

USING POLICY TO MANAGE RECIDIVISM

USING POLICY TO MANAGE RECIDIVISM AND PERSONS WITH
SERIOUS MENTAL ILLNESS: VOICES FROM HUMAN SERVICES AND
JUSTICE CO-ORDINATING COMMITTEES

By
SHERRY L. BEAL

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Descriptive Note

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**AUTHOUR: Sherry L. Beal, B.A. (Wilfrid Laurier University),
B.S.W. (McMaster University)**

SUPERVISOR: Dr. Susan Watt

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Abstract

The debate regarding the tensions between the lack of an integrated system of community based mental health care, compulsory care, and individual rights and freedoms in the context of serious and persistent mental illness, is not new. It contains a delicate and changing balance of rights and obligations. Valid arguments can be made on both sides of the protection balance – protection of a common sense of the social good and protection of the rights of individuals needing mental health treatment. The evolution of the Ontario Mental Health Act (R.S.O. 1990) (MHA) is discussed and situated in the Canadian context to illustrate how our current mental health system came to exist and unwell forensic clients reside in communities. Deficiencies are highlighted in applying mental health legislation to situations of persons with persistent psychosis, who are chronically interacting with the criminal justice system, treatment non-collaborative, and lack insight into their own behaviour and its consequences – a symptom often associated with psychosis.

The Government of Ontario has funded initiatives to attempt to monitor the safety/risk of forensic clients. An inter-ministerial initiative – Human Services and Justice Coordinating Committees (HSJCC) is the focus of research. This unique convergence of healthcare, the criminal justice system, community service providers, and stakeholders have been mandated to meet to discuss their common forensic clients with a mission toward prevention, system designs, crisis and community intervention planning, court assessments, and case management. Latent consequences of the diverse convergence of policies guiding individual HSJCC members are discussed. Confusion about the protocols for sharing needed information within meetings and with identified community stakeholders to plan for client management and potential Committee

member self-preservation were the primary findings. The potential impacts of the findings and how these might impede HSJCC's from realizing their potential are highlighted. Promotion of simplified education in privacy policies to enhance the important work of the Committees is proposed.

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Dedication

This research is dedicated to those who live with symptoms of serious mental illness in striving to meet their individual needs and work toward understanding and enhancing their quality of life.

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Section 1

Introduction

The debate regarding the tensions between the lack of an integrated system of community based mental health care, compulsory care, and individual rights and freedoms in the context of serious and persistent mental illness, is not new. It contains a delicate and changing balance of rights and obligations. Valid arguments can be made on both sides of the protection balance – protection of a common sense of the social good and protection of the rights of individuals needing mental health treatment. The evolution of the Ontario Mental Health Act (R.S.O. 1990) (MHA) is discussed and situated in the Canadian context to illustrate how our current mental health system came to exist and unwell forensic clients reside in communities. Deficiencies are highlighted in applying mental health legislation to situations of persons with persistent psychosis, who are chronically interacting with the criminal justice system, treatment non-collaborative, and lack insight into their own behaviour and its consequences – a symptom often associated with psychosis.

Canadians believe that there is a social obligation to protect and treat individuals who are deemed legally incapable to make decisions about their care or who can not reasonably foresee consequences of choosing not to receive care due to the impairment caused by symptoms of serious mental disorders. These beliefs are reflected in provincial mental health acts throughout Canada. It is further believed, as reflected in our criminal and civil codes, that

there is an obligation to protect society from criminal behaviours in an effort to maintain social order.¹

The following literature review outlines, briefly, the evolution of the Ontario Mental Health Act (R.S.O. 1990) (MHA) and sets its development in the Canadian context to illustrate how our current system of mental health care came to exist and how unwell forensic clients have come to reside in Ontario communities. It demonstrates how legislative reforms to the MHA have been motivated by crisis events which became publicly charged and highlights the reactive, rather than proactive, mechanisms used to maintain our social order. Still the reforms struggled to safeguard both individuals and the wider society while balancing the rights and freedoms granted to all Canadians. The literature review identifies some deficiencies in applying mental health legislation in a very complex system of care to situations of persons who are chronically interacting with the criminal justice system, experiencing symptoms of persistent psychosis, juxtaposed in treatment non-collaboration and the lack of insight the symptoms of psychosis frequently cause. This sub-population, of forensic clients is further defined.

The Government of Ontario recognized the need for further development of services to plan and manage the significant potential damage/crisis events forensic clients can cause. It has funded a number of programs and initiatives to attempt to monitor the safety/risk of forensic clients at the provincial and local levels. Some of these are discussed. An inter-ministerial initiative has been developed – Human Services and Justice Co-ordinating Committees (HSJCC). This unique convergence of healthcare, the criminal justice system, community service providers, and stakeholders have been mandated to come together to discuss their common forensic clients

¹ Healthcare Consent Act, R.S.O. 1994; Mental Health Act, R.S.O. 1990; Personal Information Protection Act, R.S.O., 2004; Criminal Code of Canada; Police Services Act; Canadian Charter of Rights and Freedoms, and others.

with a mission that speaks to prevention, system design, crisis and community intervention planning, court assessments, and case management.

