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Canada

“Not just another call… police response to people with mental illnesses in Ontario”

(including excerpts from Bill 68, December 2000)

a practical guide for the frontline officer

Dedication:

"NOT JUST ANOTHER CALL…POLICE RESPONSE TO PEOPLE WITH MENTAL ILLNESSES IN ONTARIO"

Recommendations from various coroner's inquests such as the Donaldson inquest (1994), the Brian Smith inquest (1997) and the Edmund Yu inquest (1999) have all identified the need to develop a resource for police that would enable them to respond effectively to persons suffering from a mental illness. Although various efforts were made to address these recommendations, Ron Hoffman, Subject Coordinator of Tactical Communications from the Ontario Police College, Ministry of Community Safety and Corrections drafted the basis of this resource guide with Laurel Putnam, former Clinical co-leader of the Forensic Program, Regional Mental Health Care St. Thomas. Further input came from the Toronto Police Service, various individuals and organizations concerned about mental illness issues and later, the Centre for Addiction and Mental Health.

This guide is dedicated to those police officers and mental health care professionals who, through years of experience gained on the frontline, developed and refined the strategies presented herein.

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Forward: Perspectives from the Community

A practical guide for police officers is an event whose time has come. It reflects the increasing recognition for the need to provide a seamlessness of care to those who are mentally ill.

Dr. Shahe Kazarian and I have had the privilege of organizing training modules for police officers (in London, Ontario) as part of their in-service training. This initiative has advanced my understanding of the complex challenges faced by police officers and how these challenges interact with their core responsibility of protecting the community and public peace, while at the same time ensuring that individual rights and freedoms are not compromised. These challenges have the potential to create a conflict at times as the mentally ill person may be exhibiting behaviours that are contrary to social norms and may be a threat to public peace.

We have been impressed by the willingness of police officers to become informed about the complex nature of the behaviours arising from various mental illnesses. While they make it clear that they are not intending to become "mental health workers", and while they recognize the limits of their professional responsibilities, they certainly acknowledge that they have a critical role to play in the interface between the mental health system and the judicial system.

This resource guide is the result of extensive consultation and collaboration with those who have first-hand knowledge of the challenges faced by police officers. I commend this resource guide as an important contribution to assist police officers in discharging their duties in an effective manner. In the final analysis, each of us who interacts with those who are mentally ill has a responsibility to fully understand the nature of these illnesses and the most appropriate way to respond in order to minimize some of the deleterious effects resulting from lack of information and stigmatization.

– **Dr. Emmanuel Persad**
Professor Emeritus
University of Western Ontario
Psychiatrist
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Police officers are on the front line in dealing with people with mental illness and their families. They are important allies with health care professionals and play an important role not only in fulfilling legal obligations but also in diffusing difficult situations and providing calm, support and reassurance.

Many times in my career, I have witnessed police in our emergency department responding helpfully to the needs of people with mental illness. The skills of police officers in responding humanely and sensitively to people in distress will not be learned from this book. However, an enhanced understanding of the nature of mental illness, the requirements and rules of legislation, and the resources available will all help in refining those skills – and in serving and protecting all our citizens.

– **Dr. David Goldbloom MD, FRCP**
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What you see and read in this resource guide is the result of the dedicated efforts of the authors and many others that have contributed to its contents such as: representatives from the mental health field, including social workers, psychiatric nurses, psychiatrists, occupational therapists, various clients and client organizations involved in the mental health system as well as police and police service agencies. The authors would also like to acknowledge the contribution of the many individuals who were interviewed and those who participated in focus groups.

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Tab 5: Policy & Procedures

Background

Traditionally, police training in the area of mental illness has tended to focus on apprehension authorities related to the Mental Health Act as opposed to the development of interactive, de-escalation skills. Many police officers could even recite the section number where their authorities appear in the Mental Health Act. However, if you were to ask those same officers how they could effectively intervene in a situation with a person who, for example, exhibits paranoid delusions, or who has just attempted suicide, the answer might not be so forthcoming. Historically, there has been little emphasis by police agencies on considering other strategies in the deployment of their duties under the mental health act and how strategies, such as verbal skills, could de-escalate a potentially difficult situation. A major aim of this resource guide for police is to fill this gap by offering practical strategies to safely handle mental health situations until appropriate psychiatric services can be accessed.

Another driving force behind this resource guide is the current trend in the mental health care system towards increased community-based services, the de-institutionalization of mentally ill patients, as well as recent legislative changes to the Mental Health Act that expand the role and authority of police. For example, the number of provincial psychiatric hospital beds is decreasing. As a result, there has been an increase in community-based mental health programs and agencies to support those with mental illness to live in their own communities.

Though it may be too early to determine the long-term impact of this shift, one can only speculate that there may be an increase in the number of police interactions with people with mental illnesses in the community. Police officers need to be able to safely intervene in these situations but equally important, is their need to know where to turn for assistance from the mental health community. As part of this resource guide, it is recommended that each police service identify the contact names of agencies and community organizations that work with the mentally ill in their respective communities and interact more closely with them.

The material presented in this manual was gleaned from various sources. For example, an in-depth review of recommendations made by various Coroner's inquests was conducted, and interviews were held with psychiatrists, crown attorneys and individuals from major mental health care organizations. Focus groups were also conducted with frontline staff including psychiatric nurses, police officers, community mental health care workers, correctional officers, and social workers. Clients and family members involved with the mental health system were also extensively consulted.

Procedures

You are called to a family home for a domestic disturbance. As you arrive, a parent informs you that their adult son is having a psychotic episode. The question is: what do you do as a police officer?

- First and foremost, if at any point you suspect that the individual(s) you will be called upon to interact with has a mental illness and may possibly act in a violent manner, the principles of **isolate and contain** must guide your immediate actions.
- If the individual presents no immediate danger to himself, herself, or others, **avoid engaging** the person. Rather, thoroughly assess the situation, which should include gathering as much information as possible, reviewing force policy, and contacting specialty units, local mental health agencies, or crisis centres if they exist in your jurisdiction.

The following are the procedural guidelines from the Ministry of Community Safety and Corrections' (formerly the Ontario Ministry of the Solicitor General) Policing Standards Manual (2000) in reference to *"Police Response to Persons who are Emotionally Disturbed or have a Mental Illness or a Developmental Disability"*. Individual police service policy is usually based on, or influenced by Ministry standards.

"Every police service's procedures and processes on the police response to persons who may be emotionally disturbed, or may have a mental illness or developmental disability should:

a) require communications operators/dispatchers to provide information to officers, if known, on:
   i) any medications being taken by the person or that are prescribed
   ii) whether the individual is under the influence of illicit drugs and/or alcohol
   iii) whether the individual is presently armed or may have access to a firearm
   iv) whether the individual is in a public/open area or is barricaded
   v) whether there are any reported injuries
   vi) whether the individual is involved with any other community agencies or local health care providers and
   vii) whether the police have previously attended the same address or had prior contact with the same individual(s) involved
b) address the steps for a police officer, or communications operator/dispatcher to obtain assistance from, or refer a call/situation to, another agency
c) set of circumstances in which more than one officer should be dispatched to a call, where practical, or where containment or tactical support should be provided
d) set out the steps to be taken by a police officer when invoking the provisions under the Mental Health Act
e) require that, where an officer has reasonable grounds to believe that the individual has committed a violent crime, the officer should consider charging the individual and not consider voluntary or involuntary hospitalization as a substitute to laying a charge, absent compelling circumstances
f) require that in those circumstances where the suspect is taken to a hospital, the police officer shall advise the hospital as to the circumstances of the occurrence, the background of the person, whether he or she may be suicidal, and other information as may be provided
g) address the transportation of persons who may be emotionally disturbed, or may have a mental illness to a psychiatric facility or hospital and
h) set out the procedures for responding to calls for service at a local psychiatric facility, where one exists, or hospital, including where the call relates to an unauthorized absence of an individual who is emotionally disturbed or has a mental illness from the facility."

