landscapes, inclusive of people with lived and living experience—are involved in every jurisdiction within a given project's scope. Investment of time is needed as well. Given ambitious timelines, we had to remain adherent to a relatively focused service scope for the national inventory we developed. As such, we excluded many general community-based mental health, wellness, and social programs that also provide important reentry supports for people leaving prison.

Building sustainability plans for national or multi-jurisdictional community-based service inventories should also be a deliberate aim of future projects, to keep such resources "living" by having dedicated processes in place to update and refine service lists over time. This is particularly important for ensuring that service inventories become increasingly inclusive, allowing for any missed and/or new services, especially smaller and community-driven programs, to be identified and submitted for inventory inclusion. Ideally, this process would invite program submissions from a wide range of stakeholders and community members, including those with relevant lived and living experience, across jurisdictions. The inventory we collaboratively designed for MHCC has been translated into an accessible online tool that demonstrates this important feature. That is, MHCC has created a living directory that invites feedback and will be updated over time, to ensure that this resource remains up-to-date with active services and grows as more relevant supports are identified (see again http://mentalhealthcommission.ca/resource/national-inventory-of-mental-health-and-substance-use-services-and-supports/).

Conclusion

In this article, we have highlighted key strengths and limitations in our methods to develop a national, specialized community-based service inventory. We hope this work encourages future teams to advocate for sufficient funding and time to cultivate their own approaches to producing resources that promote awareness of and reduce access barriers to a wide range of mental health and substance use services. Acknowledging and addressing the types of search and stakeholder biases we have outlined is a critical, equity-informed component of such projects.

Declarations

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