DUAL DIAGNOSIS

JUSTICE ISSUES INFORMATION

North East Human Services and Justice Coordinating Committee

The Ontario government's policy framework for people with mental illness who come into conflict with the law, *A Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario*, was approved in June 1997, as a result of a cooperative effort among the Ontario Ministries of the Attorney General, Community and Social Services, Health, Solicitor General, and Correctional Services. Priority consideration was to be given to people with a serious mental illness, developmental disability, and acquired brain injury. The Provincial Strategy is aimed at enhancing public safety, increasing system efficiencies, and better coordination of the essential services and supports that improve the quality of service and quality of life for these individuals.

The implementation of this framework at the local level required the establishment of local coordinating committees that would interpret and implement the strategy consistent with the unique attributes of their communities.

In response to the introduction of this new service framework, the Northeast Regional Human Service Justice Coordinating Committee was established in 2005. These regional structures were established to coordinate communication and service integration planning between the service sectors of health, criminal justice and developmental service organizations. The development of local committees throughout the Northeast ensued. Local committees that are currently in place include Sudbury/Manitoulin, Algoma, Nipissing/Temiskaming/Parry Sound, and Cochrane/Timmins.

The overall purpose of the Northeast Committee is to provide a vehicle to share and transfer knowledge to and from communities and provincial networks. Two primary areas of emphasis for both the regional and local committees are 1) to provide a planning table to bring together service providers to find local solutions to local issues and 2) to provide a model of shared responsibility and accountability when responding to the unique needs of this client population. Local committees work to identify, coordinate and educate to ensure this vulnerable client population receives the right services, by the right agencies, and at the right time while upholding the importance of public safety.

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Dual Diagnosis Justice Issues

An increasing number of people with dual diagnosis are making admirable strides in residing, and playing an active role within our communities. With increasing participation and presence, there is the potential for people with dual diagnosis to become in conflict with the law. As a result, it is vital that police services and the criminal justice system be informed of the unique challenges of people experiencing developmental disabilities and mental health issues.

Many efforts have been made to assist the developmental services and the mental health systems to work more cooperatively in addressing the needs of individuals with dual diagnosis.

Networks of Specialized Care were developed in 2006 and funding was made available in the Northeast to employ Dual Diagnosis Justice Case Managers. Their primary goal is to divert people from the criminal justice system into more appropriate mental health and developmental services.

This booklet was adapted from the Lanark Human Services and Justice Coordinating Committee, and was originally created by the Midland Dual Diagnosis Committee for the Simcoe County Dual Diagnosis Committee. Thanks to their initiative and insight in developing this evolving document.

The Northeast Human Services and Justice Committee has revised their information to reflect advancements in this area, and to identify services available in Northeastern Ontario, and to serve as a training tool to help anyone who encounters people with dual diagnosis in their work.

Special thanks to Judy Kosmerly, Community and Developmental Services Programs, Ministry of Community and Social Services and to Pam Einboden, Manager, Northern Network of Specialized Care, for their work in updating this document.

For information or suggestions to improve this handbook, please contact:

Northeast Human Services and Justice Coordinating Committee
c/o Canadian Mental Health Association–Sudbury/Manitoulin Branch

Sandie Leith
Chair
Northeast Regional HSJCC
2008/2009

Definition of Terms

Dual Diagnosis:

The person with a Dual Diagnosis has the coexistence of a developmental disability and a psychiatric or emotional disturbance.

The implications of this kind of profile, when dealing with the police or other authoritarian figures are as follows:

- When asked questions, such individuals confess and plead guilty more often because they do not understand what they are being asked. In addition, their past experience usually shows that if one agrees with everything, people will eventually leave you alone.
- These persons plea bargain less often, because despite the explanation of the charges, they are still unsure, thereby choosing the plea of guilty to avoid more questions.
- They are defended by court appointed counsel more often, as most persons with a dual diagnosis receive Ontario Disability Support Program (ODSP) or Ontario Works, leaving them little funds to hire a lawyer.
- Fewer appeals are made as they find this process very complex.
- They serve longer sentences, and are denied parole more often.
- They receive less time off for good behaviour (often because of the extreme victimization to which they are subjected in the penal/correctional system).

Despite these factors, it is interesting that an offender's developmental disability cannot be introduced as a mitigating factor in the judicial proceedings, unless the individual is identified as such. This "official identification", verified by a psychiatric or psychological assessment, is being seen less frequently due to the educational system's reluctance to identify and "label" individuals. There is also less financial support to pay for the expensive process of analysis

and identification. Although numerous people appear to have a dual diagnosis, very few have been formally assessed.

Developmental Disability:

People with developmental disabilities have intellectual and adaptive skill limitations substantially below others of their age and often require support in many areas of everyday living. A developmental disability is generally a life-long condition with an onset before 18 years of age. Typically, a person with a developmental disability has intellectual deficits as well as limitations in two or more of these areas:

- Communication
- Health and safety
- Social skills
- Learning skills
- Leisure
- Personal hygiene and dressing
- Independent living
- Use of community resources
- Work

- **Generalization and abstraction of common information**: The person is unable to take the information that he/she has already learned in one situation and adapt it to another situation.
- **Communication impairment**: The range of problems includes, for example, auditory comprehension difficulties that make it harder to process information, as well as to communicate. Language deficits further impede effective communication. These deficits could be in expressive language skills which will be limited by immature speech and word retrieval problems. In terms of receptive language, a person may not understand what is being said to them because a sentence is too long, or the words are too abstract or contain idiosyncratic terms.
- Individuals with a developmental disability are **concrete and absolute thinkers**. They see situations in "black or white" terms. They do not understand the "gray" areas such as the range of emotions.