The HSJCC's are admirable in theory, but likely quite idealistic in practice in the context of human rights set out in the MHA, Personal Health Information Protection Act (RSO 2004) (PHIPA), and individual organizational policies prescribing strict circumstances for the sharing of information needed to permit the HSJCC's to meet their goals. The latent consequences of these policies seem to prevent the kind of communication expected of HSJCC's by the Ontario government. How can this unique group carry out their professional requirements at this policy level? How can they discuss the needs of individuals who are living in the community, known to engage in recidivist behaviours due to symptoms of chronic psychosis, who place society at risk, are non-collaborative with treatment plans, will not provide consent to share information about them with other service providers, are not yet quite unwell enough to meet involuntary commitment criteria, deemed "competent" in law? As will become evident, these are the assumed complex difficulties with which the HSJCC's struggle.

This research seeks to uncover some specific latent outcomes created by legislation and organizational policies, as experienced by members of HSJCC's. This goal has been accomplished through a qualitative study that involved experts who contribute their time and expertise to HSJCC's. The research sought to understand their perceived abilities to be effective HSJCC members and what forces support or impair their ability to participate in this committee.

1.1 Literature Review

Attempting to Strike a Balance: Human Rights and Mental Health Reform in Ontario

At the end of the 1950's the provision of care for Ontarians suffering with symptoms of mental illness was institutionalization in large government-run Provincial Psychiatric Hospitals (PPH's) housing between 1,000 and 5,000 patients often in inadequate, understaffed, facilities located in remote areas, out of the public eye. In 1962 there were 11,362 beds funded in the PPH's. General hospitals were granted strict, very minimal funding for psychiatric beds, having the effect of creating a two-tier system. PPH's became burdened with overcrowding, meagre staffing, and inadequate funding (Hartford, et al. 2003).

As early as 1959 proposals drafted for the then new Minister of Health promoted greater emphasis on community-based psychiatric services, the establishment of psychiatric units in general hospitals, and community care for "*convalescent patients*" (Hartford, et al, 2003). Parallel recommendations were made in 1962 by a national Royal Commission on Health Care (Hartford, et al, 2003; Simmons 1990). Transmissions of concern about the insufficient conditions of Ontario mental health services were common themes of policy reform discussions for the subsequent two decades. Criticisms surrounding the lack of coordinated long-term planning services, ignoring mental health as a priority, and inadequate aftercare discharge services were themes conveyed by the 1969 Ontario Council on Healthcare, and the 1979 Council Committee on Mental Health Services. However, these reviews of mental health policy did not generate any policy reforms (Hartford, et al, 2003).

In 1983, a 1981 Ministry-mandated policy and service review conducted by academic psychiatrist Gilbert Heseltine advocated for:

a mental health care system ... which directs energy and resources toward providing services outside the hospital ... (and)... the provision of

alternative settings for treatment and care in the least restrictive and disruptive settings which are as close to patient's or client's home as practical. (Heseltine, 1983, p. 205)

These types of recommendations raised questions about what would constitute "home" when care shifted to the community and became clear during the late 1970's when ex-patients were discharged in significant numbers from hospitals to inadequate and unregulated housing. A housing shortage led to homelessness for many formerly hospitalized patients. Simmons (1990) stated that the number of articles discussing mental health related issues in Toronto's major daily newspapers tripled between 1979 and 1981 which focused on the absence of community-based care and affordable housing for deinstitutionalized persons, insufficient welfare remuneration, and political bickering about responsibility for supports (Simmons 2003). Heseltine's 1982 Interim Report acknowledged considerable media attention and subsequent public scrutiny.

Despite efforts of governments to reorganize mental health services, the number of beds in PPH's rose from 11,362 in 1962 to 15,257 in 1965, then plummeted to 4,949 by 1980. A very small part of this decline was offset by the reopening of psychiatric units in general hospitals. The advent of psychotropic medications was considered an additional contributing factor. The decline in psychiatric beds was accompanied by legislative changes providing for involuntary hospitalization. The landmark 1978 MHA amendments established focus on the *safety* of patients and others, replacing "*welfare*", as a basis for involuntary psychiatric examination or committal (Hartford, et al, 2003; Bay, 2003; Prowse, 2003; Simmons, 1990). Regional Review Boards were established to hear appeals from patients who had been involuntarily hospitalized. The Canadian Mental Health Association (CMHA) promoted on-going interest in clarifying the vagueness of criteria for involuntary hospitalization, in addition to the involvement of a 1977 Minister of Health that led to proposals for what became the milestone MHA amendments of 1978 (Hartford, et al, 2003; Simmons, 1990). Changes surrounded criterion restriction for both

involuntary psychiatric assessment and committal which could only be permitted if a person's mental disorder had resulted or would result in "serious bodily harm", or "imminent and serious physical impairment of the person." These remained in effect until the 1990's, met with significant criticism from psychiatrists who perceived the criterion as too restrictive (Everett, 2000; Hartford, et al, 2003; Simmons, 1990).

