BEST PRACTICES IN FOUR CITIES IN SOUTHWESTERN ONTARIO: THE INTERFACE BETWEEN PEOPLE WITH MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM

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Thanks are graciously extended to the many key informants who gave of their time and ideas with the hope of improving services to the mentally ill in our communities.

Kathleen Hartford, RN, PhD
Scientist – Epidemiologist
Lawson Health Research Institute
375 South Street, NRA220
London, Ontario, Canada
N6A 4G5
Associate Professor, Faculty of Health Sciences
and Faculty of Medicine & Dentistry,
University of Western Ontario
Tel.: (519) 685-8500 ext. 77035
Fax: (519) 432-7367
kathleen.hartford@lhsc.on.ca

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INDEX:

INTRODUCTION:

The purpose of this study was to examine the issues at the interface between the criminal justice system and the mental health system and to assess the need for a mental health court in southwestern Ontario. The result is a Best Practices document that should enable those working in the field to examine creative ways of addressing similar issues. Best Practices documents take different forms: from an extensive review of the literature, to a meta-analysis of clinical trials, to consensus building about indicators of best practices, to surveys of those working in the field for their insights and suggestions. This document is based on the latter: it is a survey of those working in the field.

Method: Key informant interviews were held with six pertinent organizations in Chatham, London, Sarnia and Windsor. Key informants interviewed in each city included: 1) police services, 2) crown attorneys, 3) judges, 4) defense attorneys, 5) Canadian Mental Health Association branches, and 6) Probation Services. These informants were selected in order that people in similar positions but in different jurisdictions could address similar issues. It was anticipated that both commonality and divergence of responses would emerge and that the ideas generated would be applicable to other communities. Where possible, other informants were also interviewed. It is just as important to identify the types of persons/agencies who were not interviewed as these omissions mean that broader responses to the issues under study were unable to be solicited. Hospitals and jails/detention centers were the major groups that were not interviewed, due to time constraints. Also many community agencies including consumer survivor groups and not-for-profit groups were not interviewed, again, not because they would not have important opinions about the issues, but simply because of time constraints.

Where protocols existed and practices lent themselves to description, a common format was used that included the following headings: 1) background, 2) description, 3) adaptability to other communities, and 4) names to contact for further information. Within the many documents that key informants sent, the identification of contact names will be helpful, as readers wanting more information or discussions about implementation or modification, can now easily follow-up. Where consultations did not lend themselves to written protocols, insights and suggestion are included in these introductory remarks.

Background: Much provincial work preceded the development of this document and thus neither the published literature nor the unpublished planning documents were extensively reviewed. For a major US review, the 2002 Criminal Justice Mental Health Consensus Project at http://consensusproject.org/ is recommended. A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario was developed in 1997 that was to be implemented within five years. Other documents related to forensic services followed (Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementing Strategies; 1997; The Provincial Forensic System: Strategic Directions, 1997; The Distribution of Mental Health Forensic Beds in Ontario, 1998; Range of Forensic Services in Ontario, 2002). The major planning document Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports was published in 1999. Currently, Ontarians await government action on two major planning endeavors: the Forensic Mental Health Services Expert Advisory Panel and the Mental Health Implementation Task Forces.

Both reports are overdue and participants voiced much frustration at delays in government responses during this consultation process. Further, the April 30, 2003 Speech from the Throne contained no indication that identified mental health funding will go into direct services. In spite of these frustrations, my requests for consultation were met with positive and timely responses from people committed to improving the interaction between the criminal justice system and citizens with mental health problems.

This document is a collation of creative responses from communities and service providers to issues related to mentally ill persons and their contact with the criminal justice system within flat-lined budgets. Given that no new funding for community mental health agencies has occurred since 1992, it is hoped that the ideas contained in this document will be useful to readers.

Police Responses: To begin, all police services recognize that due to lack of community options, mentally ill persons' behavior is being criminalized through arrests for nuisance type offenses. Many police services are organizing so that community mental health agencies can be contacted to help with calls involving mentally ill persons and, rather than charge the individuals, assist them to obtain treatment. This operates as a *charge diversion* program. Additional training for identified police officers that serve as first responders to calls concerning mentally ill citizens is another response. Relationship building between police and mentally ill citizens is another creative response.

Police and Hospitals: It is also recognized that valuable police time is often spent waiting in Emergency Rooms with mentally ill persons. When police have arrested a person under the Mental Health Act, they are required to wait until the person has been admitted. Streamlining of this procedure releases police resources for other community responses. When police accompany mentally ill persons to Emergency Rooms and no charge under the Mental Health Act has been laid, communities are recognizing that police time spent waiting is not necessarily the best use of resources.

Court Diversion: When mentally ill persons are charged with nuisance type offenses, some communities have responded with court diversion programs. These programs are to be recommended as treatment is coordinated and charges are stayed. These programs can prevent mentally ill persons from having criminal records and ensure that treatment is offered. These programs are also intended to reduce recidivism by providing treatment instead of custody. Monitoring of compliance requires resources and a court diversion program is incomplete without this monitoring function. Examples of two different court diversion programs are highlighted. In the absence of formal court diversion, mental health court workers can assist the mentally ill person as advocates to navigate the legal and court system.

Mental Health Court: Support was widespread for a mental health court in London to serve southwestern Ontario. Using the mental health court for fitness assessments in other cities via the technology of videoconferencing was seen a possibility. The process in a mental health treatment court would be to ensure *therapeutic jurisprudence*. Dialogue among the judge, crown, defense, psychiatrist, psychiatric nurse, client and family revolves around problem solving and the implementation and coordination of treatment. Monitoring by the judge of: 1) community provision of services and 2) client compliance with treatment ensures

effectiveness and enables charges to be stayed at completion. It is anticipated that a designated judge will be soon be identified in London and that funding for the forensic specialty resource team will be applied for. A judge in London with expertise in mental health law was viewed as an excellent resource to other cities as was a forensic specialty resource team.

Fitness Assessments: In most jurisdictions, concerns were heard that individuals wait in custody too long for fitness assessments determinations and often their condition deteriorates. While an inter-ministerial agreement exists on the fee for fitness assessments, this fee is reportedly often ignored and surpassed. Many jurisdictions contract with forensic psychiatrists from the Regional Mental Health Care-St. Thomas to conduct fitness assessments and this certainly adds to the waiting time. Recognizing that it is only necessary to have a qualified physician conduct the fitness assessment, Windsor has contracted with a general practitioner for timely assessments. If jurisdictions are considering contracting with physicians to conduct the assessment, the Crown should be prepared to invest time preparing the physician for the types of questions to be expected from the defense. Primary care physicians are usually independent solo practitioners who are unused to having their professional judgment questioned. Should the legislation be changed to allow other qualified health care professionals to conduct fitness assessment, the time spent in custody awaiting assessment could be significantly decreased. Fitness assessments lend themselves very well to videoconferencing and most jurisdictions have facilities. When a mental health court is implemented in London-Middlesex, videoconferencing of fitness assessments and court challenges would be feasible.

Forensic Assessment: The most frequently expressed concern was the waiting time for forensic assessment. While the goal is to admit persons to a forensic hospital within 48 hours of the Orders of Assessment for Criminal Responsibility by the Court (Range of Forensic Services in Ontario, 2002) this has clearly not been achieved. There was universal concern expressed that when the Crown's office called the Forensic Unit to request a bed prior to filling out the Order, the response was invariably that no bed was available and the individual would be placed on the waiting list. There were no reports of clinical diversion, that is, individuals in custody who are certifiable under the Mental Health Act and who are referred directly to a Schedule 1 facility.

Perceptions of untimely admission to the Forensic Unit may or may not be based on previous years' experiences. The most recent data was provided by the Forensic Unit who conducted a survey in 2002 and found that the average waiting time was 19.9 days for clients in jails or detention units, from the time that the Court notifies the Forensic Unit. For clients in treatment facilities the average waiting time was 42.5 days, as these clients were given a lower priority since they were already in a treatment facility. Undoubtedly, the 20-day waiting time requires attention. Also reports of waiting time should include ranges and standard deviations, as it may be these outliers are the cause of the frustration that was consistently reported. Also waiting times between apprehension and application to the Forensic Unit is often attributed to the Forensic Unit, when it is not a function of the unit. Forensic Services currently has approximately three empty beds due to a shortage of psychiatrists and this undoubtedly exacerbates waiting times. This issue of waiting time is two-fold: 1) justice is untimely and 2) clients reportedly deteriorate in jails and detentions centers, which are stated to have limited resources to treat pharmacologically and no

resources to treat unwilling clients if they have not been arrested under the Mental Health Act. Clients who may originally have been capable of directing counsel, but as they deteriorate they lose this ability. It is unclear why jails and detention centers would not be able to treat willing clients pharmacologically when treatment has previously been established in the community.

When clients are transferred to the Forensic Unit, lawyers outside of Middlesex often lose contact with their clients. It was not unusual to hear that counsel subsequently saw their client next at the Ontario Review Board hearing. Attending a Review Board hearing represents a day's work for lawyers from Windsor and Sarnia. A sense of futility was voiced that Review Boards 'never' vary from the Forensic Assessment.

Readers of this document may be interested to know that Directors of the Forensic Units want to provide a better service and have identified the type of service required in a document entitled Range of Forensic Services in Ontario. Approved by the Directors in May 2002, it has been forwarded to the Ministry of Health and Long-Term Care. In addition to the mental health court, the development of community-based forensic resource center was proposed which would provide high-support residential care for clients whose forensic assessments were complete or almost complete. This community-based residence would facilitate forensic clients' reintegration to the community and would also provide residential support for those requiring treatment from court diversion programs or mental health court orders. This was viewed as a method to reduce length of stay in the forensic unit and to increase turnover of forensic beds.

Probation: When a mentally ill offender is released from custody where they may or may not have had treatment, they may have a probation, parole or conditional sentence that requires treatment. When after completing an assessment, a parole officer concludes that treatment is required (or has been ordered), Special Needs Provincial Funding is available and can be applied for by Probation Services. CMHA-Windsor Essex has a psychiatric nurse who works closely with the probation officer and the client who has agreed to a voluntary treatment plan as part of probation.

Police Training: Police training in mental health conditions and treatment begins with basic training at the police college. The Ontario Police College Advanced Patrol Training Mental Illness Guide used in Aylmer is included. Continuing in-service education is also required and different examples are included. Identifying an officer on the force who is primarily responsible for mental health issues ensures a coordinated response and is to be encouraged. All police services have adequacy standards for dealing with mentally ill persons and these emanate from the provincial level. Since there was little variation among the services, these were not included in this document. It should be noted that Crowns, Judges and defense counsels were all in favor of additional training in mental health issues.

Committees: It was acknowledged that the disbandment of the inter-ministerial Human Services and Justice Coordination Project Steering Committee has resulted in a void in leadership at the provincial level.
Yet planning at the community level for appropriate responses from the criminal justice system when dealing with mentally ill citizens is required. More concrete action was observed in those communities with local planning committees.

Other: Finally, communities have developed some unique ways of 'doing business'. Windsor Police have made a strategic decision to enable officers to stand for election to the CMHA Board. Sarnia's Police Services have the opportunity to work overtime in the hospital as security guards on the psychiatric ward. Since involvements with the law can be stressful at the best of times, London Health Sciences Centre's psychiatric ward has developed a legal clinic for in-patients. And finally, CMHA-Lambton County has an outreach team that works with homeless and at-risk persons.

Summary: The variation in responses to similar issues involving the mentally ill in contact with the criminal justice system was tailored to individual communities. The creativity of responses, in the midst of flat-lined budgets was inspiring to this consultant and will hopefully provide stimulation to others.

CHATHAM – KENT POLICE SERVICES HELP TEAM PROTOCOL

Members: Chatham-Kent Health Alliance
Chatham-Kent Program of Assertive Community Treatment
Canadian Mental Health Association
Chatham-Kent Branch

1. Definitions

CKHA	Chatham-Kent Health Alliance
CMHA	Canadian Mental Health Association - Chatham-Kent Branch
CPIC	Canadian Police Information Centre
C.T.O	Community Treatment Order
ECO	Emergency Communication Operator
E.D.P	Emotionally Disturbed Person, including those considered mentally ill

HELP Team Members - A group of front -line officers that receive enhanced training to handle incidents involving Police interaction with emotionally disturbed persons

HELP Team Coordinator - is responsible for the HELP Team and Community partner communications, ongoing training issues, statistical analysis, problem solving, team program effectiveness

PACT Team - Chatham-Kent Program of Assertive Community Treatment

Responding Officer - Any front line officer other than the HELP Team

Partners - Chatham-Kent Health Alliance, Canadian Mental Health Association, Chatham-Kent Program of Assertive Community Treatment, Chatham-Kent Police Service.

Police Officer - as defined in the Police Services Act

Qualified Physician - psychiatrist, family physician, general practitioner and physicians working in psychiatric facilities who have knowledge of the Mental Health Act.

Background:

2. Purpose

The HELP Team has been established to better serve this community and, specifically, emotionally disturbed persons in crisis. The purpose will be attained through increased training of the HELP Team Members and a partnership with local mental health care professionals and advocacy/support groups.

3. Statement of Principles

The guiding principles of this protocol are:

- Police and mental health professionals working collaboratively to better serve the mentally ill in our municipality
- To promote respect and civility pertaining to all emotionally disturbed persons
- Committed to the well-being of all emotionally disturbed persons
- Committed to preserve dignity to all emotionally disturbed persons
- Safety of the Emotionally Disturbed Person
- Safety of the Public
- Safety of the Community Partners
- Safety of the Police

As much as possible, Partners will cooperate and assist each other in carrying out their individual responsibilities

4. Philosophy

We believe in a united collective responsibility towards care of persons in crisis. We will be the front line members of the professional community collaborating with appropriate caregivers and family members to provide individuals with compassionate, immediate treatment.

5. Values and Beliefs

Emotionally Disturbed Persons are valued members of our community who are suffering from a disease and deserve our respect and assistance.

Continuous advanced training
Individual responsibility towards this community
Access to appropriate care, resources and support
Strengthening, renewing and building community partnerships
Continuous self analysis and positive adjustments of our program with the input and assistance of our community partners to maintain the highest program integrity and effectiveness.

6. Goals

- Better serve the emotionally disturbed persons in our community
- Reduce the possibility of tragic consequences during interactions between the Police and the emotionally disturbed persons
- Re-design, evaluate and change as we develop further partnerships and identify program deficiencies

- Education of team members - specialization and program enhancement to be shared with other team members in annual training
- Education of Police Service members
- Share information on our program with the community
- Promote public support to expand community programs
- Advocate for changes to local programs to benefit consumers and their families
- Advocate for government funding for the HELP Team program, which includes community partners and all programs to benefit this community
- Stimulate public understanding and support through community presentations
- Promote and investigate the benefits of additional community partnerships
- Assist our partners to more effectively carry out their responsibilities to care for emotionally disturbed persons

7. The Concept

As downsizing of mental health facilities proceeds in the Province, more police officers are responding to situations involving the mentally ill.

The Chatham-Kent Police Service HELP Team consists of specially trained police officers, assisted by partnerships with the Chatham-Kent Health Alliance, Canadian Mental Health Association - Chatham-Kent branch and the Program of Assertive Community Treatment. These partnerships have been established to develop and implement safe, proactive, preventative methods of containing emotionally explosive situations involving emotionally disturbed persons that could lead to violence.

All HELP Team members in Chatham-Kent will be dispatched to or provide assistance to the investigating officer for calls involving emotionally disturbed persons. In most cases, the HELP Team will be available 24 hours a day, 7 days a week.

The HELP Team members use their training to attempt to deescalate volatile situations without resorting to the use of force. The partnerships forged with mental health professionals provide invaluable assistance to the officers. In similar programs, police have recognized a significant reduction in consumer and police injuries during crisis calls. We anticipate that this benefit, as well as improved relationships with the mentally ill and mental health professionals will be realized in Chatham-Kent as a result of the HELP Team.

Description:

8. HELP Team Response

8.1 HELP Team or Community Patrol Branch involvement is initiated by calling the Emergency Communications Centre, 911 for emergency or (519) 352-1234 for Non-emergency.

8.2 A HELP Team member will be dispatched to any incident involving the EDP whenever practical. (The ECO will decide who will respond to the call for service based on nature of the call and availability of the HELP Team)

8.3 If a HELP Team Member is not immediately available, calls for service can be responded to by the Community Patrol Branch and a HELP Team Member can be sought as a resource by the Community Patrol Branch.

8.4 HELP Team officers normally will be responsible for interaction with the EDP at the scene.

8.5 Where necessary, take the EDP to Public General Campus for assessment by the emergency room doctor and mental health care partners to further identify the needs of the consumer and/or their immediate family.

8.6 The Police Officer is responsible for person in custody until the physician or psychiatric facility takes custody of the individual.

8.7 If attending the hospital, the EDP will either do so voluntarily or will be in police custody. (The ECO will contact the Public General Campus MH Crisis Nurse and advise that an EDP be being brought in for assessment).

8.8 The admitting procedure is as follows:

When an EDP is brought to the emergency room the Triage Nurse in the Emergency Department will initially assess him/her. The Triage Nurse will contact the Mental Health (MH) Crisis Nurse to do a complete crisis assessment (for a 16-year-old or older). The MH Crisis Nurse will report the assessment information to the emergency room physician, who will conduct an examination. If the EDP is to be admitted to two-west, the MH Crisis Nurse will accompany the EDP to the unit. (Police will also accompany the Crisis Nurse to two-west to ensure the safety of the EDP and the MH Crisis Nurse, if required). If the EDP is discharged, the MH Crisis Nurse will assess follow-up needs and, with EDP's consent, will make a referral to the appropriate and community agency. If the Mental Health Clinic is the most appropriate community agency, the MH Crisis Nurse will notify the Mental Health Clinic and a Mental Health Clinic staff person will call the EDP the following day.

8.9 If the EDP is admitted to the hospital and requires medications, the medications will be administered to the EDP in the Emergency Department to lessen the likelihood of violent behaviour during admission to the psychiatric unit. The officer is responsible for the person in custody until the psychiatric facility takes custody of the EDP.

8.10 If the EDP is not taken to the hospital, the police will investigate and attempt to ascertain if the EDP is involved with a community partner currently and that partner is to be contacted.

8.11 The Partners and contact numbers are:

Canadian Mental Health Association - Chatham Branch, Pager (519) 436-9250 available 24hrs for Police Officers, Tel # (519) 436-6100 (8:30AM-4: 30PM)

When you contact the pager company, page all teams and indicate it is an emergency and a number where you can be reached. If for any reason there is not a response, re-contact the pager service.

PACT Team, Tel# (519) 355-0667, 24 Hour service
Chatham-Kent Health Alliance, Mental Health Clinic (9AM-5PM) Tel# (519) 351-6144.

Chatham-Kent Health Alliance, Tel# (519) 351-6144 Ext #1(after hours).

8.12 The Chatham-Kent Health Alliance number provided is primarily an after hours contact. In order to contact a Crisis Nurse during business hours (9AM-5PM) calls are to be made directly to the Mental Health Clinic and the secretary will direct you to the Crisis Nurse available either at the Mental Health Clinic or on two-west.

8.13 If the responding officer or HELP Team member is unable to determine if the EDP has been involved with a community partner, the officer will call the C-K Health Alliance MH Crisis Nurse (at above #) who is available 24hrs a day, and provide the following information: individuals name, particulars, officer concerns and action taken. If it is determined that the EDP is not involved with a community partner, Police will make all attempts to ascertain which, if any, advocacy group or support group the EDP is involved in and contact that group.

8.14 The MH Crisis Nurse may provide advice to the officer or, if necessary and available, immediately notify a partner agency to provide assistance.

8.15 The PACT Team will respond (providing the EDP is their client) to the scene or the hospital with the Police if required. The Chatham-Kent Health Alliance MH Crisis Nurse will not respond to a Police scene. The Canadian Mental Health Association - Chatham-Kent Branch will respond to the Police scene or the Public General Campus (EDP must be their client). If the CMHA does not attend, the Police Officers will be provided with the reason. The Chatham-Kent Police will ensure the safety of all Partners and will assess the scene before the partners will attend.

8.16 The referral information provided as per Sec. 8.12 will go to the Access Group for individuals not already involved with mental health service providers in the community. The ACCESS group will determine most appropriate service provider for the EDP based on his/her assessed a level of need. .