- They are **immediate and dependent thinkers**, who are set in "the here and now", and poorly integrate past experiences, making it difficult to solve current problems. They must use environmental cues which are immediately available to them. These factors contribute to their poor problem solving skills, and would also explain why they are vulnerable to abuse.
- Individuals may reflect a common theme of **insecurity and a high level of dependency.** Often rejected by the world, they experience anxiety about safety and separation and are thereby defensive and protective about their own feelings. This is part of the reason why these individuals have a difficult time building personal relationships and this may show up in argumentative or reactive behaviours.
- People with a developmental disability typically have a very **low tolerance level for stress and change,** and their coping skills are poor.
- "**Diagnostic Overshadowing**" can lead to misdiagnosis by professionals attributing behaviour difficulties or mental health problems to the diagnosis of developmental disability and not investigating other etiologies.
- A **"Cloak of Competence"** can sometimes confuse diagnosis, with splinter skills in one area masking a lack of competence in another. "Cloak of Competence" can make it appear that the person understands more than he/she really does: in fact, it could in this way even mask a developmental disability. For example, questions may be evaded or answered in the positive. The individual's verbal skills may suggest someone who has fairly normal functioning, when in fact these skills are just a highly developed technique of coping, and the individual in fact has very little understanding of the presenting issues.
- **"Splinter Skills"** are a variation of this phenomenon, with a person being extremely skilled in one specialized area. An example of this is the character which Dustin Hoffman played in the movie, 'Rainman'. The character was dually diagnosed, however he retained a genius-like ability to identify number sequencing. People will use their strengths or "splinter skills" to mask their denial of their developmental disability.
- Individuals are **suggestible** when questioned and commonly **acquiesce** when in a situation that may be frightening, confusing to understand, or above their level of competence.

{Clinical bulletin of the Developmental Disabilities Program Dual Diagnosis: defining the dynamics and determining the dimensions.}

{Luckason, R., Coulter, D., Pollowas, E.A., Reiss, S., (2002) Mental Retardation: Definitions, Classification, and Systems of Supports. 10th Edition}.

It is important to include adaptive functioning levels in addition to the IQ level when describing people with a developmental disability as two individuals with identical intellectual quotient scores may be quite different in terms of their social functioning and behaviour.

{Tudiver, J., Broekstra, S., Josselyn, S., Barberee, H., Addressing the Needs of Developmentally Delayed Sex Offenders}.

Psychiatric/Mental Illness:

- Mental illness is an acute or chronic psychiatric condition that affects thoughts and/or emotions.
- It can occur at any age and has nothing to do with intelligence.
- Mental illness conditions include Schizophrenia, Depression, Bi-Polar Disorder, Borderline Personality Disorder, Obsessive Compulsive Disorder, and Fear/Anxiety/Panic Attacks.

Please refer to the section titled Conditions for more details regarding these diagnoses in a person with a developmental disability.

Common Myths/Assumptions

#1 Persons with a developmental disability are often viewed as either impulsive or childlike.

These people are not children in adult bodies. They have many life experiences, but may misinterpret those experiences. Denying or minimizing the impact of the offensive behaviour effectively removes the consequences for his/her actions and robs the individual of the chance to learn a more appropriate behaviour.

#2 Persons with a developmental disability engage in sexual behaviour with children because they see them as their intellectual equal.

This is a dangerous myth. The person with a developmental disability who sexually offends against children should be held accountable for his/her offending behaviour, thus allowing them to change the offending behaviour and decrease the risk to the community.

#3 Most people with a developmental disability are unable to understand right from wrong.

The person with a developmental disability sees things as either right or wrong, and lacks judgment and inter-personal skills to effectively deal with grey areas. Understanding these behaviours will assist the individual to change the behaviour and enhance their ability to integrate into the community. By understanding the underlying causes, we can assist the person to change the behaviour.

System Generalizations

Generalizations about the system for persons with developmental disabilities:

- Persons with disabilities feel a greater impact from any labels which they may receive as they are very reliant on the social system.
- Persons with a developmental disability, because of their limited communication skills, are more predisposed to bias responding – answering affirmative or negative, given the demand of the question. They may acquiesce to leading questions.
- They may be reluctant to disclose that some questions are beyond their ability or knowledge (comprehension).
- They may have difficulty processing large chunks of information. Hence, information must be presented in smaller pieces and repeated several times.
- They may assume blame in an attempt to please the questioner.
- They may believe their innocence is transparent to the questioner.

To help minimize the intellectual challenges identified above, the following strategies may be useful:

- Speak slowly and face the individual.
- Use short sentences of 3-6 words.
- Allow time for processing the information (5 second pause).
- Use body language as much as possible.
- Ask questions in a very neutral fashion.
- Avoid using abstract phrases, i.e. phrases such as “keep cool”, “hang in there!”, which can be very confusing.
- Be clear, rephrase questions, repeat statements, modify your vocabulary.
- Use pictures or written information to supplement verbal instructions.

- These persons may have difficulty distinguishing fact from fiction, and may report or confess to actions that they have never taken.

Investigation of Offences

With limited social skills and ability to understand abstract ideas, many of the “innocent” actions of the developmentally disabled person may be misinterpreted as illegal.

It is often difficult to distinguish between sexually inappropriate behaviour and sexually deviant behaviour. Behaviours such as public exposure, inappropriate touching, and even sexual assault may NOT reflect deviant arousal, but arise from living in a system in which appropriate sexual knowledge and relationships are not supported. Counterfeit deviance is the term used to describe behaviour which topographically is deviant, but which upon investigation is a result of some other unidentified factor.