Although involuntary patients could be competent to refuse treatment, the Review Boards could override their decisions. A high-profile 1983 case brought this issue to the forefront when an involuntary patient retained a lawyer to contest the Review Board's decision to override her decision to refuse invasive electroconvulsive therapy (ECT). The case was settled out-of-court respecting her decision to refuse this treatment (Hartford, et al, 2003). Additionally, a landmark 1973 Michigan case, Kaimowitz vs. Department of Health, ruled in favour of the patient's right to refuse invasive psychosurgical procedures stating the patient could not appropriately consent to such treatment when the patient's status was involuntary. California and Oregon made the administrative process of applying for involuntary psychosurgical procedures so cumbersome, that the process made the granting of such procedures all but impossible (Simmons, 1990). Given its consistency with trends in the United States, the Ontario case led to a 1987 amendment in the MHA providing for a patient's rights to appeal Review Board decisions to the courts (Hartford, et al, 2003; Simmons, 1990).

In a series of amendments, provisions for a prioritized list of substitute decision makers from whom consent for treatment may be obtained were established. Amendments also separated the issue of involuntary hospital admission from consent to treatment. In 1992, further amendments replaced Regional Review Boards with Provincial Review Boards. In 1982, three highly publicized deaths at a Toronto's Queen Street Mental Health Centre led to the development and establishment of Psychiatric Patient Advocate Office (PPAO) and Patient

Rights Advisors in cases of involuntary admissions (Hartford, et. al 2003; Ontario Ministry of Health, 1987; Simmons, 1990). In 1981, Aldo Alvani, a 230 lb, 19 year old male who was described as extremely assaultive and psychotic, subsequently chemically restrained, died while unattended on a stretcher in the hallway was the subject of a Coroner's Inquest. The day following his death the documentation pertaining to the administering of the medication used to restrain him was lost. At the inquest, Coroner Margaret Milton was quoted as attributing political stalling as preventing improvement to Ontario's mental health care services (Simmons, 1990). The Coroner additionally criticized hospital policy, the deplorable housing conditions of ex-patients, and the lack of community services and supports (Ontario Ministry of Health, 1987; Bagby and Atchison, 1988; Psychiatric Patient Advocate Office, 2003).

The PPAO was introduced as an advocacy program to operate at arm's length from the government. This reform was in response to many crises and events that took place during the 1970s and 1980s. Additionally, the rise of various patients' rights and ex-patient groups and movements lobbied for improvements in the treatment of patients in PPH's. Newspaper articles continued to reference oppressive mental health legislation denying due process of law which subjected patients to repressive decision-making by psychiatrists and public officials. A movement toward restricting psychiatric power and strengthening patients' rights highlighted the need to reform antiquated portions of the MHA to become consistent with the Canadian Charter of Rights and Freedoms (1982) (CCRF). One of the duties of the PPAO was to assist in this process (PPAO Website, 2007; Everett, 2000; Reaume, 2003).

The latter part of the 1980's witnessed efforts at comprehensive mental health legislative reform. Two reports provided the necessary momentum. First, the 1988 Graham Report, echoing earlier reports, again highlighted the need for clear policy regarding who was to be served and how, the lack of an integrated systems approach, the disparities in the provision of

services between rural and urban communities; and lack of continuity of care (Everett, 2000; Graham, 1988). The Graham Report introduced a category of “seriously mentally ill” defined with regard to – diagnosis, disability, and duration of illness as a basis for determining priorities for treatment (Everett, 2000; Graham, R., 1988).

A committee was developed to devise an implementation plan for The Graham Report’s recommendations (Everett, 2000). A ten-year strategy for mental health reform was captured in the second report, Putting People First (Ontario Ministry of Health, 1993) which outlined “four solitudes of mental health” – enabling people with mental health issues to remain in the community, using hospitals only when clinically necessary, providing more community-based supports, and integrating mental health with other services (p. 5). Putting People First again allocated the highest priority in service provision to those with the most severe mental illnesses.

In 1995 the Ontario Progressive Conservative Party adopted an approach to expenditure control including the appointment of a Health Services Restructuring Commission (HSRC), whose job was to reorganize Ontario hospital services. HSRC was legislated with permission to close general hospitals and proposed to do so, in addition to substantially reducing the number of psychiatric beds through transfers to general hospitals, adversely affecting the operation of PPH’s. HSRC also recommended the designation of regional Mental Health Implementation Task Forces charged with advising the Ministry of Health about community reinvestment areas (Hartford, et al, 2003; HRSC, 1999; HRSC, 2000).

The government still needed to respond to community concerns surrounding several highly publicized cases of violence involving previously hospitalized psychiatric patients. Subsequent to Newman’s 2000 and Beyond report (1998) a government “comprehensive 5-week consultative review of mental health reform in Ontario”, MHA amendments (2000) resulted, removing the word “imminent” from the harm test as criteria for involuntary police

apprehension and involuntary patient admission, making provisions that police no longer had to witness the ill person acting in a manner that caused harm to self or others, but on reasonable grounds could simply suspect that a person might cause harm to self or others if not assessed by a physician. (Hartford, et al, 2003; Ontario, 2004). These amendments were consistent with recommendation numbers twenty-three and twenty-four from the Antidormi Coroner's Inquest (Ontario Ministry of the Solicitor General, 1999).

