

Police & Mental Health

A Critical Review of Joint Police/Mental Health
Collaborations in Ontario

Provincial Human Services and Justice Coordinating Committee

January 2011



Acknowledgements

The Provincial Human Services and Justice Coordinating Committee (HSJCC) would like to thank the Local and Regional HSJCCs who participated in the HSJCC Police/Mental Health Survey.

The Provincial HSJCC would also like to express our kind appreciation to the following individuals for their assistance with this report:

Peter Aharan, St. Leonard's Society London and South West Regional HSJCC
Judy Alton, Ontario Provincial Police and Provincial HSJCC
Kim Burson, Lennox & Addington Addiction and Community Mental Health Services and L&A Local HSJCC
Annette Buzdygan, Algoma Treatment and Remand Centre and HKPR Regional HSJCC
Lisa Cameron, Ministry of the Attorney General and Provincial HSJCC
Jennifer Chambers, Empowerment Council, Centre for Addiction and Mental Health
Theresa Claxton, Ontario Association of Patient Councils
Trish Crawford, Elizabeth Fry Society Kingston
Jim Cyr, Ontario Shores Centre for Mental Health Sciences and Durham Regional HSJCC
Sharon Deally-Grzybowski, CMHA Grand River and Waterloo-Wellington Regional HSJCC
Michael Feindel, Ministry of the Attorney General
Curt Flanagan, Ministry of the Attorney General and Provincial HSJCC
Ryan Fritsch, Psychiatric Patient Advocate Office
Michelle Gold, Canadian Mental Health Association Ontario and resource to Provincial HSJCC
Annetta Golder, Algoma Treatment and Remand Centre
Robert Herman, Ontario Association of Chiefs of Police and Thunder Bay Police Services
Chris Higgins, Ministry of Health and Long-Term Care and Provincial HSJCC
Ron Hoffman, Ontario Police College
Vicky Huehn, Frontenac Community Mental Health Services and Provincial HSJCC
Liisa Leskowski, John Howard Society Thunder Bay and Thunder Bay Local HSJCC
Diana McDonnell, Lanark County Mental Health and Lanark County Local HSJCC
Paul McGary, Lakeridge Health Oshawa and Durham Regional HSJCC
Terry McGurk, COAST Hamilton and Hamilton Local HSJCC
Jennifer McVittie, Canadian Mental Health Association Ontario
Sheila Neuburger, Ontario Shores Centre for Mental Health Sciences
Ian Peer, Ontario Association of Chiefs of Police, London Police Services and Provincial HSJCC
Glenna Raymond, Ontario Hospital Association Mental Health and Addiction Provincial Leadership Council
Deb Sherman, Ontario Peer Development Institute
Allan Strong, Provincial Consumer Survivor LHIN Leads Network and Self-Help Alliance
Cinnamon Tousignant, CMHA Kawartha Lakes and HKPR Regional HSJCC
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For more information about the Provincial Human Services and Justice Coordinating Committee, and to access the full *Police & Mental Health* report, visit: www.hsjcc.on.ca

Police & Mental Health Report Highlights

This report presents the findings of the Provincial Human Services and Justice Coordinating Committee (HSJCC) project on police/mental health collaboration in Ontario. The document offers a provincial examination of issues related to police/mental health collaboration, and highlights successes and challenges of collaboration.

Information contained in this report was obtained through three methods: a document review, a survey of Local HSJCCs, and a series of key informant interviews. Three key questions are addressed:

- What legislation and policies impact on police/mental health collaboration?
- What types of police/mental health collaboration initiatives currently exist in Ontario?
- What are the issues related to police/mental health initiatives?

Part 1 of this report identifies issues relating to police/mental health collaboration that were raised during the key informant interviews, and Part 2 provides an overview of the HSJCC police/mental health survey findings. Part 3 provides extensive background information about the justice and mental health systems in Ontario. Innovative solutions that are being applied to enhance police/mental health collaboration in Ontario are profiled throughout.

Part 1 presents fifteen key issues relating to police/mental health collaboration:

1. Lack of comprehensive provincial policy for police/mental health collaboration
2. Increase in mental health diversion is needed
3. Lack of provincial standards for police/mental health education
4. Provincial guidelines for crisis intervention services should be monitored
5. Memorandums of understanding between hospitals and police services are needed
6. Lack of provincial protocol for sharing, collecting and disclosing client information
7. Provincial policy regarding the disclosure of mental health police records is needed
8. Lack of provincial policy regarding client transportation
9. Review of community treatment orders, Assertive Community Treatment Teams and safe bed programs is needed
10. Engaging multiple stakeholders is necessary to promote police/mental health collaboration
11. Shortage of funding and resources for police/mental health collaborations
12. Lack of mental health services in rural and northern communities
13. Anti-discrimination initiatives are needed to address mental health discrimination
14. Increased support is needed for vulnerable populations who face systemic barriers
15. Lack of Ontario-based research on police/mental health collaboration

Highlights from HSJCC Police/Mental Health Survey

- Response rate for this survey was **72%**
86% of survey respondents were from Local HSJCCs and 14% from Regional HSJCCs.
- **18%** of HSJCCs provide services to areas with a population of less than 100,000.
- **29%** of HSJCCs have a mobile crisis intervention team in their area.
- **43%** of HSJCCs have crisis intervention team officers in their area.
- **61%** of HSJCCs have formalized partnerships with police services.
- **79%** of HSJCCs are involved in police/mental health education and training.
- **43%** of HSJCCs are involved with policy development in the area of justice and mental health.
- **25%** of police/mental health collaborations are funded by the Ministry of Health and Long-Term Care and/or Local Health Integration Networks.
- **32%** of police/mental health collaborations are supported through HSJCCs.
- **25%** of HSJCCs have conducted formal evaluations of their police/mental health programs.

Part 3 presents background information about the justice and mental health systems in Ontario:

- 3.1) Interface between the Criminal Justice and Mental Health Systems
- 3.2) Legislation and Policies that Impact Police/Mental Health Collaboration
- 3.3) Mental Health Diversion Policies
- 3.4) Overview of Mental Health Education and Training
- 3.5) Mental Health Crisis Response Initiatives
- 3.6) Police Encounters in the Hospital
- 3.7) Overview of the *Personal Health Information and Protection Act*
- 3.8) Mental Health Police Records
- 3.9) Innovative Solutions for Transporting Clients
- 3.10) Overview of Community Treatment Orders
- 3.11) Overview of Assertive Community Treatment Teams
- 3.12) Working with Marginalized Communities

For more information about the Provincial Human Services and Justice Coordinating Committee, and to access the full *Police & Mental Health* report, visit:

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Contents

Acknowledgements	ii
Police & Mental Health Report Highlights	iii
Contents	v
Project Background	1
Introduction	2
Purpose	2
Definitions	3
Limitations of Project	3
Part 1: Issues Relating to Police/Mental Health Collaboration	5
Part 2: Highlights from HSJCC Police/Mental Health Survey	12
Part 3: Background Information on the Justice and Mental Health Systems in Ontario	17
3.1) Interface between the Criminal Justice and Mental Health Systems	18
3.2) Legislation and Policies that Impact Police/Mental Health Collaboration	22
3.3) Mental Health Diversion Policies	27
3.4) Overview of Mental Health Education and Training	31
3.5) Mental Health Crisis Response Initiatives	34
3.6) Police Encounters in the Hospital	37
3.7) Overview of the <i>Personal Health Information and Protection Act</i>	39
3.8) Mental Health Police Records	42
3.9) Innovative Solutions for Transporting Clients	43
3.10) Overview of Community Treatment Orders	44
3.11) Overview of Assertive Community Treatment Teams	45
3.12) Working with Marginalized Communities	46
Appendices	
Appendix A: Provincial HSJCC Police/Mental Health Advisory Committee	47
Appendix B: HSJCC Police/Mental Health Survey	48
Appendix C: HSJCC Police/Mental Health Survey Respondents	50
End Notes	51
Bibliography	53

Project Background

Based on the *Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario*¹, the Human Services and Justice Coordinating Committees (HSJCCs) were established in response to a recognized need in the province to coordinate resources and services, and plan more effectively for people who are in conflict with the law. Priority consideration is for people with a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, and/or fetal alcohol syndrome.

The HSJCCs are a joint collaboration between the provincial Ministries of the Attorney General, Community and Social Services, Children and Youth Services, Health and Long-Term Care, and Community Safety and Correctional Services, as well as various health and social service, community mental health and addictions organizations across Ontario. All ministry representatives are ex-officio members of the HSJCCs.

The Regional HSJCCs coordinate communication and service integration planning among health, social services and criminal justice organizations within specific regions, and the Local HSJCCs provide input to these regional groups. Currently there are 14 Regional HSJCCs and 32 Local HSJCCs. The Provincial HSJCC, consisting of regional chairs and ex-officio ministry representatives, functions as a provincial planning body.

In October 2009, the Provincial HSJCC conducted a needs assessment of the Regional HSJCCs and created an inventory of potential policy projects that the Provincial HSJCC could undertake to strengthen its provincial capacity. Based on the policy issues identified, the Provincial HSJCC carried out a priority setting exercise to determine the first policy project to undertake. When setting priorities for policy projects, the Provincial HSJCC considered projects that build on existing successes, engage multiple sectors, can benefit Ontarians in contact with the law, have the possibility of resolving an issue, and address the issue in a way that builds momentum at the Provincial HSJCC.

Police/mental health collaboration was ranked as the highest priority. The Provincial HSJCC thus began working on this policy project to raise the provincial issues regarding police/mental health collaboration in Ontario. This project was supported by a Police and Mental Health Advisory Committee, which was a working group of the Provincial HSJCC (see Appendix A).

Introduction

Although the majority of people with mental health conditions rarely come into contact with police, psychiatric emergencies do occur. In most cases, 911 is dialled and police, by virtue of their role as emergency responders, are called upon to assist in the mental health crisis. In fact, policy and legislative changes over the past 30 years, such as changes to the *Mental Health Act*, mental health reform, de-institutionalization, and the shift toward providing community-based mental health services, have greatly expanded the role and authority of police in their interactions with individuals with mental disorders and the mental health system.

Crisis response, however, is only one of several types of interactions between police and people with mental disorders. The Canadian Association of Chiefs of Police has identified a range of encounters, including:

- Circumstances in which the public or families of a person with a mental disorder ask for help
- Apprehensions and other powers of police under the *Mental Health Act*
- Arrests in which the accused person appears to have a mental disorder
- Minor disturbances in which a person appears to have a mental disorder
- Situations in which a person with a mental disorder is the victim of a crime
- Situations in which a person with a mental disorder threatens others
- Non-criminal or non-offence situations in which the police become aware that someone who has a mental disorder appears to be at risk or in need of assistance
- Suicide interventions
- Circumstances in which police become instrumental social support contacts for persons with mental disorders (situations in which police provide practical assistance and support to people in need)²

When assisting in these situations, police services often collaborate with other agencies across the province to provide a coordinated response. The police work collaboratively with various agencies across multiple sectors, including community mental health services, hospitals, corrections organizations, and consumer/survivor organizations. This paper offers an examination of the high-level provincial issues related to police/mental health collaboration, and highlights some successes and challenges of collaboration.

Purpose

This report provides a critical review of collaborations between police and mental health services in Ontario by addressing three key questions:

- 1. What legislation and policies impact on police/mental health collaboration?**
- 2. What types of police/mental health collaboration initiatives currently exist in Ontario?**
- 3. What are the issues related to police/mental health initiatives?**

Information contained in this report was obtained through three methods: a document review, a survey, and a series of key informant interviews.

The documents reviewed included legislation, policies, academic articles and grey literature relating to police and mental health issues (all documents reviewed are listed in the Bibliography of this report).

Secondly, a survey was administered to the Local HSJCCs to gather information about existing collaborations between police and mental health services (see Appendix B). In areas where there are no Local HSJCCs, the Regional HSJCC was requested to respond. The response rate was 72 percent, as 28 of a possible 39 responses were received. A complete list of responding HSJCCs is included in Appendix C.

Thirdly, a series of key informant interviews were conducted. Twenty-five informants participated from across multiple sectors, including healthcare and mental health services, justice, corrections, consumer/survivor organizations and municipal and provincial police services. Fifty-two percent of the key informants were also members of an HSJCC.

Part 1 of this report identifies the issues regarding police/mental health collaboration that were raised during the key informant interviews, and Part 2 provides an overview of the survey findings. Part 3 provides extensive background information about the justice and mental health systems in Ontario. Innovative solutions that are being applied to enhance police/mental health collaboration in Ontario are profiled throughout.

Definitions

Mental disorder: the *Criminal Code of Canada* identifies mental disorder as a disease of the mind.³ For the purposes of this report, the term “mental disorder” is used to refer to individuals with diagnosed and/or undiagnosed mental health conditions, including severe mental illnesses, developmental disabilities and other mental health related conditions.

