

Halton Crisis Protocol

Purpose of the Protocol:

Police and social services often interact when individuals with a mental illness experience a crisis. The goal of this protocol is to ensure that these services work together in a manner that:

1. Ensure that services are provided by the most appropriate provider(s) and that a team approach be used to fully meet the needs of the individual.
2. Ensure that the expectations of each participant are consistent with the mandate of their service agency.

Goals of the Protocol:

1. To better the emergency response provided to individuals with a mental illness in crisis.
2. To increase the effectiveness and cohesiveness of crisis services for the Halton region.
3. To promote the use of the Common Crisis Plan to improve service coordination for individuals who are likely to utilize crisis services.

Guiding Principles:

1. Every individual deserves to be treated with dignity, compassion and respect.
2. Individuals with a mental illness may require supplementary community supports to assist them during a time of crisis.
3. The Crisis Plan and Protocol are entirely client-directed and are for the sole purpose of assisting and providing support to an individual with a mental illness during crisis.
4. We are inclusive and equitable and sensitive to gender, race, age, ability, sexual orientation, culture, socio-economic and religious backgrounds.

Review:

1. Agencies will review the Crisis Plan and Protocol with the individual on a regular basis to determine relevance and update any changes, as per each service provider's respective policy and mandate.
2. The Diversity, Equity and Inclusivity Coordinator at the Halton Regional Police Service will have access to the total number of crisis plans on file, and will keep track of this.

Scope of the Protocol:

This protocol is inclusive of services provided by the following emergency crisis services providers:

- Summit Housing & Outreach Programs
- Halton Regional Police Service
- Canadian Mental Health Association-Halton Region Branch

By signing this Protocol and the attached Schedule "A"- Memorandum of Understanding-Exchange of Information- the above mentioned service providers are committing to their involvement in this protocol for responding to crisis in the community.

Common Crisis Plan for Halton Regional Police Service

Personal Information

Name: _____ Date of Plan: _____

Address/City: _____ Postal Code: _____

Phone #'s: _____ Date of Birth: _____

Primary Worker: _____ Primary Worker Phone #: _____

Diagnosis:	
Mental Health & Medical Concerns: (i.e. allergies, sensitivities, physical and mental health issues, suicidal behavior, addictions/dependencies, mode of communication)	

Emergency Contact Information:

Name:		Phone #:	
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My "triggers" for a crisis:

1.
2.
3.

My "early warning signs" for a crisis:

1.
2.
3.

My "coping strategies" when I experience early warning signs for a crisis:

1.
2.
3.

What usually happens when I am in crisis:

- 1.
- 2.
- 3.

When I am in crisis, my coping strategies are:

- 1.
- 2.
- 3.

Please list approaches that would be helpful during crisis: (i.e. soft voice, avoiding eye contact)

- 1.
- 2.
- 3.

Please list approaches that may not be helpful during crisis: (i.e strong tone of voice, direct eye contact)

- 1.
- 2.
- 3.

Places I can go or people I can talk to and when are they available:

- 1.
- 2.
- 3.

Community Connections/Supports I use and how they help me:

- 1.
- 2.
- 3.

Primary Worker Signature

Signature

Consent Form to Share Crisis Plan Information

I, _____, D.O.B. ____/____/____
Print Full Name *DD MM YY*

of this address _____

understand the purpose for disclosing my Personal Information/Personal Health Information.
I understand that _____

Agency Name

may share my common crisis plan and my personal health information as stated on the common crisis plan with the Halton Regional Police Service and that this exchange of information may be by hand delivery or electronic systems. This information will only be shared during a time of crisis. I understand that I may withdraw this consent at any time.

Signature: _____ Date: _____

A substitute decision maker is a person authorized under PHIPA (Personal Health Information Protection Act) to consent for the client, and may sign on behalf of an individual, to disclose personal health information about the individual.

Witness Name: _____ Address: _____

Witness Home Tel: _____ Work Tel.: _____

Witness Signature: _____ Date: _____

This consent will expire on _____. Upon expiry, the crisis plan will be securely destroyed. If you should wish to renew this consent, please see your agency.