The Antidormi Inquest (1999) resulted from a high profile 1997 Hamilton tragedy. A two year old boy, Zachary Antidormi, was fatally stabbed by neighbour, Lucia Piovesan, who was experiencing symptoms of paranoid schizophrenia and believed the spirit of her deceased son could be reborn if he were freed from Zachary's body. Despite attempts through the criminal justice system by Zachary's parents to stop Piovesan's on-going harassment of the Antidormi family, this tragedy occurred (Simmie, 1998; Clairmont, 2007).

Another example of tragedy of this type occurred August 1, 1995 when Jeffrey Arenburg shot and killed Ottawa radio sports caster Brian Smith. Arenburg, suffered from symptoms of paranoid schizophrenia and went to Smith's radio station, because he thought the station was broadcasting his thoughts. It was later discovered that prior to moving to Ottawa, Mr. Arenburg physically assaulted a radio station manager in Nova Scotia believing that station was broadcasting his thoughts. He was found guilty of assault and sentenced to pay a \$300 fine or spend two weeks in jail in 1992. He fled that jurisdiction and moved to Ottawa. Mr. Arenburg was found not criminally responsible for Brian Smith's death, due to the incapacity caused by symptoms of his mental illness (Simmie, 1998; CBC News, 1995; Moore, 2000).

Brian Smith's tragic murder spawned public outrage. Brian's Law (Bill 68), establishing Community Treatment Orders (CTO) in Section 33 of the MHA, was the resulting Ontario MHA legislative reform, in 2000, with a legislated five-year review of the effectiveness of CTO's.

The CTO amendment was surmised to be an alternative to mandate treatment in the community for seriously mentally ill persons with the propensity for criminal behaviour (Moore, 2000). The CTO amendment to the MHA (Section 33.1) at first glance, seems to grant the provision for a person's treatment to be mandated under a prescribed set of circumstances where a person is deemed to need continual supervision of treatment in order to eliminate risk while residing in the community. However, when this legislation is reviewed, Section 33.1, Subsection 4(f), sets the subject's consent as part of the criteria for implementing a CTO². So, while a physician can issue the CTO mandating treatment, devise a treatment plan to treat the subject of the CTO, which the person is deemed legally capable of complying with even though the subject of the CTO may remain at least somewhat unwell, the subject retains the right to refuse treatment.

Mental Health Legislation: The Canadian Context

Each province and territory has an act that contains provisions delineating the process for involuntary detainment and treatment of those assumed to have a mental disorder. After the 1982 implementation of the CCRF it was determined that any Canadian mental health legislation must address "pressing and substantial" matters in order to infringe on an individual's rights. In 1987 an inter-provincial committee drafted a Uniform Mental Health Act which complied with the CCRF hoping, provinces would introduce more consistent mental health legislation (Davis, 2006). Notwithstanding, Canadian mental health acts vary slightly from province to province.

Psychiatric patients' rights advocates and the introduction of the CCRF became the basis on which "dangerousness" criterion was introduced into legislation. In 1979 Ontario was the first province to introduce this criteria into their mental health legislation. In 1987, British Columbia followed introducing a "protection" standard. The standard in Yukon and Northwest

² Ontario. Ontario Mental Health Act Section 33.1, Subsection 4. (f) *"The person ... consents to the community treatment plan in accordance with the rules for consent under the HealthCare Consent Act, 1996. 2000, c.9, s.15"* (MHA, 1990, CH M7).

Newfoundland and Labrador, 2008; Prince Edward Island, 2009). In other provinces, issues of treatment are dealt with under separate legislation. The idea that a psychiatric patient who is unwell has the right to refuse treatment has been highly controversial. A common rationalization is that the very organ used to make such decisions – the brain – is the very organ that is disordered. Given this, how can a patient make an appropriate decision? (Kress, 2006) Additionally, in a system where psychiatric beds are scarce, treatment refusals result in longer involuntary detentions, resulting in further mental and physical deterioration of the patient placing staff and co-patients at risk. (Davis, 2006)

Certification of a patient typically refers to inpatient treatment. However, in recent years, there has been more employment of statutory provisions for outpatient certification. These are basically are found in two forms. The first is a conditional or extended leave from hospital where conditions to receive treatment are maintained and monitored in the community. The second is a community treatment order (CTO) (Davis, 2006). In most provinces the subject must consent to involuntary status in the community however in Newfoundland and Labrador, the subject's consent is not required (Newfoundland and Labrador, 2008).

A 2000 Ontario provision allows for a conditional leave of a maximum of three months, mandating a person to continue treatment, and attend scheduled appointments (Ontario Mental Health Act). Procedurally, the leave promotes a transition to community living, with a transfer of responsibility to the community physician who can renew the involuntary status on a schedule that mirrors the hospital (Davis, 2006). However, in practice, when the legislation is reviewed, it seems unclear whether or not the hospital must hold a bed for the patient on leave in case the patient is recalled. If the hospital is required to hold a bed for patients, in an environment of bed shortages, employment of this provision seems unlikely to occur. The actual frequency of use of this type of leave is not reported in the literature.