Mental Illness (causes & treatment)

WHAT CAUSES MENTAL ILLNESS?

Different mental illnesses may have different causes. Important factors may include:

- emotional trauma
- chemical imbalance in the brain
- structural abnormalities in the brain
- social environment in which one is raised
- interpersonal problems
- heredity
- substance abuse*
- other
- or a combination of any of the above – while the cause of any mental illness is not known, the above factors affect each other.

HOW IS MENTAL ILLNESS TREATED?

Treatment may include the following:

- medication
- counseling/psychotherapy
- life skills training
- addiction counseling
- self help groups
- education
- peer & family support
- other
- or a combination of any of the above.

Treatment often includes many facets and different professionals working together with the client and his/her family. The current standard of practice is based on what is called a "biopsychosocial" model and is dependent on an integrated multidisciplinary team to ensure that all aspects of a client's care are addressed. Members of a mental health team may include psychiatrists, psychologists, nurses, social workers, occupational therapists and recreational therapists. Psychiatric clients might also require the services of family physicians, pharmacists, as well as other specialists in medicine and surgery. Dentists can also be involved in their care, as psychiatric clients may have special dental problems requiring subspecialty expertise.

* It is also important to note that over half of the people who suffer from a mental illness also suffer from a substance use disorder. The effects of alcohol and other drugs often interact with the symptoms of mental illness and can create behaviours that could come to the attention of police. While your role and response as a police officer does not change, it becomes another factor for you to consider in the deployment of your duties.

Major Mental Illness Disorders & Response Strategies for Police

A) SCHIZOPHRENIA

"I was diagnosed with schizophrenia in my early 20's. No one knew why I was acting so strange. I didn't want to be with anyone and kind of retreated into my own little world. When I take my medication it really helps me cope and I am able to live my life almost like everyone else."

– CLIENT

Definition:

A biological brain disease believed to be related to faulty brain chemistry that affects thinking, perception, mood and behaviour.

Recognition:

- may sense things that do not exist e.g., hear voices **(hallucinations)****
- may hold false personal beliefs, e.g., people are after me **(delusions)****
- may demonstrate emotions inconsistent with speech/thoughts (e.g., laugh when sad)
- may have jumbled thinking
- may have difficulty sorting out or connecting thoughts
- may say things that do not make sense to others

** The two most prevalent symptoms of schizophrenia are hallucinations and delusions. Recognizing and understanding these symptoms will help you choose the appropriate response strategy. The terms themselves are not as important as describing in detail the behaviours you observe and then conveying them to the attending physician/mental health worker.

HALLUCINATIONS:

"My hallucinations are not always there but when I see and hear imaginary things, it is very frightening and painful to me. I know some people think I can just control myself and tell myself they are not real. But I can't will them away. They are real to me when I am experiencing them."

– CLIENT

Definition:

Person senses perceptions that do not exist in the real world such as:

feel such as bugs crawling under the skin

smell such as smoke or gas

taste such as poison in food

sight such as visions of God, other persons, etc.

hearing such as voices telling the person to do something

auditory the most frequently encountered hallucination involves the auditory sense, i.e. hearing

Recognition:

- has faulty sensory perceptions, i.e., hears, sees, smells, feels things that do not exist
- talks to self
- appears preoccupied and unaware of surroundings
- has difficulty following conversations and instructions
- momentary or extended lapses in attention, as if listening to something
- misinterprets words and actions of others
- may isolate self
- may use radio or other sounds to tune out voices

Police Response Strategies:

- **isolate and contain**
- do not invade personal space
- do not touch without permission or stand too close
- speak slowly and quietly using simple concrete language
- avoid verbal confrontation
- remember it may take the individual longer to process information
- instruct to "listen to my voice, do not listen to the other voices"
- explain your actions
- ask questions:
  - "Are you hearing voices other than mine?"
  - "What are they telling you?"
  - "What do you see, feel, taste?"
- reduce confusion, i.e., bright lights, television, radio
- be aware that stress may increase hallucinations
- address the person by name/if do not know it, ask how they would wish to be addressed
- **do not** pretend that you are experiencing the hallucination along with the person.

Remember – you are the grounding in reality. Respond by saying, "I don't hear the voices, but understand that you do." It is critical to ask questions regarding the content of the message in that it may be a directive to hurt someone including you. Try to get a sense of how they feel and how you could help.

Remember – the person may not be able to adequately process the information or may have recent memory problems making it difficult to follow instructions.

DELUSIONS:

"My son is a good man but when he gets sick I am really frightened. He behaves so strangely and out of character. I become 'the enemy'. I don't want to call the police and have him treated like a common criminal. But I don't know what else to do."

– MOTHER

Definition:

False beliefs not grounded in reality.

Recognition:

The person may:

- believe self to be someone of importance (grandeur)
- be excessively religious
- be extremely suspicious *
- act violently towards others
- avoid food/medication for fear of poisoning
- have sleep difficulties because of fear of being harmed
- misinterpret others' words and actions
- appear afraid
- isolate self

* Paranoid delusions are the most common. Remember that for the person suffering from paranoid delusions, trust is extremely difficult and his/her level of fear is extremely high. This person will frequently misinterpret ordinary things in his/her environment as a threat.

Police Response Strategies:

- **isolate and contain**
- keep your distance with a reactionary gap or if this can not be done try to keep something between the two of you, for example, a piece of furniture
- do not touch without permission
- position yourself at their level if it is safe to do so
- avoid whispering and laughing, as this may be misunderstood
- remember that what is on an individual's mind is not always obvious
- ask questions about what the delusion is all about (potential for self harm or violence), i.e., "Are you having any thoughts that are disturbing/upsetting you or others?"
- explain your intentions before you act
- do not argue or try to convince that the thoughts are not real, **DO NOT ATTACK DELUSIONS**
- do not show or say you believe in the delusion, instead explain, "I believe you are telling me this is as you see it."
- ask if there is anything that would make the person feel more comfortable
- do not smile or nod your head when he/she is talking to avoid misunderstanding
- **never underestimate the power of the uniform** or the impact of your presence, both of which may have an extremely intimidating effect on someone suffering from paranoia
- assure them that they are safe and you are not going to harm – that the uniform and the equipment you carry are for protecting him

B) MAJOR DEPRESSION:

"I can't explain the deep feelings of sadness and unhappiness that just seems to fall over me like a dark cloud. I feel so hopeless and alone."

– CLIENT

Definition:

Depression is a biological illness affecting brain chemistry which can lead to a state of morbid and extreme sadness, despair and hopelessness.

Recognition:

- feelings of sadness, helplessness, hopelessness
- sad facial expression
- teary eyes
- sleep and appetite disturbances (increased or decreased)
- lack of interest in everyday activities and relationships, i.e., housekeeping, personal hygiene, grooming
- social withdrawal
- lack of energy or agitation
- irritability
- poor concentration and impaired memory

Police Response Strategies:

- be patient
- do not attempt to cheer the person up, rather, recognize the pain by stating, "I know you are in pain and I would like to help."
- convey hope by stating, "With help, you can feel better. You don't have to suffer like this."
- assess for suicidal/homicidal behaviour
- refer/escort to appropriate mental health service

C) BIPOLAR DISORDER (MANIC-DEPRESSIVE ILLNESS):

"I have lived with this illness for over 30 years. The ups and downs have been terrifying and debilitating. I've lost friends and jobs. I'm just now becoming stable and productive. But it's a constant struggle."

– CLIENT

Definition:

A state characterized by extreme mood swings, depression alternating with manic behaviour.