{Hingsburger, D.H., Griffiths, D. Detecting Counterfeit Deviance. Differentiating sexual deviance from sexual inappropriateness. Habilitative Mental Healthcare. Newsletter, 1991; 10:51-54}

An incident arose in which a developmentally disabled individual was charged with multiple sexual offences related to exposing himself to children in a park on a number of occasions. Upon closer examination, however, it was revealed that the daily routine of the accused included being picked up by a worker at a park near the end of the day. Unable to wait to get home, the accused would urinate in the park as he waited for his ride to come along.

It is important to note, that not all sexual behaviours manifested by developmentally disabled individuals are as benign.

The Need for a Consistent Approach

When law enforcement personnel are called to a scene to deal with an individual who has a mental health problem/dual diagnosis, it is important that every police officer be consistent in their approach each time.

Police officers view their interactions with each individual as an investment, not only because they will gain knowledge from such an experience but also because it will make it easier the next time they are called to deal with a similar situation.

Reinforce the client for trusting you (the officer), to follow through on what you have communicated to them. An individual may lose trust in officers and thereby make it all that much more difficult for another officer who has to deal with the same individual the next time.

Vulnerabilities In The Criminal Justice System

When a person with developmental disabilities enters the criminal justice system, multiple challenges and vulnerabilities become apparent. Some are obvious but most relate to the person's understanding of their rights and the legal process.

It has been found that due to their cognitive deficits, persons with developmental disabilities have difficulty in understanding their legal rights, especially in written form. Studies have shown individuals misunderstand basic legal terms such as 'guilty' and 'not guilty', and presume that their innocence is transparent.

Some such individuals appear to be verbally competent despite underlying comprehension difficulties (sometimes referred to as a 'cloak of competence') and therefore their level of understanding may be overestimated.

This superficial social ability causes problems for police at the initial stages when they have to actually 'identify' someone with a developmental disability and mental health problem.

When individuals are charged, there is an assumption of fitness to stand trial unless the issue of fitness is raised.

- Fitness deals with the **current** mental state of the accused**.**
- "Not Criminally Responsible" (NCR) deals with the mental state of the accused **at the time of the offence.**

When persons with developmental disabilities are assessed, difficulties arise due to the definitional criteria used in mental health assessments. Fitness assessments measure an individual's ability to:

(a) understand the nature and object of the proceedings
(b) understand the possible consequences of the proceedings, or
(c) communicate with counsel

When individuals with developmental disabilities are found unfit they can be kept for an indefinite amount of time in the forensic health

system due to the issue of treatment response and foreseen ability to return to court for sentencing.

Criteria for fitness assessments and potential treatment used with mentally disordered offenders does not successfully apply to persons with developmental disabilities due to the chronic nature of their difficulties and life long support needs.

Conditions

Persons with a developmental disability can experience any or all of the same mental health conditions that are experienced by the general population. Listed below, are some of the more common conditions and their presenting characteristics.

1) CONDITION: SCHIZOPHRENIA

SYMPTOMS ACCORDING TO DSM IV:

- May hear voices
- Delusions (e.g. in the form of persecution "someone is after me, they are going to kill me!")
- Incoherent speech, paranoia (distrust, fear, suspicion), and hallucinations which are convincing and disturbing to the individual
- Emotional state is not consistent with the ideas they are expressing (e.g. they may say they are sad yet they are laughing)
- Bizarre behaviour (e.g. catatonic state or overly excited)

DUAL DIAGNOSIS (WHAT IT MAY LOOK LIKE):

- Diminished self-care skills
- Aggressive behaviour
- Uncontrolled yelling
- Difficulty dealing with other people
- Labile affect (laugh or cry at inappropriate times)
- Behaviour indicating new fears or suspicion of others
- Talking to non-existent people or to objects
- Regression in language skills
- Appearance of new, unusual mannerisms
- Quick glances or movements as if looking at something
- Complaints of strange smells (e.g. something burning, smell of moth balls)
- Insecurity will manifest itself by statements such as, "Are you here to take me back to jail/institution, etc."
- Denying or admitting guilt related to delusional thoughts (eg. "I killed him", "I burned that house" but the events didn't occur)

- May have been prescribed anti-psychotic medication(s).

PROPOSED STRATEGIES:

- Tell the person you are there to help them
- Remain as calm as possible
- Decrease other distractions (turn off radio, TV)
- Only one person should do the communicating
- Speak slowly, clearly and in a low calm voice
- Acknowledge their fear or delusion
- Ask them what is making them afraid, angry or confused
- Ask them what helps them calm down
- Present a neutral stance (but to be safe use an L stance) i.e. no crossed arms, no arms behind the back
- Ask them if they have a doctor whom you could contact
- Use resources necessary to get them to respond i.e. a family member/care giver, etc., as these people know them best

CAUTION:

- DO NOT stand over the person or get too close
- DO NOT use patronizing or authoritative statements such as, “You’re being foolish”, or “You’ll do as I say”.
- DO NOT shout
- DO NOT criticize
- DO NOT challenge the individual
- DO NOT get into a power struggle with the individual
- DO NOT invade their personal space - stand a leg length away (note: this may change when dealing with a different gender or a different culture)
- AVOID making continuous eye contact

2) CONDITION: DEPRESSION

SYMPTOMS ACCORDING TO DSM IV:

- Feelings of despair
- Continued fatigue/loss of energy
- On-going sleep disturbance
- Withdrawn, lacking in enthusiasm, lacking feeling of enjoyment
- Sadness and crying for no apparent reason
- Inability to concentrate or make decisions
- Thoughts of suicide
- Suicide attempts

DUAL DIAGNOSIS (WHAT IT MAY LOOK LIKE):

- Increased aggression
- Destructive to property
- Restlessness
- Increase in self injurious behaviour
- Spending more time alone away from other people
- Lack of interest in favourite activities, or people
- Spontaneous crying
- Refusal of meals or disruption at meal time
- Fearfulness
- Changes in sleep patterns
- Reported weight changes: either loss or gain, but it is quite significant
- May be taking antidepressant medication(s) or a mood stabilizer such as lithium carbonate.