8.17 Partners as defined in section #1 can contact an on-duty HELP Team Member for advice anytime. The Partner will call the (519) 352-1234 non-emergency number and the HELP Team Member will return the call. The ECO who receives the call will create a Police Assistance incident for tracking purposes.

8.18 Responding officers or HELP Team members will submit a report or clear the incident with the name of the EDP, particulars of the incident, action taken and, if applicable, medications involved, the Partner contacted and their response, and the emotional/mental condition of the EDP.

8.19 All officers will notify a HELP Team member of the details of the call that was responded to and incident number for tracking and statistical purposes.

8.20 All HELP Team Members will notify the HELP Team coordinator by an in-house computer message of all details of the call.

8.21 A database to track all calls involving the EDPs will be maintained on "G" Drive by the HELP Team coordinator. It will be accessible to all members as 'read only'. Information on this database will be kept confidential pursuant to the Freedom of Information Act.

9. Community Treatment Orders

9.1 Purpose of a Community Treatment Order - To provide a person who suffers from serious, persistent mental illness with a comprehensive plan of community based treatment or care and supervision that is less restrictive than being hospitalized.

9.2 Any Qualified Physician who is familiar with the Mental Health Act can place an individual on a C.T.O.

9.3 The individual must agree to being put on the C.T.O. and must be able to comprehend and fulfill the conditions placed on it.

9.4 If the Qualified Physician writing the CTO feels it would be appropriate and helpful, the Chatham-Kent Police will be named in the C.T.O. as a partner in the treatment plan. According to the Mental Health Act, sharing of information with other named partners in the CTO is permitted without a Form 14. It is the prerogative of the Chatham- Kent Police to decide whether they will agree to be a partner in the CTO.

9.5 If the Qualified Physician has reasonable cause to believe that a person has failed to comply with the obligations of the C.T.O. the physician can issue an ORDER FOR EXAMINATION. FORM 47

9.6 A Police Officer may take an individual into custody for a breach of CTO conditions ONLY when the physician has issued a FORM 47 - ORDER FOR EXAMINATION and the order is current (30 day expiry).

9.7 The authority for a Police Officer to take into custody an individual under an ORDER FOR EXAMINATION is Section 33.3(1) and 33.4(3) of the Mental Health Act

9.8 When an ORDER FOR EXAMINATION is issued, the Physician will notify the Chatham-Kent Police Service HELP Team coordinator, or the Officer in Charge of the Service at (519) 436-6626, as soon as practical and forward the original Form 47 to that person.

9.9 The coordinator or Officer-in-Charge receiving the original Order for Examination shall notify the members of the service through BOLO and/or Lotus Notes that the Order of Examination is in effect and can be executed in accordance with CKPS policy and procedures.

9.10 The coordinator or Officer-in-Charge shall ensure that an incident report is created; the Order for Examination is filed in the warrant files and entered on CPIC as per normal warrant procedures.

9.11 Should the Physician not forward the original Order for Examination, that Order will not be executed unless the original has been viewed or confirmed with the physician in possession of the original immediately prior to execution.

9.12 When an ORDER FOR EXAMINATION has expired or is otherwise no longer in effect, the physician will immediately notify the Chatham-Kent Police Service HELP Team coordinator or the Officer in Charge of the service at (519) 436-6626. (Sec. 33.5 MHA), who then shall ensure that the Order is so marked and the CPIC entries removed.

9.13 The HELP Team coordinator will notify and advise all officers of the Order for Examination by way of a Force Broadcast as well as advise all officers if and when the order has expired or the individual has been taken into custody.

9.14 When a COMMUNITY TREATMENT ORDER has expired the physician will contact the Chatham-Kent Police Service by fax and advise the Officer in Charge that the Order has expired.

9.15 Prior to the execution of the Order for Examination, the Chatham-Kent Police shall first ensure that the physician who signed the order or the named alternate will be available to conduct the examination of the individual.

9.16 Once an individual, who is subject to an Order for Examination, is taken into custody, Police shall PROMPTLY take the person in custody to the physician who issued the order or the alternative physician named in the order.

9.17 The Police Officer is responsible for the person in custody until the physician or psychiatric facility takes custody of the individual.

9.18 An arrest report, person's details and descriptors will be added to the police records management system (OMPPAC/OPTIC) by the arresting Police Officer.

9.19 The Chatham-Kent Police Service, if in possession of the Order for examination, shall ensure that it is marked as executed and removed from CPIC.

10. COSTS

No costs or liabilities will be assessed by or against any partner relative to the HELP Team protocol.

11. Dispute Resolution

The coordinator will be the main contact person and will communicate with the Partners to assist in the continued progress of the team. The Operations Support Inspector, Clare Wiersma (436-6605), can be contacted in the coordinator's absence, or if issues have not been resolved to the satisfaction of the Partners.

If the Community Partners have an immediate concern, they will contact the Officer-in-Charge at (519) 436-6626.

12. Information Sharing and Disclosure

Partners, while assisting each other to better serve the emotionally disturbed person, must be cognizant of their rights and relevant statutes such as the Freedom of Information Act, Health Care Consent Act and Bill 68.

13. Joint Training

Training will be an important component of our ability to better serve the emotionally disturbed. Our partners are committed to assist each other in their training needs. Training will be constantly modified to enhance our ability to serve the emotionally disturbed.

HELP Team members will attend an initial 40 hours of training under instructional supervision of mental health providers, family advocates and mental health consumer groups. Further, individual members will receive enhanced training as available and will be expected to bring this experience and training back to the rest of the team to further develop and renew our program.

The initial training involves officers being exposed to basic dynamics of common types of mental illness and to viewpoints and feelings of mental health consumers first hand. Training assists officers to understand that mental illness is not a crime, but a disease. Skills are developed in deescalating potentially volatile situations, gathering relevant history, assessing medical information and evaluating the individual's social support system.

14. Authorization

We, the undersigned on behalf of our respective agencies agree to the joint Protocol to better serve this community and, specifically, emotionally disturbed persons.

Len Caro — date: _____
Executive Director
Canadian Mental Health Association,
Chatham-Kent Branch

Sandra Whittle — date: _____
Vice President,
St. Joseph's Health Care, London

Barb Tiessen — date: _____
Program Director, Mental Health Services
Chatham-Kent Health Alliance

Carl Herder — date: _____
Chief of Police
Chatham-Kent Police Service

Could this work in other communities? Yes, the model was first published in Memphis Tennessee and is widely emulated.

For more information contact:

Inspector Clare Wiersma
Operational Support Branch
Chatham Police
24 Third St. P.O. Box 366
Chatham, ON N7M 5K5
Tel.: (519) 436-6600 ext 605
Fax: (519) 436-6643
clarew@city.chatham-kent.on.ca

RELATIONSHIP BETWEEN LONDON POLICE AND LONDON PACT TEAM REGARDING PACT CLIENTS

Background: In 1996, London's Program Assertive Community Treatment (PACT) Team I formed while PACT II Team II formed in 1998. The two teams approached the London Police Service to develop a working arrangement for PACT clients involved with the Police.

Description: When clients become involved in treatment with PACT, they are asked to sign a Form 14 (Consent to Disclosure, Transmittal or Examination of a Clinical record under Subsection 35(3) of the Act) permitting the London Police to notify PACT should the clients become involved with the Police. The clients also provide their address. The form and address are faxed to the Police. As of Jan 10, 2003, there was a 40% refusal rate (24/60) on Team I and a 54% refusal rate (24/44 clients) on Team II.

The Police, under the auspices of the Supervisor of the Family Consultant/Victim Services Unit attach an internal flag to the individual's name and address with directions to notify the PACT team if the client is involved with the Police. PACT updates the addresses weekly.

The officer involved with a PACT client can become aware of the information in two ways: a) if Dispatch is sending the officer to an address the officer would be informed that the individual is a PACT client and that PACT should be notified and b).if the officer makes contact with the individual without notification from Dispatch, they will query the name on their computer and see the flag informing them to contact PACT.

PACT will send a worker immediately to attend the call. The Police find that a PACT team member attends promptly. Their role has been to provide support, interpret client's behaviour and advocate for an appropriate resolution.

Could this work in other communities? Could easily work in other communities and with other mental health service agencies.

For more information contact:

Ms. S. Jalbert
PACT Manager
388 Dundas Street, Suite 100
London, ON
N6B 1V7
Tel.: (519) 434-9666

London Police Services
601 Dundas St.
London, ON N6B 1X1
Tel.: (519) 661-5636
Fax: (519) 661-6495
lheslop@police.london.ca

Lisa Heslop
Supervisor, Family Consultant/Victim
Services Unit

IDEAL MANAGEMENT OF MENTALLY ILL PERSONS WHO COME IN CONTACT WITH POLICE FOR NUISANCE-TYPE OFFENSES

Background: Realizing that many mentally ill persons are criminalized for their behaviour and don't receive required treatment for their illness, CMHA Windsor-Essex has articulated how an adequately resourced system would operate.

Description: For petty nuisance-type crimes, police would have the option of charge/arrest diversion whereby the police could contact CMHA's court outreach workers to assist them at the scene, if possible. Outreach workers are currently available from 8am to 8pm , Monday to Friday. If it was determined that the person required hospitalization, CMHA workers would attend at hospital thus freeing up police resources to return to their regular field duties in the community while the mental health professional support the individual with hospital admission. If admission is not required CMHA can offer support to the individual through their usual array of services. The result of such a system is to decrease criminalization of mental illness and obtain treatment for the individual. If the police call came after hours, the outreach worker would see at the earliest opportunity.

Could this work in other communities? Could easily work in other communities and would require mobile response from CMHA and agreement for charges eligible for diversion by police.

For more information contact:

Karen Gignac
CMHA Manager – Windsor Essex Branch
Community Support Services
1400 Windsor Avenue
Windsor, ON NBX 3L9
Tel.: (519) 255-9940, ext. 236
Fax: (519) 255-7817
kgignac@cmha-wecb.on.ca

DRAFT PROTOCOL FOR FAST TRACKING PERSONS WITH MENTAL ILLNESS UNDER POLICE ACCOMPANIMENT TO WINDSOR HOTEL - DIEU GRACE HOSPITALS EMERGENCY DEPARTMENTS

Background: Because police resources were being used waiting with persons with mental illness in the ER waiting room, the Windsor Mental Health/Community/Police/Hospital Ad Hoc Working Group designed a psychiatric triage protocol in 1998.

Description: When a police officer has taken into custody a suspected mentally ill person and is in transport to the nearest Schedule I Hospital, he/she shall:

- Notify the triage nurse in the Emergency Room of their pending arrival.
- Upon arrival at the emergency department announce their presence to the psychiatric assessment nurse (0900-2100) and provide pertinent information.
- Remain with the patient until the facility accepts custody (take the patient to the multipurpose room or sit in the waiting room).

When the emergency room triage nurse is notified that the police will be arriving imminently with a suspected mentally ill person, he/she shall:

- Upon arrival at the emergency department, obtain pertinent information from the police and do an assessment.
- Work with crisis staff, police and other emergency room staff to transfer the care of the patient as quickly as possible.

If the psychiatric assessment nurse is not on duty, the crisis center staff is called instead (24hrs/day).

Note: Transfer of custody occurs when the hospital arranges for their staff to take charge of the individual or when a person is taken for an assessment. Every effort will be made to giving priority to the transfer of custody.

Could this work in other communities? Such agreements could easily work.

For more information contact:

Robert Atkinson
Director, Community Crisis Centre of Windsor-Essex County
Jeanne Mance Building, 1st Floor
Hotel-Dieu-Grace Hospital
1030 Ouellette Avenue
Windsor, ON N9A 1E1
Tel.: (519) 973-4411, ext 3264
Fax: (519) 973-1989
batkinson@hdgh.org

CHATHAM-KENT POLICE SERVICES' HELP TEAM'S RELATIONSHIP WITH GROUP HOMES AND PEER SUPPORT CENTRES

Background: When the HELP team was initially trained in 2001, part of the training included a discussion with three persons from the Consumer Survivor Network of Chatham-Kent about their functions and service delivery. Funded by the Ministry of Health & Long-Term Care and the Trillium Foundation, CK Consumer Survivor Network is a peer support agency, staffed by and composed of people who have had or still have a mental illness. At the training session the consumer survivors talked about their experience with mental illness and its sequelae. They also expressed concerns about the way in which police dealt with them.

Description: HELP Team members started visiting the Consumer Survivor office; at first in uniform and then when they realized that people were uncomfortable about the uniform, they subsequently came in plain clothes. They met people, talked with them and had lunch with them and established a relationship. Consumer survivors talked to the police about their problems and about legal issues. The HELP expanded this outreach by also visiting group homes. The result of this relationship building is that when the police interact in a professional capacity at a later date, they have a familiarity with the person and the interaction goes more smoothly.

Could this work in other communities? Yes, this relationship building is a component of neighborhood policing.

For more information contact:

Inspector Clare Wiersma
Operational Support Branch
Chatham Police
24 Third St. P.O. Box 366
Chatham, ON N7M 5K5
Tel.: (519) 436-6600 ext 605
Fax: (519) 436-6643
clarew@city.chatham-kent.on.ca

CANADIAN MENTAL HEALTH ASSOCIATION, LAMBTON COUNTY BRANCH'S INFORMAL WORKING AGREEMENT WITH MALLS

Background: Since the inception of the Outreach Worker, Crisis and Court Program CMHA has been striving to be seen as a community resource to be utilized with, or instead of, the police in difficult situations with individuals with a serious mental illness. The goal is to become involved at the initial point of contact and connect these individuals with more appropriate resources outside of the justice system.

Description:

- Network with store employees to educate them regarding our role and to be visible in the community.
- To respond quickly when contacted.
- To partner with other community agencies.
- Educational sessions to the police on a yearly basis.
- To maintain professional relationships with commonly accessed organizations (such as Ontario Disability Program and Ontario Works office).
- To build on positive experiences in the community.

Could this work in other communities? This proactive outreach could easily work in other communities.

For more information contact:

Penny Witcher
Team Leader
CMHA-Lambton County Branch
210 Lochiel St.
Sarnia ON N7T 4C7
Tel.: (519) 337-5411
Fax: (519) 337-2325
penny@cmha.sarnia.net

ELGIN- MIDDELSEX COURT DIVERSION PROGRAM

Background: In response to a recognized need to better coordinate, resources and implement services for people with mental health and/or developmental needs who come into conflict with the law, a cooperative effort among the Ontario Ministries of the Attorney General, Community and Social Services, Health and the Solicitor General and Correctional Services has been established. Such individuals are identifies as common clients in keeping with ministries' shared goals of achieving healthy and safe communities and recognition that solutions are a joint responsibility.

As a result, in early 1995, the sponsoring ministries related a policy entitled, "The Provincial Strategy to Coordinate Human Services and Criminal Justice System in Ontario." This policy document is part of a series of agreements between the ministries, which is intended to implement key components of the provincial strategy framework. A key component of this framework was the development of Diversion Services. The County of Elgin piloted a Diversion Service in 1996. This project, viewed as a success was expanded and implemented in the county of Middlesex in 1998.

Description: The goals of the Elgin-Middelesex Court Diversion Program are to:

1. Assist individuals with a serious mental disorder, developmental disability and/or brain injury that are in conflict with the law.

2. Partner with the Crown Attorney's Office, defense bar, police, mental health service providers, families and consumers to ensure the appropriate intervention for each individual.

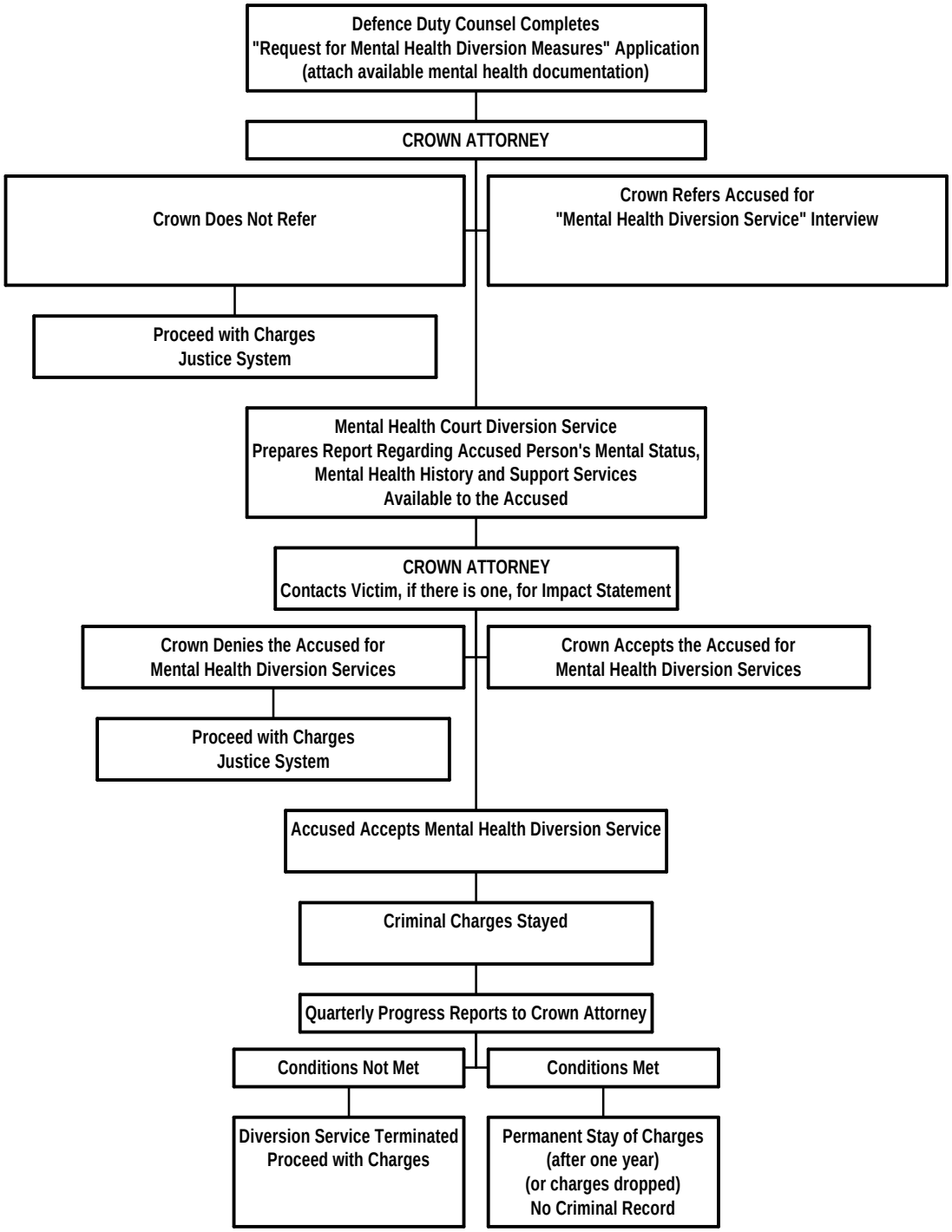
3. Facilitate Diversion as a suitable alternative to criminal proceedings for those mentally disordered, developmentally disabled and/or brain injured people charged with a minor criminal code offence.