Recognition:

Manic Behaviour (for Depression, see Major Depression)

- elated, cheerful, playful, high mood
- hyperactivity
- inflated self image
- inability to sleep
- irritability, anger, rage
- weight loss
- increased activity and too busy to eat
- distractibility, short attention span
- disorganized
- boundless energy
- bizarre dress
- accelerated speech, difficult to interrupt
- delusions
- poor judgment
- uninhibited sexual interest or sexual acting out

Police Response Strategies:

- decrease noise and confusion in the area, i.e. turn off radio/T.V., etc.
- if possible remove other people from area
- allow pacing if desired
- ask short, direct and concrete questions
- do not engage in long conversations
- determine if they are able to care for themselves
- refer/escort to appropriate mental health service

D) SUICIDAL BEHAVIOUR:

" When I became suicidal, I felt alone, unloved and a failure. I took all my mother's pills. I was saved by the hospital, but have had many of the same suicidal thoughts since. "

– CLIENT

Definition:

Those attempts or verbal threats that result in death, injury or pain consciously inflicted upon oneself.

High risk indicators:

- single and divorced
- in spring and summer
- no family ties
- history of suicidal behaviour or psychiatric illness
- drug addiction/alcohol use
- family history of suicide, depressive or psychiatric illnesses
- the elderly

Recognition:

- depression, particularly as it is lifting and there is more energy
- preoccupation with death, i.e. continually talks & reads about it
- giving things away
- ending relationships or commitments
- words or actions that are end oriented, i.e. checking on insurance policy, tidying up loose ends
- black and white thinking

Police Response Strategies:

- **myth:** people who talk about suicide do not really want to do it
- ask questions, **BE DIRECT** and talk about it in clear language
- do not be afraid that you are putting the idea into their heads
- use direct matter of fact language, for example:
  "Do you want to kill yourself?"
  "How would you do it?"
  "When and where are you planning to do it?"
  "What preparations have you made, i.e., saving pills, etc?"
  "Have you ever tried to kill yourself in the past?"
  "Are voices telling you to kill yourself?"

** **If yes to any of the above – DO NOT LEAVE THE PERSON ALONE and escort to nearest hospital as soon as possible.**

Remember: all threats of suicide (direct or indirect) must be taken seriously!

E) PANIC:

" The attacks feel like a knife is slicing through my stomach. My heart beats so fast I feel like I'm having a heart attack and I can hardly breath. "

– CLIENT

Definition:

A state of extreme anxiety and even terror.

Recognition:

- increased breathing rate
- wide eyed expression
- rapid and pounding heartbeat
- sweating, shaking
- feeling of impending doom
- difficulty communicating
- fear of losing it, going crazy, having a heart attack

Police Response Strategies:

- speak slowly and calmly
- encourage deep regular breathing to facilitate calming
- use short simple sentences
- assure that they are safe and you are there to help – you will take control if needed
- explain all actions
- remove from noise and confusion
- refer/escort to crisis service

F) MUTE, PASSIVE BEHAVIOUR:

Recognition:

- no response to questions
- does not appear aware of surroundings
- may remain in one position

Police Response Strategies:

- approach as you would a responsive person as opposed to isolate, contain, etc.
- do not assume they do not know what is going on
- follow the general "**DOs**" and "**DON'Ts**"
- escort to nearest hospital
- **ESSENTIAL:** explain your intentions before you act

G) EXCITED DELIRIUM:**

Definition:

A disorder that could lead to death, the onset of which has been highly associated with illicit drug use, alcohol abuse and failure to take prescribed anti-psychotic medications properly.

"Persons suffering from excited delirium can die suddenly even while in hospital or in custody. Though the research in this area is incomplete, the following should be noted. Excited delirium can be caused by drug intoxication or psychiatric illness or a combination of both. Cocaine is the best-known cause of drug-induced excited delirium. Cocaine users in excited delirium struggle violently when restrained and can suffer cardiac arrest at any time during or after the struggle. Alcohol is another common drug which may be a factor in the development of excited delirium. Some psychiatric illnesses have the potential to suddenly worsen to the point of excited delirium. There are persons living in community settings who have recurrent bouts of excited delirium particularly if they neglect to take their anti-psychotic medication. Many cases of excited delirium are caused by a combination of drugs, alcohol and psychiatric illness."

** [from Memorandum #630 Revised, Young, James Dr., Chief Coroner for Ontario, "To Coroners, Policing Services, Correctional Institutions, Ministry of Health (for the Attention of General and Psychiatric Hospitals and Ambulance Services)", Office of the Chief Coroner, Ontario, April 21, 1995]

Recognition (bold are most critical):

- bizarre and/or aggressive behaviour
- disorientation
- acute onset of paranoia
- panic
- shouting
- violence towards others
- **hallucinations**
- **impaired thinking**
- **unexpected physical strength**
- **apparent ineffectiveness of pepper spray**
- **significantly diminished sense of pain**
- **sweating, fever, heat intolerance**
- **sudden tranquility after frenzied activity**

Police Response Strategies –
Principles to guide your actions:

1. Know the symptoms listed above, particularly those in bold.
2. If it is your belief that the individual is experiencing excited delirium, death may occur suddenly, therefore call for an ambulance to have the person transported by medical professionals to a medical facility equipped to cope with the potential complications of the disorder.
3. If the person must be transported in a police vehicle, it is recommended that two officers do so to ensure the person is properly restrained and monitored continuously.
4. Recognize that certain restraint positions should not be used (e.g., hog tying). Avoid transporting with the individual in a face down position.

General Guidelines for Police

DOs	DON'Ts
• do collect as much information as possible from all possible sources prior to intervening	• do not deceive – be honest and open in all situations – you are reality
• do take your time & eliminate noise and distractions, i.e. television, radio, bright lights	• do not challenge
• do ask permission first	• do not tease or belittle
• do treat with dignity and respect as you would want a family member to be treated	• do not forget the pain and fear s/he is experiencing – remember emotions can be painful
• do keep your distance and respect personal space	• do not violate personal space
• do talk slowly and quietly – identify yourself and others and explain your intentions/actions – your actions should be slow and prior warning should be given if you intend on moving about the room	• do not forget to ask about medications that are being used
• do explain in a firm but gentle voice that you want to help. Ask how you can be of assistance	
• do develop a sense of working together "help me to understand what is happening to you"	
• do if they are fearful of your equipment, take the time to explain that you carry the equipment to enable you to perform your job which is to protect the public and them	
• do give choices whenever possible to allow some level of control	

Possible Dispositions/Options when Interacting with Persons with Mental Illness

OPTION	OPEN TO	ONLY IF	HOPEFULLY LEADING TO	SPECIAL CONDITION
Disengage	Anyone	• the situation is or can be contained (i.e. no danger to self or others)	• re-assessment for back-up, etc. • consider other use of force options	• take your time! • remove distractions • avoid excitement • continue to contain until special response unit or back-up arrive
Unconditional release	P. O.	• minor incident • mental disorder is not incapacitating • person is calm • reasonably certain no reoccurrence	• no reoccurrence	• document all interaction/referrals • enter on SIP/FIP
Release to families / friends	P. O.	• same as above except you believe incident would reoccur • releasing on own would be unsafe	• having family/friends assume responsibility	• document all interactions/referrals
Convince to voluntarily admit self	P. O.	• it is possible (this may be the only option when there is no available care-taker and does not fit criteria for apprehension)	• voluntary admission	• document all interactions/referrals
Consult with mental health professional	P. O. Anyone else	• one is available • the incident falls between unconditional release and apprehension	• additional information • choice of appropriate disposition	• telephone • on-scene • central location
Apprehend under MHA (S. 17/ Form 47)	P. O.	• R&PG a person acting in a disorderly manner • you believe is due to a mental disorder and you have reasonable cause to believe the person is a danger to self or others • dangerous to wait	• admission information Physician's order (form #1 detains a person for up to 72 hours in a psychiatric facility).	• custody be transferred as soon as reasonably possible • police officer be notified promptly when decision is made to accept or not accept custody of a person by the psychiatric facility
Information (S. 16)	Anyone	• when waiting would not be dangerous, must convince J.P.	• J.P.'s order (form #2 for apprehension and transport to a psychiatric facility for assessment)	• valid for only 7 days after signing • apprehension is made by P. O. in that jurisdiction
Arrest	P. O.	• an offence **has been** committed	• judge's order (consult with Crown)	• notify lock-up staff and jail staff