PROPOSED STRATEGIES

- Tell the person you are there to help them
- Get them to a safe environment. If possible engineer the environment if they are in any danger eg. remove glass vases, etc.
- Ask them what they found has helped them calm down (music/relaxation)
- Be concrete when communicating
- Elicit communication if possible, and listen empathetically to what is being said

- One person should do the communicating
- Get family member/caregiver to call the family doctor or their psychiatrist in order to obtain information as to what will help the individual to calm
- Set limits
- Take them to help if not willing to go on their own

CAUTION:

- If suicidal ideation occurs DO NOT LEAVE THE PERSON UNATTENDED
- Direct them to appropriate help eg. Hospital crisis service

3) CONDITION: BI-POLAR DISORDER (MANIC DEPRESSIVE)

NOTE: It is a manic episode which will be of concern

SYMPTOMS ACCORDING TO DSM IV:

- Increased anxiety
- Sleep problems (too little)
- Overly interested in interacting with people
- Change in eating habits
- Extreme irritability
- Increased sexual drive
- Suicidal and occasional homicidal thoughts
- Racing thoughts and/or flight of ideas
- Poor judgment (eg. overspending, substance abuse).
- Grandiosity and/or paranoid delusions

DUAL DIAGNOSIS (WHAT IT MAY LOOK LIKE):

- Self-injurious behaviour associated with irritability
- Increased distractibility
- Inflated self-esteem or grandiosity
- Increased swearing
- Repetitive speech may or may not be present
- Refusal to cooperate
- Easily provoked to scream, swear
- Teasing others
- Suicide attempts
- Use of medications such as antidepressants, anti-psychotic medications or mood stabilizers.
- Public masturbation
- Decreased need to sleep
- Disorganized speech
- Pacing and restlessness
- Agitation leading to aggression
- Want their needs met immediately

PROPOSED STRATEGIES:

- Decrease demands and expectations during their episodes
- Keep out of their personal space during these difficult times

- Set limits
- Reduce stimuli if possible
- Stay calm
- Speak to the person in a CALM voice
- Try to get them to tell you who their doctor is, as the doctor will be a good resource for how to handle this person

CAUTION:

- DO NOT become confrontational
- DO NOT get into a power struggle with the individual
- DO NOT shout at the individual

NOTE:

For each of the above categories, i.e. schizophrenia, depression and bipolar, a history of being hospitalized for psychiatric treatment is often noted given the severity of the condition and (likely) the occasional need for an interval of inpatient care.

4) CONDITION: BORDERLINE PERSONALITY

SYMPTOMS ACCORDING TO DSM IV:

- Unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (eg. spending, binge eating, substance abuse)
- Recurrent suicidal behaviour, gestures, threats or self-mutilation
- Intense episodic irritability or anxiety, usually lasting a few hours
- Chronic feelings of emptiness
- Intense anger, or difficulty controlling anger (i.e. frequent displays of temper, recurring physical fights)
- Stress related paranoid ideation or severe dissociate symptoms
- Chronic disorder (has been in existence for quite some time)

DUAL DIAGNOSIS (WHAT IT MAY LOOK LIKE):

- Volatile nature of interpersonal relationships
- Impulsive, goal directed which could include drinking binges, stealing, etc.
- May use suicidal behaviours to gain attention
- Difficulty controlling angry feelings, usually takes the form of verbal tirades
- Constant unreasonable demands placed on people around them, and becomes hysterical or threatening if demands are not met
- Limited understanding of lethal nature of their behaviour (specifically when threatening to commit suicide or other self-destructive action).

PROPOSED STRATEGIES:

- Set limits
- Establish firm boundaries
- Make statements to the individual letting them know that they are not well, and you could assist them at getting the necessary help
- Ensure that they get help
- Be scrupulously consistent in following through on promises you make

CAUTION:

- DO NOT discuss or feed into their obsessive topics of conversation, as it may escalate and prolong their behaviour
- DO NOT respond to their attempts to block the process
- DO NOT take their behaviour as personal

5) CONDITION: OBSESSIVE COMPULSIVE DISORDER

SYMPTOMS ACCORDING TO DSM IV:

- Repetitive physical behaviours (such as hand washing, putting things in order, and checking)
- Repetitive mental behaviours or thoughts (such as praying, counting, and repeating words)
- Strong need for routine

DUAL DIAGNOSIS (WHAT IT MAY LOOK LIKE):

- Persistent focus and persistence on same topic
- The person may or may not recognize these behaviours as excessive
- May become aggressive with people who interfere with their ritualistic behaviours
- Ritualistic pacing, repeatedly closing of drawers or doors
- Insisting on absolute sameness
- Anxiety-like symptoms

PROPOSED STRATEGIES:

- Tell the person you are there to help them
- Understand that compulsions are hard to stop
- Be aware that the use of compulsive behaviours are tools for reducing anxiety associated with obsessions
- Ask the individual what is upsetting them, as this could be something which can easily be altered and may help diffuse the situation (eg. it could be something as simple as a personal belonging being out of place)
- Ignore repetitive actions, words or activities
- Use transitional statements like “Okay, you can do it/say it one more time and then it is time to go into the car”.
- Try to get people to the scene who know the individual best, as they may know what the root of the problem is
- Recognize the person’s frustration
- Try to get them to do simple relaxation exercises such as deep breathing
- Wait out their compulsions
- Environmental changes will sometimes help to alleviate compulsions

Obsessional symptomatology is often seen in individuals with autism spectrum disorder including Asperger's Syndrome. Serotonin-enhancing drugs are often prescribed and may be a further clue to the possibility of OCE/Autism Spectrum Disorders.