4. Negotiate support, rehabilitation and/or treatment options that address an individual's mental health needs.

5. Prevent repeated contacts between individuals with mental health needs and the criminal justice system.

The following diagram illustrates the path that a mentally ill accused person who meets the eligibility criteria can follow:

Mental Health Diversion Service Protocol



Classes of offences that are eligible for diversion are:

CLASS ONE OFFENCES

For these offences, the presumption is that the accused is a suitable candidate for diversion. The following list is non-exhaustive but provides examples of offences which may fall into Class One:

THEFT UNDER $5,000.00
JOYRIDING
FRAUD UNDER $5,000.00
FRAUD ACCOMMODATION
FALSE STATEMENT UNDER $5,000.00
POSSESSION UNDER $5,000.00
MISCHIEF UNDER $5,000.00
FOOD FRAUD
CAUSE DISTURBANCE
FALSE PRETENSE UNDER $5,000.00

CLASS TWO OFFENCES

This class includes all of the offences not included in Classes One and Three. Many of these offences will resemble the offences in Class One and thus, should be presumptively considered for Diversion. Any offence, which was committed in circumstances of violence, (other than very minor assaults) should not be diverted and any offences in which a weapon was employed will not be suitable for Diversion. A good guide for whether or not an offence should be diverted is its resemblance to offences in Class One. The more the offence appears to involve offences described as Class Three offences, then the less likely it is to be diverted. Where Diversion is being proposed for a Class Two offence, the consent of the administrative Crown Attorney is required. The following list is non-exhaustive but provides examples of the types of offences which fall into Class Two:

UTTERING THREATS
PUBLIC MISCHIEF
RESISTING ARREST
FRAUD
FALSE PRETENSES
SOLICITING
SECRET COMMISSION
CRIMINAL BREACH OF CONTRACT
KEEPING A COMMON BAWDY HOUSE
SIMPLE ASSAULT (EXCEPT DOMESTIC/WIFE ASSAULT)
DANGEROUS DRIVING (WHERE NO BODILY HARM OR DEATH WAS CAUSED)
BREAK AND ENTER
ASSAULT PEACE OFFICER (UNLESS A WEAPON IS INVOLVED OR THERE IS BODILY HARM)
ADVERTISING REWARD

PERSONATING A PEACE OFFICER
THEFT
FORGERY
KEEPING A COMMON GAMING HOUSE
MISCHIEF TO PROPERTY
OBSTRUCTING A HIGHWAY
ATTEMPT TO OBSTRUCT JUSTICE

CLASS THREE OFFENCES

The offences in this class are so objectively serious that they will not be appropriate for inclusion in the Diversion policy. In other words, these offences cannot be recommended for Diversion. Some examples of offences that are not divertible are as follows (this is not a complete list):

MURDER
ANY OFFENCE INVOLVING WIFE ASSAULT
PROCURING FOR PURPOSES OF PROSTITUTION
ASSAULT CAUSING BODILY HARM
ANY OFFENCE INVOLVING EXPLOSIVES
SEXUAL ASSAULT
MANSLAUGHTER
ROBBERY
AGGRAVATED ASSAULT
CRIMINAL NEGLIGENCE
ANY DRINKING AND DRIVING OFFENCE

If the accused is eligible for diversion and there is agreement from the Crown that they should be diverted, the Mental Health Court Diversion Worker (MHCDW) conducts an assessment prior to developing a diversion treatment plan. The accused signs the following consent:

Request for Mental Health Diversion Service

(for persons with a mental disorder, developmental disability and/or brain injury)

Part 1

Name.....

Last First Middle

Address.....

Postal Code..... **Phone**.....

I hereby request that I be considered for a Diversion Service in relation to the following offence(s)

(1).....

(2).....

(3).....

Next court appearance..... Court.....

Police Department.....……..... Investigating Officer.....

I..... **DOB**.....

(Print full name of person) *(d,m,y)*

hereby consent to be assessed by the Elgin/Middlesex Court Diversion Service personnel. I understand that the Elgin Court Diversion Service personnel may be obtaining and exchanging information concerning me with other sources to assist in the completion of the assessment. I hereby consent to any disclosure, transmittal, examination or exchange of such information between these interested parties. I understand and consent that anything I say and any information obtained about me in the course of preparation of the assessment may be shared with the Crown Attorney /Defense/ Duty Counsel.

Dated the.....day of.....20.....

....

(signature) *(Witness/Defense Counsel)*

Please print name.....

Part 2 Acknowledgment and Recommendation by Crown Attorney Office

Based on the Crown Brief prepared at:

1) In my opinion, sufficient admissible evidence exists to conclude that there is a reasonable prospect of conviction in respect of, and that it is in the public interest to proceed with, the prosecution of each of the offences in respect of which this request for Diversion is made:

2) I recommend...../do not recommend..... that the Elgin Court Diversion inquire into the treatment, rehabilitation, and/or support needs of the above noted accused person and determine the suitability of the accused person for Diversion Service and complete an assessment of the accused person concerning Diversion Service for presentation upon completion to the Crown.

....

(Date) *(Crown Attorney)*

Part 3 Acknowledgement by Crown Attorney's Office

1) I am satisfied...../not satisfied..... that the accused is a suitable candidate for admission into the Elgin Court Diversion Service:

2) Having reviewed the Elgin Court Diversion Service assessment concerning the above noted accused person, the Crown agrees to stay the charge(s). Pursuant to section 579 of the criminal code of Canada, pending, in the opinion of the Crown, the accused person=s satisfactory completion of the Diversion Service.

....

(Date) *(Crown Attorney)*

ELGIN/MIDDLESEX MENTAL HEALTH COURT DIVERSION SERVICE

(for persons with a mental disorder, developmental disability, and/or brain injury)

INFORMED CONSENT

The Elgin/Middlesex Mental Health Court Diversion Service allows the Crown Attorney a support, rehabilitation, and/or treatment option for individuals with a mental disorder, developmental disability, and/or brain injury charged with a minor criminal code offence(s). Access to the service will be made by completing a "Request for Mental Health Court Diversion Service" form available at the St. Thomas Provincial Court House, 30 St. Catharine Street, St. Thomas, Ontario or at the Middlesex Court House, 80 Dundas Street, London, Ontario and submitting it to the Crown Attorneys office. Participation in this service is voluntary and must not be contrary to public interest. As part of the process of applying for this service, you will be required to complete a written consent form. This consent form indicates that you agree to be interviewed by a member of the Diversion Team and that the information gathered can be shared with all participating partners, including the Crown Attorney, Legal Counsel, Police Services, psychiatric hospital services and community mental health agencies.

Upon referral from the Crown Attorney, a psychiatric nurse will determine the mental health supports available to you and submit this information to the Crown Attorney. The Crown Attorney must then determine whether you would be better served by participating in a support, rehabilitation, and/or treatment service rather than proceeding through the criminal justice system. The Crown Attorney must weigh what is in your best interest and what is in the best interest of public safety.

The interview process is an information gathering session and <u>is not</u> a plea of guilt or innocence to the charge(s) before the court.

If you choose to participate in the Mental Health Court Diversion Service interview and if it is determined by the Crown Attorney that your needs would be better served through a system addressing and supporting you mental health needs, the Crown Attorney may elect to stay the criminal charge(s) for a period of one year while you seek and receive appropriate support, rehabilitation, and/or treatment services.

It is hoped that through this service you will have access to the various support, rehabilitation, and/or treatment services that are available with in the community. These services are designed to help you obtain the necessary skills and supports to successfully live in the community without further involvement with the criminal justice system.

The Mental Health Court Diversion recommendations proposed must meet with the satisfaction of both you and all other participants, including the Crown Attorney, Legal Counsel, and the mental health service providers involved.

At your next court appearance date, the Mental Health Court Diversion recommendations, as outlined by the Crown Attorney, will be presented to you by Legal Counsel. You may choose to follow the support, rehabilitation, and/or treatment options outlined to address you heath needs or you may choose to proceed through the criminal justice system as advised by Legal Counsel.

The Mental Health Court Diversion option offers you a one-year period of participation in support, rehabilitation, and/or treatment as outlined by the Crown Attorney.

Successful completion of the Diversion recommendations will result in a permanent stay of the original criminal code charge(s). You will not retain a criminal record for the diverted charge(s).
If at any time during the one-year period you fail to comply with the recommendations outlined by the Crown Attorney, the Crown Attorney may revoke the stay of charge(s) and commence criminal proceedings.

Signature:..... Date:.....

Witness:.....

If the accused has been referred by any hospital, community service providers/agencies, doctor's office or any other source, the MHCW obtains a Form 14 from the accused and faxes the following form to the hospital seeking background information:

The above named person has requested consideration for Mental Health Diversion and has been referred for assessment by the Elgin/Middlesex County Crown Attorney's Office for possible participation in our program. It is our understanding that you have seen this person in the past.
We would appreciate receiving a summary (faxed to above # is satisfactory, if preferred) of your records to assist us in the development of an individualized intervention plan. Please include copies of psychiatric admission/discharge summaries, psychosocial histories, consultation reports and psychological reports.

This information is then used as part of the following assessment by the Mental Health Court Diversion Worker:

MIDDLESEX/ELGIN MENTAL HEALTH COURT DIVERSION SERVICE ASSESSMENT

(for persons with a mental disorder, developmental disability and /or brain injury)

Location of Interview: Middlesex Court Diversion Office
Date of Assessment:
Name: **DOB:**
Address:
Sources of information:
Present Charge(s):
Circumstances of Alleged Offence(s):
Prior Criminal Charge(s):

MENTAL STATUS
General description:
Orientation: oriented in all three spheres- person, place, and time.
Memory:
Intellectual functioning:

Thought process:
Content of thought:
Depression:
Risk to self:
History of risk to others:
Affect/mood:
Insight:
Alcohol/drug abuse/gambling problems:
Psychiatric history and current diagnosis:
Medical history:
Relevant social history:
Summary: As documented in this report,_____ has a diagnosis of _____ verbalized an understanding of and agreement with the diversion process. Should the Crown Attorney choose to stay the charge(s) and divert this individual, these recommendations might be beneficial.
Recommendations for disposition and treatment plan:

Alerts:
_____Increasing degree of violence in offences
_____Offence committed in circumstances of violence
_____Weapon used
_____Other
Date_____

Signature_____
Mental Health Court Diversion Worker

Your client has requested to participate in the Mental Health Court Diversion Service. It is a one-year program in which your client chooses to participate in treatment and support to address his/her mental health needs. Any information that you have already in your files to verify a diagnosis of a mental disorder, a developmental disability, or a brain injury, prescribed medications, or recommendations that you may have, would be beneficial. We would gladly accept a fax, photocopy, or verbal report of this information. Your client has requested to participate in this service; however, we are unable to remit payment for the before mentioned documentation.
We appreciate your consideration of the special needs of your client. If there are any questions or concerns, please don't hesitate to call.
Attached is information regarding the service.

After discussion with the defense lawyer, accused and family, if appropriate, the Crown examines the material and then the Crown and the accused sign the following contract:

DIVERSION OF A MENTALLY DISORDERED, DEVELOPMENTALLY DISABLED, AND/OR BRAIN INJURED PERSON

Name of Accused Person: …… **DOB:** ……..

Charge(s): …….……

Date of Diversion/ Stay of charge(s) ..... **20**….....

Defence: …….. …….
(Name/duty please print) (phone)

Recommendations for disposition and treatment plan:

1) Take medications as directed by doctor/designate.
2) Attend appointments, cooperate with necessary monitoring such as blood work, consultations as directed by doctor/designate.
3) Participate with programs, groups, activities, etc. such as anger management, A.A., relapse prevention etc., as directed by doctor/support team or agency as directed.
4) Develop a Crisis Intervention Plan with the London Mental Health Crisis Service, phone (519) 433-2023.
5) …and so on as needed for individual planning

.....
(Assistant Crown Attorney)

I, ……..… **DOB:** ……
(*Print full name of accused person)*

of ……..……..……
(Address, postal code) *(Phone)*

Hereby consent to participate in the Middlesex/Elgin Mental Health Court Diversion Service as recommended. I understand that the Middlesex/Elgin Mental Health Court Diversion Service Personnel may be obtaining and exchanging information concerning me with other sources to assist in the completion of the Diversion. I hereby consent to any disclosure, transmittal, examination or exchange of such information between these interested parties for this purpose.
I understand that, in the opinion of the Crown, should I fail to adhere to the recommendations and not satisfactorily complete the Diversion philosophy imposed upon me, the Crown may recommence the above noted criminal proceedings.

Dated the.....**day of...** ..... **20**.....

....…….....
(signature of accused person) *(Witness/Defence/Duty Counsel)*

.....
(signature of guardian)

When the contract is signed, the charges are stayed at the next court date:
The next step is to notification of the community services provider/s with the following fax and asked them to provide progress reports:

_____ *has been accepted for mental health diversion and has signed his/her diversion contract. It is a one-year program in which he/she agrees to follow the recommendations in her contract. I am sending you a copy of the contract along with my diversion assessment for your files. Please don't hesitate to call if there are any questions or concerns.*

Sincerely,

Mental Health Court Diversion Worker

ELGIN/MIDDLSEX MENTAL HEALTH COURT DIVERSION SERVICE

(for persons with a mental disorder, developmental disability and/or brain injury)

RE: Servicing Persons With A Mental Disorder, Developmental Disability And/Or Brain Injury

Thank you for your participation in our program and for providing services to _____ .

Because of the legal requirements of our program, progress reports must be received by the following dates:

Please consider the following guidelines when completing your reports for the Crown Attorney; identified problems, goals of intervention, client's progress, client's attitude/ insight/compliance, and any further recommendations that you may have. You may send a fax, photocopy or give a verbal report of your most recent progress update, (or you may use the form provided).

Please notify the undersigned immediately should your client fail to comply with the recommendations, or if your client's mental status deteriorates. A meeting can be arranged to review and/or revise the mental health treatment plan and recommendations as needed, to help promote a successful completion of the Diversion program.

Thank you once again,

Mental Health Court Diversion Worker

ELGIN/MIDDLESEX COURT DIVERSION SERVICE

80 Dundas Street, Ground Floor, Unit "A" Room 1083
London, Ontario N6A 6A3 Fax: (519) 679-9352

PROGRESS NOTE **Date:**

Agency/Service Provider:

Address:

Phone: **FAX:**

RE: **DOB:**

Identified Client Problems:
Situational/Relational? Financial? Residential?

Intervention:
Medications - yes/no
Changes in medications - yes/no
Counseling/coaching - yes/no
Regular one-to-one support - yes/no

Progress:
Improved/stable - no change, unstable

Attitude/Insight:

Compliance:
Attending appointments - yes/no
Taking medications - yes/no
Attending programs, counseling, etc. - yes/no
Abstaining as required - yes/o

Problems (if any):

Recommendations (if any):

Signature_____

When the program is completed, the Mental Health Court Diversion Worker notifies the Crown and provides to the following form to the client and to the community agency.

ELGIN/MIDDLESEX MENTAL HEALTH COURT DIVERSION SERVICE
(for persons with a mental disorder, developmental disability and/or brain injury)

80 Dundas Street
Ground floor, Unit "A", Room 1083
London, ON N6A 6A3
Ph:(519)660-3168
Fax:(519)660-2433

Ministry of The Attorney General
Crown Attorney
County of Middlesex
Ground Floor "B"
80 Dundas Street
London, ON N6A 6A2

Date: …….

Re: ……..…… ***DOB:*** ……

Charge(s): ……

was accepted into the Mental Health Diversion Program on _____
This note will reflect the successful completion of the program and the final report required. This individual has continued to comply with the recommendations as per the contract. The above charge(s) will now be permanently stayed (dropped).
It is our sincere hope that this program has been of benefit. We encourage the continuation of the mental health services, which have been organized, and recommend contacting the organized services for any problems should they occur in the future.

Yours truly,

Mental Health Court Diversion Worker

c.c. to client.
c.c. to community support.

For more information contact:

Roni Voigt
Mental Health Court Diversion Nurse
80 Dundas St.
First Floor, Unit A, Room 1083
London, Ontario, N6A 6A3
Tel.: (519) 660-3168
Fax: (519) 660-2433
roni.voigt@jus.gov.on.ca

CMHA WINDSOR-ESSEX COUNTY BRANCH JUSTICE SUPPORT SERVICES (COURT OUTREACH/ DIVERSION)

Background: CMHA programs strive for flexibility in response to the emerging/changing needs of both consumers of mental health services and the community. It is well documented that throughout Ontario, many individuals with serious and persistent mental illness become involved with the criminal justice system. Many of these individuals are untreated or have discontinued treatment largely due to lack of supports available to them. The CMHA Ombudsman (Advocacy) Services historically has been a resource to Windsor Police Services, the Windsor Jail, Probation and Parole, as well as numerous other community services.

In June of 1995, after community consultation, the agency dedicated resources to formalize a Court Outreach/Mental Health Diversion Program with one staff. The Court Outreach staff (now a compliment of two) works as part of a multi-disciplinary team including a psychiatric nurse with a strong linkage to the Probation and Parole Office (see Windsor Probation document). The program is now called Justice Support Services as supports have expanded beyond the Court process.

Description: The purpose of the Justice Support Services program is not only to assist individuals facing criminal charges navigate the Criminal Justice System, but also to put mental health services in place in order to avoid further conflict with the legal system. Ideally, individuals meeting the criteria for Mental Health Diversion would have criminal charges withdrawn once mental health supports are in place. The Justice Support Worker is available to provide brief service support and linkages to the mental health system. Services are voluntary and for this reason cannot be mandated by the court.

The Outreach worker is available as a resource to:

1. Individuals with a mental illness who come to the attention of the police and court;
2. The justice system in regard to programs and services available to an individual with a mental illness;
3. The mental health system in regard to the process, powers and rights of the justice system;
4. Families, the public, and friends concerning the individual with a mental illness.

Justice Support Services provides short-term intensive support. Those individuals who require on-going supports are referred for case management through CMHA's Community Support Services or the Essex PACT teams once the criminal charges have been dealt with.

Admission Criteria - client must be 16 years of age or older, a resident of Windsor-Essex County, and have either been diagnosed with a serious persistent mental illness, or be behaving in such a way as to warrant referral from the justice system or others for initial assessment.

Referral Source - referrals are accepted from police, probation, the jail, the crown's office, lawyers, other community agencies, family members, friends, as well as the individual facing charges.

For example: CMHA's Court Outreach Worker may be alerted by Windsor Police's "Show cause" officers, who oversee files of individuals who are arrested and held in custody overnight while awaiting release. The Show Cause officers alerts the outreach worker to the fact that an individual may have a mental health problem, what the officer's recommendations as to detention or release from custody, and aid the Assistant Crown Attorney to stipulate bail conditions or recommend bail hearings if they think that release would endanger the community. Police notations in court files indicate areas of concern, e.g, Mental Health Act, violent, suicidal.

Access to custodial clients: In order to attend to a request while the individual is in custody, the CMHA court outreach worker needs to obtain official clearance from the Windsor Jail. They require a letter of introduction from CMHA to the Jail Administrator, a police clearance and have a photo ID taken before they are allowed admission to the jail. CMHA court outreach workers are then able to visit referred clients in private rooms normally reserved for Duty Counsel or Probation Officer visits. CMHA- court outreach workers have a good working relationship with the health care workers at the Windsor Jail and frequently consult with them in order to ensure client safety and provide information to them about current medical and psychiatric treatment of clients.

CMHA Court Outreach workers attend at court and speak with the individual client, Show Cause officer, Assistant Crown Attorney and Duty Counsel in order to establish a treatment plan for the individual. This may range from finding the individual temporary housing, escorting the individual to hospital, contacting family members, contacting the client's psychiatrist for directions, etc. Staff provide whatever assistance is needed if they assess that the individual meets the criteria for the Court Outreach program

Could this work in other communities? Could easily work in other communities.

For more information contact:

Karen Gignac
CMHA Manager – Windsor Essex Branch
Community Support Services
1400 Windsor Avenue
Windsor, ON NBX 3L9
Tel.: (519) 255-9940, ext. 236
Fax: (519) 255-7817
kgignac@cmha-wecb.on.ca

CANADIAN MENTAL HEALTH ASSOCIATION, LAMBTON COUNTY BRANCH'S COURT OUTREACH WORKER

Background: In 1997 it was estimated that of the 2000 individuals in Lambton County with a Serious Mental Illness, 25-30 of these persons could benefit from a Court Outreach Program. In 1998 through an internal reorganization a .5 FTE Court Outreach position was created, in 1999 it was enhanced to .6 FTE and in January, 2003 to a 1 FTE due to ever increasing demand.

Description: The court outreach worker:

- Engages individuals at their initial point of contact with the criminal justice system and connects them with more appropriate resources outside of the justice system.
- Addresses the housing and support service needs of the individual.
- Acts as a resource person to assist individuals in obtaining information/access to services/supports which they deem necessary.
- Maintains professional relationships with other community service providers with whom the incumbent comes in contact within performance of the duties of the position.
- Liaises, when appropriate, with other care givers/support providers who are involved with individuals to ensure that service provision is co-ordinated and as non-intrusive as possible.
- Acts as a resource to CMHA staff and other service providers in the Lambton area.
- Provides education to Duty Counsel, Court personnel and police regarding mental illness and services available for individuals with a serious mental illness.
- Maintains regular contact with commonly accessed organizations, (such as the Ontario Disability office) so that purposeful interactions on behalf of program members can be effectively accomplished.

Could this work in other communities? In communities without a court diversion program, this could work well.