Documentation/Records

It is generally accepted that the "disorderly" behaviour referred to in the Mental Health Act does not have to be physically acting out behaviour. The person can be calmly talking to you about voices he/she is hearing. Also, according to Bill 68, reliable second party information may suffice in terms of evidence of disorderly or irrational behaviour. If the person maintains a calm disposition, the behaviour might still be considered disorderly if there is some form of irrational thought involved. Whether there is a danger to self or others is an opinion **you** form based on the evidence you collect from the individual and other witnesses. Similarly, whether it would be dangerous to wait to go to a Justice of the Peace is also a judgment call. Given that it is **your** opinion that will be questioned, detailed notes documenting your investigation are essential.

The most important change in the Mental Health Act in this area is that you, as a police officer, no longer needs to DIRECTLY observe the disorderly behaviour, you simply need evidence that it occurred.

The following should be considered when documenting information:

- you must file a report in as much detail as possible
- if you believe the person suffers from an apparent emotional or mental health disorder and there are reasonable grounds to believe that the person is, or is likely to be, a threat to himself/herself or someone else as a result of that disorder **recommend that the person be entered on SIP – SPECIAL INTEREST POLICE category of CPIC** including all reasons for the entry on CPIC
- a person who is involved in an incident as described in Section 5 of the Firearms Act of Canada, who, in the last five years has been treated for mental illness, whether in a hospital, mental institution, psychiatric clinic or otherwise, (whether or not in residence), and acts violently toward another person (including threats or attempts) **recommend that the person be registered on FIP – FIREARMS INTEREST POLICE**
- fill out a "contact with mentally/emotionally disturbed person" form if your police service uses them and file appropriately
- even if the person is calm when you arrive, engage in dialogue and ask probing questions such as, "Are you hearing voices?", "Are you getting messages?", "Are they telling you to do something?" **RECORD VERBATIM COMMENTS** from the individual particularly those comments that are directives that is, messages directing the individual to say or do something

Your report should:

- **describe** the behaviour or conversation, i.e. talking to self, plans to take an overdose of (specific) pills, receiving a message directing him/her to…
- refrain from using psychiatric terms
- note any change in the **pattern** of behaviour of the individual, i.e. indication that the individual is behaving more aggressively than in the past, (i.e. physically assaulting others; self abuse; and other more subtle indicators such as giving valued possessions away, attempting to obtain a weapon, etc.)
- **IMPORTANT TO NOTE IF THE PERSON HAD APPLIED AND/OR BEEN REFUSED A PAL** (possession and acquisition licence) or an FAC (firearms's acquisition certificate) which may indicate that he/she is possibly preparing to act out on his/her delusions or beliefs

If appearing before a JP (s. 16):

Remember, anyone can appear before a JP, including the victim, witness, family, and even you, as a police officer. When should you, as a police officer consider going to a Justice of the Peace yourself? When you have exhausted **all** other options.

Ensure that you bring the following:

- thorough documentation including verbatim comments and changes in pattern of behaviours – anything that might reveal that the person may be preparing to act out on their beliefs/delusions, etc.
- bring in all records including previous convictions, charges, calls to residence, and any other statements, etc.
- bring witnesses including family/neighbours, etc.

Hospitalization of the Mentally Ill (MHA Sections 11, 12, 15, 16, 17)

Note: Schedule 1 psychiatric facilities include:

- specialized psychiatric hospitals
- certain public hospitals with psychiatric units

Voluntary admission:

Anyone in Ontario may be admitted voluntarily to a psychiatric facility if, in the opinion of a physician, he or she is in need of psychiatric care and he or she is willing to be hospitalized for psychiatric assessment and treatment.

Involuntary detention:

Individuals suffering from mental disorder who:

- may cause serious bodily harm to themselves or others and/or
- may suffer serious physical impairment

may be brought to an appropriate facility for psychiatric examination/assessment.

Ontario's Mental Health Act provides authority, under certain circumstances, to:

- physicians
- justices of the peace
- police

to ensure that the individuals who meet the above criteria receive psychiatric examination/assessment and, if necessary, appropriate psychiatric care.

Physicians and justices of the peace (but not police) may also authorize apprehension if they believe that a mentally ill person needs treatment and that a detailed list of criteria set out in the MHA has been met.

Note: Where admission may be refused:

- Admission to a psychiatric facility may be refused where the immediate needs of a proposed patient are such that hospitalization is not urgent or necessary.
- **It may be wise for a police officer about to take a patient to a psychiatric facility to call the facility in advance.**

Pertinent Changes to the Mental Health Act

Bill 68 – Mental Health Legislative Reform, 2000

In June 1998 the government of Ontario announced a review of the Mental Health Act which culminated in the passing of Bill 68 that which received Royal Assent on June 23, 2000 and was proclaimed on December 1, 2000. Bill 68 contains significant amendments to the Mental Health Act and, in particular, police powers.

POLICE POWERS – WHAT HAS CHANGED?

Three Changes:

1. **NO OBSERVATION REQUIRED (MHA Section 17)**
2. **COMMUNITY TREATMENT ORDERS (CTOs)**
3. **TRANSFER OF CUSTODY RULES**

---

1. NO OBSERVATION REQUIRED (MHA Section 17):

- Police must have reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner. Personal observation of the alleged behaviour of the person by the officer is no longer required.
- Police must still have reasonable cause to believe that it would be dangerous to wait to proceed before a justice of the peace, prior to apprehending the patient and bringing him or her to a hospital for psychiatric assessment and that all of the other criteria in section 17 of the MHA are met.

2. COMMUNITY TREATMENT ORDERS (CTOs):

The introduction of Community Treatment Orders (CTOs) is designed to assist families, police and social workers by providing a mechanism to ensure that certain individuals who meet a strict set of criteria get the care and treatment they need. A CTO may be issued by certain physicians to provide a person with community-based treatment and, often, care and supervision, that is less restrictive to the person than being detained in a hospital environment. CTOs have been implemented in Saskatchewan (1995), Manitoba (1997) and British Columbia (1999). Internationally, CTOs have been implemented in the United States (41 states), in Australia, New Zealand and the United Kingdom. CTOs are for individuals who suffer from serious mental disorders and meet other strict criteria. CTOs may be appropriate:

- As an alternative for hospitalization for certain individuals in the community, or
- As a discharge strategy for some patients in psychiatric facilities.

MHA criteria for issuing a CTO:

- a history of mental illness requiring continuing treatment or care and supervision in the community
- a likelihood that the person will cause serious bodily harm to self or others or suffer serious physical impairment or substantial mental or physical deterioration if not treated
- a prior history of hospitalization
- a community treatment plan for the person has been made
- examination by a physician within the previous 72 hours before entering into the treatment plan
- ability of the person subject to the CTO to comply with it and availability in the community of the treatment or care and supervision specified

- consultation of the person and the person's substitute decision-maker, if any, with a rights adviser and
- valid informed consent to the community treatment order by the person (if capable) or the person's substitute decision-maker (if the person is incapable).

CTO's are valid for six months unless they are renewed or terminated at an earlier date:

- by the physician upon the request of the person or his or her substitute decision-maker after determining that the conditions for a CTO no longer exist
- where the person fails to comply with the CTO
- when the person or his or her substitute decision-maker withdraws consent to the community treatment plan.