CAUTION:

- DO NOT participate in their obsessive-compulsive behaviours
- DO NOT try to talk them out of their compulsions
- DO NOT suggest other things they could obsess over (eg. if they are counting cars, don't ask them to count trees) as this will just enhance the problem

6) CONDITION: FEAR/ANXIETY

(includes panic attacks, agoraphobia – fear of being in places where help might not be available, typically fear of crowds, bridges or of being outside alone)

Definition: A discrete period or discomfort in which there are four or more of the listed symptoms displayed.

SYMPTOMS ACCORDING TO DSM IV:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Feelings of unreality or depersonalization (being detached from oneself)
- Fear of losing control or going crazy
- Fear of dying
- Numbness or tingling sensations
- Chills or hot flashes

DUAL DIAGNOSIS (WHAT IT MAY LOOK LIKE):

- Continuous body movements (eg. rocking back and forth, rubbing hands together)
- Usually related to Post Traumatic Stress (eg. physical/ sexual/emotional abuse or neglect)
- Aggression
- Self injurious behaviour
- Destruction of property
- Hyperventilation

PROPOSED STRATEGIES:

- Tell the person you are there to help them
- Explain the situation as a positive experience

- It may be useful to attempt to have the individual identify the cause of their fear and anxiety
- It may be useful to encourage the individual to communicate what the root of their fear/anxiety may be
- Get them to take deep breaths as this could have been one of the coping skills taught to them
- Try to label what they are experiencing, eg. “you look afraid, that must feel awful, we are here to help”.
- Useful to reassure the person that even though they are frightened, nothing is going to physically happen to them
- May be prescribed anti-anxiety medication(s).

CAUTION:

- DO NOT take lightly the extent of their fear and anxiety
- DO NOT go into a panic yourself – REMAIN CALM as you are the role model for calming behaviour

Appendix 1

Mental Health Court Diversion Services Services Include: Diversion, Consultation and Education

Diversion

Diversion is defined as a pre-trial procedure where crown attorneys can, at their discretion, decide not to prosecute when the charge is a minor offense, and major illness is determined as the underlying cause. Instead, the accused is referred to appropriate mental health services in the community, professional treatment and support to reduce the chances of re-offending.

Who is the Program For?

This service is for people who:

- Are 16 years of age or older
- Are charged with a minor offense that has an underlying cause of mental illness
- Have their case proceeding through the Ontario Court of Justice
- Demonstrate commitment to recommended treatment (i.e. medication, psychosocial rehabilitation, etc.)
- Agree to participate in mental health diversion
- Do not pose a significant risk to the community

Referrals

Anyone may make a referral – the accused, family, friends, police, defense counsel, community agencies, etc.

Process

A provincial crown attorney must approve the individual service plan in order to proceed with diversion. The mental health court worker will meet with the diversion candidate to assess his or her suitability for diversion. The assessment will include the individual’s mental health status and current living situation, as well as the availability of appropriate supports and services.

The mental health court support worker will work with the candidate to develop an individual service plan. The plan will outline the treatments and services the individual will be expected to utilize.

Once accepted into the diversion program, the crown attorney may elect to stay criminal charges.

Consultation and Education

These services provide:

- Support and information to the accused and the family
- Information on mental illness and community services to the criminal justice system
- Education on court processes and procedures to other service providers
- Referral to service providers for mental health support and appropriate assessment

Appendix 2
Province of Ontario
Ministry of Attorney General

CROWN POLICY MANUAL

March 21, 2005

Mentally Disordered/Developmentally Disabled Offenders

Principles

Mentally disordered or developmentally disordered people often come into contact with the criminal justice system. These offenders should not be subjected to more onerous consequences than the general population, solely as a function of their disorder/disability.

In recognition of their particular circumstances, mentally disordered or developmentally delayed offenders may warrant special consideration within the criminal justice system, depending on the nature and circumstances of the offence and the background of the offender. This may require an emphasis on restorative and remedial measures, such as specialized treatment options, supervisory programs or community justice programs, as alternatives to prosecution. To the extent consistent with public safety, and in appropriate circumstances, offenders with mental disorders, and those who are developmentally delayed, should be given access to alternatives to prosecution.

Protection of the public, including the victim, if any, is the paramount consideration in the assessment of whether alternatives to prosecution are appropriate. No single factor will be determinative; however Crown counsel should consider the seriousness of the offence, public safety, and whether the consequences of prosecution would be unduly harsh, among other factors.

Appendix 3
Province of Ontario
Ministry of Attorney General

CROWN POLICY MANUAL

March 21, 2005

COMMUNITY JUSTICE

PRINCIPLES

For the purpose of this document, community justice provides for the resolution of some types of criminal justice using resources outside the formal justice system. Community justice processes can supplement or entirely replace the procedures of the formal criminal justice system in some cases including, but not limited to, those involving mentally disordered and/or developmentally disabled offenders.

In many locations across Ontario, community justice programs have been established. These programs offer alternative means of resolving criminal matters that do not require formal adjudication in the court system. The Ministry of the Attorney General endorses community justice programs and encourages and supports Crown Attorneys offices to participate in developing community justice processes to address local needs and conditions.