For more information contact:

Penny Witcher
Team Leader
CMHA-Lambton County Branch
210 Lochiel St.
Sarnia ON N7T 4C7
Tel.: (519) 337-5411
Fax: (519) 337-2325
penny@cmha.sarnia.net

PROPOSALS FOR MENTAL HEALTH COURT CLINIC AND FORENSIC SPECIALTY RESOURCE TEAM

Task Force:

Chaired by John Hanbidge, Acting Crown Attorney, County of Middlesex

with contributions by the following task force committee participants:

Representatives of Medical Advisory Committee, S.T.P.H.
Forensic Clinical Team, S.T.P.H.
Patricia Chapman, Middlesex Court Diversion Coordinator
Laurel Putnam, Forensic Program, S.T.P.H.
Michael Petrenko, Executive Director, CMHA, London/Middlesex Branch

INTRODUCTION

Background: In response to a recognized need to better coordinate, resource and implement services for people with mental health and/or developmental needs who come into conflict with the law, a cooperative effort among the Ontario Ministries of the Attorney General, Community and Social Services, Health and the Solicitor General and Correctional Services has been established. Such individuals are identified as common clients in keeping with ministries' shared goals of achieving healthy and safe communities and recognition that solutions are a joint responsibility.

As a result, in early 1995, the sponsoring ministries related a policy entitled, "The Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario." This policy document is part of a series of agreements between the ministries, which is intended to implement key components of the provincial strategy framework. A key component of this framework was the development of the Diversion Service. The County of Elgin piloted a Diversion Service in 1996. This project, viewed as a success, was expanded and implemented in the County of Middlesex in 1998.

As a part of this process, a local Human Services and Justice Coordinating Committee was established in the London/Middlesex district. Membership of the committee is comprised of representatives of the various aforementioned ministries, as well as community service providers. The mandate of this committee was established to coordinate communication, joint problem solving and planning efforts among health, Criminal Justice and Social Services for these common clients. Concurrently, in response to the mental health reform initiatives of the Ministry of Health, the Thames Valley District Health Council was engaged in a community consultation process leading to the development of a mental health systems design for the district. These planning efforts have not been isolated, but through cross representation, are indicative of a broad based collaborative process.

The LPH/STPH Forensic Program was involved in this process and provided input regarding the efforts to coordinate services for the mentally disordered offender, consistent with the mental health systems design development. This led to the release of the May 1999 report entitled, "Multi-year Mental Implementation Plans for Thames Valley: 1999 - 2001." Specific recommendations addressed in this report regarding the Forensic and Justice systems include:

1. Expansion of the Court Diversion Service
2. Creation of a Forensic Specialty Resource Team
3. Development of a Mental Health Court Clinic

The Ministry of Health Operational Framework policy document entitled, "Making it Happen" released in August 1999, clearly defines the need to develop the services outlined above. The following proposal outlines the creation of:

- A Forensic Specialty Resource Team to service the southwest region.
- A Mental Health Court Clinic to be piloted in a site in the southwest region. This service could be expanded throughout the southwest region.

Forensic Specialty Resource Team

Mission: To improve the lives of the mentally disordered offender while balancing the need for public safety.

Goal: To provide consultation and education to the mentally disordered offender service system throughout the southwest region regardless of ministry affiliation.

To provide this service through a multidisciplinary team, consisting of a blend of clinicians with skills and expertise in addressing the unique needs of the forensic population.

OBJECTIVE	METHOD/ PROCESS	OUTCOME CRITERIA	RECORD RECORDING SYSTEM
To provide information re: the mentally disordered offender throughout the southwest region.	To orient service providers, educational institutions and families re: the role of the resource team and access procedure. To assess information needs. To provide information.	All forensic related requests for information will receive a response from the Forensic Resource Team within a reasonable period of time.	To track the number of requests and type of response time.
To provide forensic consultation with a focus on Risk Assessment, and recommendations for Management and Treatment throughout the southwest region.	To orient service providers re: consultative role of resource team. · To provide consultation on site or recommendations to service providers on site or through telepsychiatry. · To provide review of clients integrated into general psychiatry upon request	All forensic related requests for consultation will receive a response from the Forensic Resource Team within a reasonable period of time.	To track the number and nature of request and type and timing of response.
To provide non-hospital based fitness assessments throughout the southwest region; initial plans to establish this initiative in London/Middlesex County.	To provide a psychiatrist at court, at detention centres or where necessary to complete requested fitness assessments.	All requests for fitness assessments will be completed within the time frame prescribed by law. (See Appendix I)	To record the number of requests and assessments completed and to track the number of days to respond to request.
To provide input in planning services for the mentally disordered offender throughout the southwest region.	To offer representation to planning bodies focusing on the needs of the mentally disordered offender throughout the southwest region.	Members of the Resource Team will actively participate in planning bodies throughout the southwest region.	To record the number and nature of planning involvement. To review relevance and effectiveness of this involvement

Mental Health Court Clinic

Mission: To act in concert with other community agencies to improve the lives of the offender with a mental disorder/developmental disability or brain injury while balancing the need for public safety.

Goal: To provide court ordered mental health assessments for the purpose of determining fitness to stand for trial.

Consumer

OBJECTIVE	METHOD/ PROCESS	OUTCOME CRITERIA	RECORDING/ REPORTING SYSTEM
To receive a fitness assessment in a timely manner.	To establish a court referral process (Form 48) to access a Forensic Specialty Resource Team in a timely manner.	The court request (Form 48) will receive response within a reasonable period of time.	To track the number of days awaiting a fitness assessment and to record the findings of the assessment.
To receive expedited access to hospital and/or community based treatment, support and rehabilitation services.	To facilitate individualized treatment support and rehabilitation in conjunction with the mental health staff.	Each client will be linked to treatment support and rehabilitation as appropriate to meet their needs.	To record in the client file.
To experience decreased confusion/anxiety during the court process.	To provide information concerning their involvement with the criminal court process.	Each client will have the support of a mental health staff member available as needed throughout the court process.	To review the client record regarding the number of mental health staff contacts.

System

OBJECTIVE	METHOD/ PROCESS	OUTCOME CRITERIA	RECORDING/ REPORTING SYSTEM
To optimize utilization of inpatient forensic assessment beds.	To provide court ordered assessments concerning fitness to stand trial, on site.	Fitness assessments will be conducted on site as per court order	To track the number of fitness assessments conducted and/or completed on site.
To provide fitness assessments and triage services on site.	To establish a collaborative arrangement between the Ministry of Health and Long-Term Care and Ministry of Attorney General to provide resources for this clinic.	There will be fitness to stand for trial assessments and triage services on site.	To track the number of court ordered fitness assessment requests and assessments (Form 48) and any triage recommendations.
To reduce duplication of collection of client information.	To develop, in partnership with other mental health service providers, a common client database.	The client information system will be operational within 6-9 months of funding the capital request.	To track client information/record data.

Public Safety

OBJECTIVE	METHOD/ PROCESS	OUTCOME CRITERIA	RECORDING/ REPORTING SYSTEM
To recognize and respond to concerns of public safety including that of the alleged victim.	To report observations pertaining to public safety to the court.	The court will be made aware of observations pertaining to public safety.	To track observations reported to the court pertaining to public safety.

"APPENDIX I"

GENERAL RULE FOR PERIOD / Exception in fitness cases / Exception for compelling circumstances.
672.14 (I) An assessment order shall not be in force for more than thirty days.

(2) No assessment order to determine whether the accused is unfit to stand trial shall be in force for more than five days, excluding holidays and the time required for the accused to travel to and from the place where the assessment is to be made, unless the accused and the prosecutor agree to a longer period not exceeding thirty days.

(3) Notwithstanding subsections (1) and (2), a court may make an assessment order that remains in force for sixty days where the court is satisfied that compelling circumstances exist that warrant it. 1991, c.43, s. 4.

CROSS-REFERENCES
The terms "accused", "assessment" and "hospital" are defined in s. 672.1. An assessment order may be extended pursuant to s. 672.14. For further cross-references respecting the making of assessment orders, see the references under s. 672.12.

SYNOPSIS
This provision provides a 30-day limitation for assessment orders despite the purpose of the assessment except in the case of a fitness assessment which is limited to five days. Notwithstanding these time limitations, however, the court does have the discretion to issue an assessment order for a period of not more than 60 days where the court is satisfied that "compelling circumstances" exist to do so.

For more information contact:

John Hanbidge
Assistant Crown Attorney – Middlesex County
Courthouse - Main Floor
80 Dundas St E
London, ON N6A 2P3
Tel.: (519) 660-3003
Fax: (519) 660-3087
john.hanbidge@jus.gov.on.ca

CMHA, WINDSOR-ESSEX BRANCH INVOLVEMENT WITH MENTALLY ILL PERSONS IN PARTNERSHIP WITH PROBATION AND PAROLE SERVICES

Background: CMHA has been providing court outreach services since June 1995. Many individuals with serious mental illness who are involved with the criminal justice system are often undiagnosed and/or treatment resistant. Although these individuals may be diverted from the justice system to the mental health system, there were no adequate means in place to ensure that the individual would follow though with the services they require or even successfully engage in psychiatric services. Individuals who were required to report to probation often had difficulty in meeting the reporting requirements and were often still lacking the necessary mental health support services/treatment.

Description: CMHA partnered with Probation and Parole with the understanding that:

- Individuals with serious mental illness often require intensive supports;
- Treatment resistant individuals would have considerable difficulty reporting to a probation officer in addition to a mental health professional and a psychiatrist
- Engagement in the mental health system would take time and continuous effort (establishing a trusting relationship) and would require a mental health professional with extensive knowledge of the system and community resources.

A service component has been developed whereby a voluntary agreement is entered into between Probation and Parole Services and the individual to report to a psychiatric nurse housed at CMHA instead of the probation office. The primary rationale for this service is that reporting to an experienced psychiatric nurse would better facilitate the appropriate linkages to psychiatrists and other community resources. With agreement in place, it is mandatory for the individual to report to the psychiatric nurse, however this is enforced through the Probation office not by CMHA. There were initial concerns that the mandatory reporting requirement would be in conflict with CMHA's own mandate of providing voluntary service. After consulting with CMHA's Ontario Division, assurance was provided that compromising of values was not occurring. It was determined that the mandatory reporting requirement was the result of a voluntary choice that the individual made when entering into the agreement with Probation. The nurse's only obligation would be to report to probation if the individual did not keep the appointment.

Other benefits have resulted from having a designated psychiatric nurse position housed at CMHA. Not only would those individuals currently involved with Probation Services be offered a more comprehensive service, but those individuals referred to the court outreach program would also be able to access the nurse. The nurse provides expertise by educating CMHA staff in nursing areas such as medications and side effects, etc. and providing consultation and or assistance to other CMHA community support clients. Since CMHA,Windsor-Essex is working towards providing more comprehensive services by integrating psychosocial rehabilitation principles with medical treatment components, the addition of the nursing position is a natural evolution.

Could this work in other communities? Yes, this could easily work in other communities.

For more information contact:

Karen Gignac
CMHA Manager – Windsor Essex Branch
Community Support Services
1400 Windsor Avenue
Windsor, ON NBX 3L9
Tel.: (519) 255-9940, ext. 236
Fax: (519) 255-7817
kgignac@cmha-wecb.on.ca

Lisa Kitchen
Probation and Parole Officer
Ministry of Public Safety and Security
Correction Division
75 Eire St. Suite 104
Leamington ON N8H 3B2
Tel.: (519) 326-9005
Fax: (519) 326-6357
lisa.k@jus.gov.on.ca

PROBATION, PAROLE & CONDITIONAL SENTENCE POLICY & PROCEDURES MANUAL

Ministry of Correctional Services
Special Needs – CRAs
May 2000
Special Needs Contingency Fund

Introduction

The Ministry recognizes the importance of providing services that respond to the special needs of adult offenders.

Special needs services have been supported by the ministry for a number of years through the provision of community residential agreements for adult offenders, special needs contracts for young offenders and contributions to the Inter-ministerial Action Committee (IMPAC).

The ability to continue to identify and provide services that respond to the special needs of adult offenders remains a priority as the ministry is committed to supporting offenders with opportunities for positive change, responding to the diverse needs of offenders, and ensuring that the needs of

incarcerated women are equally addressed. As a result, a provincial contingency fund has been established for the continued provision of special needs services.

Adult Special Needs Contingency Fund

Adult offenders with special needs who are eligible for community supervision may be considered for specialized residential programming and/or other specialized programs and services through utilization of a provincial contingency fund.

The contingency fund allows PPOs/area managers (and superintendents in some cases) to purchase specialized residential programming or other specialized programming that may not otherwise be available to offenders with special needs.

MCS Act s.5, 8, 25 and 27

Special needs and specialized programs and services are defined as:

Special needs -adult offenders with needs that are the result of a physical or mental disability, language or cultural barriers, victims of abuse, individual circumstances, (e.g. geographical isolation from family support system), speech or learning disability, or gender or minority group (e.g. fewer and geographically spread institution beds often inhibit equal access to services for female offenders). Addressing special needs will often facilitate appropriate correctional intervention.

Specialized Programs and Services -includes any form of planned intervention delivered to adult offenders or groups and designed to assist the offender(s) to change certain behaviors, attitudes or incapacities. Specialized programs and services can be provided by social workers, counsellors and other specialized professionals. These programs and services may also include treatment delivered by psychologists, psychiatrists or other specialized health care professionals and behaviour management strategies employed by various front line staff

ELIGIBILITY
All adult offenders under Ministry supervision are eligible to access this fund. Female offenders, ethnic

http://intra.mcs.gov.on.ca/content/manuals/pp/includes/16sp-needs-a.html5/1/2003

minorities, Aboriginal offenders, offenders with substance abuse issues and offenders with maternity and child care needs are given a priority.

a) Temporary Absence/Electronic Monitoring
Provincial inmates who qualify for temporary absence/extended temporary absence/ electronic monitoring and have special needs shall be considered for specialized programs.

b) Probationers/Parolees/Conditional Sentence
Offenders on probation/parole/conditional sentence with specialized counselling and/or treatment needs may be considered.

INITIAL SELECTION CRITERIA

As the application of special needs and specialized services may be broad by definition, all applications must be carefully screened. The following selection criteria have been developed to further assist in more readily and effectively identifying appropriate candidates for use of the central fund:

a. Have the offender's history and use of existing services been a consideration in determining the application for the special needs fund?

b. Have the offender's special needs been identified as a result of the LSI-OR (case management strategy)?

c. Can a meaningful intervention be made during the period the offender is under ministry supervision?

d. Is the type of intervention available from or funded by another agency/ministry?

e. Does the community resource and/or specialized residential program have the capacity to address the special needs of the offender?

f. Have all other sources (e.g., referral by physician, ARF agencies) for probationers and parolees been exhausted prior to application?

g. Will the offender derive maximum benefit from specialized program consideration or an existing correctional program?

h. Have the special needs of the offender been considered on an individual basis?

i. Would the specialized program consideration promote the use of the least restrictive method of intervention based on a risk management strategy which emphasizes offender responsibility and accountability?

j. Is the offender a special needs client who has or should have an adult protective services worker?

k. Are the offender's special needs of a nature that a multi-ministerial approach, as afforded by IMPAC, is necessary?

Processing the Application

Applications to use the special needs contingency fund will originate from the area office or institution.

The superintendent or area manager may designate an employee to be responsible for coordinating special needs applications, conducting investigations, monitoring active cases, consulting with the regional office designate and making recommendations. All applications received through the regional office shall be reported to the central committee for consideration.

http://intra.mcs.gov.on.ca/contentlmanuals/pp/includes/l6sp-needs-a.html5/1/2003

Agencies with Community Residential Agreements, in consultation with the ministry office or institution may be eligible to access to the provincial fund. However, these agencies will not be able to access the fund for residential services unless their funding has been completed used. Agencies may request other specialized services for ministry clients through consultation with ministry contacts, e.g., area managers or superintendents.

A policy/program analyst, North Bay, chairs the central committee and is responsible for reporting the recommendation/decision of the committee to the appropriate area manager or superintendent.

Each decision-making committee meeting consists of a policy/program analyst, the member representative of the region bringing forward the case and the member representative of another district.

The committee determines the eligibility of the applicant within **five** working days of receipt of the application. In emergency situations, the committee may be convened immediately. The committee shall generally meet via teleconference to ensure a timely response.

Each case is viewed as unique and is considered on its own merits in the context of the application.
The committee considers:

- individual need as identified in the case management strategy or supervision plan
- whether the need is linked to assessed criminogenic factors
- offender motivation and history of prior intervention
- level of risk as indicated by the LSI-OR and criminal history
- Ministry accountability
- other options available to the offender and .,
- whether the offender is in one of the identified target groups.

Documentation

The attached application form is to be fully completed by the case manager. All recommendations, decisions, sources of information and supporting reasons shall be accurately recorded on the application. Reports, summaries or submissions pertaining to an individual case shall be appended to the application. Payment and Reimbursements
The area office or institution will be required to submit expenses incurred for the duration of placement to North Bay on a quarterly basis for reimbursement.

Specialized residential programming agreements or other specialized programs will be coordinated on an ad-hoc basis only.

http://intra.mcs.gov.on.ca/contentlmanuals/pp/includes/16sp-needs-a.htl5/1/2003

REQUEST FOR SPECIAL NEEDS PROVINCIAL FUNDING (Adult Offenders)

Offender Name _____ Given _____

Date of Birth _____ Sex _____ Date of Referral _____

dd/mm/yy dd/mm/yy

Present Location / Address _____

Home Address _____

_____ Telephone _____

Reason for Referral:

Estimated Treatment/Care Cost: Per Diem _____ Monthly _____	
Custody Discharge Date _____ dd/mm/yy	
Conditional Sentence / Probation / Parole Start Date _____ dd/mm/yy Termination Date _____ dd/mm/yy	
Estimated Cost: $ _____ Actual Cost $ _____ (to be completed by Adult Community Services	
Case Manager's Name _____ Office _____	
Area Manager/Superintendent Approval _____	
Regional Director Approval _____	
Region _____ Date _____ dd/mm/yy	
Application for funds **accepted / rejected -** (circle one)	Conditions of Approval
Adult Community Services (or designate)	
Date _____ dd/mm/yy	

Instructions:
1. Complete form and attach all supporting documentation
2. Once approved by area manager/superintendent fax to regional representative for consideration
3. Committee will advise local office within 5 working days upon receipt
4. Contact J. C. Rondeau at (705) 494-3358 for information or concerns

Could this work in other communities? Yes, it is applicable in all areas.

For more information contact:

Daryl Link
Deputy Regional Director Community & YO Services – Western Region
Ministry of Public Safety & Security
150 Dufferin Ave. Suite 704
London ON N6A 5N6
Tel.: (519) 661-1696
Fax: (519) 679-0699
daryl.link@jus.gov.on.ca

CHATHAM – KENT POLICE SERVICES HELP TRAINING PROGRAM

Background: The Chatham – Kent police services provide one week additional training to three officers per platoon to be first responders to calls involving mentally ill individuals. Special Constables who work in the courts and Emergency Communications Operators (in the 911 Communication Centre) are also trained.