Enforcement of CTO's:

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

1. Consent to a CTO is withdrawn and the person fails to allow an examination by the physician within 72 hours or
2. The person fails to comply with a CTO and the physician has reasonable grounds to believe that the person still meets the criteria for a CTO and has made reasonable efforts to:
   - locate the person
   - inform the person (or substitute if the person is incapable) of the failure to comply
   - inform the person (or substitute if the person is incapable) of the possibility of a Form 47 and
   - provide assistance to the person to comply with the terms of the CTO.

Obligations of the physician when issuing an order for examination:

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

a) have complete and up-to-date information about the name, address and telephone number of the physician responsible for completing the examination.
b) if the information changes, the doctor must provide the changed information.
c) are immediately notified if the person subject to the order voluntarily attends for the examination or, for any other reason, the order is revoked prior to its expiry date.

When a valid Order for Examination (under Form 47) is issued, police need to know that it:

- gives police authority to apprehend a person in the community in the absence of any other usual requirements (ie., Form 1 or 2, Section 17, etc.),
- is unlike a Form 1 or Form 2 (apprehension in the community) – the person is NOT taken to the nearest psychiatric facility but rather to the physician who issued the Form 47,
- is valid for 30 days from its issuance, which is much longer than a Form 1 and
- acknowledges that police may need more information from the issuing physician for the correct identification and apprehension of the person.

3. TRANSFER OF CUSTODY RULES

Bill 68 allows rules to be set for the transfer of custody between a police officer and a psychiatric facility (usually an emergency room).

These rules apply when a person is brought in custody to hospital by police under authority of the MHA.

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

What else has changed for police?

Reasonable rules have been set by regulation which require that:

- the police officer be notified promptly when a decision is made to accept or not accept custody of a person by the psychiatric facility
- staff at the psychiatric facility responsible for making the decision shall consult with the police officer who has taken the person in custody to the facility
- a staff member shall communicate with the officer about any delays in making the decision and
- custody be transferred as soon as reasonably possible.

Relevant Forms, Orders and Authority under the Mental Health Act (as of December 2000)

Form 1:
Application by Physician for Psychiatric Assessment

Form 2:
Order for Examination

Form 8:
Order for Admission

Form 9:
Order for Return

Form 13:
Order to Admit a Person Coming into Ontario

Section 17 of the Mental Health Act:
Authority of the Police Officer

Form 47:
Order for Examination

Guardianship Order

Ulysses Contract: Power of Attorney for Personal Care under section 50 of the Substitute Decisions Act

FORM 1: APPLICATION BY PHYSICIAN FOR PSYCHIATRIC ASSESSMENT – ROLE OF THE PHYSICIAN (Section 15)

- Refer to table on page 23 for criteria for application under Section 15.
- Any physician in Ontario has authority to sign a Form 1.
- Form 1 states that the physician has personally examined the person within 7 days prior to signing the Form 1 and on the basis of this examination and information provided by others (such as police, friends or relatives), the physician has gathered all the information necessary to form his or her opinion about the nature of the mental disorder and the degree and type of risk.

Form 1 Authority:

- Form 1 remains valid for a period of 7 days from and including the day it was signed and dated.
- Form 1 provides authority for anyone (including police) to take the individual in custody to a Schedule 1 psychiatric facility.
- The individual may be detained for assessment at the Schedule 1 facility for not more than 72 hours.
- Prior to the end of the 72-hour period, hospital staff will, if appropriate, admit the person on a voluntary or involuntary basis or will allow the person to leave following the psychiatric assessment; a Form 1 is NOT a guarantee of hospitalization. It is entirely legal and may be clinically appropriate that a person brought to an emergency room on a Form 1 is allowed to leave the hospital an hour later following a psychiatric assessment.

Important notes:

Responsibility of Police at the Place of Assessment (Section 33)

- The police officer bringing an individual in custody to a psychiatric facility, must remain until the facility has accepted custody.

Place of Examination or Assessment
(under form 1 and form 13)

- Individual may be taken to and detained by a Schedule 1 Psychiatric Facility for an assessment of up to 72 hours.
- Prior to the end of the 72-hour period, hospital staff will, if appropriate, admit the person on a voluntary or involuntary basis.

FORM 2: ORDER FOR EXAMINATION BY A JUSTICE OF THE PEACE

Role of the Justice of the Peace (Section 16)

- Refer to attached table under Section 16 for criteria for application.
- Any person (including police) may apply to a justice of the peace to have a Form 2 completed on another individual if the circumstances warrant it.
- Form 2 is completed by the Justice of the Peace on the basis of sworn information.

Form 2 Authority:

- Form 2 remains valid for a period of 7 days from and including the day it was signed and dated.
- Form 2 authorizes and directs police officers to whom it is addressed to take the person named or described in the order in custody to an appropriate place where a physician can examine the person to determine if a Form 1 is appropriate.

Under Form 2 or Authority of Police Officer: Place of Examination

- The individual requiring examination, under Section 16, or apprehended by a police officer under Section 17 should be taken for examination by a physician.
- Physician will decide whether it is appropriate to sign a Form 1 authorizing detention and assessment for up to 72 hours.
- The examination should be conducted at a hospital emergency room — preferably at a schedule 1 psychiatric facility. However, technically, the person may be brought to any physician for the examination.

Important notes:

Responsibility of the Police at the Place of Assessment (Section 33)

- The police officer bringing an individual in custody to a psychiatric facility must remain until the facility has accepted custody.

Length of detention under a Form 2

- Form 2 does not provide the authority to detain a person in hospital any longer than is necessary for an examination by a physician.

- Further detention requires a Form 1.

Role of police officer – criteria for apprehension

- Refer to attached table under Section 17, role of a police officer, for criteria for apprehension of an individual for purposes of examination by a physician.

FORM 8: ORDER FOR ADMISSION (Issued by a Judge, Section 22)

The MHA allows a judge to remand a person in custody to a psychiatric facility for up to 2 months if:

- the person is charged with an offense and
- the judge has reason to believe that the person suffers from mental disorder.

Important notes:

The hospital needs to accept the patient before the judge can issue a Form 8.

This authority is in addition to similar powers in the Criminal Code.

FORM 9: ORDER FOR RETURN (ISSUED BY OFFICER IN CHARGE OF PSYCHIATRIC FACILITY, Section 28)

- The person is subject to detention at a psychiatric facility but is absent without leave.
- You may be authorized by the officer in charge to return the person to the psychiatric facility, or to the psychiatric facility nearest the place of apprehension.

Authority of Order for Return:

- If a patient is absent without leave, an Order For Return (Form 9) signed by the officer in charge of the facility is required.
- An order for return provides authority for one month from the time the absence of the patient is known to the officer in charge.

FORM 13: ORDER TO ADMIT A PERSON COMING INTO ONTARIO (Section 32)

- The Minister of Health or his or her delegate may issue an Order to Admit a Person Coming into Ontario (Form 13).
- Form 13 is most often used when Ontario residents, detained in facilities outside the province, are returned to Ontario.
- Form 13 has the same authority as a Form 1 except that right to apprehend is not subject to a 7-day limit.

FORM 47: ORDER FOR EXAMINATION (issued by the physician who issued or renewed the Community Treatment Order, Sections 33.3 & 33.4)

Please see "Enforcement of CTOs" on page 17 for an explanation of the prerequisites for issuing a Form 47.

Authority of Order for Return:

- An order for examination provides authority for thirty days after it is issued for a police officer to take the person named in it into custody and then promptly to the physician who issued or renewed the order.

GUARDIANSHIP AND "ULYSSES CONTRACT"

These are very specific legal documents that may or may not provide authority to apprehend a person in certain situations.