When, properly resourced and implemented, community justice programs can help fulfill community and individual needs to:

- More actively participate in the justice process
- Accelerate just results
- Promote a sense of community safety
- Encourage concrete action aimed at preventing future offending behaviour
- Allow victims to have meaningful participation in the justice process with safety and dignity
- Encourage offenders to accept responsibility for their actions
- Offer victims reparation for the harm they have suffered

A justice system open to the use of these complementary programs should allow quicker resolution of offences, permitting the courts, Crown Attorneys offices, and police services use their resources effectively.

Crown Attorneys offices are encouraged to cooperate in enabling the development of local community justice processes that suit their communities. As the needs and community resources of jurisdictions vary, it is not possible to provide a standard model for all communities. In particular, eligibility criteria for referrals to community justice programs may vary among programs and communities. Generally speaking, however, crimes involving violence, other than minor, non-spouse/partner offences, will not be eligible for community justice as an alternative to adjudication.

APPENDIX 4

SERVICES AVAILABLE IN NORTHEAST FOR PEOPLE WITH DUAL DIAGNOSIS

A) Dual Diagnosis Justice Case Managers
B) Regional Forensic Program
C) Northern Network of Specialized Care
D) Developmental Disabilities Program
E) Service Entry, Adult Developmental Services

A) DUAL DIAGNOSIS JUSTICE CASE MANAGEMENT PROGRAMS

Purpose: Dual Diagnosis Justice Case Managers assist court support workers and discharge planners in the appropriate transitional case management of persons with a dual diagnosis in conflict with the law. They establish collaborative contacts with community-based services to divert these people to services in the community including developmental (funded by the Ministry of Community and Social Services) and mental health (funded by Local Health Integration Networks) resources and services.

In collaboration with caregivers, developmental services and mental health providers, members of the justice system, other community based services, and key individuals, the Dual Diagnosis Justice Case Managers identify, inform and facilitate the development of a plan that will address the person's mental health needs and community support needs at key intervention points in the judicial process with the aim of minimizing the person's involvement in the criminal justice system.

PROGRAM LOCATIONS

Sault Ste. Marie
Canadian Mental Health Association – SSM Branch
386 Queen Street East
Sault Ste. Marie, ON P6A Z1
Phone: (705) 759-0458
Fax : (705) 945-0261

Sudbury
Sudbury Community Service Centre
1166 Roy Avenue
Sudbury, ON P3A 3M6
Phone: (705) 560-0430
TOLL FREE 1-800-685-1521
Fax: (705) 560-0440

Muskoka/Parry Sound
Muskoka-Parry Sound Community Mental Health Services
173 – 202 Manitoba Street
Bracebridge, ON P1L 1S3
Phone: (705) 645-2262
Fax: (705) 645-7473

Timmins/Cochrane/Timiskaming
Canadian Mental Health Association – Cochrane – Timiskaming Branch
210 – 330 Second Avenue
Timmins, ON P4N 8A4
Phone: (705) 267-8100
Fax: (705) 268-9742

B) REGIONAL FORENSIC PROGRAM

Purpose:
The forensic program provides specialized mental health services to the criminal justice system and people with mental illness who are involved in the legal system. Referrals to the program are ordered by the courts.

Clients may require assessments and/or treatment and rehabilitation. Court-ordered assessments include fitness to stand trial and/or criminal responsibility. Fitness to stand trial relates to a person's mental capacity to understand the nature, object or consequences of what happens in court or communicate and instruct a lawyer. Criminal responsibility relates to an individual's mental capacity at the time of the offence and appreciation of the nature or quality of the act and knowing that it is wrong. Clients admitted to the program may also be on a disposition order of the Ontario Review Board after having been found unfit to stand trial or not criminally responsible.

Services are individualized, focused on recovery and community reintegration, and provided by a multidisciplinary team. They include inpatient and outreach services.

All Catchment Areas in Northeast :

Northeast Mental Health Centre
North Bay Campus
P.O. Box 3010, Hwy 11 North
North Bay, ON P1B 8L1
Phone: (705) 474-1200 ext. 7833
Fax: (705) 495-7814
Email: info.forensic@nemhc.on.ca

C) NORTH COMMUNITY NETWORK OF SPECIALIZED CARE: SPECIALIZED SERVICE PROVIDERS – CLINICAL TEAMS

Purpose: The role of the member agencies of the North Community Network of Specialized Care is to coordinate specialized services for people with a developmental disability and mental illness or with behavioural challenges who need extra support to participate in the community and enjoy a meaningful quality of life. These services include day treatment, crisis response, in-patient hospital treatment, case management, community-based clinical services and specialized residential accommodation. Services are provided by qualified agencies and health professionals and are designed to treat a person's physical, mental, and social health.

The website for the North Community Network is **www.community-networks.ca**

Muskoka/Parry Sound
Hands TheFamilyHelpNetwork.ca
23 Ball's Drive
Bracebridge, ON P1L 1T1
Phone: (705) 645-7378 ext. 230
Fax: (705) 645-7988
Service area: Muskoka/Parry Sound
Website: **www.thefamilyhelpnetwork.ca**

* Note: Hands-TheFamilyHelpNetwork.ca is also the lead agency for the Northern Network of Specialized Care

Sault Ste. Marie
Community Living Algoma
421 Bay Street
Sault Ste. Marie, ON P6A 1X3
Phone: (705) 253- 1700
Fax: (705) 253-1777
Service area : District of Algoma

Sudbury/Manitoulin
Hôpital Régional de Sudbury Regional Hospital
Developmental Clinical Services -
Community Mental Health Programs
127 Cedar Street
Sudbury, ON P3E 1B1
Phone: (705) 675-5900
Fax: (705) 669-1499
Service area: Districts of Sudbury/Manitoulin

North Bay
Community Living North Bay
161 Main Street East
North Bay, ON P1B 1A9
Phone: (705) 476-3288 ext. 236
Fax: (705) 476-4788
Service Area: District of Nipissing