Description: The agenda for one week training follows:

Day One - Friday, November 16, 2001

Chatham-Kent Police Service, Pact Team, Pharmacist

0800 Training packages and materials
0810 Chairman of HELP Team (Wiersma) opening remarks, Welcome of Team members, Intro of Chief for Kick off
0830 Training package explanation and introduction of agenda, short presentation on goals, values and mission statement, explain team growth, design and team work assignments, the beginning of help and our evolution of partnerships that positively affect all of our working systems (Biskey)
1000 Break
1015 Firing up the Front Line (Biskey).
1200 Lunch
1300 Barb Lacey & Tammy Luciow, What is the role of the Pact Team?
1515 Break
1530 Pharmacist .1630pm -End of day

Presenters:

Inspector Wiersma - Chatham-Kent Police Service
Sergeant James Biskey - Chatham-Kent Police Service
Barb Lacey - Chatham-Kent Program of Assertive Community Treatment (PACT TEAM)
Tammy Luciow - Chatham-Kent Program of Assertive Community Treatment
Nancy Kay - Shoppers Drug Mart

***Topics* :**

Introduction
Explanation of Training Package
Presentation "Firing up the Front Line"
People In Turmoil - The Front Line Officers Response to a Community Member in Personal Crisis
Pact Team presentation, What do they do?
Psychotropic drugs, symptoms, side affects and what Medications go with what Mental Illness

Day Two - Monday, November 19, 2001

Consumer Survivor Network, C-K Health Alliance

0800 Introduction of Presenters (lnspector Wiersma)
0815 Consumer Survivor Network, .1000am -Break
1015 Continuation of Consumer Survivor Network.
1200 Lunch
1300 "How to Tell Mad from Bad", Dr. Chandrasena
1430 Break
1445 Mental Health Clinic, Paula Reaume-Zimmer
1630 End of Day

Presenters:

Marlene Vicory -Consumer Survivor Network (Keith Leadley, Bill MacNeil)
Dr. Chandrasena- Chief of Psychiatry, C-K Health Alliance
Paula Reaume-Zimmer- Clinical Manager, Inpatient & Outpatient Mental Health Services, Chatham-Kent Health Alliance

Topics:

Presentation of Speakers
What Survivors Go Through
Do's and Don'ts Dealing with the Consumers
Signs and Symptoms of Mental Illness
Criteria Dr.'s Look for to Admit Consumers
What Does 2 West Do?
What does the Mental Health Clinic do?
The CKHA Mental Health Services crisis program
The ACCESS Group

Day Three - Tuesday, November 20, 2001

Chatham Kent Health Alliance, Canadian Mental Health Association

0800 Introduction of Presenters (lnspector Wiersma)
0815 Dale MacDonald, CMHA, Past President
0900 Barb Tiessen, C-K Health Alliance, Mental Health Services
1100 Break
1115 Shannon Sasseville, CMHA, Family Network
1230 Lunch
1300 Anita Fuerth, CKHA Mental Health Services & John Zarebski, Centre for Addiction and Mental Health
1500 Willi Kirenko, Emergency Room Procedures
1515 Continued
1630 End of Day

Presenters:

Dale MacDonald -Past President CMHA
Barb Tiessen -Program Director, Mental Health Services, CKHA
Shannon Sasseville -Canadian Mental Health Association
Anita Fuerth -Concurrent Disorders Therapist, Mental Health Services, CKHA
John Zarebski -Program Director, Community Health & Education, Centre for Addiction & Mental Health
Willi Kirenko -

Topics:

Personal Perspective, The Real Thing .The Mental Health Act
Community Treatment Orders
Bil168
The Family Perspective
What does the Family Network Offer?
What does it mean to have a Concurrent Disorder?
How does an addiction affect Mental Illness & Vice Versa
What does the CKHA MHS, offer to concurrent disorders in clients?

Day Four - Wednesday, November 21, 2001

CMHA -Canadian Mental Health Association

0800 Introduction of Presenter (Inspector Wiersma)
0815 Judy Mackenzie, Mental Health Services, CMHA
1000 Break
1015 Continued
1200 Debbie Waterworth, Mental Health Services, CMHA
1400 Break
1415 Continued
1600 Constable J. Foster, Chatham-Kent Police Service
1630 End of Day

Presenters:

Judy Mackenzie - Central Intake Worker, Canadian Mental Health, Canadian Mental Health Association
Debbie Watterworth - Team Leader Mental Health Services, Canadian Mental Health Association
Jodie Foster - Chatham-Kent Police Service

Topics:

How people access community mental health services
Services of Canadian Mental Health Association -Chatham-Kent Branch

Pierre's story
Tape on stigma -Face to Face (15 min)
Questionnaire
Experiences of The Mental Illness (symptoms)
Why People go off there Medications, Role play (hallucinations)
Do's and Don'ts -Intervention Strategies, video -Mental Illness: Police Response
Q&A

Could this work in other communities? Yes, it could easily be replicated.

For more information contact:

Inspector Clare Wiersma
Operational Support Branch
Chatham Police
24 Third St. P.O. Box 366
Chatham, ON N7M 5K5
Tel.: (519) 436-6600 ext 605
Fax: (519) 436-6643
clarew@city.chatham-kent.on.ca

LONDON POLICE SERVICES PROPOSED TRAINING SUBMISSION TO THE OFFICE OF VICTIMS OF CRIME

Background

The London Police Service has a complement of 651 employees: 473 police officers, 9 cadets, and 169 civilians. It has an operating budget of $45,441,890 (2001) or $130.58 per capita.

The Family Consultant/Victim Services Unit was developed in 1973 to assist victims of crime and tragic circumstances. The Unit serves as a bridge between the police and the community agencies offering crisis intervention and support for victims and has become an integral part of the London Police Service budget and planning process. Through the leadership of the London Police Services Board and senior administration, in conjunction with the Unit's Professional Advisory Council, the Unit has continued to develop and respond to changing community needs.

The Unit operates from Police Headquarters seven days a week and provides on-scene clinical interventions to victims of crime and tragic circumstances from 8:00 a.m. to 2:00 a.m. An after hours on-call system is managed by the team supervisor, extending the team's availability to 24 hours/day, 7 days per week. The team is mobile and is in continuous radio contact with the police communications centre, allowing for immediate assistance when police are involved in cases needing the expertise of the Unit. In 2002, the Family Consultant/Victim Services Unit responded to 1,946 occurrences involving a variety of traumatic events. These occurrences are aggregated into the following key categories:

Addiction
Family Conflict
Aging
Food/Shelter
Children/adolescents/youth
Mental health
Community consultation
Victimization
Domestic Violence
Other

In addition to these interventions, the Unit offers a variety of programs aimed at meeting the needs of specific victim populations, such as robbery victims, older adults, hate crime victims and property crime victims. The Unit also coordinates and participates in the London Police Service, Critical Incident Debriefing Team. The Unit operates within a collaborative model and as such dedicates time to community development projects including public education, inter-agency committee and board work.

1. <u>Brief Description of the Project's primary purpose</u>:

a) What are the objectives of your project proposal?

Objectives:

1. Enhance recognition of and respect for the needs of victims with serious mental illness and to develop an appreciation of the consequences of systemic victimization.
2. To strengthen community-police partnerships through enhanced awareness of community based resources and the development of service protocols.
3. Provide police officers with an enhanced understanding of the causes of mental illness and the associated myths and stigma.
4. Reduce the trend towards criminalization of individuals with serious mental illness by providing officers with a range of practical intervention strategies through the use of vignettes and information packages.

Training Proposal:

The training material is divided into five modules. Each module addresses one learning goal and is 40 minutes in duration. Module 1 is done with the whole group, (approximately 25 officers). The group is then divided into four smaller groups to complete the subsequent modules. The total training time is 3.5 hours.

<u>Module 1</u>: "Trends in police contact with person with serious mental illness"

Objective:
1. To provide an overview of the CAREMH research findings.
2. To provide participants with a systemic view of the interface between police and individuals with serious mental illness.
3. To provide validation and affirmation of the police experience.

<u>Module 2</u>: "Psychosis"

Objective:
1. Provide participants with an overview of the causes of psychosis and the presenting symptoms of this illness.
2. Distinguish between myths and facts.
3. Identify intervention strategies and community resources available to assist.

<u>Module 3</u>: "Personality Disorders"

Objective:
1. Provide participants with an overview of the personality disorders and the presenting symptoms.
2. Distinguish between myths and facts.
3. Identify intervention strategies and community resources available to assist.

Module 4: "Mood Disorders" & "Suicide Intervention"

Objective:
1. Distinguish between suicidal and para-suicidal behaviour.
2. Provide skills to do a brief lethality assessment.
3. Identify intervention strategies and resources available to assist.

Module 5: "Psychosis simulation"

Objective:
1. Provide participants with the opportunity to experience the symptoms of psychosis through the use of an audio/visual simulator.
2. Reinforce the effectiveness of intervention strategies.
3. A mental health professional and consumer/family member will be present during this module to answer questions and debrief the simulation experience.

Each module will include:

1. Videotapes of the clinical information and vignettes.
2. Written materials, including fact sheets.
3. A template for community resource information, formatted to wallet size.

b) How do your project proposal's objectives support the grant program objective?

There is a well document link between vulnerability to victimization and serious mental illness (Friedman, 1984, Lehman, 1984, Padgett, 1992). Individuals with serious mental illness have been shown to be between 2 -3 times as likely to be victims of violent crimes, robbery and thefts than the general population (Darvez-Bornoz, 1995, Hiday, 1999). Goodman et al. (1997) found that "a large proportion of women with serious mental disorders are victimized repeatedly in the course of their lives."

The link between traumatic victimization history and serious mental illness has also been established particularly among female victims. The prevalence of historical victimization among women with serious mental illness ranges from 53% -97% depending on the study cited (Goodman, Rosenberg et al, 1997).

A review of the literature illustrates that those individuals with serious mental illness who are well supported in the community are less likely to be victimized that those who are not (Hiday et al, 2002). Creating links between policing services and those community agencies, which provide support to individuals with serious mental illness, therefore is vital to reducing the incidence of victimization.

2. Evidence of Need and Demand:

a) List the groups that will be served by this project:

Individuals with serious mental illness will be served by this project through the development of a more comprehensive, effective and victim-focused response to their needs when interfacing with the criminal justice system.

b) List the communities that will benefit from your project and their geographic locations:

This project proposes to serve the city of London but will be developed as a template for other police services. The training program will be delivered to communities using a 'train the trainer' model. Local resources, such as mental health professionals, consumers, and family members would be utilized in the delivery of the modules and to answer questions arising from the material.

c) Identify the major problems and priorities that the Project will address:

The purpose of this project is to provide training for police personnel that promote an increased awareness of the unique challenges facing individuals with serious mental illness. The London Police Service is highly involved with individuals with serious mental illness. The London community has been challenged to develop thoughtful, innovative strategies to support those individuals with SMI who are, and will continue to be, impacted by the process of de-institutionalization. It is clear, however, that the London Police Service will remain highly involved with these individuals for the foreseeable future. It is incumbent on policing services to address the issues of:

a) creating and sustaining linkages with mental health service providers to ensure that optimal service is provided to victims with serious mental illness
b) knowledgeable, appropriate interaction to reduce the incidence of criminalization.

Could this work in other communities? The intention of the proposal was to develop a template that could be used in other jurisdictions.

For more information contact:

Lisa Heslop
Supervisor, Family Consultant/Victim Services Unit
London Police Services
601 Dundas St.
London, ON N6B 1X1
Tel.: (519) 661-5636
Fax: (519) 661-6495
lheslop@police.london.ca

ONTARIO POLICE COLLEGE ADVANCED TRAINING MENTAL ILLNESS STUDY

Advanced Training

Mental Illness

Study Guide

Validated July 2002

The following Study Guide was prepared by permanent staff at the Ontario Police College for the Advanced Patrol Training Course.

Revised September 1998
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While every effort is made to ensure the accuracy of the material, mistakes are inevitable.

If you find any errors, please notify:

The Ontario Police College
P. O. Box 1190
AYLMER ON N5H 2T2
Tel.: (519) 773-5361
Fax: (519) 773-5762

Attention:
Team Leader
Advanced Patrol Training

Contents:

Section 17 - Mental Health Act

17. Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

has shown or is showing a lack of competence to care for himself or herself,

and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

serious bodily harm to the person;
serious bodily harm to another person; or
serious physical impairment of the person,

and that it would be dangerous to proceed under section 16, the police officer or may take the person in custody to an appropriate place for examination by a physician.

Section 17: Action by a police officer

New provision:

The officer must have reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner before taking that person into custody for examination by a physician, provided that the other criteria in s. 17 are met.

Past/Present Test: (danger to self or others)

Some indicators that may assist an officer in determining whether a person is acting or has acted in a disorderly manner may be whether or not the individual:

has threatened or is threatening to cause bodily harm to self; **or**
has attempted or is attempting to cause bodily harm to self; **or**
has behaved or is behaving violently towards another person; **or**
has caused or is causing another person to fear bodily harm from self; **or**
has shown or is showing a lack of competence to care for self.

The Future Test: (danger to wait for JP's order)

The officer is of the opinion that the person is *apparently* **suffering from mental disorder** that will *likely* result in:

serious bodily harm to others; **or**

serious physical impairment of self.

and that it would be dangerous to proceed by way of an application to a justice of the peace.

Bill 68 (Brian's Law) - Mental Health Legislative Reform, 2000

In June, 1998 the government of Ontario announced a review of the Mental Health Act which culminated in the passing of Bill 68 (*Brian's Law*) which received Royal Assent on June 23, 2000 and will be Proclaimed on December 1, 2000. Bill 68 contains significant amendments to the *Mental Health Act* and, in particular, police powers.

Police Powers - What Has Changed?

Three Changes:

1. **No Observation Required**
2. **Enforcement Of Community Treatment Orders (Cto's)**
3. **Transfer Of Custody Rules**

1. No Observation Required

Police no longer need to "observe" a person who is acting or has acted in a disorderly before taking the person in for an examination by a physician.

Police may rely on reasonable and probable grounds (third party information).

Police must still have reasonable cause to believe that it would be dangerous to wait to proceed before a justice of the peace, and that other criteria in section 17 of the MHA are met.

2. Enforcement Of Community Treatment Orders (Cto)

A physician who issues or renews a CTO can issue an Order for Examination (Form 47) of a person on a CTO if:

1. The person withdraws consent to a CTO, or
2. The person fails to comply with a CTO.

N.B. The physician must do certain things first, before issuing the Order for Examination, which are listed in section 33.3(2). This includes such things as locating the person, informing the person of his or her failure to comply, and helping him or her to comply.

If The Physician Who Issued Or Renewed The Community Treatment Order Decides To Issue An Order For Examination:

The police have authority, for 30 days after the order is issued to:

a) take the person named in the order into custody, AND
b) to take the person promptly to the physician who issued the order.

Obligations When Physician Issues An Order For Examination:

If a doctor issues an order for examination, he or she must ensure that the police:

a) have complete and up-to-date information about the name, address and telephone number of the physician responsible for completing the CTO.

b) if the information changes, the doctor must provide the changed information.

c) are immediately notified if the person subject to the order voluntarily attends for the examination or, for any other reason, the order is revoked prior to its expiry date.

3. Transfer Of Custody Rules

Bill 68 allows rules to be set for the transfer of custody between a police officer and a psychiatric facility. (Usually an Emergency Room)
These rules apply when a person is brought to hospital by police under authority of a J.P. order for examination (Form 2), or the police on their own authority under the MHA.

Police complained that they were often left waiting for very long periods in emergency rooms waiting for transfer of custody to occur.

What Has Changed In Regard To Transfer Of Custody?

Reasonable rules have been set by regulation which require that:

custody be transferred as soon as reasonably possible, and

the police officer be notified promptly when a decision is made to accept or not accept custody of a person by the psychiatric facility.

SCENARIO

You are dispatched to the home of Mr. and Mrs. Desmond in a suburban area of the city at about 10:00 p.m. in response to a "neighbor trouble" complaint. Upon arrival you find the complainant, Mrs. Desmond, visibly shaken. She had been home alone with her two year old son when she heard loud banging noises outside her back door.

She related to you that her neighbor, a 60-year-old female by the name of Sarah Holmes was mentally disturbed. That is, she had been on medication for schizophrenia for many years. She lived alone except for a daughter who occasionally visited. The complainant told of a history of "abuse and harassment" from Holmes directed at the complainant and her family and other neighbors. Holmes thought that her deceased son had been killed by a local priest who she believed had fed him an aids infected communion wafer.

The complainant also revealed that approximately three months earlier an assault charge had had been laid against Holmes for assaulting her while walking her two year old son. Unfortunately, there were no witnesses to the assault and under rules of evidence, information pertaining to Holme's troubled past could not be introduced. The case was dismissed.

The complainant explained that upon hearing the banging at the back door, she was fearful that Holmes may be attempting to harm her or her son. Upon investigation, you notice dents and other marks on the door. You go next door to confront Mrs. Holmes but the house is dark and no one answers the door.

Questions

What would you do at this point?
Do you have grounds for apprehension under the Mental Health Act?
What options are available to you and the complainant?

MENTAL ILLNESS

1. Psychosis and its Major Symptoms

Psychosis is considered one of the most severe categories of mental illness. Schizophrenia is a major form of psychosis and two of the most common symptoms are hallucinations and delusions. The following are examples of each.

Delusions

persecution	(e.g. belief that others are trying to cause harm to you; the more severe form is referred to as ***paranoia***)
grandeur	(e.g. the belief you are God, a saint or some famous personality)

Hallucinations

feel	(e.g. bugs crawling under the skin)
smell	(e.g. smoke or gas)
taste	(e.g. poison in food)
hearing	(e.g. voices telling the person to do something)
sight	(e.g. visions of God, dead bodies etc.)

Note: It is not uncommon to find both hallucinations and delusions present at the same time. For example, they may be able to *taste* poison in their coffee and *think* that someone is trying to kill them.

To differentiate between hallucinations and delusions, think of the former as *defects* in the ***sense organs*** and the latter as *defects* in the ***thinking*** process.

Other Common Symptoms of Psychosis

Though hallucinations and delusions are the most frequently encountered symptoms of psychosis, there are several others including: *extreme anxiety, panic or fright, social withdrawal, dramatic mood swings, depression, incoherent speech and disorientation.*

It is of critical importance to realize that the person who exhibits these symptoms **may not** have control over them. In other words, they cannot "*will*" them away. The symptoms are ***real*** to the person who is experiencing them. Therefore, attempts to convince them otherwise may prove futile.

2. Can you be certain a person is mentally ill if the major symptoms are present?

Just because a person exhibits psychotic symptoms does not necessarily indicate the presence of a mental disorder because other factors can produce the same symptoms, for example:

- injuries to the head
- medical disorders (diabetes, epilepsy)
- side effects of medication
- mixing medication with other substances
- substance abuse (alcohol, drug, inhalants, etc.)

"***excited delirium***" there are certain behaviours associated with this condition, for example, impaired thinking, unexpected physical strength, apparent ineffectiveness of pepper spray, significantly diminished sense of pain, sweating, fever, heat intolerance, sudden tranquillity after frenzied activity.

The important point is that you can *never* presume that psychotic symptoms are solely the result of mental illness. Other factors can produce the same symptoms.

3. Humour and Deception

It is critical to keep in mind that those who suffer from a mental illness have very little control over the symptoms of the disorder. Moreover, the symptoms are often very painful; that is, feeling depressed, thoughts of being persecuted, hearing voices, and other similar experiences, can be extremely unpleasant. Humor is an inappropriate response when dealing with ***anyone*** experiencing emotional trauma or pain, let alone someone suffering from a mental illness. Additionally, there is always the possibility of it being misinterpreted as an attempt to patronize, to "*make fun of*" or, to "*belittle*".

Deception is to purposely mislead by trickery or falsehood. For example, saying that you are not going to take the person to a psychiatric facility when, in fact, you intend on doing so. The use of deception is **never** appropriate because it undermines trust. Trust is essential for two reasons. First, it may have a direct effect on future compliance and level of danger. That is, the individual may not be as willing to comply in the next encounter with police and this would have a direct impact on level of danger. Second, trust is essential if psychiatric treatment is to be effective. Using deception is contrary to accepted treatment practices and therefore its use by police officers may actually hinder efforts made by mental health professionals involved in the case.

Humor and deception may be indirectly related to the question of intelligence. Do people who suffer from mental illness have a lower level of intelligence? In fact, there is **no** evidence to support this notion. Thus, if you use humor and/or deception and it is misinterpreted there is a high probability that it may adversely effect treatment and future dealings with the individual.

4.

If the person refuses to accompany you to the hospital, do **not** use deception. Explain that the issue is not debatable, that taking them to the hospital is part of your job. *Empowering* may prove particularly effective in this scenario. For example, offer the choice of ambulance or your vehicle, if you have such a choice, or, if you are handcuffing, inquire if they are too tight, etc.

5. Talking to Someone Who is Suicidal

When talking to someone who is suicidal, be open and direct. Empathetically listen, remain calm and matter of fact, and bring the subject out in the open and don't avoid using specific concrete words such as, *kill*, *death, die*, etc. For example, you might ask direct questions, such as:

Why are you thinking of killing yourself?
Why do you want to die?
How are you going to kill yourself?
Where are you going to kill yourself?

The rationale for this approach is twofold. First using concrete words such as, *"kill"* may help counter any attempt to detach themselves from reality.

Second, the questions should help you determine how detailed their plan is. Generally speaking, the more detailed the plan, the higher the risk. Other "high risk" indicators include:

- history of previous attempts
- feeling a sense of hopelessness
- recent loss
- debilitating physical illness
- alcohol or other substance abuse
- dramatic changes in lifestyle

Always remember, everyone who expresses an intent to commit suicide must be taken seriously.