Guardianship of the Person:

- An Order for Guardianship of the Person may be issued by a judge of the Superior Court of Justice.
- Depending on the specific wording of the order, it may allow the named guardian to authorize police to apprehend the subject of the order for the purpose of treatment or admission to a residential or health facility.

Power of Attorney for Personal Care under Section 50 of the Substitute Decisions Act (often referred to as a Ulysses Contract):

- If made in strict compliance with specific procedural requirements, it may give the same type of authority as a guardianship order (see above).
- Inspection of the document, by itself will not allow you to determine if it is valid.

Important Notes:

Action on "Ulysses Contract"

- Examination of a "Ulysses Contract," by itself will not establish validity or the extent of your authority (if any).
- Refer to command for further instructions.
- Command may want to refer to legal counsel for instructions on how to proceed.

Forms under the *Ontario Mental Health Act*

FORM #	FORM NAME	MHA	SIGNED BY SECTION #	WHEN CAN IT BE SIGNED ?	WHEN DOES IT EXPIRE ?
1	Application by Physician for Psychiatric Assessment	15	Physician who has examined the patient	Within 7 days from and including the examination date.	7 days from and including the date form was signed.
2	Order for Examination	16	Justice of the Peace	No statutory time restriction.	7 days from and including the date form was signed.
8	Order for Admission	22(1)	Judge	When a person in custody appears before a judge charged with an offence and the judge has reason to believe that the person suffers from a mental disorder and when the hospital has agreed to accept the person	No statutory restriction on time within which an order must be executed. Once executed, it authorizes detention for up to two months.
9	Order for Return	28(1)	Officer in charge of psychiatric facility	When the absence of a person who is subject to detention becomes known to the officer in charge	One month after absence became known to officer in charge.
13	Order to Admit a Person Coming into Ontario	32	Minister of Health and Long Term Care or his or her delegate	No statutory time restriction.	No statutory restriction on time within which order must be executed.
47	Order for Examination	33.3(1) 33.4(3)	Physician who issued or renewed the Community Treatment Order (CTO)	It can be issued at any point during the six-month duration of a Community Treatment Order	Authority for 30 days after issue for a police officer to take the person named in it into custody and then promptly to the physician who issued the order.

Apprehension in the Community under the *Ontario Mental Health Act*

SECTION 15: BY ORDER OF A PHYSICIAN

Any physician in Ontario may order the person to be taken into custody and brought to a psychiatric facility for an assessment of up to 72 hours if satisfied that the requirements of

either or both of METHOD ONE or METHOD TWO are met.

The physician must have examined the person within the last 7 days but the decision may be based on the physician's own information/examination and/or information from others.

METHOD ONE

Past/Present Test:

The physician must have reasonable cause to believe that the person:

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

AND

The Future Test:

The physician is of the opinion that the person is **apparently suffering from mental disorder** of a nature or quality that will likely result in one or more of the following:

- serious bodily harm to self or others or
- serious physical impairment of self.

METHOD TWO

1) **The physician must have reasonable cause to believe that:**

The person has previously received treatment for a mental disorder of an ongoing or recurring nature that, when not treated, will likely result in:

- Serious bodily harm to the person or others or
- Serious physical impairment or substantial mental or physical deterioration of the person.

AND the person has shown clinical improvement as a result of the treatment.

AND

2) **The physician must be of the opinion that the person is apparently suffering from the same or similar mental disorder as the one for which he or she was previously treated.**

AND Given the person's history of mental disorder and current mental or physical condition, the person is likely to:

- Cause serious bodily harm to the person or others, or
- Suffer serious physical impairment or substantial mental or physical deterioration of the person.

AND the person is incapable, within the meaning of the Health Care Consent Act, of consenting to treatment in a psychiatric facility and the legal consent of a substitute decision-maker has been obtained.

The form is valid for 7 days.

Apprehension in the Community under the *Ontario Mental Health Act*

SECTION 16: BY ORDER OF A JUSTICE OF THE PEACE

A justice of the peace may order a person taken into custody to a physician for a Section 15 examination if satisfied that the requirements of

either or both of METHOD ONE or METHOD TWO are met.

METHOD ONE

Past/Present Test:

The justice must receive evidence under oath that the person:

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

AND

The Future Test:

The justice of the peace must have reasonable cause to believe that the person is apparently **suffering from mental disorder** that will likely result in one or more of the following:

- serious bodily harm to self or others or
- serious physical impairment of self.

METHOD TWO

1) **The justice must receive evidence under oath that:**

The person has previously received treatment for a mental disorder of an ongoing or recurring nature that, when not treated, will likely result in:

- Serious bodily harm to the person or others or
- Serious physical impairment or substantial mental or physical deterioration of the person.

AND the person has shown clinical improvement as a result of the treatment.

AND

2) **The justice must have reasonable cause to believe that** the person is apparently suffering from the same or similar mental disorder as the one for which he or she was previously treated.

AND Given the person's history of mental disorder and current mental or physical condition, the person is likely to:

- Cause serious bodily harm to the person or others or
- Suffer serious physical impairment or substantial mental or physical deterioration of the person.

AND the person is apparently incapable, within the meaning of the Health Care Consent Act, of consenting to treatment in a psychiatric facility and the legal consent of a substitute decision-maker has been obtained.

The form is valid for 7 days.

Apprehension in the Community under the *Ontario Mental Health Act*

SECTION 17: ACTION BY A POLICE OFFICER

If the following **4 requirements** are met, a police officer may take a person and bring the person before a physician for a section 15 examination.

The officer must have reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner.

(The courts have interpreted this to mean behaviour that is to some extent irrational, although not necessarily unruly. There is no need for the officer to have reasonable and probable grounds to believe that criminal conduct is occurring or has occurred.)

Past/Present Test:

The officer must have reasonable cause to believe that the person:

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

The Future Test:

The officer must be of the opinion that the person is apparently suffering from mental disorder that will likely result in one or more of the following:

- serious bodily harm to self or
- serious bodily harm to others or
- serious physical impairment of self.

The officer must be of the opinion that it would be dangerous to proceed by way of an application to a justice of the peace.

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Appendix A

GLOSSARY OF PSYCHIATRIC TERMS

acting out
emotions expressed in actions

affective disorder
or mood disorders, are disorders in which there is a primary disorder of the person's mood which secondarily affects the person's thinking and behaviour. The forms of mood disorders are Bipolar Disorder (Manic Depressive Disorder) I and II, Major Depressive Disorder and Dysthymia. These disorders are lifelong but individuals can attain a symptom-free state with the aid of effective treatment.

anti-psychotic drugs
drugs used to treat psychosis

anxiety disorders
are characterized by a subjective sense of intense fear and apprehension and characterized by symptoms such as increased heart rate, difficulties in breathing, sweating, tremulousness and a general sense of foreboding. Anxiety disorders can include phobic disorders, panic disorders, obsessive-compulsive disorders and social phobia.

attention
is the ability to focus on events in the environment as well as closely monitoring internal changes. Attention can be disturbed in a variety of ways from distractibility or inability to concentrate, to hyper vigilance in which there is excessive attention and focus, to a trance-like state.

chemotherapy or pharmacotherapy
treatment or therapy consisting of the use of drugs

community mental health centre
typically a community or neighbourhood facility or a network of agencies serving the mentally ill

compulsion
an uncontrollable persistent urge to perform an act

consciousness
is equivalent to a state of awareness where the individual is fully aware of his/her environment. Disturbances of consciousness can include disorientation, confusion, as well as specific changes, such as "sun-downing". The latter is a syndrome common in older people that usually occurs at night and is characterized by drowsiness, confusion, ataxia and falling as a result of being overly sedated with medications.