Mentally disordered accused: refers to an individual with a mental disorder who has been accused of committing a crime under the *Criminal Code*, including individuals who are deemed unfit to stand trial under Section 672 of the *Criminal Code*, and individuals who have been rendered a verdict of not criminally responsible on account of mental disorder.⁴

Mentally disordered offender: refers to an individual with a mental disorder who has been determined by a court to be guilty of an offence under the *Criminal Code*, whether on acceptance of a plea of guilty or on a finding of guilt.⁵

Forensic client: refers to an individual who has a major mental disorder, is in conflict with the law, and is being dealt with by the courts or the Ontario Review Board under Section 672 of the *Criminal Code*.⁶

For an overview of the interface between the criminal justice and mental health systems, refer to Part 3.1

Limitations of Project

The purpose of this project is to develop a brief that critically reviews police/mental health collaborations, highlighting what we know about such collaborations, as well as any outstanding

issues that the Provincial HSJCC may wish to address. Given the purpose of the project, the scope and activities were limited to this focus.

Key Informant Selection

Key informants were all persons known to the HSJCCs, thus limiting the scope of the responses. Key informants were either recommended by the HSJCCs and the Police/Mental Health Advisory Committee, or were members of the HSJCCs who volunteered to be interviewed.

Document Review

The scope of the document review was limited to recommendations made by the members of the Police/Mental Health Advisory Committee, the Provincial HSJCC, as well as the key informants. Thus, there may be relevant resources that were not included in the document review.

Population

While the Provincial HSJCC gives priority consideration to people with a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, and fetal alcohol syndrome, the focus of the project was on police\mental health collaboration. Therefore, the scope of the review was limited to this one HSJCC priority population.

While the key informant discussions primarily focused on individuals with mental illnesses, informants often did not distinguish between individuals with varying mental health conditions. Some key informants generalized these conditions under the umbrella of “mental disorders.” The lack of a commonly agreed upon, accepted definition of the population in question poses a limitation.

Along the same lines, key informants primarily discussed police/mental health collaboration issues relating to adult populations. It may be that additional research related to other populations would have yielded more comprehensive or different information.

Part 1

Issues Relating to Police/Mental Health Collaboration

The key issues identified below were obtained through a series of key informant interviews. Twenty-five informants participated from across multiple sectors, including healthcare and mental health services, justice, corrections, consumer/survivor organizations, and municipal and provincial police services. Fifty-two percent of the key informants were also members of an HSJCC.

Issues Relating to Police/Mental Health Collaboration

1) *Lack of comprehensive provincial policy for police/mental health collaboration*

Key informants raised the issue that there are no standard provincial protocols for collaborating across healthcare, justice and police services sectors that set out accountability mechanisms to monitor and evaluate such collaborations. Accountability mechanisms are needed to ensure that existing policies, guidelines and legislation, such as the *Mental Health Act*, the *Police Services Act*, the *Contemporary Policing Guidelines for Working with the Mental Health System*, and the *Policing Standards Manual*, are being operationalized appropriately. For an overview of these documents, refer to Part 3.2.

64% of informants raised concerns that there was a lack of a comprehensive provincial policy for collaboration between police and mental health services.

2) *Increase in mental health diversion is needed*

Key informants indicated the need to increase diversion programs for individuals with mental disorders, both at the pre-charge and post-charge stages. With regards to pre-charge diversion, police officers have the discretion to informally divert individuals from the criminal justice system when appropriate, and on a case by case basis, regardless of whether the individual has a mental disorder. However, different methods of informal pre-charge diversion are being utilized across the province based on the police detachment and based on the mental health and social services available in the community. With regards to post-charge diversion, standard mental health diversion policies and protocols exist, but the practices vary across the province. Standard provincial protocols are needed to ensure that existing mental health diversion policies are being operationalized consistently throughout the province. For an overview of existing diversion policies, refer to Part 3.3.

3) *Lack of provincial standards for police/mental health education*

A wide range of initiatives across the province provide education and training to police officers on police/mental health issues. Provincial standards, which include monitoring and accountability mechanisms, are needed to ensure that these education initiatives are being carried out consistently across the province.

There is also an expressed need for increased cross-sector education. Provincial standards are needed for education and training for healthcare and social service providers about the justice system and police protocols for responding to individuals with mental disorders.

Education for individuals living with mental disorders and their family members about crisis services available in the community is typically lacking. Informants indicated that many people resort to dialling 911 or contacting the police during mental health crises, and many are unaware of the 24/7 crisis phone lines and warm lines (crisis lines staffed by peers) that are available as an alternative to calling police. Public awareness needs to be increased about the community mental health services and supports that are available to individuals with mental disorders.

For an overview of the types of education initiatives currently being offered across the province, refer to Part 3.4

4) Provincial guidelines for crisis intervention services should be monitored

Informants indicated that, although the Ministry of Health and Long-Term Care (2005) and the Registered Nurses Association of Ontario (2002) have developed guidelines for crisis intervention services, these guidelines are not being operationalized consistently throughout the province. Accountability mechanisms should be developed to monitor existing crisis intervention guidelines.

There is a range of crisis response services in Ontario, including police/mental health liaison officers, crisis intervention team (CIT) officers and mobile crisis intervention teams (MCITs), but these initiatives are not standardized across the province. Program standards should be developed for MCITs and CIT officer programs.

For an overview of existing crisis intervention guidelines and services, refer to Part 3.5

Consumer/survivor representatives highlighted the need for mental health crisis services that are peer-led and designed by consumers/survivors themselves. They stated that having peer support during a mental health crisis can result in more positive outcomes for the individual.

5) Memorandums of understanding between hospitals and police services are needed

Memorandums of understanding (MOUs) between police services and hospitals are needed to help facilitate communication between police officers and hospital staff. Informants indicated that these MOUs should address the following issues:

- Police officers are required to escort any individuals apprehended under the *Mental Health Act* to the nearest hospital for an assessment by a physician. During these escorts, officers are often subjected to extended wait-times in the hospital emergency room (ER). These waiting periods can be quite costly as two officers typically escort the individual to the ER. Moreover, this can result in public safety issues because police officers are waiting in the ER instead of being out on patrol ensuring the safety of the community. Informants indicated that ER wait-times should be reduced for police officers and individuals being escorted by police should be triaged faster.
- The “revolving door” also occurs in the ER. Police officers may escort an individual to the ER because they appear “high risk,” yet once the individual is examined by a physician, the individual may be released back into the community because they did not meet the criteria for involuntary admission to the hospital. Once released, the individual is often not connected to community mental health providers, and as a result, a few days or even a few hours later, police officers may reencounter the individual in the community. Informants indicated that joint policies and procedures should be developed between hospitals and police services to reduce the revolving door effect.

“Right now the emergency room is the only available option for us (to escort a person with a mental illness). There needs to be another door.”

~Police Officer

- Standardized MOUs are needed to guide routine interactions between police officers and hospital staff. In situations where a patient is considered “high risk” and poses a danger to staff and other patients, police officers can be hired by hospitals as “constants” to stand guard to ensure everyone’s safety; this type of constant assistance is often utilized by hospitals that do not have security guards in-house. Similarly, in situations where hospital staff have been unable to manage a “high risk” situation safely, police officers are called on to assist with restraining the patient. In addition, police can be called to the scene of a hospital if a patient or a staff member has committed a crime (such as harassment or assault). In these situations, officers arrive at the facility to conduct an investigation and, when appropriate, lay a charge under the *Criminal Code* and arrest the person in question. Informants indicated that MOUs between police services and hospitals would help facilitate these types of routine interactions.

See Part 3.6 for innovative solutions for facilitating communication between police officers and hospital staff.

6) Lack of provincial protocol for sharing, collecting and disclosing client information

The *Personal Health Information and Protection Act* (PHIPA)⁷ often acts as a barrier for sharing information between police and mental health services. Under PHIPA, consent is needed from the client before healthcare providers can disclose mental health information to police officers, unless the disclosure is necessary for the purpose of eliminating or reducing a significant risk or serious bodily harm to individuals or the community. Many informants stated that this provision under PHIPA is not clear enough, and thus, a standard provincial protocol is needed for operationalizing PHIPA.

See Part 3.7 for an overview of PHIPA and innovative solutions for sharing, collecting and disclosing client information.

7) Provincial policy regarding the disclosure of mental health police records is needed

Mental health police records have a negative impact and often pose barriers for individuals with mental disorders. Mental health police records pose negative repercussions for individuals with mental disorders if they are required to obtain a police records check or a “vulnerable sector screening” for the purpose of working or volunteering. Having a police record also increases the stigma experienced by individuals with mental disorders.

Multiple informants said that they have a high regard for community safety, and affirmed the importance of police records as a tool for sharing information about a client’s history to police officers responding to mental health crises. However, they also stated that mental health police records should only be accessible to police officers to assist them to better respond to mental health crisis situations, and that this information should not be released to potential employers or the public. A standard provincial protocol regarding police mental health records, including monitoring and accountability mechanisms, is needed to ensure the proper disclosure of such records. For more information on this issue, refer to Part 3.8.

8) Lack of provincial policy regarding client transportation

Under Section 29 of the *Mental Health Act*, police officers may act as an escort to transfer a client from one psychiatric facility to another. In rural and northern areas of the province, police

officers are also called upon to escort clients with mental disorders to the nearest Schedule 1 facility. Transportation can be costly because two officers are required to escort a client, and it can be time-consuming because officers often have to drive long distances. Police officers may also be called upon to escort “high risk” mentally disordered accused/offenders out in the community, to medical appointments, court appearances and other meetings. Additionally, police officers may be asked to escort clients under sedation, posing a liability for police services because they do not have the capacity to respond if a medical emergency was to occur during the transportation. As such, key informants voiced the need for a standard provincial protocol regarding client transportation that specifies the situations where police involvement is and is not appropriate.

For innovative solutions for addressing transportation issues, refer to Part 3.9

9) *Review of community treatment orders, Assertive Community Treatment Teams and safe bed programs is needed*

Program reviews and evaluations of community treatment orders (CTOs), Assertive Community Treatment Teams (ACTTs) and safe bed programs are needed to determine the effectiveness and impact of these types of community support programs on individuals with mental disorders.

- Informants stated that although CTOs can provide a medication monitoring structure for some individuals, this comes at the cost of their rights and freedoms because CTOs can be a coercive mechanism for psychiatric treatment. CTOs can also lead to criminalization of individuals with mental disorders, as police officers have the authority to apprehend individuals who are in breach of a CTO.

Many informants stressed the need to revisit the recommendations made in the 2005 CTO review, *Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the Mental Health Act: for the Ontario Ministry of Health and Long-Term Care*, and implement the recommendations across the province. For an overview of CTOs and the 2005 CTO review, refer to Part 3.10.

- Informants shared that although there are program standards developed for ACTTs, not all ACTT programs across the province adhere to the standards. For example, several informants indicated that some ACTTs do not have a peer support person on the team, and if peers are included, their role is devalued and diminished compared to the other professionals. ACTTs are not available in all regions, especially in rural and northern areas of the province, and in many communities, ACTTs are not made available 24 hours a day. There is a need for additional ACTTs across the province, and all ACTTs should develop accountability mechanisms to ensure they are operating according to the established standards. Furthermore, a review is needed to look at ACTT effectiveness with respect to working with mentally disordered offenders, including promising and best practices. For more information about ACTTs, refer to Part 3.11.
- Informants stated that safe beds are a good alternative to hospitalization. Safe bed programs provide short-term housing to individuals with mental illnesses, and assist these individuals to stabilize their immediate physical and mental health needs and develop long-term interventions.⁸ Consumer/ survivor representatives commented that safe beds provide less-intrusive treatment in an “at home” environment. Police representatives viewed safe beds as an alternative option to emergency rooms for escorting individuals in crisis. Many informants stressed the need to increase safe beds

across the province. They noted that safe beds are most often located in larger urban centres, and they are less accessible in rural and northern areas. Furthermore, informants called for a review of safe bed programs across the province to determine their effectiveness and impact on individuals with mental disorders. Such a review has been conducted by the Ministry of Health and Long-Term Care, but remains an internal document that has not yet been released to the public.

10) *Engaging multiple stakeholders is necessary to promote police/mental health collaboration*

Overall, there was general consensus among informants that the Provincial HSJCC is the most effective mechanism for engaging in larger provincial discussions regarding police/mental health collaboration and for coordinating mental health and justice services across the province. Informants from community criminal justice organizations and consumer/survivor organizations expressed interest in joining and contributing to the HSJCCs, especially at the provincial level. These informants felt that they could each bring a unique perspective to the Provincial HSJCC table to assist in province-wide coordination of mental health and justice services.