Should you allow other family members to be present? Extreme caution should be exercised in that the family member in question might be the reason underlying the attempted suicide. The following intervention strategies may prove useful:

- approach in a calm, direct, matter-of-fact manner
- remove the means and do not leave unattended
- bring the subject out in the open by using direct questions
- ask open-ended questions to keep the conversation going
- empathetically listen and do not challenge
- problem-solve/mediate/mutually explore options
- establish a specific plan of action
- notify and meet with significant others

INTERACTING WITH PEOPLE WITH MENTAL ILLNESSES ..... *Strategies*

BEHAVIOR	*STRATEGY*
Delusions or hallucinations (from thinking others are plotting against them, i.e. paranoid delusion, to seeing frightful images, i.e. hallucinations)	avoid physical contact and do not invade personal space if you intend on moving about the room, announce your intentions beforehand do **not** dispute their claim or allow yourself to be drawn into an argument offer reassurance and help (e.g. if paranoid - "I don't know anything more than what you telling me. I can see you have a concern and I'd like to help you.")(e.g. if hallucinating - "I don't see it but I *know* you can see it. I'd like to learn more about it so I can help. How can I help you?")
Conscious but not responsive (remaining in a motionless state e.g. "catatonic)	make every effort to obtain a response by quietly asking questions and being sensitive to any types of reply such as head not, etc.
Compulsive talker (e.g. rapid, non-stop talking with little relation to the topic at hand)	first, request that they slow down if this has no effect, interrupt by asking specific, concrete questions (e.g. "What day were you born on?" or "What street do you live on?")
Training *Psychotic and aggressive* (e.g. thinks you are there to hurt them and they present as physically threatening)	same as delusions/hallucinations gather as much information as possible **prior** to arrival *isolate* and *contain* whenever possible use the *first contact approach* remove distractions and avoid excitement of any kind disengage if the situation can be contained keep the conversation going and employ empathetic listening techniques be honest, do not use deception or humour, and do not dispute the reality of their claims if you intend on moving about the room, announce your intentions beforehand if the uniform and pistol frighten the individual, explain that they assist you to do your job avoid physical contact or invasion of personal space treat with *firm-gentleness*; *firm* meaning a take-charge and insistent attitude without being threatening and *gentleness* meaning to treat gently and with care
Training *Suicidal*	approach in calm, direct, matter-of-fact fashion remove the means do not leave unattended bring the subject out into the open by asking specific questions (e.g. "Why do you want to kill yourself?" or "How are you going to do it?" or "Where are you going to do it?") employ empathetic listening techniques, problem solve notify and meet with significant others
Excited Delirium	**Symptoms (bold are most critical):** bizarre and/or aggressive behaviour disorientation hallucinations acute onset of paranoia panic shouting violence towards others **impaired thinking unexpected physical strength apparent ineffectiveness of pepper spray significantly diminished sense of pain sweating, fever, heat intolerance sudden tranquility after frenzied activity**
Training	**Principles to guide your actions:** a) Know the symptoms listed above particularly those in bold b) Recognize that certain restraint positions may not be advised (this will be examined in case study #2), and, c) Treat as a medical emergency and transport to a medical facility equipped to cope with the potential complications of excited delirium with two attendants to ensure the person is being restrained and monitored continuously. **Officer safety factors?** first contact approach take time to thoroughly *assess* the situation before engagement teamwork each with different use of force option disengage for reassessment do not invade personal space persistently reassure due to the paranoia *isolate and contain* ensure enough officers are present

Name:_____ Score:_____

MENTAL HEALTH QUIZ

Circle the correct response either "T" *for* True *or* "F" *for* False

1. Delusions and hallucinations are two major symptoms of psychosis.
   T F

2. If a person exhibits psychotic symptoms, there can be no doubt that the person suffers from a mental illness.
   T F

3. The group of drugs known as anti-psychotics, if taken as prescribed, can reduce and even eliminate, symptoms of psychosis.
   T F

4. The most effective way to deal with a compulsive talker is to make a loud noise or command to startle the person into stopping.
   T F

5. When talking to someone who is threatening to commit suicide, you should be as direct as possible when conversing with the person; for example, don't be avoid asking such as why do you want to kill yourself? How do you intend to do it? etc.
   T F

6. It is acceptable to use deception with a mentally ill person if it is not used with intent to belittle and if it aids in securing compliance.
   T F

7. The most frequently encountered delusion involves feelings of persecution.
   T F

8. As a general rule, you should not touch someone who shows signs of paranoia.
   T F

9. When interacting with someone who suffers from a mental disorder, humour is not recommended.
   T F

10. The best way to respond to individuals experiencing hallucinations involving dead bodies is to try and convince them that the hallucination is not real and therefore cannot hurt them.

T F

11. On the average, people suffering from a mental illness are less intelligent.

T F

12. Someone who plans their suicide attempt down to the last detail is considered high-risk.

T F

13. It is unusual to encounter an individual who is experiencing both hallucinations and delusions.

T F

14. The most frequently encountered hallucination involves the sense of vision.

T F

15. The condition referred to as "*excited delirium*" can cause psychotic symptoms.

T F

POSSIBLE DISPOSITIONS/OPTIONS WHEN INTERACTING WITH A MENTALLY ILL PERSON				
OPTION	***OPEN TO...***	***ONLY IF...***	***HOPEFULLY LEADING TO...***	***SPECIAL CONDITIONS***
DISENGAGE	Anyone	the situation is or can be contained (i.e. no danger to self or others)	re-assessment for back-up, etc. consider other use of force options	*take your time!* remove distractions avoid excitement continue to contain until special response unit or back-up arrive
UNCONDITIONAL RELEASE	P. O.	minor incident mental disorder is not incapacitating person is calm reasonably certain no reoccurrence	no reoccurrence	document all interaction/referrals enter on SIP/FIP
RELEASE TO FAMILIES / FRIENDS	P. O.	same as above except you believe incident would reoccur releasing on own would be unsafe	having family/friends assume responsibility	document all interactions/referrals
CONVINCE to voluntarily admit self	P. O.	it is possible (this may be the only option when there is no available care-taker and does not fit criteria for apprehension)	voluntary admission	document all interactions/referrals
CONSULT with mental health professional	P. O. Anyone else	one is available the incident falls between unconditional release and apprehension	additional information choice of appropriate disposition	telephone on-scene central location
APPREHEND under MHA (S. 17/ Form 47)	P. O.	R&PG a person acting in a disorderly manner you believe is due to a mental disorder and you have reasonable cause to believe the person is a danger to self or others dangerous to wait	· admission information (physician's order form #1)	telephone on-scene central location
INFORMATION	Anyone	when waiting would not be dangerous, must convince J.P.	J.P.'s order (form #2)	valid for only 7 days after signing apprehension is made by P. O. in *that* jurisdiction
ARREST	P. O.	an offence *has been* committed	judge's order (consult with Crown)	notify lock-up staff and jail staff

For more information contact:

Ron Hoffman
Coordinator, Mental Health Issues
Ontario Police College
10716 Hacienda Rd.
Atlmer ON N5H 2T2
Tel.: (519) 773-4220
Fax: (519) 773-8225
ron.hoffman@jus.gov.on.ca

SARNIA POLICE SERVICE IN-SERVICE EDUCATION ON MENTAL HEALTH ISSUES IN PARTICIPATION WITH CMHA-LAMBTON COUNTY BRANCH

Background: Sarnia Police Service recognizes that enhanced knowledge about mental illness, methods of de-escalation and community liaison is an ongoing educational need. In 1996, 1999 and 2002, Canadian Mental Health Association (CMHA), Lambton County was invited by Sarnia Police Services (SPS) to participate in the annual training of officers. The length of in service training for all officers has been a full day. Barriers to offering the training on a more consistent basis have included: 1) pertinent and mandated police training issues have taken precedence over mental health training, and 2) the recognition that when SPS staff turnover is low, the information is perceived by officers to be repetitive.
Support for the training has been based on the following: 1) a significant growth and change in CMHA services and other community mental health services, 2) a recognition on behalf of SPS that officers are increasingly called to intervene in situations that involve people living with a mental illness, 3) a recognition that the SPS and CMHA staff can access each other for information ,assessment and support, and 4) changes to legislation (i.e. Bill 68).

Description: Training is facilitated by CMHA's Public Educator. The presentation outline includes:

- A general overview of CMHA mandate, eligibility for services and programs,
- Specific overviews of the Lambton Mental Health Crisis Service, Court Outreach Program and Assertiveness Outreach Program
- Updates to the Mental Health Act (Bill 68)
- An overview of serious mental illnesses (schizophrenia, mood disorders) including signs and symptoms, and videos depicting 'episodes' of mental illness.
- 'Episodic' intervention techniques (an hour and a half video on "Mental illness and how to identify and approach as first responders".
- CMHA's Partnership Speakers' Bureau, is a panel of individuals living with mental illness, and their family members. The speakers talk from their own experiences, and when appropriate recount their own encounters with police. This valuable link allows police and mental health workers to identify ways of working together when dealing with persons with serious mental illness in the community. CMHA's Coordinator has also attended officer line-up to make presentations. Alzheimer's awareness training has also been conducted. A video entitled "Dealing with the Mentally Ill" will be shown in the future.

Sarnia Police Services' Containment Team and Hostage Negotiators received one week of extra training from the Metropolitan Toronto Police Emergency Task Force in dealing with situation involving emotionally disturbed persons and persons with mental illness.

Could this work in other communities? Could easily work in other communities.

For more information contact:

Inspector Phil Nelson
Uniform Division
Sarnia Police Service
555 N. Christina Street,
Sarnia, ON N7T 7X6
Tel: 519) 344-8961, ext 5270
Fax: (519) 344-6001
pnelson@police.sarnia.on.ca

Penny Witcher
Team Leader
CMHA-Lambton County Branch
210 Lochiel St.
Sarnia ON N7T 4C7
Tel.: (519) 337-5411
Fax: (519) 337-2325
penny@cmha.sarnia.net

WINDSOR'S COURT PRACTICE FOR FITNESS ASSESSMENT

Background: As a result of a number of factors including: 1) the lack of local psychiatrists willing to attend the jail to conduct fitness assessments, prepare a report and attend court; 2) the lack of forensics beds available at St. Thomas and the delay in waiting for a placement; And recognizing that:3) the code in section 672.1 provides for an assessment by a medical practitioner meaning a person entitled to practice medicine; and 4) the assessment order for fitness shall be in force for 5 days [672.14(2)].

Description: The Windsor Crown arranged with a local doctor who is also a coroner to conduct the assessments in a timely fashion at government rates. The Crown provided him with the applicable law; a sample report and suggested he speak to a psychiatrist with experience in this area. A procedure was developed whereby the Crown's office would provide relevant information to the doctor; he would arrange to attend at the jail, provide a report and attend court if necessary. This practice has worked well especially in meeting the short time frames.

Could this work in other communities? Such agreements could easily work in other communities. A key factor is the willingness of the physician to appear in court when necessary. It is helpful if the physician is prepared by the Crown for the types of questions he/she is likely to be asked in court. Appearance in court requires some flexibility in rescheduling office hours, but it happens infrequently

For more information contact:

Denis Harrison
Crown Attorney – Essex County
200 Chatham St. E, Level 5
Windsor, ON N9A 2W3
Fax: 519-253-1813
Tel.: (519) 253-1104
denis.harrison@jus.gov.on.ca

RANGE OF FORENSIC SERVICES IN ONTARIO

Prepared by the Forensic Directors Group - May 2002

CONTENTS

A. INTRODUCTION

The purpose of the "Range of Forensic Services in Ontario" document is to provide recommendations prepared by the provincial forensic directors to the Minister of Health and Long-Term Care via the Forensic Mental Health Services Expert Advisory Panel. These recommendations establish common definitions and identify the range of forensic services in Ontario required to provide the quality of care and supports that leads to safe reintegration of mentally disordered accused and offenders into the least intrusive environment.

The basic structure of a comprehensive forensic service system for Ontario is outlined. This framework, which is consistent with government policy, must incorporate several facets of an integrated system that impact directly and indirectly on the efficient and effective delivery of forensic services throughout Ontario. As such, violence prevention and court diversion services are considered of equal importance to assessment, inpatient, outpatient, consultation and specialty services. The provincial coordination of forensic services is also integral to the development of a comprehensive forensic service system for Ontario.

Not all services described in this document exist at this time. A series of recommendations are provided in order to develop and implement a comprehensive forensic service system for Ontario that will meet the needs of the mentally disordered accused and offenders in the manner described.

B. RANGE OF FORENSIC SERVICES

A comprehensive forensic service system must incorporate a range of forensic services. These will define an integrated system that impacts directly and indirectly on the efficient and effective delivery of forensic services throughout Ontario. All components outlined below are necessary and integral to the development and implementation of a comprehensive framework.

1. VIOLENCE PREVENTION

1.1. Education

Education directed toward professionals and the community provided by Regional Forensic Programs and the Provincial Forensic Hospital will promote a better understanding of mentally disordered accused and offenders. This will assist in the mentally disordered accused and offenders' transition to, and acceptance by, the local community. A regional approach to education involving consumers, families, service providers, and interested citizens will promote community acceptance and responsibility. Effective communication links will be maintained with local media, school boards, government, citizen groups, agencies, consumer/survivor groups and other organizations. The Regional Forensic Programs and the Provincial Forensic Hospital will be resources to educational institutions engaged in training of individuals for careers in the health care sector. Educational services within the forensic/correctional area could be undertaken jointly with other ministries and with participating Academic Health Sciences groups.

1.2. Research

Regional Forensic Programs and the Provincial Forensic Hospital will be affiliated with recognized university Divisions of Forensic Psychiatry, or their equivalents, having joint responsibility for conducting forensic research, identifying best practices, and educating professionals (health, legal, correctional) in forensic mental health specialization. Regional Forensic Programs and the Provincial Forensic Hospital will endeavour to establish relationships with programs for the training of Allied Health Professionals (e.g., Psychologists, Nurses, Social Workers, Occupational Therapists). Each Regional Forensic Program and the Provincial Forensic Hospital will contribute to a forensic database for research purposes. The database will be consistent across all Regional Forensic Programs and the Provincial Forensic Hospital and provide part of a research network in forensic psychiatric services for the Province of Ontario. Research will include a focus on risk assessment, risk management, and ongoing clinical needs assessment in relation to dedicated forensic psychiatric programs. Treatment outcome measures, treatment programs and protocols should be in place in the different facilities that will facilitate best practices and promote the integration of research findings into practice. Each Regional Forensic Program and the Provincial Forensic Hospital will have representation on a Provincial Forensic Research Committee to review proposals and make recommendations that involve more than one region.

1.3. Case Management and Outreach

Numerous agencies and institutions provide supports and services in the community that have an indirect impact on criminal behaviour. Outpatient teams associated with general rehabilitation psychiatry services could provide community supervision and support for low risk forensic clients, or those at somewhat higher risk but with non-violent histories. The Regional Forensic Programs will be adequately resourced to provide the necessary consultation and legal liaison supports to teams engaged in this activity. Only the Regional Forensic Programs will supervise those clients at higher risk for re-offending. The utilization of Assertive Community Treatment Teams (ACTTs) may serve as an adjunct to services provided by Regional Forensic Programs to meet the community-based needs of forensic clients.

1.4. Community Forensic Psychiatric Consultation

Regional Forensic Programs and the Provincial Forensic Hospital will consider requests for specialized forensic consultation from professionals in private practice, community agencies (e.g., CMHA Programs) and governmental agencies (e.g., probation, dual diagnosis services, developmental disability service providers, corrections, court outreach services) with regard to matters having to do with the convergence of mental disorder and criminal conduct. Access to specialized forensic consultation is a valued resource for clinicians in non-forensic settings who are presented with clinical challenges involving such issues as risk for violence and/or sexual violence, fire-setting, and other behaviour likely to represent a significant threat to public safety. Timely access to consultation services is an important factor in the proper management of high risk clients.

2. COURT DIVERSION SERVICES

2.1. Administrative Diversion

The Regional Forensic Programs may be requested by the police and Crown Attorney to assist them in their efforts to divert/triage minor, non-violent, offenders who apparently suffer from a mental disorder. The objective of Administrative Diversion is to secure appropriate mental health services for individuals with particular clinical needs without invoking controls and sanctions available in the Criminal Code as well as to reduce repeat offending through treatment of the mental disorder. The diversion mechanisms will include the dropping or staying of charges, or other procedures available to the Crown Attorney or police. Persons subject to this process will not be appropriate referrals to a specialized Regional Forensic Program.

2.2. Clinical Diversion

Clinical Diversion will involve the evaluation of individuals, charged with a criminal offence, who present as having a mental disorder and may be certifiable under the Mental Health Act of Ontario. These individuals will be evaluated by a forensic clinician in the police cells, local court or detention centre. Those who may be candidates for involuntary hospitalization under the Mental Health Act may be referred directly to general psychiatry or in specific circumstances to the Regional Forensic Program (see below). Charges may be withdrawn or stayed by the Crown Attorney.

3. ASSESSMENT SERVICES

3.1. Forensic Assessment – No Hospital Admission

Regional Forensic Program and the Provincial Forensic Hospital psychiatrists, and/or other forensic clinicians, will undertake brief psychiatric assessment of mentally disordered accused in order to provide opinion evidence or consultation regarding the issues of Fitness to Stand Trial and need for hospitalization. These assessments may be undertaken at the request of the Crown Attorney or defence counsel, in the context of a fee for service consultation, or for the court in response to a Form 48 under Section 672.11 of the Criminal Code of Canada (CCC).
The Regional Forensic Programs and the Provincial Forensic Hospital may offer limited psychiatric assessment, in response to a Form 48, at the hospital site or detention site. If the assessment is to be conducted at the hospital site, the accused will be transported from detention to the hospital and returned to detention the same day. Brief assessments do not involve inpatient hospital admission. However, if, in the opinion of the assessor, a more comprehensive inpatient assessment is required, this may be arranged pursuant to Section 672.11(a) CCC (i.e., to make a determination as to whether the accused is unfit to stand trial).

3.2. Forensic Assessment – Hospital Admission

The Regional Forensic Programs and the Provincial Forensic Hospital will assess mentally disordered accused who are subject to Orders of Assessment for Criminal Responsibility by the Court under Section 672.11(b) of the Criminal Code of Canada to make a determination as to "whether the accused was, at the time of the commission of the alleged offence, suffering from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection 16(1)" (Criminal Code of Canada). Necessary resources required for these assessments include: sufficient inpatient beds to accommodate demand, specialized clinical staff to enable thorough assessments to be completed in a timely manner, access to medical diagnostic services and a physical plant that balances the health care and safety needs of the accused with the safety of co-patients, staff and the community. Mentally disordered accused who are subject to an Assessment Order for Criminal Responsibility will be admitted to hospital within 48 hours of the Order being endorsed by the Court. The Ministry of Health and Long-Term Care will ensure that the Regional Forensic Programs and the Provincial Forensic Hospital are adequately resourced to conduct timely assessments of all mentally disordered accused persons seen in courts within their referral area. Those clients who require a high security service for court-ordered assessments will be assessed at the Provincial Forensic Hospital.

3.3. Treatment Orders

The Ministry of Health and Long-Term Care will ensure that the Regional Forensic Programs and the Provincial Forensic Hospital are adequately resourced to ensure compliance with Treatment Orders of unfit persons under the Criminal Code of Canada.

3.4. Dangerous Offender Evaluations

Regional Forensic Services and the Provincial Forensic Hospital may provide Dangerous Offender evaluations on either an inpatient or an outpatient basis at the direction of the courts where resources and expertise permit.

4. FORENSIC INPATIENT SERVICES

Inpatient Regional Forensic Programs and the Provincial Forensic Hospital must have the flexibility to increase or decrease bed capacity as demand dictates. Failing to ensure this capability will only serve to continue the established practice of detaining mentally disordered persons in the correctional system when they are entitled, by lawful order, to be in hospital.

4.1. Short Term Crisis Management Service

On consent of all parties, inpatient beds will be available to provide short term treatment and management of mentally disordered offenders who present a high risk of serious reoffence due to illness (see also Temporary Medical Absence). The Ministry of Health and Long-Term Care will ensure that Regional Forensic Programs and the Provincial

Forensic Hospital are adequately resourced to ensure the immediate admission of clients requiring a high level of specialized support that will see them safely through a period of behavioural and/or clinical crisis. This service will provide a higher level of static and dynamic security than could be offered by other non-forensic services and will be separate from those services.