Saskatchewan, in 1995 and Ontario in 2000 enacted legislative provisions for CTO's where some past evidence of treatment failure has been noted (Davis, 2006; Saskatchewan, 2004; Ontario, 2004). Legislative CTO amendments were enacted by Newfoundland and Labrador in 2006³, in 2007 Alberta⁴, and in Nova Scotia in 2007⁵. Many provinces make reference to least restrictive treatment in their legislations. Supporters of outpatient certification seem to agree that CTO's have some empirical efficacy in reducing re-hospitalization rates and fulfill the requirement of being least restrictive (Davis, 2006; Ontario Ministry of Health, 2005).

Involuntary patients have provincial and territorial legal protections and safeguards where their involuntary detention and treatment can be contested to review boards, panels, or courts available in all Canadian jurisdictions provided at no cost to the patient. In some provinces intermittent reviews of the detention/treatment are mandatory. Involuntary patients must also be advised of their rights. Patients' advocates, made available to patients to discuss these rights, seek a practical approach to accessibility for patients for example, by housing themselves on-site in psychiatric facilities (Davis, 2006; Ontario Ministry of Health, 1987).

The Interface: Criminal Justice and Mental Health Systems

An unfortunate fact about persons with serious and persistent mental illness is that they are overrepresented in the criminal justice systems. An enormous body of research supports this assertion showing that the prevalence of persons with serious and persistent mental disorders in prison populations and remand/pre-trial proceedings far exceeds that of the general population (Davis, 2002; Roesch, 1995; Notiuk and Porporino, 1992; Bland et al, 1990; Gingell, R., 1991). One

³ Newfoundland and Labrador website, 2006

⁴ Alberta website, 2009.

⁵ Nova Scotia website, 1998.

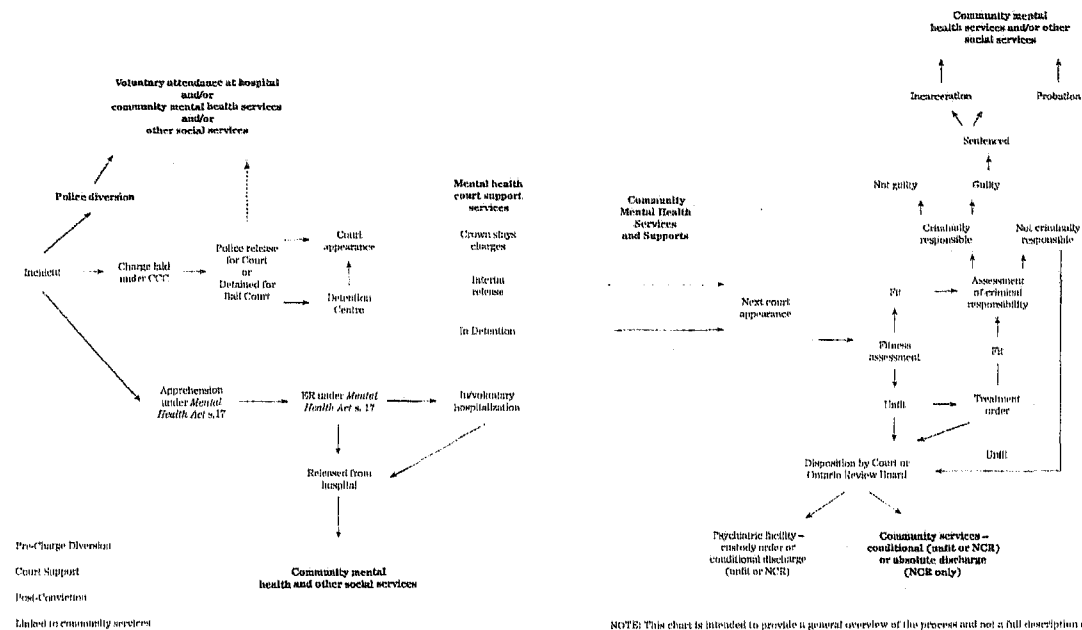
study found the prevalence of schizophrenia, bi-polar affective mood disorder, and depression among Quebec penitentiary inmates was 7.5, 4.8, and 16.9 percent respectively (Hodgkins and Cote, 1990). A 2001 British Columbia study found that 15 percent of persons in the B.C. corrections system had a serious and persistent mental disorder, estimating the recidivism rate for these individuals at 62 percent (Office of the Mental Health Advocate of British Columbia, 2001). The phenomenon of the criminalization of the mentally ill is thought to be a failure of deinstitutionalization (Davis, 2006; Davis, 2002; Gingell, 1991). Diagram 1.1 illustrates some juncture points between criminal justice and mental health systems in Ontario (Ontario Ministry of Health and Long Term Care, 2002).