11) *Shortage of funding and resources for police/mental health collaborations*

The majority of the funding for police/mental health collaborations is received from the Ministry of Health and Long-Term Care, the Local Health Integration Networks, and the Local and/or Regional HSJCCs. Informants indicated that, currently, staff time for joint collaborations is provided in-kind from police detachments, community mental health agencies and other partners involved in the collaborations. There is need for increased funding and resources to sustain existing collaborations and to develop new joint initiatives.

12) *Lack of mental health services in rural and northern communities*

There is a lack of a comprehensive basket of services available to rural and northern communities. As a result, individuals with mental disorders are not able to access much needed services. Often, these individuals must travel to larger urban centres to obtain appropriate mental health services and supports, which can be very costly and time-consuming. There is a lack of MCITs in rural and northern regions, and an absence of full-time, around the clock, mental health crisis services. Informants stressed the need for additional mental health resources in these communities to help reduce the pressures on local police services who are often expected to be the default mental health crisis responders.

“More community mental health resources must be put in place in rural areas so that the police are not the default responders to mental health crises.”

~ Healthcare Provider

13) *Anti-discrimination initiatives are needed to address mental health discrimination*

Informants stated that mentally disordered offenders face multiple barriers when attempting to access mental health and social services. The negative impact of stigma often increases when individuals with mental disorders come into contact with the criminal justice system. These

individuals, as well as forensic clients and individuals labelled “high risk,” are often perceived as violent offenders. As a result, they experience increased levels of overt and covert discrimination in the criminal justice, healthcare and social services systems. Informants also shared that forensic patients and mentally disordered offenders are often victimized in the correctional system. Furthermore, once these individuals are released from custody, they are often screened out of support services by family physicians, psychiatrists and community support programs. Anti-discrimination initiatives are necessary to educate service providers and to help reduce systemic discrimination against mentally disordered offenders within the justice, healthcare and social services systems.

14) Increased support is needed for vulnerable populations who face systemic barriers

Informants indicated that individuals from racialized communities are over-represented in the criminal justice system. Across the province, individuals from Aboriginal and other racialized communities are increasingly coming into contact with the justice system and increasingly being incarcerated. Individuals from these communities have unique needs and face multiple barriers to accessing the social determinants of health, including income, employment, education and housing. These communities are vulnerable to mental disorders and addictions, as well as criminalization. As a result, key informants stressed the need to foster supportive communities and develop strengths-based approaches to protecting these groups from mental disorders and addictions, as well as preventing individuals from coming into contact with the justice system. Informants urged the need to build community capacity for Aboriginal and racialized communities, and support these communities as partners in promoting health and wellness, social inclusion and equity.

For information about an innovative HSJCC initiative involving Aboriginal communities, refer to Part 3.12

15) Lack of Ontario-based research on police/mental health collaboration

Informants indicated the need for research on the effectiveness of police/mental health collaborations, and specifically, the need for more Ontario-based research. When conducting research, informants stated that both quantitative and qualitative data should be utilized. Several research areas were identified, including:

- Best practices for police/mental health education and training
- Best practices for police/mental health crisis intervention services
- Cost/benefit analysis of MCITs
- Cost/benefit analysis of CIT officer programs

Consumer/survivor representatives urged the need for consumer-focused research regarding police/mental health issues. Suggested research topics include: consumer/survivor satisfaction with MCITs and CIT programs, consumer/survivor outcomes relating to interactions with police, research on how mental health police records have impacted the lives of consumers/survivors, and best practices research for MCITs and ACTTs that includes a peer support component.

Part 2

Highlights from HSJCC Police/Mental Health Survey

The survey was administered to the Local HSJCCs to gather information about existing collaborations between police services and mental health services across Ontario (see Appendix B). In areas where there are no Local HSJCCs, the Regional HSJCC was requested to respond. The response rate was 72 percent, as 28 of a possible 39 responses were received. A complete list of responding HSJCCs is included in Appendix C.

HIGHLIGHTS FROM HSJCC POLICE/MENTAL HEALTH SURVEY

- 72%** The response rate for this survey.
86% of survey respondents were from Local HSJCCs and 14% from Regional HSJCCs.
- 18** Percentage of survey respondents that provide services to areas with a population of less than 100,000.
- 29** Percentage of survey respondents that have a mobile crisis intervention team in their area.
- 43** Percentage of survey respondents that have crisis intervention team officers in their area.
- 61** Percentage of survey respondents that have formalized partnerships with police services.
- 79** Percentage of survey respondents that are involved in police/mental health education and training.
- 43** Percentage of survey respondents that are involved with policy development in the area of justice and mental health.
- 25** Percentage of police/mental health collaborations that are funded by the Ministry of Health and Long-Term Care and/or Local Health Integration Networks.
- 32** Percentage of police/mental health collaborations that are supported through HSJCCs.
- 25** Percentage of survey respondents that have conducted formal evaluations of their police/mental health programs.

Types of Collaborations

Survey responses indicated that HSJCCs work in partnership with a wide range of agencies including adult mental health agencies, addictions agencies, Assertive Community Treatment Teams (ACTTs), community criminal justice organizations (CCJOs), developmental disability organizations, fetal alcohol spectrum disorder (FASD) organizations, hospitals, and youth mental health agencies. Table 1 displays the types of collaborations that currently exist across Ontario.

Table 1: Types of Collaborations

	Adult Mental Health	Hospitals	ACTTs	Addiction	CCJOs	Developmental Disability	FASD	Youth Mental Health	Others
Algoma	√	√	√	√	--	√	--	√	√
Brant	√	√	√	√	--	√	--	√	√
Chatham-Kent	√	√	√	√	--	--	--	--	--
Downtown Toronto	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Essex County	√	√	Not Known	√	√	√	Not Known	√	Not Known
Frontenac	√	√	--	√	--	√	--	--	√
Haldimand Norfolk	√	--	--	--	--	--	--	√	--
Haliburton	√	√	√	√	√	√	--	√	√
Hastings and Prince Edward County	√	√	√	√	√	√	√	√	√
Kenora District	√	√	√	√	√	√	--	√	--
Lanark County	√	√	--	√	--	√	--	√	√
Leeds-Grenville	√	√	√	√	√	√	Not Known	√	--
Lennox- Addington	√	√	√	√	--	√	--	√	--
Niagara	√	√	√	√	--	--	--	√	--
Nipissing-Timiskaming-Parry Sound	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
North West Region	√	√	√	√	√	√	√	√	√
North York	√	√	--	√	--	√	--	√	√
Northumberland	√	√	√	√	√	√	--	√	√
Oxford County	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pembroke-Renfrew	√	√	√	√	√	√	Not Known	Not Known	√
Peterborough	√	√	√	√	√	√	Not Known	√	--
Scarborough	√	√	√	√	√	√	Not Known	√	√
Simcoe-Muskoka Region	√	√	--	√	√	--	--	√	--
Sudbury-Manitoulin	--	√	--	√	√	√	--	--	--
Timmins-Cochrane	√	√	n/a	√	√	√	√	n/a	n/a
Waterloo-Wellington Region	√	√	--	--	--	--	--	√	--
West Toronto	--	√	--	√	--	--	--	--	√
York-South Simcoe Region	√	√	√	√	√	√	Not Known	√	--

In terms of collaborations with police services, HSJCCs partake in joint planning committees, crisis intervention services and inter-agency service agreements. Many of the HSJCCs are involved with both formal partnerships and informal collaborations: 61 percent of survey respondents indicated their involvement in formal partnerships and 57 percent of survey respondents indicated that they are involved in informal collaborations with police services.

“Informally, OPP officers routinely come by our agency to ask questions, or to bring by their new recruits to orient them to our agency.”

~Healthcare Provider

Informal collaborations typically do not have signed agreements between agencies. These collaborations are focused on communicating, information-sharing and building working relationships.

Formal partnerships typically have a signed agreement between agencies, and a policy or protocol in place that outlines the responsibilities of each party. Some examples include the LEAD Protocol in the Southeast region, the memorandum of understanding (MOU) between Waterloo-Wellington Crisis Services and Wellington Police Services, and the HELP Team Protocol in Chatham-Kent.⁹

INNOVATIVE SOLUTIONS IN ONTARIO

HELP Team Protocol is a multi-partner service agreement between the Chatham-Kent Police Service, Health Alliance, Assertive Community Treatment Team and Canadian Mental Health Association. The HELP Team consists of specially trained police officers, assisted by the community mental health service partners, who are dispatched to or provide assistance to the investigating officer to develop and implement safe, proactive and preventative methods of assisting mental health crises. The HELP Team members use their training to attempt to deescalate volatile situations without resorting to the use of force.

Providing Services

The priority consideration for HSJCCs is serving individuals who come into contact with the law who have a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, and/or FASD. All respondents indicated that they serve populations with mental illnesses, and in addition, 18 percent indicated that they serve populations with developmental disabilities, 18 percent indicated that they serve populations with drug and alcohol addictions, 14 percent indicated that they serve populations with acquired brain injuries, and 14 percent indicated that they serve populations with FASD.

In terms of geographic areas, 18 percent of respondents indicated that they serve areas with populations of less than 100,000 people, such as Algoma, Haliburton, and Lanark County. Conversely, 43 percent indicated that they serve areas over 100,000 people, which indicates that a higher percentage of initiatives are located in larger more urban areas of the province (39 percent of respondents did not provide information for this question).

Twenty-nine percent of respondents indicated the presence of a mobile crisis intervention team in their region, compared to 43 percent of respondents who indicated the presence of crisis intervention team officers.

Education, Training and Policy Development

Seventy-nine percent of respondents indicated that their HSJCC is involved in training and education about police/mental health issues. To name a few, Peterborough offers an annual education day, Sudbury-Manitoulin offers release from custody training/education for jail guards and police officers, and the Southeast region offers LEAD Team Training (Lanark County Police Services and Lanark County Mental Health, Emergency Department, Ambulance Services, Diversion).¹⁰

INNOVATIVE SOLUTIONS IN ONTARIO

LEAD Team Training is a crisis intervention training program for police officers offered in the Southeast region of the province. The program, consisting of a two-day workshop, involves information about common types of mental disorders, and firsthand exposure to the viewpoints and feelings of mental health consumers. The training assists team members to understand that mental illness is not a crime, but a disability. Skills are developed in de-escalating potentially volatile situations, gathering relevant history, assessing medical information and evaluating an individual's social support system. The program, offered annually, is not mandatory, but is available to interested officers on a voluntary basis.

In terms of policy development, 43 percent of survey respondents indicated that they are involved with policy development in the area of justice and mental health. A few examples include Essex County's efforts to identify and eliminate gaps between the criminal justice system and mental health system, North York's efforts to create policies and protocols regarding the use of MCITs, and Scarborough's focus on creating a protocol for police releasing custody of an apprehended individual to the hospital.

Funding for Joint Collaborations

Twenty-five percent of survey respondents indicated that they receive funding for their police/mental health initiatives from the Ministry of Health and Long-Term Care and/or Local Health Integration Networks. Thirty-two percent of respondents received support from their Local or Regional HSJCC.

Research and Evaluation

Twenty-five percent of survey respondents indicated that they conduct formal evaluations of their police/mental health initiatives. Conversely, 21 percent indicated that they do not conduct formal evaluations (54 percent of respondents did not provide information for this question).

Part 3

Background Information on the Justice and Mental Health Systems in Ontario

The following sections of the report provide extensive background information about the criminal justice and mental health systems in Ontario. The information below was gathered through a document review that included legislation, policies, academic articles and grey literature relating to police and mental health issues (all documents reviewed are listed in the Bibliography of this report).