4.2. Secure Short Term Assessment & Treatment

The Regional Forensic Programs and the Provincial Forensic Hospital will conduct assessments for fitness to stand trial, criminal responsibility and, where funding arrangements exist, dangerous offender evaluations on mentally disordered accused and offenders referred by the legal system. These services also may be provided based on a transfer payment funding system. Through the forensic application of behavioural sciences, this service will provide short to medium term, court ordered treatment or, on consent of all parties, treatment of mentally disordered offenders.

4.3. Medium Term Rehabilitation and Community Reintegration Service

Assessment and treatment facilities must provide step down transitional programming to support clients to achieve their optimal level of functioning. The Ministry of Health and Long-Term Care will ensure that each Regional Forensic Program will be adequately resourced to admit from court, or from any other facility, any person who becomes subject to a Disposition of the Ontario Review Board or Order of the court directing them to that service. Accused persons who are subject to such Orders will be admitted without delay. The Ministry of Health and Long-Term Care will ensure that Regional Forensic Programs are adequately resourced to serve the needs of their respective regions.

Rehabilitation and Community Reintegration Services is a program designed to facilitate return to community life at the earliest reasonable opportunity by the application of a psychosocial rehabilitation model of care.
Forensic clients suitable for this service will be those who will be expected to have significant independent community access within two years of admission to the program, or those admitted immediately following a finding of Unfit or Not Criminally Responsible (NCR) and for whom placement decisions have not been finalized. Programs will emphasize close psychiatric support, relapse prevention, risk management, education, occupational and vocational preparation, and establishment and maintenance of social supports (see Community Supports). The physical plant will not require extensive perimeter security but will require adequate rehabilitation facilities and a staff complement sufficient to the intensive clinical work, and close supervision, required during the community reintegration phase of rehabilitation.

4.4. Provincial Forensic Hospital

Many mentally disordered offenders who have committed a violent crime and are at high risk of reoffending because of their mental illness require considerable time in a secure hospital setting. These clients require secure treatment and who are not suitable candidates for significant community access within two years.

Consistent with Mental Health Reform initiatives and Ministry policy articulated in Making It Happen, this service will be provided at a single provincial site designated as the Provincial Forensic Hospital. The Provincial Forensic Hospital is a facility designed and resourced so as to provide for both privacy and significant freedom of movement within a secure perimeter for persons who are not permitted significant community access and who require interventions for the treatment and management of disturbed behaviour. Services provided by the Provincial Forensic Hospital will emphasize quality of life issues by ensuring access to a variety of diversional activities and by providing for access to a broad range of therapeutic, educational and vocational activities within the secure perimeter. Clinical program elements will emphasize insight into illness and risk factors, coping with anger and other high risk internal states, sexual preferences and other needs areas that require concentrated attention in the rehabilitation phase prior to the point when community access is considered possible without subjecting the public to unacceptable risk to their safety. Program development is with the collaboration of the provincial Academic Health Sciences programs and coordinated with other Regional Forensic Programs.

The Provincial Forensic Hospital also serves a small number of clients within the Ontario forensic system who represent uniquely difficult challenges for institutional care. These are clients who engage in behaviours such as repetitive institutional violence, represent very high risks for escape, engage in sexual predation within the institutional setting, engage in fire setting behaviour or are seriously regressed.

The Provincial Forensic Hospital has very high levels of both static and dynamic security and staff specifically trained and highly experienced with this client group.

5. CONSULTATION SERVICES

5.1. Consultation

Regional Forensic Programs will establish consultation/liaison services to inpatient units within their facilities and with other service providers in their respective regions, recognizing that these professionals have unique knowledge, experience and expertise which are of valuable assistance in the treatment of clients. Consultations should assist in facilitating timely treatment/management decisions by the consulting clinicians, thereby enhancing efficiency and reducing cumulative risk to the safety of others. The consultation process will generally not result in the transfer of clinical responsibility to the Regional Forensic Program. Regional Forensic Programs will offer forensic consultation for the purposes of assisting the consulting agent with case management, strategic planning, or public relations regarding the reintegration of persons with mental disorder into the community.

The Provincial Forensic Hospital will provide similar consultation and support to the Regional Forensic Programs.

6. OUTPATIENT SERVICES

6.1. Mobile Outreach

Regional Forensic Programs will have mobile outreach capacity sufficient to provide community support for forensic clients living in their respective regions.

6.2. Day Program

Day Programs will be offered in conjunction with existing programs provided within the overall Regional Forensic Programs.

6.3. Family Support

Regional Forensic Programs and the Provincial Forensic Hospital will maintain ongoing family support initiatives, including counseling and information sessions, education of families, limited outreach and assistance in maintaining contact amongst family members, recognizing that community tenure is more likely to be sustained and successful with a functioning family unit to provide support.

6.4. Transitional Community Residential Support

Length of stay in a hospital is, in many cases, directly related to difficulties encountered in finding appropriate community accommodation. Community housing assists clients to acquire the skills necessary for successful re-integration with the general community. Successful tenure in the community will reduce the likelihood of re-hospitalization during the critical first months of community placement.

Regional Forensic Programs will provide support and consultation to community mental health housing and support providers to facilitate safe re-integration of mentally disordered accused and offenders into the community.

7. SPECIALTY SERVICES

7.1. Specialty Clinics

Depending on staff expertise, some Regional Forensic Programs and the Provincial Forensic Hospital may operate specialty clinics, such as for sexual deviation, violence, impulse control disorders, fire setting, etc. A Regional Forensic Program may also offer other specialized services based on regional needs (e.g., specialty services for Aboriginal peoples). Such programs will be consistent with best practice principles. These specialty clinics may be made available to appropriate non-forensic clients and to other Regional Forensic Programs upon referral.

8. PROVINCIAL COORDINATION SERVICES

8.1. Provincial Forensic Planning/Coordination Committee

Each Regional Forensic Program and the Provincial Forensic Hospital will have representation on, and work in coordination with, a provincial forensic planning/coordinating structure. These committees will ensure the continued provision of necessary services and the coordination of those services in a provincial rather than regional manner.

8.2. Regional Forensic Planning/Coordination Structure

Each region may have a planning/coordinating structure to ensure the coordination of services between multiple sites served by a Regional Forensic Program and amongst the affiliated Academic Health Sciences groups in the region.

8.3. Regional Forensic Coordinating Committee

Each Regional Forensic Program will endeavour to maintain an active Regional Forensic Coordinating Committee (or Human Services and Justice Coordinating Committee). This committee will be comprised of representatives from agencies providing services to the forensic client population and may include police, Crown Attorney, community mental health agencies, local detention facilities, defence bar, probation and parole, the judiciary, etc. The purpose of this committee is to coordinate the provision of services to the benefit of the forensic client and community in such a manner as to make the most efficient use of available resources.

8.4. Provincial Forensic Database

Under the direction of the Provincial Forensic Planning/Coordinating Committee (see above), a database will be designed, constructed and maintained. A forensic database is a coordinated, continuously expanding repository of information on the forensic system and the persons receiving service from it. Subject to any confidentiality requirements, this database will be accessible to the Ministry of Health and Long-Term Care, Regional Forensic Programs and the Provincial Forensic Hospital contributing data to it, and will form a basis for research and planning initiatives.

C. RECOMMENDATIONS

The following recommendations are provided in an effort to develop and implement a comprehensive forensic service system in the Province of Ontario. These recommendations are consistent with and complement current government policy to provide the quality of care and supports that leads to safe reintegration of mentally disordered accused and offenders into the least intrusive environment.

The Ministry of Health and Long-Term Care must clearly define the service responsibilities for Regional Forensic Programs. Resource requirements to support these programs in meeting the needs of heterogeneous, non-forensic client populations requiring the support of specialized forensic programs in each region must be identified. The non-forensic client populations include:

A. High Risk/Violent Clients

The Regional Forensic Programs and the Provincial Forensic Hospital must be provided with additional dedicated bed capacity and suitable staffing enhancements to offer their services to civilly committed high risk/violent clients. A very small number of civilly committed persons are extremely dangerous. Among this group may be persons who have significant histories of predatory sexual behaviour, fire setting behaviour or extreme violence against others, and who are likely to be detained involuntarily for very lengthy periods of time. Regional Forensic Programs or the Provincial Forensic Hospital will endeavour to be of assistance with the management of high risk behaviours by offering consultation to programs/ physicians attending to these clients. In exceptional circumstances, where in the opinion of the Regional Forensic Program or Provincial Forensic Hospital the specialized expertise and/or physical resources of the provincial forensic system are the only current ones likely to prevent serious bodily harm to other persons, the client may be accepted on transfer to the Regional Forensic Program or, if appropriate, to the Provincial Forensic Hospital. In all cases of transfer, a written agreement will be in place authorizing the return of the client to the referring program/physician when, in the opinion of the Regional Forensic Program or Provincial Forensic Hospital, the client is a suitable candidate for return to the referring program/physician.

Regional Forensic Programs and the Provincial Forensic Hospital will accept referrals only for civilly committed individuals who are already on involuntary certificates and for whom a written agreement exists for repatriation.

B. Young Offenders

Clear delegation and definition of responsibilities for Young Offenders is required. The Regional Forensic Programs must be provided with additional dedicated bed capacity and suitable staffing enhancements to offer this service. Given the current state, Regional Forensic Programs have no provision and are not configured to provide these services for adolescents. Until such provisions are in place, all Young Offenders (adolescents) requiring inpatient services must be referred to the SYL APPS Youth Centre.

C. Probation/Parole

Where the probationer/parolee is seeking medically necessary health services, such services will be provided as an OHIP-funded service or may be supported through the base budget funding from the Ministry of Health and Long-Term Care.

Where the referral is made by the probation/parole officer or other agent of the correctional authority, and where the object of the referral is to treat criminogenic need
for the purpose of reducing risk for re-offence, services to probationers /parolees will be supported through service contracts with federal or provincial correctional services.

D. Temporary Medical Absence

1. Clear delegation and definition of responsibilities for a Regional Forensic Program or the Provincial Forensic Hospital to provide services to persons serving provincial sentences who require brief admissions to a secure mental health facility during the course of their sentence is required.

Persons on Temporary Medical Absence from provincial correctional facilities may be admitted to a Regional Forensic Program or the Provincial Forensic Hospital on the consent of all parties.

2. The Ministry of Health and Long-Term Care's integration policy, articulated in Making It Happen, must be adhered to by Regional Forensic Programs and their parent hospitals in order to increase the utilization of general psychiatry beds by forensic clients.

A number of forensic clients do not require the specialized expertise/resources of a Regional Forensic Program. Some forensic clients should be integrated with general psychiatry programs as per Ministry policy.
Protected/Integrated Bed Programs, which is an administrative device to achieve greater integration of lower-risk forensic clients in broader mental health programs, must be implemented by all health care facilities that have Regional Forensic Programs.

Regional Forensic Programs from which lower-risk forensic clients were referred do not continue to bear the responsibility for supervision and legal/administrative paperwork. This responsibility will fall more correctly to the person-in-charge and could be discharged by a person assigned to that task centrally within the facility. Transfers to non-forensic services should only be contemplated for persons:
On custodial orders (with or without conditions) who do not have a history of significant violent offending; or
Whose risk of violent offending, as assessed by a uniform accepted protocol, is considered as being low; or
Subject to conditional discharge orders.

Clients transferred to non-forensic programs will become the clinical responsibility of that program. Requests for return to the Regional Forensic Program will be managed in the customary referral and consultation manner except where a revised Disposition requires placement in a Regional Forensic Program.

3. The Ministry of Health and Long-Term Care must develop a method to determine the appropriate number of protected/integrated beds for each health care facility that has a Regional Forensic Program.

In order to effectively implement the Ministry's integration policy articulated in Making It Happen, the Ministry must develop a method to determine the appropriate number of protected/integrated beds for each health care facility that has a Regional Forensic Program. Without this formula, significant continuous challenges from non-forensic programs will be offered to prevent the transfer of forensic clients and, consequently, will compromise the implementation of the Ministry's integration policy.

4. The Ministry of Health and Long-Term Care must ensure that adequate resources are in place in order to implement an effective comprehensive forensic service system in Ontario.

In order to provide these services in the manner described, the Ministry must ensure that adequate resources are assigned to the Regional Forensic Programs and the Provincial Forensic Hospital.

Specifically, this document acknowledges the specialized expertise of forensic clinicians in serving the needs of high-risk clients and proposes to systematize the historic ad hoc practice of treating high-risk civilly committed clients on forensic services. To undertake this additional responsibility, while at the same time discharging all other obligations responsibly, forensic programs must be provided additional beds and staff.
These additional resources must be factored in decisions regarding minimum bed counts for each Regional Forensic Program and for the Provincial Forensic Hospital.

Consultation/liaison, Diversion, and Outreach services have historically been offered on an ad hoc basis. It is proposed in this document that these services, because of their value to clients and to the community and because they result in substantial resource savings over time, should become part of the Regional Forensic Service mandate. These additional responsibilities cannot be undertaken in the absence of specific considerations of the resource implications for each Regional Forensic Program. It is anticipated that investment in these services will result in substantial savings in other services provided by the mental health and judicial systems.

5. A comprehensive plan for a coordinated provincial forensic system must be developed and communicated.

All forensic documents that have contributed to provincial forensic policy need to be coalesced to develop a comprehensive plan for a coordinated provincial forensic system for the Province of Ontario. The resultant policy document must be sanctioned by the Ministry of Health and Long-Term Care and communicated widely to ensure consistent implementation across the province.

6. Services provided by Regional Forensic Programs must be coordinated.

Some type of provincial strategy/infrastructure and process is required for coordinating the provision of all forensic services throughout the province. This strategy/infrastructure should consist of an authoritative body to manage all forensic issues to enhance efficiency and effectiveness in the delivery of services to forensic clients.

7. In order to provide the least restrictive environment for forensic clients, the security provided by Regional Forensic Programs must be clearly defined and standardized.

Forensic clients in Ontario will reside in facilities providing the least restrictive environment consistent with public safety. Those clients not requiring hospitalization will reside in community accommodation. While living in the community, these clients will be monitored by hospital staff external to the Regional Forensic Programs. Those clients whose level of risk requires hospitalization but not secure custody will reside in general psychiatry rehabilitation programs at general or tertiary care facilities. Those clients whose level of risk requires secure custody but who do not represent serious institutional management problems will be placed in the appropriate Regional Forensic Program. Those clients representing high security risk and/or who present with serious institutional management problems, or who require longer-term secure care, will be placed in the Provincial Forensic Hospital.

8. Standardized modular treatment programs that each Regional Forensic Program and the Provincial Forensic Hospital will offer must be developed.

Through a provincial forensic coordinating structure (see above), standards (best practices) will be established and implemented with annual review for programs and services offered across the provincial forensic system. These programs and services may include: risk assessment and management, case preparation for Ontario Review Board hearings, needs assessment, program evaluation, clinical program elements, and standardization of static and dynamic security.

9. Forensic bed distribution in Ontario must be based on valid and current information.

The appropriate sizing and configuration of the Ontario forensic mental health system can be determined only following consultation with all stakeholders and the accumulation of valid demographic, demand, and utilization data in addition to projection of future trends. Currently available data are not sufficiently up to date, or sufficiently comprehensive, to justify decisions that may be based on them. Stakeholders in this context will include, but may not be limited to, the courts, the Ministry of the Attorney General, the Ministry of the Solicitor General, the Ministry of Community and Social Services, the Ministry of Correctional Services, Forensic Program Directors, the Ontario Review Board, and Academic Health Sciences Centres affiliated with the Ontario forensic system.

Research and Education must receive priority by Regional Forensic Programs and the Provincial Forensic Hospital and the resources and funding options need to be identified.

10. Research and education are both vital elements in sustaining quality of service at traditional high levels. The provincial forensic coordinating structure (see above) should establish a subcommittee to address system research and training requirements. Sufficient fiscal resources should be invested in research of forensic issues and education/training of direct services staff to ensure the ongoing evolution of quality clinical services to clients and risk management services offered on behalf of the community. Specific funding allotments should be identified. These should be reviewed annually.

WINDSOR POLICE SERVICES INVOLVEMENT WITH CMHA'S WINDSOR-ESSEX BRANCH BOARD OF DIRECTORS

Background: In the late 1980's and early 1990's, a Windsor Police Services (WPS) inspector served on the CMHA Board as part of his community service.

Description: In 1996 because of the positive interaction CMHA had with the Inspector, they approached WPS's Chief and asked if he would consider suggesting another representative for the board. The Chief approached an officer with their Special Investigations Branch, which regularly dealt with persons with serious mental illness. The officer's name was put forward and he was elected on the board. He served in the following capacities,

- May 1996 to April 1999 board member
- May 1999 to April 2000 Vice President
- May 2000 to April 2001 President
- May 2001 to April 2002 Past President

When the officer stepped down from the Board, an Inspector ???) 's name was put forward and he was elected to the CMHA Board. The Part-President is still quite involved with CMHA, he sits on two fund raising committees. In addition he has been sitting as a member on the Windsor Regional Hospital, Mental Health and Addiction Committee, he also sits on the Mental Illness Justice System Task force and the Police Mental Health Advisory Comm.

Could this work in other communities? The advantages of having a representative of Police Services run for election to a CMHA Board are many. This informal liaison can result in better understanding of mandates and issues on each side and lead to more formal involvements.

For more information contact:

Inspector Ken McFarland
Community and Support Services Branch
Windsor Police Services
P.O. Box 60
Windsor ON N9A 6J5
Tel.: (519) 255-6700 ext. 4220
Fax: (519) 255-7052
kmcfarland@police.windsor.on.ca

MENTAL HEALTH AND JUSTICE SYSTEMS TASK FORCE OF WINDSOR - ESSEX COUNTY

TERMS OF REFERENCE

Purpose

The Mental Health and Justice Systems Task Force (JTF) has been established to monitor and address the specialized needs of individuals with serious and persistent mental illnesses who have become involved in the criminal justice system.

Membership

The Task Force will comprise of individuals representing or affiliated with various facets of the justice and mental health systems. Membership will consist of the legal profession, including representation from the Crown's office, corrections, judges, lawyers, police, mental health professionals and other interested community members. Membership may also include consumers and their families.

Objectives

The Task Force will report to the standing Mental Health Committee. The Task Force will build and foster working relationships between mental health systems, criminal justice system, and other community partners. The objective is to identify and improve the care of the target population, to improve the care and ensure the appropriate treatment and support is provided.
The Task Force will provide training and education for member organizations. (In collaboration with Police/Mental Health Liaison Committee)

The Task Force will assist in better identifying the special needs of this population, how they are currently being met and how they should be met in the future.

The Task Force will identify issues and promote improvements within the mental health and justice systems.

Frequency of Meetings

Meetings shall be held at a minimum of twice per year at mutually agreeable dates and times.

Quorum

A quorum will be a simple majority of members present for any meeting.

For more information contact:

Karen Gignac
CMHA Manager – Windsor Essex Branch
Community Support Services
1400 Windsor Avenue
Windsor, ON NBX 3L9
Tel.: (519) 255-9940, ext. 236
Fax: (519) 255-7817
kgignac@cmha-wecb.on.ca

POLICE / MENTAL HEALTH LIAISON COMMITTEE OF WINDSOR-ESSEX TERMS OF REFERENCE

INTRODUCTION

The legislation and operational policies relating to the management of persons with mental illness, by Police Services and Mental Health Service Providers, continues to change and necessitates increasing cooperation between the two sectors.

The policy guidelines established by the Ministry of the Solicitor General, Policing Services Branch directs all police services to work in partnership with mental health providers. Likewise the Ministry of Health and Long Term Care sets out an Operational Framework which emphasizes partnerships with inter-ministry service providers who have a role in providing services for persons with mental illness. Without prejudice to the above, this committee does not replace or replicate work completed by the Justice Task Force, but rather serves to deal with implementation issues associated with mental health and police interface activity.