The components of the pre-incarceration criminal justice system include police, courts, and the forensic mental health system. Encounters with police represent a significant point of entry to the criminal justice system. However, police can exercise some discretion when dealing with mentally ill persons dependent on the nature of their encounter. Police can take no action, informally intervene, for example by removing the person, utilize an alternative resources such as a crisis centre, shelter, voluntarily take a person to a hospital, invoke police powers under mental health statutes and take the person involuntarily to a hospital, or invoke the Criminal Code and arrest the person. Admission to a psychiatric facility resides with the receiving doctor, not the police officer (Davis, 2006; Ontario MHA; Wilson-Bates, 2008). Police interface with mentally ill persons, subsequent to crisis events, has generated a significant interest, research, and program development. Training initiatives like crisis intervention training (CIT) for police have been implemented in many Canadian municipalities. Partnership programs, such as Police-Mental Health Worker programs found between the Toronto Police Service and St. Michael's Hospital, and the Hamilton Police Service and St. Joseph's Healthcare Hamilton, have been implemented to better manage community psychiatric crises (Davis,

Diagram

1.2

Key Junctures Between Criminal Justice and Mental Health Systems



NOTE: This chart is intended to provide a general overview of the process and not a full description of all possible variations. There may be other scenarios that have not been reflected.

Adapted from: Ministry of Health and Long-Term Care, A Program Framework for Mental Health Diversion and Court Support Services

2006).

After arresting a mentally disordered person, the courts need to determine if the individual is fit to stand trial. A judge can order a fitness assessment conducted by a Forensic Psychiatrist. Fit persons are primarily released on bail with conditions to report to a bail supervisor and return for additional court appearances. Bail conditions can be problematic for mentally disordered persons due to the nature of the disorders causing disorganization, cognitive impairments and lack of community supports for example, may mean they fail to comply resulting in further charges. If convicted, persons may be sentenced to probation or time in custody (Davis, 2006; Ontario Ministry of Health, 2002). Probation conditions pose problems similar to bail conditions which can include complying with treatment supervised by the forensic psychiatric system (Davis, 2006).

There is agreement in Canada among stakeholders that convicting and incarcerating mentally ill persons for minor offences is inappropriate. Diversion programs have been developed to alleviate this difficulty. Diversion is the suspension of criminal charges in lieu of the person agreeing to comply with prompt treatment usually occurring post-arrest but pre-trial. Additionally, Canada has two mental health courts – Vancouver and Toronto. The goal of mental health courts is to “prevent criminalization and recidivism by providing critical mental health services” (Davis, 2006, p. 183; Ontario Ministry of Corrections, 2006; Ontario Ministry of Health and Long-term Care, 2005) with charges being deferred if defendants agree to participate in mental health treatment. Target populations of these diversion programs are adults; with substantial mental disorder of mood, thoughts, and perceptions, that grossly impairs judgment and behaviour; and charged with a low risk offence. In diversion studies, thus far, recidivism seems to be reduced (Davis, 2006; CMHA Website; Ontario Ministry of Corrections, 2006; Ontario Ministry of Health and Long-term Care, 2005).

Finally, the forensic system provides court mandated assessment and treatment which can arise in several ways. A pre-trial assessment can be requested by the courts to determine fitness at court appearances and of the accused's mental capacity at the time the offence was committed. Persons who are found either unfit to stand trial or not criminally responsible by reason of mental disorder (NCR) may be detained in custody or given a conditional discharge. Determination by a Review Board is made regarding if the accused needs to be detained in a forensic psychiatric facility or can be maintained with outpatient treatment and supervision. Persons found NCR usually graduate from detention, to conditional discharge, to absolute discharge. Conditional discharge conditions are similar to those contained in probation orders, but always contain treatment compliance. The onus is placed on Review Boards to find the "least restrictive" disposition unless the individual poses a threat to society. Enforcement of any conditional orders can be a burdensome process. For example, if a person fails to show up for treatment, or is in breach of the order, no immediate action will necessarily be taken. Rather, a new court appearance date may be assigned and a person deteriorates awaiting the lengthy process of a new court date (Davis, 2006; Bettridge and Barbaree, 2004).

It may be useful here to clarify what is meant by forensic patient/client in Ontario. Forensic patients are those who have been referred by the Courts for psychiatric assessment or who have been declared not criminally responsible (NCR) or unfit to stand trial. They are admitted to the Ontario provincial forensic mental health system and are under the jurisdiction and supervision of the Ontario Review Board (ORB) which monitors their progress and reviews their cases on an annual basis (Hucker, 2006; Bettridge and Barbaree, 2004). For the purposes of this research, the definition of forensic patient/client will be expanded to include those adult

criminal behaviour, can be controlled/put into remission with pharmacological treatment and community supports (Fish, Frances, and Princus, 2004).

From reviewing Ontario's/Canada's mental health system, it appears that we are actually providing sick care to those with mental illness, rather than health care, in a system built from the top down. Unwitting community members remain at risk of violation from the forensic client population, whose rights to choose 'no treatment' seem to reign by system design. Although most provinces have provisions for some types of involuntary outpatient treatment it seems these may not be utilized frequently. Research suggests that use of CTO's seems to hold promise for promoting wellness among forensic patients¹⁰. However, it seems that presently the courts are the only mechanism available to mandate community treatment compliance. This means that an unsuspecting community member must first be violated by a forensic client. However, regardless of whether a person is supervised by the ORB, probation and parole, a CTO, or on some type of conditional leave which sets out treatment compliance, the process of having someone in violation of an order brought for treatment is cumbersome at best. Persons remain in communities awaiting new hearing dates while their mental health continues to deteriorate.