3.1) Interface between the Criminal Justice and Mental Health Systems

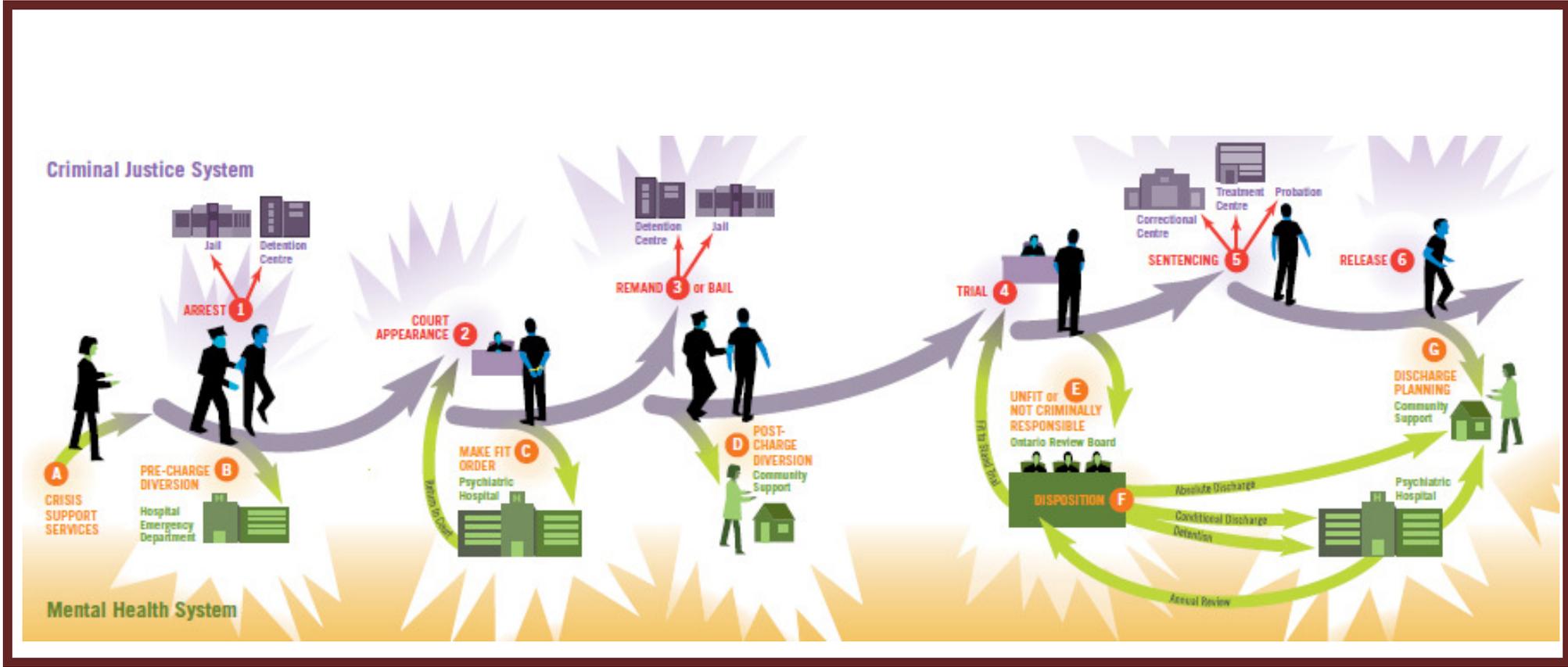


Diagram 1: A simplified map of the various pathways faced by mentally disordered offenders and forensic clients. It is important to note that each person’s case is very different, and some journeys through the justice and mental health systems are not reflected here. The map and the following descriptions are meant as a general overview.

Ontario's forensic mental health system is based on the *Criminal Code of Canada*, Part XX.1: Mental Disorder, Section 672,¹¹ which outlines the criminal justice process for mentally disordered accused.

The map above (reprinted with permission from Canadian Mental Health Association, Ontario's *Network* magazine¹²) illustrates the points of intersection between the criminal justice system and the mental health system, and where people with mental disorders may encounter police. The following descriptions refer to various points of intersection identified in the map.

(A) *Mental Health Crisis: First Encounter with Police*

Often the first encounter between police and people with mental disorders occurs at the scene of an emergency. Municipal and provincial police may be called upon to respond as a result of a disturbance call (where the individual in question turns out to have a mental disorder), a call regarding unusual behaviour (where the person in question appears to have a mental disorder) or an identified mental health crisis call (police often refer to these calls as “emotionally disturbed persons” or EDP calls).¹³

Key informants interviewed for the HSJCC Police & Mental Health project indicated that, while at the scene of a mental health emergency, police services may call on the assistance of community-based mental health crisis response services, mobile crisis teams (MCITs) and police officers who are trained in crisis intervention (CIT officers) if these resources are available in the area. In extreme cases where a weapon is involved or a person has barricaded themselves, the police may call on additional law enforcement support, such as an Emergency Task Force. Regardless of the circumstances, the police first ensure that the scene is secured and ensure everyone's safety before crisis services are provided to the individual.

(B) *Pre-Charge Diversion*

The decision to arrest or charge a person with a mental disorder is based on a variety of factors including the seriousness of the offence, whether the individual is known to police, and whether there is a risk of harm to the individual, someone else or the community.

Key informants indicated that there are a variety of options for pre-charge diversion. Depending on the seriousness of the offense, the police officer may:

- 1) Release the individual and provide them with contact information for local community mental health services.
- 2) Escort the individual to their home or place of residence.
- 3) If MCITs and CIT officers are on the scene, they may take over custody of the individual (refer to Part 3.5, Mental Health Crisis Response Initiatives).
- 4) Apprehend the individual under Section 17 of the *Mental Health Act* and escort the individual to a local hospital emergency room (refer to Part 3.2, Legislation and Policies that Impact Police/Mental Health Collaboration).
- 5) Arrest and charge the individual, and escort them to a jail or detention centre to await their first court appearance (bail hearing).

(C) *First Court Appearance*

At the first court appearance, the accused person may be released on bail, remanded into custody, or an order for a fitness assessment may be issued by the court.

Under Section 672 of the *Criminal Code*, the issue of “fitness to stand trial” can be raised at any time in the court process. A person is unfit to stand trial if they have a mental disorder that prevents them from understanding the nature of what happens in court, understanding the possible consequences of what happens in court, or communicating with and instructing their lawyer. In such cases, the court will typically issue a fitness assessment order to determine the capacity of the person to go through the trial process.

If the person is found unfit, the judge may issue a “make fit order” (treatment order) for the accused to receive treatment in a psychiatric facility for up to 60 days in order to return them to court in a “fit” state.¹⁴

If the accused is fit to stand trial, then they may be released on bail or remanded into custody at a detention centre. Key informants indicated that at this stage, police officers may be involved with escorting the accused person to and from the court, psychiatric facility, and/or the detention centre.

In some cases, key informants indicated that the remanded individual may be released into the custody of a community criminal justice organization (CCJO), such as the John Howard Society, Elizabeth Fry Society or St. Leonard’s Society. Typically, these individuals are issued a recognizance order by the court which states that the accused must abide by the policies, procedures and the “house rules” of the CCJO. If the accused is in breach of the recognizance order, then the police may be called to arrest the individual and return them to a jail or detention centre.

(D) Post-Charge Diversion

After charges have been laid, the Crown Attorney has the option to not prosecute the accused, and instead divert the accused into appropriate treatment and support in the community. Diversion can take place at any stage of the proceedings. If the accused is eligible for diversion, a court support worker, typically from a community mental health agency, will work with the person to develop a program that may include community support, supervision and/or treatment.

(E) Not Criminally Responsible: The Forensic Client

If the person is found unfit to stand trial and remains unfit even after treatment, the court will typically issue a formal verdict of unfit to stand trial under Section 672.31 of the *Criminal Code*. Once this verdict is made, the case is then transferred to the Ontario Review Board (ORB).

The accused may also be transferred to the ORB if they are found to be not criminally responsible (NCR) on account of mental disorder, under Section 672.34 of the *Criminal Code*. An NCR verdict means that at the time of the act, the accused was “suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or of knowing that it was wrong.”¹⁵

(F) Disposition: Detention or Discharge of a Forensic Client

The ORB makes a decision (called a disposition) about whether to detain or discharge the individual, by determining whether or not the individual poses a significant threat to the safety of the public, as well as the disposition appropriate to that risk.

There are three types of dispositions:

- 1) **Detention Order:** provides for the detention of the individual in a designated psychiatric hospital, which may include residing in the community under hospital supervision.
- 2) **Conditional Discharge:** the individual is released into the community under certain conditions, which typically include reporting to a designated psychiatric hospital.
- 3) **Absolute Discharge:** when the individual no longer poses a significant threat to the safety of the public the ORB must discharge the individual absolutely.

For individuals on detention or conditional discharge, the ORB holds an annual hearing to review and either renew or issue a different disposition.

Key informants indicated that, at this stage, police may continue to have interactions with persons with mental disorders. If the individual is in breach of their disposition, then police may be called to apprehend and return the individual to the jail or psychiatric facility. The individual can also be arrested by police if they are involved in a new offense. In addition, police may be called to assist the psychiatric facility where the individual is being held. Typically, if the facility's staff and security personnel are unable to manage a "high risk" situation, then the police are called to assist and secure the person in question.

(G) Discharge Plan

When a mentally disordered client or a forensic client is released from a psychiatric facility or a correctional institution, a discharge plan is created.

Typically, community mental health service providers will work with the person to help them follow the plan and reintegrate into the community. A variety of professionals may be involved in creating the individualized discharge plan, including police services, corrections services, Crown Attorneys, community mental health and addictions agencies, CCJOs and hospitals.

Key informants indicated that issues can arise at the point of discharge. Sometimes the person may be placed on a waiting list for programs and may not be connected to community supports immediately due to the lack of availability of services in the local community. In these cases, the individual may continue to be detained in the psychiatric facility or correctional institution until adequate supports can be established in the community.

3.2) Legislation and Policies that Impact Police/Mental Health Collaboration

In addition to the *Criminal Code of Canada*, there are various provincial legislation, policies and guidelines that impact on police/mental health collaboration, including the *Mental Health Act*, the *Police Services Act*, the *Contemporary Policing Guidelines for Working with the Mental Health System*, and the *Policing Standards Manual*.

Legislation

Ontario Mental Health Act

Section 17 of the *Mental Health Act*⁶ permits police officers to apprehend individuals under the following circumstances:

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,

- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
- (b) 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
- (c) 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,

- (d) serious bodily harm to the person;
 - (e) serious bodily harm to another person; or
 - (f) serious physical impairment of the person,
- and that it would be dangerous to proceed under Section 16, the police officer may take the person in custody to an appropriate place for examination by a physician.

Once an apprehension is made, the police officer is legally obligated to escort the individual in custody to an examination by a physician. Once the examination has taken place, Section 20 of the *Mental Health Act* permits the physician to release the individual in custody or admit the individual to the hospital as an involuntary or voluntary patient:

The attending physician, after observing and examining a person who is the subject of an application for assessment under Section 15 or who is the subject of an order under Section 32,

- (a) shall release the person from the psychiatric facility if the attending physician is of the opinion that the person is not in need of the treatment provided in a psychiatric facility;
- (b) shall admit the person as an informal or voluntary patient if the attending physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of the treatment provided in a psychiatric facility and is suitable for admission as an informal or voluntary patient; or

(c) shall admit the person as an involuntary patient by completing and filing with the officer in charge a certificate of involuntary admission if the attending physician is of the opinion that the conditions set out in subsection (1.1) or (5) are met.

Once an apprehension is made, the police officer has a duty to remain and retain custody of the individual until the hospital has accepted custody. Section 33 of the *Mental Health Act* reads:

A police officer or other person who takes a person in custody to a psychiatric facility shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner.

The *Mental Health Act* details five additional conditions under which police officers are permitted to apprehend individuals. Under Section 15, police officers may apprehend an individual who is the subject of an application for psychiatric assessment (Form 1). This section permits police officers to apprehend the individual subjected to a psychiatric assessment for a period up to seven days, including the day the assessment was issued, and take the individual to a psychiatric facility.

Under Section 16, police officers may apprehend an individual in situations where a Justice of the Peace has issued an order for examination by physician. An order under this section permits police officers to apprehend the individual for a period up to seven days, including the day the order was issued.

Under Section 28, police officers may apprehend an individual in situations where a psychiatric facility has issued an order for return of an individual who is absent without leave from the facility. Within one month after the absence becomes known, police officers are required to make reasonable efforts to locate the individual and return them to the facility, or take the individual to a psychiatric facility nearest to the place where they were apprehended.

Under Section 29, police officers may act as an escort to transfer an individual from one psychiatric facility to another. In these situations, police officers would take custody of the individual until the transfer is complete and the new facility has taken over custody.

Under Sections 33.3 and 33.4, police officers may apprehend an individual under a community treatment order (CTO) in situations where a physician has issued an order of examination because the individual has either failed to comply with the CTO, or failed to allow the physician to review their medical condition. Police officers are permitted to apprehend the individual and take them directly to the physician who issued the order, for a period of 30 days after the order was issued.

Ontario Police Services Act

The *Police Services Act*¹⁷ outlines the roles, the responsibilities and the rights of municipal and provincial police officers. The Ontario Ministry of Community Safety and Correctional Services has the authority to administer this legislation.

The declaration of principles states that all police services shall be provided throughout Ontario in accordance with the following principles:

1. The need to ensure the safety and security of all persons and property in Ontario.
2. The importance of safeguarding the fundamental rights guaranteed by the *Canadian Charter of Rights and Freedoms* and the *Human Rights Code*.

3. The need for co-operation between the providers of police services and the communities they serve.
4. The importance of respect for victims of crime and understanding of their needs.
5. The need for sensitivity to the pluralistic, multiracial and multicultural character of Ontario society.
6. The need to ensure that police forces are representative of the communities they serve.

Under Section 4, the core services of municipal police are also identified:

1. Crime prevention.
2. Law enforcement.
3. Assistance to victims of crime.
4. Public order maintenance.
5. Emergency response.