Community Living West Nipissing
75 Railway Street
Sturgeon Falls, ON P2B 3A1
Phone: (705) 753-1665
Fax: (705) 753-2482
Service area: Town of Sturgeon Falls

Timmins/Cochrane/Temiskaming
Cochrane Temiskaming Resource Centre
600 Toke Street
Timmins, ON P4N 6W1
Phone: (705) 267-8181 ext. 231
Fax: (705) 264-4255
Service area: Cochrane/Temiskaming Districts

Developmental Disabilities Service (DDS)

The Developmental Disabilities Service is a component of the Northeast Mental Health Centre's Regional Specialized Mental Health Program and one of its outreach services. The service provides community-based psychiatric assessment, consultation and treatment for adults with developmental disabilities and mental health needs (dual diagnosis) residing in the hospital's catchment area.

The service's clinical team works collaboratively with clients, families, family doctors, and community-based multidisciplinary teams most commonly located in the client's place of residence. The core team in North Bay works in conjunction with community-based mental health clinicians located in key districts throughout the region. DDS clinicians are currently hosted in the following community-based agencies: Canadian Mental Health Association Cochrane Timiskaming, Timiskaming Health Unit, Canadian Mental Health Association Sault Ste. Marie, Muskoka-Parry Sound Community Mental Health Services, and Community Mental Health Association Nipissing. Care is provided from a bio-psycho-social perspective utilizing recovery oriented principles. The provision of psychiatric care is offered on the basis of individual needs, informed consent, and/or substitute decision making.

Services offered include community-based psychiatric assessment, consultation, and treatment for people with a dual diagnosis, as well as education, advocacy, and research.

The criteria for consultations is as follows:

1. person is 16 years of age or older, and
2. is being referred for a diagnostic assessment or review of medication/treatment plans and,
3. has a recognized developmental disability of a mild to profound severity and exhibits behaviours that may be attributable to a mental illness, OR may have a diagnosis within the autism spectrum disorders and is not adequately supported by local generic mental health services.

4. individuals will not be assessed without consent from his/her substitute decision maker and,

5. if there is a primary physician/psychiatrist, he or she must provide a written referral.

Contact Information:

Developmental Disabilities Services
Northeast Mental Health Centre – North Bay Campus
P.O. Box 3010, Hwy 11 North
North Bay, Ontario P1B 8L1
Phone: (705) 494-3180
Fax: (705) 494-3189
Email: info.dds@nemhc.on.ca
Website: www.nemhc.on.ca/programs-services/regional-specialized/developmental-disabilities-e.aspx

D) SERVICE ENTRY, ADULT DEVELOPMENTAL SERVICES

Purpose: Service entry is an individual or family's first point of contact with the formal ministry-funded adult developmental services system. Several models of service entry are used throughout the province, from independent access centres that only do this particular function, to collaborative multi-site entry points that offer service entry and also deliver services.

At service entry, the individual can receive information about the funded services in his/her community; can be assessed to determine eligibility for these services; and can begin planning to identify his or her service needs and the urgency that those needs be met. Where it is appropriate to do so, referrals are made to community services that may better meet the individual's needs.

The service entry sites for adult developmental services in the catchment area are as follows:

District of Algoma

Community Living Algoma
421 Bay Street, 3rd Floor
Sault Ste. Marie, ON P6A 1X3
Phone: (705) 253-1700
TOLL FREE 1-800-448-8097
Fax: (705) 253-1777
Service area: District of Algoma
Website: www.communitylivingalgoma.org

Districts of Sudbury/Manitoulin

Service Coordination Program
YWCA Sudbury
370 St. Raphael Street
Sudbury, ON P3B 4K7
Phone: (705) 673-4754
Fax: (705) 688-1727
Service area: Districts of Sudbury and Manitoulin
Website: www.ywcasudbury.ca

The North East Region has multi-point entry to funded services:

Nipissing/Parry Sound/Muskoka

Hands TheFamilyHelpNetwork.ca
222 Main Street
North Bay, ON P1B 1B1
Phone: (705) 476-2293 North Bay
(705) 746-4293 Parry Sound
(705) 384-5225 Sudridge
(705) 645-3155 Bracebridge
Fax: (705) 495-1373 North Bay
(705) 746-7600 Parry Sound
(705) 384-5808 Sudridge
(705) 645-7988 Bracebridge

Almaguin Highlands Community Living
78 Ontario Street
Sundridge, ON P0A 1Z0
Phone: (705) 384-5384
Fax: (705) 384-7695

Christian Horizons
114A Main Street East
Huntsville, ON P1H 1K6
Phone: (705) 789-1725
Fax: (705) 789-7042

Community Counselling Centre Nipissing
361 McIntyre Street East
North Bay, ON P1B 1C9
Phone: (705) 472-6515
Fax: (705) 472-4582

Community Living Huntsville
50 King William Street, Unit 2
Huntsville, ON P1H 1G3
Phone: (705) 789-4543
Fax: (705) 789-0752

L'Arche North Bay
590 Wyld Street
North Bay, ON P1B 1Z7
Phone: (705) 474-0081
Fax: (705) 497-3447

Community Living Mattawa
250 Tenth Street
Mattawa, ON P0H 1V0
Phone: (705) 744-2979
Fax: (705) 744-5693

Community Living North Bay
161 Main Street East
North Bay, ON P1B 1A9
Phone: (705) 476-3288
Fax: (705) 476-4788

Community Living Parry Sound
38 Joseph Street
Parry Sound, ON P1L 0A1
Phone: (705) 476-9330
Fax: (705) 746-6151