This analysis seems consistent with the writer's experiences of encountering forensic clients while employed as a member of Hamilton's joint Police-Mental Health mobile crisis program, Crisis Outreach and Support Team (C.O.A.S.T.) and is evident in the case scenario contained in Appendix A. This discussion has highlighted how forensic patients encounter the criminal justice and mental health systems, and can remain untreated, symptomatic, and at risk living in Ontario communities.

¹⁰ Ontario. Ministry of Health and Long Term Care, (Dreezer, Bay, and Hoff), 2005. Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the Mental Health Act.

Toward Service Integration Goals: Community Based Mental Health Supports

Recurrent themes of mental health legislative reform in Canada and specifically Ontario, have been to devise an integrated system of community-based mental health care in the least restrictive manner, promote and protect the rights of patients through due process, determine when our social obligation to intervene occurs, and under what set of prescribed circumstances constitutes protecting individuals and/or society versus the individual's rights. It seems that the Ontario government continues to attempt to evolve a balance between these rights, freedoms, and protections through the restricting and broadening of intervention criteria, the development of community based programs, and legislative mechanisms.

It is important to note that the forensic population is extremely small, without ignoring that it has the potential to cause significant damage, as evidenced by the case examples¹¹. A 1997 survey estimated that 3,100 to 5,200 ORB supervised, common ministry forensic clients lived in Ontario communities (Northeast Mental Health Implementation Task Force, 2002 p. 262-3). Ontario's 2004 population was estimated at 12,416,749 (Statistic Canada, 2006). If the same were true of both years, ORB supervised clients living in Ontario communities would be estimated to range from 2.4% to 4.1% of Ontario's population.

A further complication with forensic patients, evident from Appendix A and the case involving Jeffery Arenburg, is the potential for transience. As community members, the process of uncovering potentially unsafe forensic clients is far from fail proof having to rely on intolerance of odd behaviours which compel community members to report these to police or other appropriate authorities such as mobile crisis intervention teams. Poor community management of forensic clients can also have the impact of stigmatizing mental illnesses further.

¹¹ Antidormi, 1997; Arenburg, 1995; and Appendix A.

This is problematic when we consider that a recent Canadian study indicated that if severe mental illness were eradicated, the crime rate would drop by only three percent, and if concurrent disorders were eradicated, the crime rate may be reduced by just ten percent (Stuart and Arboleda-Flórez, 2001). However, with the knowledge that treatment collaboration can reduce recidivism in forensic clients, it seems an important goal to continue to work toward.

The Ontario government recognized the need for better management of forensic clients and subsequently increased funding for the development /expansion of programs to assist with treating and monitoring this population. In addition to the aforementioned initiatives,¹² Assertive Community Treatment Teams (ACTT) are comprehensive case management teams which have also been funded (Ferris, et. al, 2001). There exists a myriad of community programs and individuals that encounters and monitors forensic clients. These can include income supports such as Ontario Disability Support Program (ODSP), lodging homes, shelters/hostels, landlords/superintendents, physicians, public housing, addictions agencies, seniors' supports, churches, employers, families, and friends, to name a few.

Given the number of service providers and ministries involved in service provision to forensic clients in a segregated system of mental health care, and as governmental discussions about how to prevent community tragedies like those cited transpired, Human Services and Justice Coordinating Committees (HSJCC's) were mandated by the Ontario Government in 1998 subsequent to the release of a document entitled A Provincial Strategy to Co-Ordinate Human Services and Criminal Justice Systems in Ontario, 1994 (Leveque, 2003). Prepared by the Human Services and Justice Co-ordination Project, the document proposed a unique co-operative effort among the Ministries of the Attorney General, Community and Social Services,

¹² Mobile Crisis Programs, Forensic Mental Health Services, Court Diversion, Mental Health Courts, Crisis Intervention Training for Police (CIT).

Health and Long Term Care, Solicitor General and Correctional Services. It identified inter-ministerial initiatives to address the difficulties identified as occurring among their commonly encountered forensic clients. The expected outcome of the initiative was improved quality of service and life for clients, enhanced public safety, and increased service and system effectiveness. It proposed a provincial coordinating body with local and regional coordinating committees, recommending that the local committees articulate strategies that spoke to prevention, system design, crisis and community intervention plans, court assessments, and case management (Leveque, 2003).

Local committees were tasked with finding “local solutions to local problems.” (Northeast Mental Health Implementation Task Force, 2002, p. 264) To enable this cross-sector service co-ordination the development of collaboration through “community services agreements, interagency working agreements, information sharing protocols, and joint educational initiatives” (Northeast Mental Health Implementation Task Force, 2002, p. 264) was realized. A key component to the joint sector collaboration is identified as coordinating “joint communication” (Northeast Mental Health Implementation Task Force, 2002, p. 265) to enable problem solving within current legislative guidelines. Committees are comprised of various organizational representatives including community service providers, Ministry representatives, police, crown attorneys, federal and provincial corrections, and hospitals. There are presently twenty-eight district HSJCC’s and fourteen regional committees (HSJCC Website).

This research now turns specific focus on the directive to HSJCC’s, “collaboration through community services agreements, interagency working agreements, information sharing protocols,” (Northeast Mental Health Implementation Task Force, 2002, p. 264) and “joint communication” (Northeast Mental Health Implementation Task Force, 2002, p. 265) to enable problem solving within current legislative guidelines.