Under Section 19, the responsibilities of the Ontario Provincial Police (OPP) are identified:

1. Providing police services in respect of the parts of Ontario that do not have municipal police forces other than municipal law enforcement officers.
2. Providing police services in respect of all navigable bodies and courses of water in Ontario, except those that lie within municipalities designated by the Solicitor General.
3. Maintaining a traffic patrol on the King's Highway, except the parts designated by the Solicitor General.
4. Maintaining a traffic patrol on the connecting links within the meaning of Section 21 of the *Public Transportation and Highway Improvement Act* that are designated by the Solicitor General.
5. Maintaining investigative services to assist municipal police forces on the Solicitor General's direction or at the Crown Attorney's request.

Although the *Police Services Act* outlines the roles, the responsibilities and the rights of municipal and provincial police officers, it does not specifically identify responsibilities of police in relation to encounters with people with mental disorders. As such, the Canadian Association of Chiefs of Police, as well as the Ontario Ministry of Community Safety and Correctional Services, have developed guidelines for police encounters with people with mental disorders.

Policies

Canadian Association of Chiefs of Police

In 2006, the Canadian Association of Chiefs of Police released *Contemporary Policing Guidelines for Working with the Mental Health System*.¹⁸ The document provides guiding principles for police services in their work with people with mental disorders, as well as with the healthcare system. The document states that the guiding principles are intended to be implemented by every police service or police detachment across the country, regardless of size or geographical location. However, the manner in which the principles are operationalized depends on the needs of the community served.

The central tenet of this document reads:

Each police organization should foster a culture in which mental illness is viewed as a medical disability not a moral failure, and in which people with mental illnesses are treated with the same degree of respect as other members of society.

It is incumbent on police leaders to set an appropriate tone by modelling non-derogatory language and ensuring the assignment of police personnel to mental health-related positions in the organization is considered carefully.

There are ten principles identified:

1. Each police organization should have one or more identified personnel who are responsible for issues related to people in the community with mental illnesses. The number, role and involvement of these officers will of course vary depending upon the size of the police service or detachment.
2. Each police organization should identify and develop a relationship with a primary contact person within the local mental health system.
3. Each police organization should have an identified contact person in the emergency services department of any and all hospitals with which they do regular business.
4. Each police organization should ensure that their first responders/patrol staff have an appropriate basic level of knowledge and skill in order to deal with people with mental illnesses.
5. Each police organization should have a clearly defined policy and procedure by which personnel can access mental health expertise on a case-by-case basis.
6. Not only should police officers have an understanding of how best to work with people with a mental illness but police organizations should also ensure that all personnel who may be involved with people with mental illnesses, including those working in victim services and those answering calls and dispatching officers, have sufficient knowledge and understanding of mental illness to carry out their jobs. For dispatch personnel and those taking calls, it means that they need to be able ask the necessary questions and recognize signs that mental illness may be a factor.
7. Each police service should have available a directory or other print material that provides descriptive and contact information for mental health agencies in the area for both employees as well as people with mental illnesses and their families.
8. Each police organization should participate in a regional liaison committee which is comprised of members of the mental health system and members of the criminal justice system.
9. Each police organization should establish a data collection system that reflects the nature, quantity and outcome of interactions with people with mental illnesses.
10. Each police organization should have a central location where general information about mental illness, local resources and legislation can be stored and easily accessed when needed.

Ontario Policing Standards Manual

The Solicitor General of Ontario and the Ontario Ministry of Community Safety and Correctional Services publishes the Ontario Policing Standards Manual.¹⁹ The document contains guidelines to assist police organizations, police services boards and chiefs of police with their understanding and implementation of the *Police Services Act* and its regulations, including the Adequacy and Effectiveness of Police Services Regulation.

Responsibilities of police in relation to individuals with mental disorders are identified in Section LE-013: Police Response to Persons Who Are Emotionally Disturbed or Have a Mental Illness or a Developmental Disability.²⁰ Section LE-013 reads:

Section 29 of the *Adequacy Standards Regulation* requires a police services board to have a policy on the police response to persons who are emotionally disturbed or have a mental illness or a developmental disability. In addition, Section 13(1)(g) requires the chief of police to establish procedures and processes in respect of the police response to persons who are emotionally disturbed or have a mental illness or a developmental disability.

Furthermore, the chief of police is required to:

- a) work, where possible, with appropriate community members and agencies, health care providers, government agencies, municipal officials, other criminal justice agencies, and the local Crown to address service issues relating to persons who have a mental illness or developmental disability;
- b) establish procedures and processes that address the police response to persons who are emotionally disturbed or have a mental illness or a developmental disability; and
- c) ensure that the police service's skills development and learning plan addresses the training and sharing of information with officers, communications operators/dispatchers and supervisors on:
 - i. local protocols; and
 - ii. conflict resolution and use of force in situations involving persons who may be emotionally disturbed, or may have a mental illness or developmental disability.

3.3) Mental Health Diversion Policies

The purpose of a diversion program is to redirect individuals with mental disorders who come into contact with the criminal justice system into treatment and resources in the community. Diversion can occur at various stages of the criminal justice process.

In 2005, the Ministry of Health and Long-Term Care developed A Program Framework for Mental Health Diversion/Court Support Services, with the assistance of a Diversion/Court Support Working Group consisting of members from multiple sectors, including justice, police, community mental health services and consumer/survivor organizations. The framework identifies the core functions of diversion at three stages of the criminal justice process: pre-charge diversion, court support and post-conviction. These core functions are detailed in Table 2.²¹

Table 2: Core Functions of Mental Health Diversion/Court Support Services

Pre-Charge Diversion	Court Support	Post-Conviction
<p>Direct Service Functions</p> <ul style="list-style-type: none"> • Crisis response/emergency services (including mobile crisis response) • Safe beds • Linkages to and protocols with: <ul style="list-style-type: none"> - Supports to housing - Peer support - Intensive case management - Assertive Community Treatment Teams (ACTT) 	<p>Direct Service Functions</p> <ul style="list-style-type: none"> • Court support • Linkages to and protocols with: <ul style="list-style-type: none"> - Short-term treatment/follow-up - ACTT - Intensive case management - Supports to housing - Peer support - Client, family or joint initiatives - Social support/recreation programs 	<p>Direct Service Functions</p> <ul style="list-style-type: none"> • Sentencing (post-disposition) support • In custody, pre-release/treatment rehabilitation support • Linkages to and protocols with: <ul style="list-style-type: none"> - ACTT - Intensive case management - Supports to housing - Peer support - Client, family or joint initiatives - Social support/recreation programs - Supported employment programs - Supported education programs
<p>Indirect Service Functions</p> <ul style="list-style-type: none"> • Inter-jurisdictional coordination • Staff training/education with/ across agencies/ministries • Clinical teaching and research • Public education 	<p>Indirect Service Functions</p> <ul style="list-style-type: none"> • Inter-jurisdictional coordination • Staff training/education with/ across agencies/ministries • Clinical teaching and research • Public education 	<p>Indirect Service Functions</p> <ul style="list-style-type: none"> • Inter-jurisdictional coordination • Staff training/education with/ across agencies/ministries • Clinical teaching and research • Public education

Pre-Charge Diversion

In terms of police involvement in diversion, key informants interviewed for the HSJCC Police & Mental Health project indicated that police officers have the discretion to informally divert persons from the criminal justice system when appropriate, and on a case by case basis, regardless of whether the individual has a mental illness. However, informants also noted that different methods of informal pre-charge diversion occur based on the police detachment and based on the mental health services available in the community. Informants highlighted the need to develop a standard provincial protocol for pre-charge diversion that can be used across the province.

Post-Charge Diversion

The Ministry of the Attorney General has developed a diversion policy and a practice memorandum for individuals with mental disorders and developmental disabilities. The Crown Policy Manual includes the Mentally Disordered/Developmentally Disabled Offenders Policy (2005), which reads:

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.²²

In addition to this general policy statement, the Ministry of the Attorney General has produced a practice memorandum to counsel regarding mental health diversion. The protocol outlined in the document states:

The Crown Attorney for each jurisdiction should develop a local protocol to address options for the disposition of cases involving mentally disordered or developmentally disabled offenders. In jurisdictions where there is a Mental Health Court Support Services program, the Crown Attorney for the jurisdiction shall develop a protocol respecting the referral of offenders to the program, and the sharing of information between the Crown and mental health workers. In determining appropriate time lines for referral and assessment of these cases, the Crown Attorney should involve the local judiciary, legal aid, the defence bar, police and other interested parties.

Practices vary widely across the province from formal diversion programs, which utilize professional mental health workers where they are available, to ad-hoc case-by-case

evaluations and special handling by Crown counsel. Generally speaking, protocols should address the treatment and/or rehabilitation needs of offenders.²³

The document also details the eligibility criteria for mental health diversion.²⁴ Class I offenses are presumptively eligible for diversion, and include theft and possession under \$5,000, joyriding, mischief under \$5,000, fraud and false pretences under \$5,000, food, travel and accommodation frauds, and causing a disturbance.

Class II offenses are eligible for diversion at the discretion of the Crown Attorney. The decision about eligibility depends on the Crown's assessment of a) the circumstance of the offence; b) the circumstance of the accused; and c) the needs of the community, including the victim.

Class III offenses are not eligible for diversion, treatment plans or supervisory programs as an alternative to prosecution, regardless of the circumstances of the alleged offence or the accused:

- murder, manslaughter, infanticide, criminal negligence causing death
- causing death or bodily harm by dangerous or impaired driving
- any offence causing serious bodily harm
- simple impaired driving or driving with a prohibited blood alcohol concentration
- offences involving firearms
- criminal organization offences
- kidnapping
- spouse/partner offenses
- child abuse
- offenses involving child pornography
- sexual offenses including sexual assault, interference and exploitation, invitation for sexual touching and incest
- specific hate offenses
- home invasions
- perjury

This practice memorandum is made available to all Crown Attorneys, and is given to defence counsel or other interested people upon request.

Mental Health Diversion Research

A recent report sponsored by Peel Hsjcc and CMHA Peel (2010) looks at evidence-based diversion practices aimed at preventing individuals from becoming involved/re-involved in the criminal justice system. A Systematic Literature Review on Criminal Justice/Mental Health Liaison Diversion Initiatives in Canada and the United States identifies five points of interception, called the Sequential Intercept Model, at which interventions can be implemented to prevent persons with mental disorders from further engaging the criminal justice system:

- (1) Law enforcement and emergency services: the point where the implementation of pre-booking diversion programs takes place, and is ideally the point at which most persons are intercepted.
- (2) Initial detention and initial hearings: the point of interception that post-booking diversion programs are put into practice.

- (3) Jails and courts: addresses the needs of persons with mental illness that have been incarcerated or have come before the criminal court.
- (4) Re-entry from jails, prisons, and hospitals: the point at which people with mental illness who leave correctional settings, and ideally facilitate their transition back into the community to decrease the chance of recidivism.
- (5) Community corrections and community support services: the point of interception for individuals who are under continued supervision in the community by the criminal justice system – probation or parole; points 4 and 5 consist of post-incarceration diversion programs.²⁵

The report also provides an analysis of the effectiveness of diversion programs. Based on the literature reviewed, pre-booking diversion programs (such as MCITs and CIT officer programs) are more effective for successful diversion, improving mental health status, and increasing service utilization. There is some evidence that pre-booking diversion programs also have limited effectiveness in terms of reducing recidivism and the number of days incarcerated.

The literature review reveals evidence that post-booking diversion programs (such as jail-based diversion, court-based diversion and mental health courts) reduce recidivism and the number of days incarcerated.

Post-incarceration programs (such as mental health probation and parole, and forensic assertive community treatment) show a moderate to high degree of evidence of effectiveness in reducing recidivism and the number of days incarcerated. Post-incarceration programs also show moderate effectiveness in increasing service utilization, but a low degree of effectiveness in reducing substance use.²⁶

3.4) Overview of Mental Health Education and Training

Education for Police Officers

In Ontario, new police recruits are hired by municipal or provincial police services and required to attend the Ontario Police College (OPC) for training and education before they assume their duties. The OPC training, which is a 60 day program, is mandated by the Ministry of Community Safety and Correctional Services. Specifically, police/mental health training is required under the Policing Standards Manual, Section AI-012A: Use of Force: Ontario Police College Guidelines, Section LE-013: Police Response to Persons Who Are Emotionally Disturbed or Have a Mental Illness or a Developmental Disability, and Section LE-047: Police Response to High Risk Individuals.²⁷

The OPC has developed training standards (Basic Constable Training: Tactical Communication) that provide training relevant to frontline police officers on the subject of responding to people with mental disorders. There are three stages of training: basic constable training (consisting of two days of training on mental health issues), advanced patrol training (a refresher course that includes a 90 minute period dedicated to mental health issues), and use of force course (consisting of two 90 minute periods focusing on scenarios involving individuals with mental disorders).²⁸

The OPC, in partnership with the Centre for Addiction and Mental Health and St. Joseph's Health Care London, also developed *Not Just Another Call: Police Response to People with Mental Illnesses in Ontario*, a manual for frontline police officers responding to individuals with mental disorders.²⁹

INNOVATIVE SOLUTIONS IN ONTARIO

Not Just Another Call Manual is a practical guide for frontline police officers that provides strategies and resources for managing interactions with individuals with mental disorders. The purpose of the manual is to provide an additional resource for dealing with complex calls for assistance, and includes information about basic signs and symptoms of major mental disorders, relevant provisions of the *Mental Health Act*, and strategies for de-escalating potentially high risk situations.