consumer/survivor
refers to current/previous clients of the mental health system. Not all people with mental illness choose to use this term in describing themselves. Most people, in fact, use the term patient or client to describe themselves.

de-institutionalization
the move away from institutions such as psychiatric hospitals and toward community based treatment programs

emotions
are defined as feeling states attended by internal bodily, as well as behavioural, changes. Emotions are broken down into **affect**, which is what one observes and **mood**, which is the subjective experience of the individual.

delusions
are fixed false beliefs based on incorrect inferences and not consistent with the individual's level of education and sociocultural group. Delusions can be prosecutory or grandiose.

grandiosity
: has inflated appraisal of one's worth, power, knowledge, importance or identity; in the extreme referred to as a delusion

forensic
: individuals with a suspected mental illness who have been in contact with the criminal justice system

hallucination
: is an internal experience not based on an appropriate external stimulus and often reported as "hearing voices". On occasions, these voices assume the nature of "command hallucinations" in which the individual is directed to act in ways that appear unpredictable and potentially violent. Perception can be disturbed in any of the senses.

memory
: is defined as the function by which the individual stores information to be used at a later time. Memory can be disturbed by partial or total inability to recall past events or falsification of memory by distortion of recall. The latter phenomenon is often referred to as repressed.

intelligence
: is that ability to integrate information, to learn new material and to use information learned to understand and integrate experiences. Intelligence can be disturbed in a variety of ways. Mental retardation, also sometimes referred to as developmental disability, is the lack of intelligence to a degree in which there is interference with the individual's overall functioning. Mental retardation is divided into mild, moderate, severe or profound forms. Intelligence can also be disturbed by dementia in which there is organic deterioration of functioning without changes of consciousness. The most common example of dementia is Alzheimer's disease.

mental retardation
: significantly below average intellectual functioning commonly measured in terms of I.Q. scores: borderline retarded (70-75), mild (50-70), moderate (35-50), severe (20-35), and profound (under 20)

obsession
: is a persistent thought or impulse that cannot be willed away

panic attack
: sudden onset of intense apprehension, fearfulness, or terror often associated with feeling of impending doom, palpitations, chest pain or discomfort, choking or smothering sensations and fear of "going crazy" or "losing it"

paranoia
: delusion involving belief that one is being persecuted or unfairly treated

phobia
: persistent irrational fear of a specific object, activity or situation that results in a compelling desire to avoid same

psychiatrist
: is a medical doctor who has received five additional years of training to be certified as a specialist in psychiatry by The Royal College of Physicians and Surgeons of Canada

psychologist
: usually holds a Ph.D. and has received extensive training in clinical activities. Clinical psychologists function independently and like other professionals in Ontario, psychologists conform to standards of practice established by the Ontario College of Psychologists. Clinical psychologists are experts in psychological testing as well as in specific forms of psychotherapy.

psychosis
: severe disorder of thought and sometimes of behaviour, most often refers to a loss of touch with reality, hallucinating or delusions may be present

psychotherapy
: generic term often used interchangeably with "counseling"

schizophrenia
: is a group of conditions with an onset in early adulthood and characterized by social deterioration and psychosis as reflected by disturbances in thinking, feeling and behaviour

signs
: are clinicians' observations and objective findings such as a patient's constricted affect or psychomotor retardation

substance abuse
: is defined as the presence of at least one specific symptom indicating that substance use has interfered with the person's life. The criteria for making such a diagnosis includes the following: over a 12-month period, there is recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home; that there is a recurrent substance use in situations in which it is physically hazardous; that it is recurrent, often leading to legal problems and that there is continued substance use despite having persistent or recurrent social or interpersonal difficulties. Substance abuse includes alcoholism, so-called recreational drugs, as well as over-the-counter medications and prescribed medications. When a substance abuse disorder co-exists with that of a psychiatric disorder, the condition is called a co-morbid condition or a dually-diagnosed condition, or a concurrent disorder.

symptoms
: are the subjective experiences described by patients such as depressed mood or lack of energy.

syndrome
: is a group of signs and symptoms that together make up a recognizable condition which can be more equivocal than a specific disorder or disease.

Appendix B

MEDICATIONS AND POTENTIAL SIDE EFFECTS

Medications

Medications or psychotropics can be broken down into at least six major Categories:

1. Antipsychotic
   to decrease the symptoms of psychosis

2. Antidepressant
   to decrease the symptoms of depression

3. Anti-anxiety
   to decrease feelings of anxiousness

4. Mood Stabilizer
   to smooth out the extremes of bipolar disorders

5. Antiparkinsonian (anticholinergics)
   to help with side effects of psychiatric medication

6. Sedative/Hypnotic
   to calm and help sleep

Potential side effects

The following are some of the most frequently occurring side effects:

- weight gain
- low blood pressure
- drowsiness
- blurred vision
- shaking
- shuffling walk
- mask like facial features
- restlessness – inability to sit still – jittery
- lack of energy/unmotivated
- agitation
- involuntary movements of jaw/tongue
- dry mouth

Appendix C

QUESTIONS TO ASK REGARDING MEDICATION

1. Are you on any medication?
2. Do you take pills?
3. May I see the vials?
4. Are you taking them as your doctor ordered?
5. When did you last take your pills? How many?
6. When did you last take your medication?
7. May I take these vials with us to show the doctor? (if you are escorting to a hospital)

Remember: the person may not be the most reliable historian re: medications as thought processes may be jumbled and confused.

Appendix D

FREQUENTLY ASKED QUESTIONS (including excerpts from the Ministry of Health and Long Term Care Questions & Answers Training Material)

What is Brian's Law (Mental Health Legislative Reform), 2000 and what does it do?

Brian's Law is new legislation that amends the Mental Health Act with the intention of reducing reliance on institutionally based care and treatment. Brian's Law makes several changes to the Mental Health Act and the Health Care Consent Act. The main changes are:

- the addition of Community Treatment Orders (CTOs)
- the addition of new grounds for examination, assessment and involuntary admission based on need for treatment instead of dangerousness
- removal of the requirement for police to "observe" disorderly conduct before acting to take a person into custody. (This information may now come from collateral sources.)

What is a CTO and what is its purpose?

A Community Treatment Order (CTO) is a comprehensive plan of community-based treatment or care and supervision that is less restrictive for the person than detention in a psychiatric facility. A CTO must include a community treatment plan that is developed by the physician who issues the CTO and any other health practitioner or person involved in the person's treatment or care and supervision. The community treatment plan must be consented to by the person, or if the person is incapable, his or her substitute decision-maker.

Why was the term "imminent" removed from the legislation?

In response to numerous Coroner's Inquests, health organizations, family groups and others, the term "imminent" was removed from the Mental Health Act because it was the subject of widespread confusion. Many people wrongly believed it to be synonymous with the word "immediate". There was also considerable confusion about whether the term applied to the other criteria of "serious bodily harm" to self or others.

How have the legislative amendments changed the role of the police?

The legislative amendments have changed the role of the police in two significant ways. Under Brian's Law (Mental Health Legislative Reform), 2000, police officers are no longer required to directly observe disorderly conduct before acting to take a person into custody for examination by a physician, provided that all the criteria in s.17 of the Mental Health Act are met. The new police requirement is for "reasonable and probable grounds to believe" that a person has acted or is acting in a disorderly manner.

Provisions in the legislation related to CTOs also have changed the role of the police. In some circumstances a physician who issues or renews a CTO may be required to issue an order for the examination for the person subject to the CTO. An order for examination under the CTO provisions in the Act, authorizes a police officer to take the person named in the order in custody to the physician who issued the order, or to a physician authorized to act in place of the issuing physician.

Will there be procedures to ensure that the police requirement to remain at a psychiatric facility until the facility takes custody of the individual does not unnecessarily interfere with police duty on the streets?