RESPONSIBILITIES

The committee will provide advise and recommendations on:

- standards, policies and procedures that affect mental health issues in the community, hospitals and within police services in the Windsor-Essex area, and consistent with the Ministry of the Solicitor General's Policing Standards;
- training and education for members that will provide awareness of mental health issues, changing legislation and is in compliance with Use of Force Training. Such training is to be timely, relevant to the member's job function and respectful of inherent human rights issues with respect to mental illness;
- identify and share training resources;
- ensure that an ongoing partnership is fostered and maintained with local mental health service providers and their consumers, that is consistent with mental health reform initiatives recommended by the Ministry of Health and Long Term Care;
- liaise with and seek advice from external authorities, such as Coroners and mental health care professionals and review recommendations from inquests and judicial proceedings;

MEMBERSHIP

Service Provider Members will be appointed by nature of their position with the service, designated by the Chief Administrative Officer.

CHAIR

The Chair shall be appointed from among the service providers by the membership and shall rotate each year between one of the member police services and one of the mental health providers.

FREQUENCY OF MEETINGS

Meetings shall be held at a minimum of three times yearly, at mutually agreeable dates and times. Location of each meeting to be determined.

TENURE

Service Provider members will remain on the committee at the will of the Chief Administrative Officer of the Service represented.

QUORUM

A quorum will be a simple majority of members present for any meeting.

ACCOUNTABILITY

This Advisory Committee is a voluntary body in fulfillment of the mutual obligations of the police and mental health sectors to ensure that a partnership exists between each one. Minutes of these meetings may be used by all service provider participants to demonstrate the existence of this partnership.

For more information contact:

Karen Gignac
CMHA Manager – Windsor Essex Branch
Community Support Services
1400 Windsor Avenue
Windsor, ON NBX 3L9
Tel.: (519) 255-9940, ext. 236
Fax: (519) 255-7817
kgignac@cmha-wecb.on.ca

LONDON & MIDDLESEX COUNTY HUMAN SERVICES AND JUSTICE COORDINATION PROJECT

Background:

The Project Team was established in October 1994 and staffed by members of the Attorney General, Health and Solicitor General & Correctional Services-Ministries of the Province of Ontario. In September of 1996 the Community and Social Services was added to project team. The Assistant Deputy Ministerial Steering Committee finally provided a direction to the project team.

The Client Group which is serviced by the Project Team consists of 4 Ministries: Ministries of the Attorney General, Ministries of Community and Social Services, Ministries of Health, Ministries Solicitor General and Correctional Services. The common client is usually in need of mental health and/or developmental services and has a history of contact with the law. There are about 4,300 to 7,300 common clients across Ontario and $200M is allocated to serve this client group.

Purpose:

To coordinate in the joint planning, coordination and integration of services delivery for individuals with serious mental disorders, developmental disabilities and or acquired brain injuries, who are involved with the criminal justice system, in London and Middlesex County.

Goals:

To coordinate communication and to establish effective likages and liason mechanisms between criminal justice, health, and social service agencies with respect to common client.

In the short term, identify local priorities, develop and implement strategies for coordination of collective services.

In the long term, to promote the need for and to establish processes for coordinated planning, joint problem solving and the integrated delivery of services between criminal justice, health, and social services agencies

Meetings:

At a minimum, once every three months, or at the call of the Chair. It is anticipated that the working groups will meet as required by their mandates.

Co-Chair:

The Co-Chair will be elected by a single majority vote of the Coordinating Committee membership for a two-year term. One Co-Chair will be elected annually.

The Chair will take responsibility for circulating the minutes to the committee membership and to any relevant agency or group identified by the Chair or a committee member.

The Co-Chair will be reviewed annually.

Membership:

Membership will be comprised of representatives from consumer/family groups, human services system agencies, criminal justice system agencies, and government/planning agencies.

Could this work in other communities?: Many communities have or are establishing such a committee.

For more information contact:

Mike Petrenko
Executive Director
CMHA, London-Middlesex Branch
648 Huron St.
London ON N5Y 4J8
Tel.: (519) 434-9191
Fax: (519) 438-1167
mailbox@london.cmha.ca

SARNIA POLICE SERVICES PAID DUTIES AT SARNIA GENERAL HOSPITAL'S PSYCHIATRIC WARD

Background: There are a limited number of secure rooms for high-risk patients on the psychiatric ward at Sarnia General Hospital. On occasion, the number of high-risk patients exceeds the number of available rooms or patients may require extra security.

Description: A supervisor at Sarnia General Hospital calls the Sarnia Police Station and requests off-duty police officers for security services. One or more officers may be requested depending upon the circumstances. Officers may be scheduled, as agents of Sarnia General Hospital, to work anywhere from three hours to rotating eight hour shifts. At times these paid duties have lasted for weeks. Officers attend in civilian clothes. Sarnia General Hospital reimburses Sarnia Police Service for overtime salary and administrative costs. Sarnia Police Services covers 6% benefits of the officers, but Worker's Compensation is not covered.

Could this work in other communities? Could easily work in other communities.

For more information contact:

Inspector Phil Nelson
Uniform Division
Sarnia Police Service
555 N. Christina Street,
Sarnia, ON N7T 7X6
Tel: 519) 344-8961, ext 5270
Fax: (519) 344-6001
pnelson@police.sarnia.on.ca

PSYCHIATRIC IN-PATIENT LEGAL CLINIC AT LONDON HEALTH SCIENCES CENTRE-VICTORIA CAMPUS

Background: Legal issues may add to or precipitate crises associated with admission to a psychiatric ward. "Therapeutic jurisprudence " can be used as a component of treatment to alleviate the anxiety that a legal problem can cause to persons with mental illness. Mental health patients are now able to get the legal help they need while in hospital. London Health Sciences Centre (LHSC)-Victoria Campus, South Street, in partnership with The University of Western Ontario's (UWO) Faculty of Law has expanded the scope of its mental health services to include a community legal referral program on the psychiatric ward of the hospital. The Dean of the Faculty of Law was approached in August 2001, and was amenable to being a part of this service agreement. This program, which started in September 2002 serves a population that often doesn't have the financial or personal resources to find and hire a lawyer for themselves.

Description: Brenda Fuhrman (RN, LLB - Coordinator of Inpatient Units of the Mental Health Program at LHSC) approached UWO's Faculty of Law to organize a way to help mental health clients have increased access to legal assistance. Through the UWO Faculty of Law's Community Legal Services program, law students help with inpatients' legal issues. Community Legal Services is a program that provides law students with the opportunity to help members of the London community, while at the same time practicing their advocacy skills, under the close supervision of twelve student supervisors and three Review Lawyers. This service is a non-profit organization funded by Legal Aid Ontario and UWO, providing free legal assistance to people who cannot afford a lawyer .

Who is eligible for this service? Eligibility is based on the services offered by the UWO supervising lawyers. The students deal primarily with matters in the areas of Small Claims court, Provincial Offences, Landlord/Tenant disputes and minor Criminal offences including representation at court: areas of expertise of the supervising UWO lawyers. Family law issues are not covered to date.

The following describes how the in-patient clinic works:

1. When a client with mental illness is admitted as an in-patient to LHSC, the staff nurse will approach the client to ascertain if they have legal problems with which they would like assistance. Often when these patients are in hospital they have legal issues that are either caused by or related to their illness.

2. Forms advertising the Community Legal Services (Form 1) have been placed in visible areas on the ward.

3. Patients in need of legal assistance are referred to two law students. Ms. Fuhrman arranges and supervises the student's clinic, which is held once a week for half a day. If there are any security concerns, the interview takes place in a room that is attached to the nurses' station—a room that affords privacy but is in full view of staff.

4. Form 14 is signed by the patient, which gives permission to share information with the law student and the clinic. The students are then directed to the patient for intake.

5. The Application Form –Intake (Form 2) is filled in. Patients not eligible for the service because their need is in the area of family law are given pamphlets with information on the Family Law Information Centre (FLIC) and advised to obtain help there at discharge.

6. The students return to the Law School and review the intake information with their supervisor. The Summary Advice Form is then be completed (see Form 3). If appropriate, the student can then continue to offer legal advice/representation when the client is hospitalized.

7. After discharge, clients may elect to continue with the clinic at the Faculty of Law or be referred to the Western Ontario Therapeutic Community Hostel's (WOTCH) Community Legal Services clinic (see Form 4).

8. For purposes of compiling descriptive information on the number of patients and the nature of the legal problems, a data sheet (see Form 5) for inpatients at LHSC SSC Mental Health program seen by Community Legal Services is kept on file. This data sheet gives information on the name of the patient (addressograph), date seen, legal issue and resolution of the problem.

Could this work in other communities? Although most Schedule 1 hospitals do not have a university law school to call upon to provide legal clinics, any hospitals could negotiate with local law firms to have lawyers provide pro bono services to inpatients. Similarly, mental health community-based case management agencies could also negotiate out-patient pro bono services.

For information contact:

Brenda Fuhrman
Coordinator - Inpatient Units of
Mental Health Program
London Health Sciences Centre
375 South St.
London, ON
Tel.: (519) 685-8300 ext. 77616

Community Legal Services
Room 120, Faculty of Law
University of Western Ontario
London, ON N6A 3K7
Tel.: (519) 661-3352
Fax: (519) 661-3438
brenda.fuhrman@lhsc.on.ca

CANADIAN MENTAL HEALTH ASSOCIATION, LAMBTON COUNTY BRANCH'S OUTREACH TEAM SUPPORT WORKER

Background: In 1995 a need was identified in the community to reach out to adults who have a serious mental illness, who are unable/unwilling to access formal/traditional mental health services, and who may be homeless or at risk of homelessness. With the funding of CMHA's Supportive Housing Program, the creation of court outreach, the Lambton Hospitals Group Program of Assertive Community Treatment and funds available through the Inn of the Good Shepherds Homelessness Initiative, the outreach team support worker position is constantly evolving and changing in line with community need.

Description: The outreach team support worker provides a quick response to urgent situations that arise by:

- Networking with local businesses, professional agencies and landlords to identify individuals at risk.
- Screening for serious mental illness and assessing appropriateness for service.
- Assisting individuals in prioritizing needs/areas of consideration and developing short term plans to address these identified areas.
- Securing emergency and / or stable housing.
- Facilitating early linkage with supportive housing staff, Community Support Worker or other agency.
- Securing financial assistance.
- Liaising with family/significant others, and natural supports to facilitate the members' links within the community.
- Establishing partnerships and resources with other community agencies.
- Actively participating in related committees and community events.
- Maintaining professional relationships with other community service providers with whom the worker comes in contact within performance of the duties of the position.
- Maintaining regular professional contact with commonly accessed organizations, (such as the Ontario Disability Program and Ontario Works office) so that purposeful interaction on behalf of program members can be effectively accomplished.

Could this work in other communities? This could easily work well.

For more information contact:

Penny Witcher
Team Leader
CMHA-Lambton County Branch
210 Lochiel St.
Sarnia ON N7T 4C7
Tel.: (519) 337-5411
Fax: (519) 337-2325
penny@cmha.sarnia.net

KEY INFORMANTS:

CHATHAM

Debby Watterworth
CMHA Chatham-Kent County
240 Grand Ave. W, Suite 100
Chatham, ON N7L 1C1
Tel.: (519) 436-6100
Fax: (519) 351-9203

Judy McKenzie
CMHA Chatham-Kent County
240 Grand Ave. W, Suite 100
Chatham, ON N7L 1C1
Tel.: (519) 436-6100
Fax: (519) 351-9203

Mary Cooper
CMHA Chatham-Kent County
240 Grand Ave. W, Suite 100
Chatham, ON N7L 1C1
Tel.: (519) 436-6100
Fax: (519) 351-9203

Hon. Mr. Justice Bruce Thomas
21 Seventh Street
Chatham, ON, N7M 4K1
Tel.: (519) 352-9070 ext. 2
Fax: (519) 352-3669
bruce.thomas@jus.gov.on.ca

Paul Bailey
Crown Attorney - Kent County
Kent Courthouse
21 Seventh St 1st Floor
Chatham ON N7M 4K1
Tel.: (519) 352-2141
Fax: (519) 354-1540
paul.bailey@jus.gov.on.ca

Inspector Clare Wiersma
Operational Support Branch
Chatham Police
24 Third St. P.O. Box 366
Chatham, ON N7M 5K5
Tel.: (519) 436-6600 ext 605
Fax: (519) 436-6643
clarew@city.chatham-kent.on.ca

David Maslak
Defense Attorney
124 St. Claire St. 2nd floor
Chatham, ON N7L 3J3
Tel.: (519) 351-2261
Fax: (519) 351-2860
kathy@crmmlaw.com

LONDON

Marc Garson
Director, Crown Operations - West Region
150 Dufferin Ave. Suite 202
London, ON N6A 5N6
Tel.: (519) 661-2883
Fax: (519) 661-2887
marc.garson@jus.gov.on.ca

Lisa Heslop
Supervisor, Family Consultant/Victim Services Unit
London Police Services
601 Dundas St.
London, ON N6B 1X1
Tel.: (519) 661-5636
Fax: (519) 661-6495
lheslop@police.london.ca

Hon. Mr. Justice Alexander Graham
Regional Senior Justice - West Region
15th Floor Unit G
80 Dundas St. E
London, ON N6A 6B3
Tel.: (519) 660-2292
Fax: 519-660-3138
alexander.graham@jus.gov.on.ca

John Hanbidge
Assistant Crown Attorney – Middlesex County
Courthouse - Main Floor
80 Dundas St E
London, ON N6A 2P3
Tel.: (519) 660-3003
Fax: (519) 660-3087
john.hanbidge@jus.gov.on.ca

David G. Arntfield
Crown Attorney
Middlesex Courthouse - Main Floor
80 Dundas St. E
London ON N6A 2P3
Tel.: (519) 660-3003
Fax: (519) 660-3087
david.g.arntfield@jus.gov.on.ca

Hon. Madam Justice Deborah K. Livingstone
Ontario Court of Justice
2nd Floor, Unit E
80 Dundas St.
London ON N6A 6A5
Tel.: (519) 660-3014
Fax: (519) 660-3024
deborah.livingstone@jus.gov.on.ca

Roni Voigt
Mental Health Court Diversion Nurse
80 Dundas St.
First Floor, Unit A, Room 1083
London, Ontario, N6A 6A3
Tel.: (519) 660-3168
Fax: (519) 660-2433
roni.voigt@jus.gov.on.ca

Brenda Fuhrman
Coordinator Inpatient Units of Mental Health Program
London Health Sciences Centre
375 South St.
London ON N6A 4G5
Tel.: (519) 685-8300 ext. 77616
Brenda.Fuhrman@lhsc.on.ca

Chris Dobson
Defense Attorney
4 Covent Market Place
London ON
Tel.: (519) 433-1256
Fax: (519) 645-8516
c.dobson.dfendit@on.aibn.ca

Daryl Link
Deputy Regional Director Community & YO Services – Western Region
Ministry of Public Safety & Security
150 Dufferin Ave. Suite 704
London ON N6A 5N6
Tel.: (519) 661-1696
Fax: (519) 679-0699
daryl.link@jus.gov.on.ca

SARNIA

Alan Stevenson
Executive Director, CMHA-Lambton
Court Branch
210 Lochiel Street
Sarnia, ON N7T 4C7
Tel.: (519) 337-5411
Fax: (519) 337-2325
alan@cmha.sarnia.net

Sharon MacKinlay
Probation and Parole Officer
Ministry Public Safety and Security
720 N. Christina St.
Sarnia ON N7V 3C2
Tel.: (519) 337-2365 ext 462
Fax: (519) 332-4616

Robert McFadden
Defence Attorney
560 Exmouth St.
Northgate Plaza - Suite 104
Sarnia, ON N7T 5P5
Tel.: (519) 344-3683
Fax: (519) 337-3995

Hon. Madam Justice Deborah Austin
Justice Bldg 3rd Floor Suite 301
700 Christina St. N.
Sarnia ON N7V 3C2
Tel.: (519) 336-8830
Fax: (519) 337-5655
deborah.austin@jus.gov.on.ca

Donald Vale
Crown Attorney - Lambton County
Courthouse 1st Floor Suite 100
700 Christina St N
Sarnia, ON N7V 3C2
Tel.: (519) 337-7596
Fax: (519) 336-4663
donald.vale@jus.gov.on.ca

Inspector Ronnie Van Dam
Sarnia Police Service
555 N. Christina Street,
Sarnia, ON N7T 7X6
Tel: 519) 344-8961, ext 5270
Fax: (519) 344-6001

Inspector Phil Nelson
Uniform Division
Sarnia Police Service
555 N. Christina Street,
Sarnia, ON N7T 7X6
Tel: 519) 344-8961, ext 5270
Fax: (519) 344-6001
pnelson@police.sarnia.on.ca

Trish Wells
Court Outreach / Crisis Worker
CMHA – Lambton County Branch
210 Lochiel St.
Sarnia ON N7T 4C7
Tel.: (519) 337-5411
Fax: (519) 337-2325
trish@cmha.sarnia.net

Penny Witcher
Team Leader
CMHA-Lambton County Branch
210 Lochiel St.
Sarnia ON N7T 4C7
Tel.: (519) 337-5411
Fax: (519) 337-2325
penny@cmha.sarnia.net

ST. THOMAS

Dr. James Mendonca
Psychologist
Regional mental Health Care St. Thomas
467 Sunset Dr.
P.O. Box 2004
St. Thomas ON N5P 3V9
Tel.: (519) 631-8510 ext. 49214
jim.mendonca@sjhc.london.on.ca

Chris Bailey
Manager – Forensic Unit
Regional Mental Health Care St. Thomas
467 Sunset Dr.
P.O. Box 2004
St. Thomas ON N5P 3V9
Tel.: (519) 631-8510

WINDSOR

John Liddle
Defense Attorney
691 Oulette Ave.
Windsor ON N9A 4J4
Tel.: (519) 255-1140
Fax: (519) 255-9366
lidsj@netcore.ca

Dr. Robert Drake
Coroner
400 Cabana Rd. Unit 3
Windsor ON N9G 1A3
Tel.: (519) 972-7065

Denis Harrison
Crown Attorney – Esses County
200 Chatham St. E, Level 5
Windsor, ON N9A 2W3
Fax: 519-253-1813
Tel.: (519) 253-1104
denis.harrison@jus.gov.on.ca

June Gilbertson
Area Manager
Ministry of Public Safety and Security
880 Ouellette Ave. Suite 506
Windsor, ON N9A 1C7
Tel.: 519-254-2206
Fax: 519-973-1425
june.gilbertson@jus.gov.on.ca

Karen Gignac
CMHA Manager – Windsor Essex Branch
Community Support Services
1400 Windsor Avenue
Windsor, ON NBX 3L9
Tel.: (519) 255-9940, ext. 236
Fax: (519) 255-7817
kgignac@cmha-wecb.on.ca

Hon. Mr. Justice Saul Nosanchuk
Ontario Court of Justice
200 Chatham St. Level 7,
Windsor, ON, N9A 2W3
Tel.: (519) 973-6639
Fax: (519) 973-6671
saul.nosanchuk@jus.gon.on.ca

Robert Atkinson
Director, Community Crisis Centre of
Windsor-Essex County
Jeanne Mance Building, 1st Floor
Hotel-Dieu-Grace Hospital
1030 Ouellette Avenue
Windsor, ON N9A 1E1
Tel.: (519) 973-4411, ext 3264
Fax: (519) 973-1989
batkinson@hdgh.org

Dr. Walter Cassidy
Chief of Psychiatry
Hotel Dieu – Grace Hospital
Jeanne Mance Building - 1st first floor
Windsor ON N9A 1E1
Tel.: (519) 973-4411 ext 3354

Chief Glenn Stannard
Windsor Police Services
P.O. Box 60
Windsor ON N9A 6J5
Tel.: (519) 255-6700 ext. 4900
Fax: (519) 255-6191
gstannard@police.windsor.on.ca

Deputy Chief Roger Mortimore
Windsor Police Services
P.O. Box 60
Windsor ON N9A 6J5
Tel.: (519) 255-6700
Fax: (519) 255-6191
emortimore@police.windsor.on.ca

Inspector Ken McFarland
Community and Support Services Branch
Windsor Police Services
P.O. Box 60
Windsor ON N9A 6J5
Tel.: (519) 255-6700 ext. 4220
Fax: (519) 255-7052
kmcfarland@police.windsor.on.ca

Sergeant Jim Evans
Street Crimes Branch
Windsor Police Services
P.O. Box 60
Windsor ON N9A 6J5
Tel.: (519) 255-6700 ext. 4340
Fax: (519) 255-7052
jevans@police.windsor.on.ca