Along the same lines, the Ontario Provincial Police (OPP) provides a three-day course on mental health issues. Based on the Memphis Crisis Intervention Team training model, this course offers de-escalating training, stresses the importance of building relationships with community mental health agencies and hospitals, and provides information on different types, symptoms and behaviours associated with mental disorders. The course is voluntary and is offered to interested OPP officers (key informants interviewed for the HSJCC Police & Mental Health project indicated that 120 officers have been trained thus far). In the course, the OPP also utilize a computerized/video segment known as Critical Incident Response Training (CIRT).³⁰

INNOVATIVE SOLUTIONS IN ONTARIO

Critical Incident Response Training (CIRT) is a web-based training program about police encounters with people with mental disorders. Using scenarios, police officers can move through the situation, step-by-step, and decide how to respond appropriately. At each step, the program identifies the best response under the circumstances. The program was developed through collaboration between the University of Ontario Institute of Technology (UOIT), Durham Regional Police and Ontario Shores Centre for Mental Health Sciences (formerly the Whitby Mental Health Centre).

Various police/mental health training workshops are being carried out in the community as well. Some examples include LEAD Team Training in the Southeast region, HELP Team Training in Chatham-Kent, COAST Training in the Halton region, and the annual police training offered by the Local HSJCC and CMHA in Kawartha Lakes. These are all examples of community-based training models that are a result of collaborations across various sectors, including community mental health services, hospitals, consumer/survivor organizations and local police services. The workshops focus on providing education and resources to police officers (and occasionally other professionals in the justice system, such as judges, Crown Attorneys and corrections officers) to respond appropriately when interacting with individuals with mental disorders or emotionally disturbed persons. Key informants interviewed for the HSJCC Police & Mental Health project who are involved with providing this type of community-based training expressed the need for ongoing funding and resources to support police/mental health training across the province.

A recent report by the Canadian Alliance on Mental Illness and Mental Health (*Understanding Mental Illness: A Review and Recommendations for Police Education and Training in Canada; 2010*) emphasized the importance of police/mental health education and training, and provided criteria for developing a successful training program:

- Selection of appropriate ‘trainers,’ including those who are both subject matter experts and who are operationally credible;
- Inclusion of local mental health professionals for the purposes of providing reliable information as well as to assist police to form local connections with mental health agencies;
- Integrating people with mental illnesses and their families into the training in order to provide direct experience with this population;
- Using a variety of forms of media including participatory strategies;
- A focus on cognitive determinants of behaviour including attitudes, exercise of discretion and stigma; and
- Adaptability of the curriculum to reflect the population receiving education/training (e.g. new officers versus specialized teams versus dispatch personnel) as well as including local community needs.³¹

The report also proposes a new model for police in-service training called Training and Education about Mental Illness for Police Officers (TEMPO). TEMPO incorporates components of a variety of different education and training models, including many of the programs discussed above. TEMPO is designed to accommodate a wide variety of police learning needs, and offers a series of courses including:

1. TEMPO 100: The focus of learning at the TEMPO 100 level is to ensure that police first responders have sufficient knowledge and skills to be able to manage the types of encounters that police personnel have on a regular basis and to know when to seek additional support or, when available, more skilled intervention.
2. TEMPO 200: The TEMPO 200 level learning assumes a pre-existing basic level of competence, and builds on it, but is still focused primarily on the first police responder. It includes both a refresher/review of previously taught information and an update on new developments.
3. TEMPO 300: The 300 level learning is for police personnel in specialized assignments that require either a more in depth and higher level of skill and knowledge, or a more focused understanding compared to the first responder.
4. TEMPO 400: The TEMPO 400 level is learning for specialist officers who will be providing expert or consultative services with regard to police contact with people with mental illnesses. Personnel who successfully complete this module, as evidenced by an exam, will be awarded the TEMPO insignia to be worn on their uniform or, if working in 'plain clothes,' on their jacket.
5. TEMPO 500: Learning Module to be integrated into Use-of-Force training. This one-day module is intended to be integrated into what has traditionally been stand-alone use-of-force training. It should complement and reinforce the learning of all other TEMPO modules.³²

This multi-level training model is intended for all police personnel including police officers, call-takers, dispatchers, front desk staff and victim services workers who have contact with people with mental disorders. The report states, "This model has built-in flexibility to take into account local circumstances and the target group(s) for learning. The difference between each module is the target group, and thus the emphasis placed on each subject area, the degree of detail and the amount of practical or experiential learning."³³

Education for Healthcare Providers

In some areas of the province, healthcare providers are receiving education and training about the justice system. For example, the Ontario Hospital Association and its Provincial Leadership Council developed A Practical Guide to Mental Health and the Law in Ontario, a toolkit and resource manual for mental health care providers on the subject of law and mental health.³⁴ The document offers an overview of relevant legislation, ORB and consent and capacity issues, and issues relating to criminal law and forensic patients. Similarly, key informants interviewed for the HSJCC Police & Mental Health project indicated that members of the Durham Regional Police Services have conducted an information workshop for healthcare providers at Ontario Shores Mental Health Sciences and Lakeridge Mental Health on police protocols relating to the proper use of conducted energy weapons.

3.5) Mental Health Crisis Response Initiatives

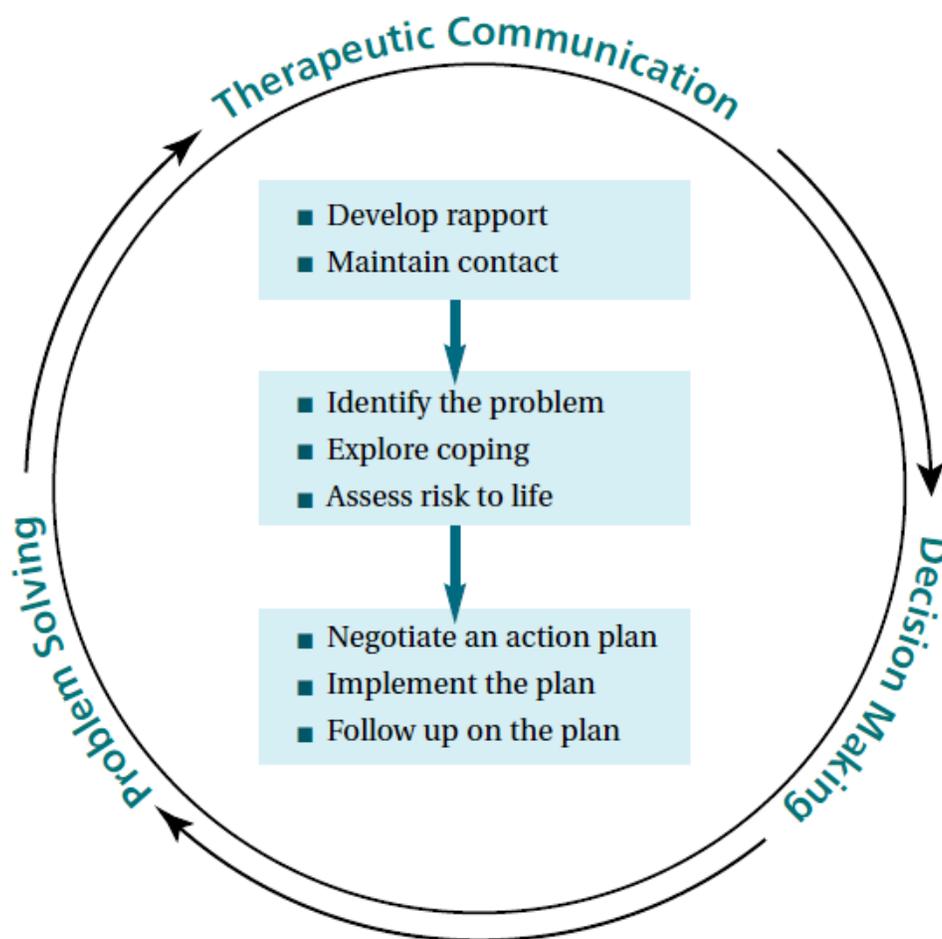
In 2005, the Ministry of Health and Long-Term Care, with the support of an inter-sectoral Stakeholder Working Group, developed Crisis Response Service Standards for Mental Health Services and Supports. The document expands on the core functions of crisis response services first outlined in *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* (1999). There are seven service functions identified:

- Assessment and Planning – includes gathering pertinent information from the consumer and other key supports to develop an understanding of recent events, and psychosocial and biological factors related to the presenting crisis. This function also includes the development of an intervention plan which takes into account the consumer’s immediate needs, strengths, weaknesses and social support system.
- Crisis Support/Counseling – provides the individual and family with emotional support, practical assistance and access to a range of appropriate resources available to resolve the immediate crisis.
- Medical Intervention – is an integral part of the crisis response system. It is important to develop links between medical and non-medical service providers to ensure access to resources to resolve the crisis. Medical interventions may be provided by nurses, physicians and pharmacists.
- Environmental Interventions and Crisis Stabilization – involves access to required services to stabilize the crisis and includes direct action within the individual’s community to provide supports such as arranging for money/income support, dealing with employers, planning for long/short-term housing/accommodation issues and addressing family issues.
- Review/Follow-up/Referral – provides appropriate referral to ongoing services and supports that have been mutually defined by the consumer and service provider once the crisis has dissipated.
- Monitoring and Evaluation – evaluates the achievement of goals (from the perspective of both the consumer and service provider) and consumer satisfaction.
- Information, Liaison, Advocacy and Consultation/Collaboration – provides information to the consumer, family/key supports and service providers regarding types of services and supports available. Works to establish partnerships among service providers to create an integrated service network, and advocates and consults on behalf of consumers and families/key supports within the service network.³⁵

Along the same lines, the Registered Nurses Association of Ontario (RNAO) has developed *Nursing Best Practice Guideline: Crisis Intervention*, a comprehensive document that provides evidence-based practices and resources for crisis intervention.³⁶ The guideline contains 13 recommendations, including a range of options from education, practice recommendations and organizational policy development. A step-by-step guide to crisis intervention is also provided (see Figure 1).³⁷

Figure 1: RNAO Integrative Model of Crisis Intervention

The focus of the model below is to identify the precipitating event, the client's cognition or perceptions of the event, his or her degree of subjective distress, failed coping mechanisms, and impaired functioning. The goal is to return the client to his or her pre-crisis level of functioning emotionally, occupationally and interpersonally.



Key informants interviewed for the HSJCC Police & Mental Health project indicated that although the MOHLTC and RNAO crisis intervention documents exist, these guidelines are not operationalized consistently throughout the province. They urged the development of standard provincial protocols for crisis intervention that include monitoring and accountability mechanisms.

With regards to police/mental health collaboration, key informants indicated that there are various initiatives across the province that are focused on providing crisis response services, including police/mental health liaison officers, crisis intervention team (CIT) officers and mobile crisis intervention teams (MCITs). Again, they noted that although these initiatives exist, there is a lack of provincial program standards.

Some police services in Ontario have a designated mental health liaison officer who is the primary contact between the police detachment and community mental health services. The officer may be a first responder to mental health crises, or may provide support to other first responders. The individual may also sit on local police/mental health planning committees, such as the HSJCCs, and be involved with coordinating services between the justice and mental health sectors. For example, key informants interviewed for the HSJCC Police & Mental Health project indicated that Lennox and Addington County has a designated 0.5 FTE Police Liaison Officer position. The officer works closely with the Lennox and Addington County HSJCC and has established a working relationship with Lennox and Addington County Community Mental Health Services.

Similarly, several police detachments across the province have crisis intervention team (CIT) officers. These are specially trained police officers who are able to respond to mental health crisis situations. Typically, a CIT officer will have undergone crisis intervention training, such as the community-based police/mental health training workshops previously detailed in Part 3.4: Overview of Mental Health Education and Training. Some examples include the OPP CIT officers in the Haldiman-Norfolk region, the LEAD Team officers in the Southeast region, and the HELP Team officers in Chatham-Kent.