Yes, this issue is addressed in regulations made under Brian's Law. The regulations state that where a person is taken to a psychiatric facility under section 33 of the Act, the officer in charge or his or her delegate shall ensure that a decision is made as soon as is reasonably possible as to whether or not the facility will take custody of the person. Where a decision is made to take the person into custody, the designated staff member shall promptly inform the police officer or other person, of the decision.

How will police assist in the enforcement of CTOs?

Police involvement in the enforcement of CTOs is limited to the execution of orders for examination issued under CTO provisions in Brian's Law. The police already come into contact with seriously mentally ill persons in the community and many of these individuals are untreated.

Does a CTO involve more than treatment? Does it involve services like housing, social assistance, etc.?

A Community Treatment Order is intended to provide a comprehensive plan of community-based treatment or care and supervision. Services related to the person's treatment, care and supervision may all be included in a CTO, if the services are available in the community. For example, a social worker may provide ongoing assistance to the individual to meet his/her shelter and other physical needs and this could involve helping the individual to access social assistance and related services. The health practitioners or other service providers named in a CTO must be consulted about the proposed community treatment plan contained in a CTO and must participate in its development.

What is the definition of a "qualified" physician as prescribed in the regulation for the issuing or renewing of a CTO?

A physician is qualified to issue or renew a CTO if he or she is:

1. a psychiatrist
2. a physician who practices in the area of mental health or
3. a physician who is an employee or staff member of a psychiatric facility.

Does an Application for Psychiatric Assessment (Form 1) need to be completed prior to an individual being placed on a CTO?

No, Brian's Law (Mental Health Legislative Reform), 2000 permits a physician to issue or renew a CTO provided he or she has examined the person and is satisfied that various conditions apply, including that the person meets the criteria for completion of an Application for Psychiatric Assessment where the person is not currently a patient in a psychiatric facility.

If you encounter psychotic symptoms (e.g. hallucinations) can you be certain that the person suffers from a mental illness?

There are many reasons why a person might exhibit psychotic symptoms including brain injury, substance abuse, medical conditions, response to trauma, victimization, etc.

How powerful are the drugs used to combat mental illness?

The group of drugs known as anti-psychotics, if taken as prescribed, can reduce and even eliminate, symptoms of psychosis. Note: The emphasis is on "reduce" and "even eliminate" the symptoms. That is, the drugs can often help make the voices stop and/or visions cease, but they cannot cure the illness.

Is it acceptable to use deception with a mentally ill person if it is not used with intent to belittle or if it aids in securing compliance.

You should avoid using deception as a means of ensuring compliance. The deception could possibly undermine trust and this could have serious consequences on the next time you or a fellow officer interacts with this individual.

What is the delusion most frequently encountered by police?

Feelings of persecution or "paranoia", that is, the feeling that something or someone is attempting to inflict harm on the individual.

How can you calm someone who displays signs of paranoia?

If you move too quickly, invade personal space or touch, you could increase the paranoia, that is, they may think you are trying to hurt them. Invasion of personal space can escalate the situation. (Refer to strategies for delusions.)

Is humour effective when interacting with someone who has a mental disorder?

We are talking about officer-generated humour, which, generally speaking is not an appropriate response to anyone who is experiencing pain or trauma.

Is it true that on the average, people suffering from a mental illness are less intelligent?

There is no evidence to suggest either lower or higher levels of intelligence.

Is it true that attempting to commit suicide is a cry for help, that in most cases it is just a way of drawing attention to oneself?

The police officer is not a therapist and is not in a position to comment on whether or not a person is serious about suicide attempt. All suicide attempts or expressed ideas concerning suicide must be taken seriously.

Can hallucinations and delusions occur simultaneously?

Hallucinations and delusions often appear together. For example, the person might taste poison or smell smoke (hallucination) and think someone is trying to kill them (delusion).

What is the most frequently encountered hallucination?

Hearing voices.

Is pepper spray less effective on someone who is suffering from a mental illness?

Pepper spray may be less effective on anyone who is experiencing an adrenaline pump. This is not restricted to persons diagnosed with a mental illness.

Does a person suffering from mental illness have superhuman strength?

The supposed superhuman strength comes from the adrenaline pump and you do not have to be diagnosed with a mental disorder for this to occur.

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Mental Health Resources & Services

It is important for your police service to contact people in your community to find out what mental health services and resources are available to help you and to help clients and families. Several things should be considered: a) community services that offer assistance 24 hours a day (and in some communities that may be very limited or even non-existent) and b) those services that offer more specialized services to meet other needs (such as language, culture, gender, religion, etc.). The psychiatry unit of your local hospital likely has a complete list of community mental health services/resources in your area.

With the exception of Victim Services, many of these services are available to both the general public and police.

Crisis Centres

Crisis centres can be walk-in or mobile, are most often staffed by individuals with a background in crisis intervention and may even offer short-term accommodation. Some are located within a hospital, while others are in the community. Use this chart to note the crisis centres that are available in your community.

CENTRE NAME	LOCATION	HOURS OF OPERATION	TELEPHONE NUMBER

Distress Centres

Distress centres offer assistance primarily over the telephone. They are operated within specific times of the day and are often staffed by volunteers. Some have an 800 number service enabling anyone anywhere to access their service. The service itself includes telephone counseling and advice as to where to receive assistance. Problems are not restricted to mental health issues, but a large percentage of calls involve people experiencing a mental or emotional disturbance of some kind. Note those distress centres that are available to people in your community.

TIP: Check inside the front cover of your telephone book for the centre nearest you.

CENTRE NAME	LOCATION	TELEPHONE NUMBER

Assistance to Families of Persons with Mental Illnesses

If it is determined that there are insufficient grounds for apprehension under the Mental Health Act, the attending officer can still recommend that the family or friends appear themselves before a Justice with the aim of securing an order for assessment. As explained earlier, it may even be appropriate for the officer to do the same. If the family is in crisis, the officer can recommend distress centres, crisis centres and mobile crisis units or contacting organizations such as the Schizophrenia Society and/or the Canadian Mental Health Association for referral and support. Information on more general topics may be found in resource books, such as Toronto's "Blue Book". The "Blue Book" is a directory of community services in Toronto containing over 20,000 pieces of information that address a variety of issues. For further information about the "Blue Book" call Community Information Toronto at (416) 397-INFO or view their web site at www.communityinfotoronto.org

AGENCY	SERVICE AREA	PHONE	REMARKS

Provincial Psychiatric Hospitals

NAME	ADDRESS	TELEPHONE NUMBER

Hospitals Accepting Psychiatric Patients

(Schedule #1 Hospitals)

NAME	ADDRESS	TELEPHONE NUMBER

Many of these psychiatric facilities utilize the services of mental health crisis workers in the Emergency Unit. Check with the facility in your area to determine whether this service is available.

Additional Community Resources/Contacts

NAME	LOCATION	TELEPHONE NUMBER

Additional Resources/Services

PROVINCIAL/NATIONAL MENTAL HEALTH ORGANIZATIONS

Canadian Mental Health Association (CMHA)

Phone: 1-800-875-6213 (in Ontario)
1-416-977-5580 (in Toronto)

www.ontario.cmha.ca

Centre for Addiction and Mental Health (CAMH)

Phone: 1-416-595-8501

Information & support line:
1-800-463-6273
416-595-6111 (in Toronto)

www.camh.net

Schizophrenia Society of Ontario and Canada

www.schizophrenia.on.ca

Mood Disorders Association of Ontario

Phone: 1-888-486-8236
416-486-8046 (in Toronto)

www3.sympatico.ca/mdamt

Info Ability (information and referral service for vulnerable adults in Ontario)

Phone: 1-800-665-9092
TTY 482-1254
416-482-4359 (in Toronto)

Psychiatric Patient Advocate Office

Phone: 1-416-327-7000