Community Living South Muskoka
15 Depot Drive
Bracebridge, ON P1L 0A1
Phone: (705) 645-5494
Fax: (705) 645-4621

Community Living West Nipissing
Intégration Communautaire de Nipissing Ouest
75 Railway Street
Sturgeon Falls, ON P2B 3A1
Phone: (705) 753-1665
Fax: (705) 753-2482

Muskoka-Parry Sound Community Mental Health Services
173 – 202 Manitoba Street
Bracebridge, ON P1L 1S3
Phone: (705) 645-2262
Fax: (705) 645-7473

Cochrane/Temiskaming Districts

Access Better Living Inc./Vie Independante et enrichie Inc.
733 Ross Avenue East
Timmins ON P4N 8S8
Phone: (705) 268-2240
Fax: (705) 268-2284

Cochrane Temiskaming Resource Centre
600 Toke Street
Timmins, ON P4N 6W1
Phone: (705) 267-8181
Fax: (705) 264-4255

Community Living Iroquois Falls
9 Veteran's Drive
Iroquois Falls, ON P0K 1E0
Phone: (705) 258-3971
Fax: (705) 258-3119

Community Living Kirkland Lake
51 Government Road West
Kirkland Lake, ON P2N 3H7
Phone: (705) 567-9331
Fax: (705) 567-5005

Community Living Temiskaming South
513 Amwell Street
Haileybury, ON P0J 1K0
Phone: (705) 672-2000
Fax: (705) 672-2722

Community Living Timmins Intégration Communautaire
166A Brousseau Avenue
Timmins, ON P4N 5Y4
Phone : (705) 268-8811
Fax : (705) 267-2011

Hearst and Area Association for Community Living
923 Edward Street
Hearst, ON P0L 1N0
Phone: (705) 362-5758
Fax: (705) 362-8093

Intégration Communautaire Cochrane Community Living
P.O. Box 2330
Cochrane, ON P0L 1C0
Phone : (705) 272-2999
Fax : (705) 272-4983

James Bay Association for Community Living
18 Fourth Street
Moosonee, ON P0L 1Y0
Phone: (705) 336-2378
Fax: (705) 336-2694

Kapuskasing and District Association for Community Living
12 Kimberly Drive
Kapuskasing, ON P5N 1L5
Phone: (705) 337-1417
Fax: (705) 337-6538

D) MENTAL HEALTH CRISIS SERVICES

Purpose: Mental Health Crisis Services serve as a crisis response to provide access to a range of services and supports on a 24/7 basis to individuals experiencing a mental health crisis, as well as support to families and caregivers.

PROGRAM LOCATIONS

Sault Ste. Marie

Crisis services sponsored by Sault Area Hospitals

- Provides 24-hour response for individuals who have a mental illness and/or their family members who are experiencing a crisis
- CONTACT NUMBER: (705) 759-3398 or toll free 1-800-721-0077

Sudbury

Hôpital Régional de Sudbury Regional Hospital
Crisis Intervention and Withdrawal Management Service
700 Paris Street
Sudbury, ON P3E 3B5

- Services provided on a 24/7 basis, 365 days per year
- Offers short term counseling services directed towards those who are unable to manage effectively as a result of personal problems including services to seriously mentally ill adults and to those experiencing acute psycho-social crisis.

CONTACT NUMBER: (705) 675-4760 or toll free 1-877-841-1101
Website: www.hrsrh.on.ca

Manitoulin Island

Manitoulin Crisis Response provided by Hôpital Régional de Sudbury Regional Hospital
To Access:
By phone Monday to Friday 8:30 am to 4:00 pm except statutory holidays call direct at (705) 368-0756 ext. 222
After Hours and on Weekends, phone Crisis Intervention and Withdrawal Service in Sudbury at phone number listed above or toll free at 1-877-841-1101

In person: Attend one of two emergency departments:
Little Current – 11 Meredith Street (phone (705- 368-2300)
Mindemoya – Hwy 55, Mindemoya (Phone 705-377-5311)
Note: Friday, Saturday, and Sunday evenings crisis staff are on-call at Sudbury Regional Hospital from 6:00 pm to 10:00 pm and will only be dispatched to the Emergency Departments in Little Current or Mindemoya if called in by Emergency Staff or Crisis Intervention Program

Cochrane/Timiskaming

Cochrane Timiskaming Resource Centre
600 Toke Street
Timmins, ON P4N 6W1

- CTRC Psychology Dept. offers behaviour supports (assessment and treatment) to adults and children with a dual diagnosis in the districts of Cochrane and Timiskaming.
- The Psychology Dept. works closely with the Developmental Disabilities Service (based in North Bay) for psychiatric support and is also a member of the Dual Diagnosis Community of Practice, an association of agencies and practitioners who meet regularly via video conference to discuss current issues and trends in the field.
- A component of the Psychology Department offers intensive behaviour services, often for clients in crisis. Although not a 24-hour service, this service can be accessed without lengthy wait times.

CONTACT NUMBER: (705) 267-8181

Timmins/Timiskaming Shores/Kirkland Lake

CMHA Cochrane Timiskaming Branch

- crisis service operated for Timmins area
- phone intervention and walk-in service available
- program operates Monday to Friday 8:30am to 4:30pm
- calls received after 4:30pm are redirected to a crisis line jointly supported by CMHA and the local hospital and located at the hospital in-patient mental health unit

CONTACT NUMBERS:
Timmins (705) 267-8100 ext. 2233
Kirkland Lake (705) 567-9596
Timiskaming Shores (705) 647-4444

After Hours Numbers:
Timmins Mental Health Crisis Phone Line (705) 264-3003
or TOLL FREE 1-800-340-3003
Timiskaming District: TOLL FREE 1-866-665-8888

NOTES