Mobile crisis intervention teams (MCITs) are another example of a collaborative police/mental health approach to crisis intervention. MCITs consist of both police officers and mental health workers that co-respond to crisis situations. Although this is typically not a rapid response service such as 911, once the MCIT arrives on the scene, the mental health worker conducts a brief assessment of the individual in crisis. The mental health worker can make a decision at the scene about whether the individual needs to undergo a psychiatric assessment at a hospital, or if the individual needs to be directed to community mental health services. The police officers on the MCIT assist in the situation by securing the scene and ensuring everyone's safety and, if needed, apprehending the individual under the *Mental Health Act* and escorting them to the nearest hospital. The Crisis Outreach and Support Team (COAST) in Hamilton is an example of this type of MCIT.³⁸

INNOVATIVE SOLUTIONS IN ONTARIO

Crisis Outreach and Support Team (COAST) is an MCIT consisting of multidisciplinary mental health workers (social workers, nurses, etc.) and specially trained, plain-clothed police officers that co-respond to mental health crises in the community. COAST arrives at the scene of the mental health crisis and completes a risk assessment and mental status exam of the individual. When the assessment is complete, a plan is developed to defuse the crisis situation while the individual remains safely within the community. A follow-up plan is developed that may involve linkage to additional community organizations. If the situation cannot be safely managed in the community, the COAST team assists the individual to hospital for further assessment and treatment. Currently, there are COAST programs in Hamilton, Halton, Peel and the Chatham-Kent area.

3.6) Police Encounters in the Hospital

Police officers are required to escort any individuals apprehended under the *Mental Health Act* to the nearest hospital for an assessment by a physician. During these escorts, officers are often subjected to extended wait-times in the hospital emergency room (ER). In response to this ER wait-time issue, some hospitals have begun to triage police escorted individuals at a faster rate. St. Joseph’s Health Centre Hamilton, the Royal Ottawa Health Care Group, and Chatham-Kent Health Alliance are among the hospitals that have inter-agency agreements with local police services to reduce the wait-times for police officers.

INNOVATIVE SOLUTIONS IN ONTARIO

HELP Team Protocol outlines a step-by-step process for Chatham-Kent police officers who are escorting individuals to the ER at Chatham-Kent Health Alliance. When an officer is *en route* to the hospital, an ER crisis nurse is notified of the pending arrival of the police escorted individual. When the officer arrives with the individual, the crisis nurse conducts an initial assessment to determine whether the individual needs to be admitted to the hospital. If the individual is admitted, then the police ensure everyone’s safety before leaving the scene. If the individual is not admitted, the crisis nurse arranges for follow-up care in the community.

The “revolving door” can also occur in the ER. To help reduce the revolving door effect, Waterloo Regional Police Service, in collaboration with CMHA Grand River and the Waterloo-Wellington Regional Crisis Services, have developed a police/mental health screening tool called Mental Health Risk Assessment Form.³⁹

INNOVATIVE SOLUTIONS IN ONTARIO

Mental Health Risk Assessment Form is a two-page screening tool that was developed in partnership with Waterloo Regional Police Service, CMHA Grand River and Waterloo-Wellington Regional Crisis Services. The form is completed by the police officer on the scene following an encounter with an individual who is showing signs of a mental disorder. If the individual is escorted to the ER by the officer, then a copy of the form is provided to the hospital. If a charge is laid by the officer and the individual is arrested, then a copy of the form is provided to the local Crown Attorney.

Hospitals can also call on the police to help manage a “high risk” situation. To facilitate communication during these situations, some hospitals have developed joint policies with police services outlining the protocol for police while in the hospital setting. Ontario Shores Centre for Mental Health Sciences has developed such a protocol with Durham Regional Police Services.

INNOVATIVE SOLUTIONS IN ONTARIO

Protocol between Durham Regional Police Services and Ontario

Shores Centre for Mental Health Sciences outlines the proper procedures for managing “high risk” situations when police intervention is needed on a hospital ward. When police officers arrive on the scene, hospital staff relinquish control and allow the officers to secure the ward with appropriate use of force. When the situation is secure, hospital staff members resume their role on the ward. Following such encounters, Ontario Shores conducts a follow-up call with Durham Regional Police to ensure that proper procedures were followed and to discuss any areas for improvement for both parties.

3.7) Overview of the *Personal Health Information and Protection Act*

In Ontario, health information is protected by the *Personal Health Information and Protection Act* (PHIPA).⁴⁰ Section 4 of the act states:

“personal health information” means identifying information about an individual in oral or recorded form, if the information,

- (a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual’s family,
- (b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,
- (c) is a plan of service within the meaning of the *Home Care and Community Services Act, 1994* for the individual,
- (d) relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual,
- (e) relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,
- (f) is the individual’s health number, or
- (g) identifies an individual’s substitute decision-maker.

Under Section 3 of PHIPA, only a “health information custodian” can have custody or control of personal health information as a result of, or in connection with, performing the person’s or organization’s powers or duties. Police officers are not included in the list of health information custodians.

Accordingly, in *Circle of Care: Sharing Personal Health Information for Health-Care Purposes*, the Ontario Information and Privacy Commissioner also indicates that police officers are excluded from “the circle of care.” Although the circle of care is not defined under PHIPA legislation, it is a term commonly used to describe “the ability of certain health information custodians to assume an individual’s implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in PHIPA.”⁴¹ The Ontario Information and Privacy Commissioner further states that a health information custodian may only assume an individual’s implied consent to collect, use or disclose personal health information if all of the following six conditions are satisfied:

1. The health information custodian must fall within a category of health information custodians that are entitled to rely on assumed implied consent (health information custodians that can rely on implied consent include, health care practitioners, long-term care homes, community care access centres, hospitals, including psychiatric facilities, specimen collection centres, laboratories, independent health facilities, pharmacies, ambulance services, and the Ontario Agency for Health Protection and Promotion).

2. The personal health information to be collected, used or disclosed by the health information custodian must have been received from the individual, his or her substitute decision-maker or another health information custodian.
3. The health information custodian must have received the personal health information that is being collected, used or disclosed for the purpose of providing or assisting in the provision of health care to the individual.
4. The purpose of the collection, use or disclosure of personal health information by the health information custodian must be for the provision of health care or assisting in the provision of health care to the individual.
5. In the context of disclosure, the disclosure of personal health information by the health information custodian must be to another health information custodian.
6. The health information custodian that receives the personal health information must not be aware that the individual has expressly withheld or withdrawn his or her consent to the collection, use or disclosure.

Furthermore, Section 29 of PHIPA states that the individual's consent must be obtained before health information is collected or disclosed:

A health information custodian shall not collect, use or disclose personal health information about an individual unless,

(a) it has the individual's consent under this Act and the collection, use or disclosure, as the case may be, to the best of the custodian's knowledge, is necessary for a lawful purpose; or

(b) the collection, use or disclosure, as the case may be, is permitted or required by this Act.

However, PHIPA does allow exceptions to the rule concerning when health information can be shared. Under Section 40, it reads:

A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

Therefore, in the context of police/mental health collaboration, consent is needed from the client before healthcare providers can share mental health information with police services, unless the disclosure is necessary for the purpose of eliminating or reducing a significant risk or serious bodily harm to individuals or the community.

Across the province, Hsjccs are utilizing different methods for sharing information with police while continuing to abide by the PHIPA legislation. COAST Hamilton has developed a document (Guide to Sharing Information with Police and Dispatchers in Police Communication) that provides a step-by-step guide to information sharing.⁴² Along the same lines, Lanark County's LEAD Team Protocol has developed a Police/Mental Health Referral Form for information sharing based on the consent model, wherein consent from the client is obtained before any information is shared with police services.⁴³

INNOVATIVE SOLUTIONS IN ONTARIO

Guide to Sharing Information with Police and Dispatchers is a guide developed by COAST Hamilton. This guide clearly outlines the circumstances under which Hamilton COAST workers can and cannot share information with Hamilton Police Services. The guide provides a discussion about legislation relating to health information sharing, situations when PHIPA can be breached to ensure everyone's safety, procedures for sharing information, and a step-by-step guide to managing telephone inquiries from police/dispatchers. The guide also highlights situations when health information absolutely cannot be shared.

Police/Mental Health Referral Form is a standardized form in the Lanark County LEAD Team Protocol. Any LEAD officer in Lanark County who escorts an individual to the emergency room completes this referral form and submits a copy to Lanark County Mental Health. Subsequently, Lanark County Mental Health conducts a follow-up with the individual. After obtaining consent from the individual, Lanark County Mental Health informs the police whether or not the individual is receiving follow-up care (the only information that is shared is whether or not the individual is attending follow-up services; treatment details are not shared).

With regards to forensic clients who are deemed not criminally responsible (NCR) under the *Criminal Code* and are issued a disposition from the Ontario Review Board (ORB), the disposition information is readily available to care providers, police services and the public. Typically, a forensic client's ORB disposition will state that the psychiatric facility where the individual is being detained must notify local police services when the individual is entering the community, and inform the police of the terms and conditions under which the individual is permitted to do so.⁴⁴ In like manner, information is shared with police in situations where a forensic client is absent without leave from the psychiatric facility where they are being detained. Ontario Shores Centre for Mental Health Sciences together with Durham Police Services has developed an electronic memorandum that facilitates this type of information sharing regarding forensic clients.⁴⁵

INNOVATIVE SOLUTIONS IN ONTARIO

Electronic Memorandum Form was developed jointly by Ontario Shores Centre for Mental Health Sciences and Durham Regional Police Services. The electronic memo, which is compatible with the police services' versadex e-records system, allows Ontario Shores to inform the local police each time a forensic client's privileges have been increased, and when a forensic client is absent without leave. If the Durham Police have an interaction with a forensic client from Ontario Shores out in the community, then they are able to easily download the electronic memo to their computer and gather the information they need about the client in order to make a decision about how to proceed.

3.8) Mental Health Police Records

A police record, also known as a “vulnerable persons check” or screening form, differs from a criminal record.⁴⁶ A criminal record provides information about any convictions an individual has received; a police record, on the other hand, can show more detailed information. For example, when police officers escort individuals in crisis to a hospital through apprehension under the *Mental Health Act*, this generates an occurrence with the local police services and creates a non-criminal police record. The record is available to any police officer in the jurisdiction, and typically stays on file for several years after the police encounter.

This type of police file frequently has negative repercussions for individuals with mental disorders if they are required to obtain a police records check or a “vulnerable sector screening” for the purpose of working or volunteering with a vulnerable population. Having a police record also increases the stigma experienced by individuals with mental disorders. As well, information from the field indicates that individuals who have mental health police records may also be refused entry into the United States at the border.

In response to this issue, the Mental Health Police Records Check Coalition, a group of over 30 stakeholders, is working to stop the practice of releasing non-criminal information related to police apprehensions under the *Mental Health Act*.⁴⁷

The Ontario Human Rights Commission (OHRC) has developed an interim guide (Police Records Checks for Vulnerable Sector Screening) that outlines procedures for releasing mental health police records.⁴⁸ Under this interim guide, an individual’s *Mental Health Act* apprehension information can be released only if the employer can provide justification for why the information is required for the job.

Currently, the Ontario Association of Chiefs of Police, with the support of the OHRC, is in the process of developing a provincial protocol regarding the proper disclosure of mental health police records. In the interim, Toronto Police Services has developed a Police Reference Check Program based on the existing OHRC guidelines.⁴⁹

INNOVATIVE SOLUTIONS IN ONTARIO

Police Reference Check Program developed by Toronto Police Services attempts to protect a person’s *Mental Health Act* apprehension information while providing a potential employer with information relevant to the job. All employers requesting *Mental Health Act* apprehension information must have a memorandum of understanding (MOU) with Toronto Police Services. In addition, police checks can only be conducted after the person has signed a form consenting to disclosure. All police records information is disclosed directly to the client, and not the employer.

3.9) Innovative Solutions for Transporting Clients

Under Section 29 of the *Mental Health Act*, police officers may act as an escort to transfer an individual from one psychiatric facility to another. Key informants interviewed for the HSJCC Police & Mental Health project indicated that transportation often poses challenges for both police officers and care providers. In response to this issue, Lanark County's LEAD Team works with local emergency medical services to assist in the transportation of individuals with mental disorders.⁵⁰

INNOVATIVE SOLUTIONS IN ONTARIO

Lanark County Ambulance Service provides transportation and escorts individuals with mental disorders from the local emergency room to the nearest Schedule 1 psychiatric facility. The LEAD Team Protocol in Lanark County outlines the procedure for transporting individuals to Schedule 1 facilities. In "high risk" situations where there are concerns regarding staff and patient safety, police officers follow the ambulance in their police car to provide assistance as needed.

Informants from corrections services indicated that police officers may also be called upon to escort "high risk" mentally disordered accused and offenders out in the community, to medical appointments, court appearances and other meetings. The Algoma Treatment and Remand Centre has developed a protocol with local police specifically for these types of community escorts.⁵¹

INNOVATIVE SOLUTIONS IN ONTARIO

Police Assistance Policy at Algoma Treatment and Remand Centre (ATRC) outlines the situations under which police services should be contacted to assist with community escorts. The policy promotes staff and public safety during community escorts, and encourages a close working relationship between ARTC superintendents and local police services.

3.10) Overview of Community Treatment Orders

The use of community treatment orders (CTOs) is legislated under Section 33.1 of the *Mental Health Act*. A CTO is an order by a physician for an individual with a mental disorder to receive treatment and supervision in the community, rather than remain in the hospital.⁵² A CTO includes a community treatment plan that outlines the medications, medical appointments and other aspects of care prescribed by the doctor. The community treatment plan is developed by the doctor in consultation with the individual (or their substitute decision-maker) and any community agencies (such as CMHAs, CCJOs, addictions agencies, etc.) that can provide support to the individual. If the individual is in breach of the CTO, then the individual can be apprehended by police officers and ordered to return to his/her doctor to ensure compliance with the CTO.

In accordance with the requirements of the *Mental Health Act*, the Ministry of Health and Long-Term Care conducted a review of CTOs in 2005. The resulting document, Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the Mental Health Act, provides an analysis of the reasons that CTOs were or were not used, the effectiveness of CTOs, and the methods used to evaluate the outcome of treatments used under CTOs.⁵³

This report consists of 45 recommendations and states that the CTO provisions in the *Mental Health Act* legislation work best when:

- Physicians and other professionals are willing to use CTOs, but only after first considering the other suitable alternatives.
- Clients and substitute decision-makers are consulted and involved in the formulation and execution of the community treatment plans and community treatment orders.
- There is a coordinated continuum of care involving both hospital and community-based professionals and resources.

Furthermore, the report highlights a number of issues relating to CTOs, including, “the paucity of research around the coerciveness inherent in CTOs versus the need to receive treatment, and the dilemma that this creates; the many enforcement issues that create problems for psychiatrists and law enforcement agencies and that do not necessarily serve the best interests of the CTO client; broadening the role of CTO coordinators to improve the management of the CTO process; and the problems in obtaining timely, accurate and complete data.”⁵⁴

3.11) Overview of Assertive Community Treatment Teams

Assertive Community Treatment Teams (ACTTs) provide client-centred and recovery-oriented mental health services for individuals with mental disorders. The Ministry of Health and Long-Term Care has developed standards for ACTTs, which include the following general principles:

- ACT serves clients with serious mental illnesses that are complex and who have very significant functional impairments, and who, because of the limitations of traditional mental health services, may have gone without appropriate services.
- ACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services clients need to achieve their goals. The team is directed by a team coordinator and a psychiatrist and includes a sufficient number of staff from the core mental health disciplines, at least one peer specialist, and a program/ administrative support staff who work in shifts to cover 24 hours per day, seven days a week to provide intensive services (multiple contacts may be as frequent as two to three times per day, seven days per week, and are based on client need and a mutually agreed upon plan between the client and ACT staff).
- ACT services are individually tailored with each client and address the preferences and identified goals of each client.
- The ACT team is mobile and delivers services in community locations to enable each client to find and live in their own residence and find and maintain work in community jobs rather than expecting the client to come to the program.
- ACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver.
- ACT teams are required to have policies and procedures for each of the areas identified in the Standards. Once policies and procedures are in place, they maintain the organizational and service structure that supports the work and are useful in orienting and training new staff.⁵⁵

3.12) Working with Marginalized Communities

Informants interviewed for the HSJCC Police & Mental Health project indicated that individuals from racialized communities are over-represented in the criminal justice system. Across the province, individuals from Aboriginal and racialized communities are increasingly coming into contact with the justice system and increasingly being incarcerated. Individuals from these communities have unique needs and face multiple barriers to accessing the social determinants of health, including income, employment, education and housing. These communities are vulnerable to mental disorders and addictions, as well as criminalization. As a result, key informants stressed the need to foster supportive communities and develop strengths-based approaches to protecting these groups from mental disorders and addictions, as well as preventing individuals from coming into contact with the justice system.

Currently, the Thunder Bay Drug Strategy Steering Committee is working with local Aboriginal communities to develop a comprehensive strategy for assisting individuals with addictions and mental disorders.⁵⁶

INNOVATIVE SOLUTIONS IN ONTARIO

Thunder Bay Drug Strategy Steering Committee is a multi-agency collaboration working to improve the health, safety and well-being of the community by working together to reduce the harm caused by substance misuse. The mission of the committee is to create a drug strategy for the City of Thunder Bay that reflects the needs and strengths of its citizens. Several local Aboriginal organizations are partners in this initiative, including Anishnawbe Mushikiki Community Health Centre, Dilico Anishinabek Family Care, Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre, and the Nishnawbe-Aski Police Service (NAPS).

APPENDIX A: Provincial HSJCC Police/Mental Health Advisory Committee

Judy Alton, Ontario Provincial Police and Provincial HSJCC

Lisa Cameron, Ministry of the Attorney General and Provincial HSJCC

Uppala Chandrasekera, Canadian Mental Health Association, Ontario and resource to Provincial HSJCC

Sharon Deally-Grzybowski, CMHA Grand River and Waterloo-Wellington Regional HSJCC

Michael Feindel, Ministry of the Attorney General

Michelle Gold, Canadian Mental Health Association, Ontario and resource to Provincial HSJCC

Chris Higgins, Ministry of Health and Long-Term Care and Provincial HSJCC

Vicky Huehn, Frontenac Community Mental Health Services and Provincial HSJCC

Ian Peer, Ontario Association of Chiefs of Police, London Police Services and Provincial HSJCC

APPENDIX B: HSJCC Police/Mental Health Survey



Provincial Human Services and Justice Coordinating Committee

Police/Mental Health Project Survey of Police/Mental Health Collaborations in Ontario

To inform the Provincial HSJCC policy project on police/mental health collaboration, please provide information about the joint police and mental health/human services initiatives in your area. Please note the collaborations that are formal and informal, and provide information about joint initiatives with police that provide services to individuals with serious mental illness, developmental disability, acquired brain injury, drug and alcohol addictions, and/or fetal alcohol syndrome.

Contact Information

Please provide the name and contact information of the person completing this survey.

Name:
Phone:
Email:

Committee Information

Please provide information about your HSJCC.

Name of Committee:
Regional Committee or Local Committee:

Information regarding police/mental health initiatives in your area:

1. What types of joint police and mental health/human services initiatives currently exist in your area? (i.e. joint planning committees, crisis intervention services, inter-agency service agreements, etc.)

2. Are they formal partnerships or informal co-operative initiatives?

3. What are the different components of these initiatives? (i.e. training/education, service provision, policy development, etc.)

4. Where are these initiatives located? What geographical areas do these initiatives serve?

5. What populations do these initiatives serve? And what is the population size?

6. How are these initiatives funded?

7. How are these initiatives monitored and/or evaluated? And by whom?

8. In your area, which mental health/human services organizations collaborate with police services? Please name the various agencies.
 - a) Adult mental health agencies?
 - b) Hospitals?
 - c) Assertive Community Treatment Teams?
 - d) Addictions agencies?
 - e) Community criminal justice organizations?
 - f) Developmental disability agencies?
 - g) FASD organizations?
 - h) Youth mental health agencies?
 - i) Other?

Thank you very much for taking part in this survey!

APPENDIX C: HSJCC Police/Mental Health Survey Respondents

1. Algoma Local HSJCC
2. Brant Local HSJCC
3. Chatham-Kent Local HSJCC
4. Downtown Toronto Local HSJCC
5. Essex County Local HSJCC
6. Frontenac County Local HSJCC
7. Haldimand-Norfolk Local HSJCC
8. Haliburton Local HSJCC
9. Hastings and Prince Edward County Local HSJCC
10. Kenora District Local HSJCC
11. Lanark County Local HSJCC
12. Leeds-Grenville Local HSJCC
13. Lennox-Addington County Local HSJCC
14. Niagara Local HSJCC
15. Nipissing-Timiskaming-Parry Sound Local HSJCC
16. North West Regional HSJCC
17. North York Local HSJCC
18. Northumberland Local HSJCC
19. Oxford County Local HSJCC
20. Pembroke-Renfrew Local HSJCC
21. Peterborough Regional HSJCC
(two surveys were received and answers were consolidated)
22. Scarborough Local HSJCC
23. Simcoe-Muskoka Regional HSJCC
24. Sudbury-Manitoulin Local HSJCC
25. Timmins-Cochrane Local HSJCC
26. Waterloo-Wellington Regional HSJCC
27. West Toronto Local HSJCC
28. York-South Simcoe Regional HSJCC

End Notes

- ¹ Ministry of the Attorney General, et al., 1997: pp. i-iii.
- ² Canadian Association of Chiefs of Police, 2006: pp. 2-3.
- ³ *Criminal Code of Canada*, 1985: Section 2.
- ⁴ *Criminal Code of Canada*, 1985: Sections 672.11, 672.22-672.37; Forensic Mental Health Services Expert Advisory Panel, 2002: pp. 139.
- ⁵ *Criminal Code of Canada*, 1985: Section 2.
- ⁶ Forensic Mental Health Services Expert Advisory Panel, 2002: pp. 12.
- ⁷ *Personal Health Information and Protection Act*, 2004.
- ⁸ CMHA Toronto, 2010.
- ⁹ Chatham-Kent Police Service, et al., 2010.
- ¹⁰ Perth Police Service, et al., 2008.
- ¹¹ *Criminal Code of Canada*, 1985.
- ¹² Canadian Mental Health Association, Ontario, 2009: pp. 14-15.
- ¹³ Cotton, et al., 2010: pp. 7.
- ¹⁴ Canadian Mental Health Association, Ontario, 2009: pp. 14-15.
- ¹⁵ *Criminal Code of Canada*, 1985: Sections 16 and 672.34 – 672.37.
- ¹⁶ *Mental Health Act*, 1990.
- ¹⁷ *Police Services Act*, 1990.
- ¹⁸ Canadian Association of Chiefs of Police, 2006: pp. 4-9.
- ¹⁹ For example, the Ottawa Police Services Board has created policies based on the Policing Standards Manual; Ottawa Police Services Board, 2010: pp. 20.
- ²⁰ Ontario Ministry of the Solicitor General, 2000: pp. 1-3.
- ²¹ Ministry of Health and Long-Term Care, 2006: pp. 11-12.
- ²² Ministry of the Attorney General, 2005.
- ²³ Ministry of the Attorney General, 2006: pp. 3.
- ²⁴ Ministry of the Attorney General, 2006: pp. 3-5.
- ²⁵ CMHA Peel, 2010: pp. 10.
- ²⁶ CMHA Peel, 2010: pp. 2-3.
- ²⁷ Sections AI-012, LE-013 and LE-047 of *Policing Standards Manual*, 2010.

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- ²⁸ Ontario Police College, 2010.
- ²⁹ Ontario Police College, et al., 2004.
- ³⁰ UOIT, et al., 2010.
- ³¹ Canadian Alliance on Mental Illness and Mental Health, 2010: pp. 5-6.
- ³² Canadian Alliance on Mental Illness and Mental Health, 2010: pp. 39-45.
- ³³ Canadian Alliance on Mental Illness and Mental Health, 2010: pp. 6.
- ³⁴ Ontario Hospital Association, 2010.
- ³⁵ Ministry of Health and Long-Term Care, 2005: pp. 6-17.
- ³⁶ Registered Nurses Association of Ontario, 2002.
- ³⁷ Registered Nurses Association of Ontario, 2002: pp.25.
- ³⁸ COAST Hamilton, 2010.
- ³⁹ Waterloo Regional Police Service, et al., 2010.
- ⁴⁰ *Personal Health Information and Protection Act*, 2004.
- ⁴¹ Information and Privacy Commissioner, 2009: pp. 4.
- ⁴² Beal, S., 2010: pp. 1-10.
- ⁴³ Perth Police Service, et al., 2008.
- ⁴⁴ Ontario Review Board, 2008: pp. 2.
- ⁴⁵ Durham Regional Police, 2010.
- ⁴⁶ Mental Health Police Records Check Coalition, 2010.
- ⁴⁷ Mental Health Police Records Check Coalition, 2010.
- ⁴⁸ Ontario Human Rights Commission, 2010.
- ⁴⁹ Toronto Police Services, 2010.
- ⁵⁰ Perth Police Service, et al., 2008.
- ⁵¹ Algoma Treatment and Remand Centre, 2010.
- ⁵² Psychiatric Patient Advocate Office, 2003: pp. 1-4.
- ⁵³ Dreezer & Dreezer Inc., 2005: pp. 9-20.
- ⁵⁴ Dreezer & Dreezer Inc., 2005: pp. 9-20, 123-137.
- ⁵⁵ Ontario ACT Association, 2010.
- ⁵⁶ Thunder Bay Drug Strategy Steering Committee, 2010.

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