1.2 Statement of Problem

The writer attended a recent (2008) Hamilton HSJCC to observe, process, and understand how an HSJCC works. At this local committee meeting, new attendees must sign a confidentiality agreement prior to the meeting commencing. New cases were brought to the panel, discussed, problem-solved, and assigned to others to attempt to coordinate service with the service provider that brought the case to the table, if the initial service provider could obtain consent from the subject individual (forensic patient), who was not necessarily named unless prior consent was obtained. Next, old cases were discussed to decide whether they needed to remain on the agenda for the next meeting, needed additional/alternative problem-solving or services, or could be closed, at least for the time being, after an update on the progress of the subject individual was provided to the panel. Those subject individuals that had consented to being discussed at the meetings were named, and those that did not provide consent, were identified by a number. Issues with service provision were discussed, and at this meeting, particularly as safety pertained to community workers. Ideas were generated in attempts to resolve the safety concerns and other concerns identified. Some service provision/coordination tasks were requested of specific Committee members by the Chair and some members volunteered to perform others necessary tasks.

Two impressions resonated with the writer at the conclusion of the meeting. The first impression was the dedication and collaboration the expert working group displayed. The majority of the members appeared extremely motivated by the work of this Committee, attempting to brain storm ways to overcome barriers. The second impression was the sheer frustration which seemed to be experienced by the panel members in complying with the privacy legislation, and individual organizational policies. For example, if a police services

representative offered to flag an individual on the police data bases in compliance with the plan developed by the panel, so police coming into contact with that person would have direction on the method devised by the expert panel for dealing with that person, without the individual's name it is evident that executing this plan is impossible. Additionally, as particular crisis plans are developed for encounters with specific individuals, again, without the subject individual's name, and permission to share that plan with C.O.A.S.T. workers for example, executing any kind of a specific crisis plan is again impossible. This seemed particularly problematic for the members of the Committee when the majority of their client base is derived from forensic clients who, due to the symptoms of their illness are non-collaborative with service providers and perceive themselves as non-clients preventing them from providing consent to share information about them with others.

Although various reports, (e.g., Northeast Mental Health Implementation Task Force, 2002; Forensic Mental Health Task Force, 2002; Government of Ontario Program Framework for: Mental Health Diversion/Court Supports, 2006; A Provincial Strategy to Co-Ordinate Human Services and Criminal Justice Systems in Ontario, 1994), stress the paramount need for HSJCC's abilities to communicate with each other about coordinating services for these forensic patients, their task of communicating at the meeting observed, seemed almost grandiose in theory. When confronted with the actual practice of communicating, individual professional College regulations, organizational policy regulations designed to be consistent with the legislation outlined in CCRF (1982), Privacy and Freedom of Information Act (1990, Consolidated to 2008), MHA (1990, Consolidated to 2004), Ontario's PHIPA (2004, Consolidated to 2007), Ontario's Health Care Consent Act, (HCCA) (1996, Consolidated to 2007), and others, seemed to contradict their ability to openly communicate with each other. The latent consequences of these policies seemed to make an uncomfortable, frustrating convergence of healthcare providers, criminal justice system representatives, and community

programs committed to working collaboratively to meet their professional obligations as Hamilton HSJCC members.

Specifically, questions arose for the researcher about how the obligations of the committee are impacted by such policies. It is surmised that given the convergence of the various legislations and policies involved, there is some significant confusion even though service agreements have been devised. The research question became: **How do organizational policies, privacy and human rights legislation impact/contradict professional members of HSJCC's in relation to the Ontario government's recommendation to freely share information about clients to collaborate on planning for community and individual safety?**

1.3 Purpose of Study

This thesis is a requirement for completing my Master of Social Work degree at McMaster University. There was no known research about the operation of these committees at the time of writing. It was hoped that this study would highlight some of the contradictions inherent in planning for community and individual safety juxtaposed in policies which seem to inhibit the HSJCC's ability to communicate with one another about specific clients in some instances. The criteria clients must meet for the Hamilton group to discuss them is the diagnosis of at least one serious mental illness, generally non-collaborative with service provisions/treatment plans, and some interface with the criminal justice system. The clients the committee discusses have been highlighted as problematic and potentially unsafe for the community by the sources of referral, otherwise the group would not discuss them. Their need to be able to freely share information about these clients is paramount if they are to effectively plan for monitoring and managing these clients in the best interests of the individuals and the greater community. If

contradictions in directives exist and are not discussed or researched, resolution of the dilemma then seems impossible.

Understanding the Committees' communication contradictions will be important to help facilitate how these groups might proceed in clarifying how communication parameters might be modified to accomplish their goals. It was hoped that this study would be a preliminary step in identifying what privacy communication contradictions are encountered, and how and why they believe their ability to communicate may be impaired/impacted through privacy policies. From understanding communication barriers posed by policies, potential avenues to begin to seek resolution to the contradictions may evolve. Other HSJCC's may be experiencing similar difficulties. If that is the case, this study may also assist them in the same manner it hopes to assist the HSJCC's studied. Additionally, it is anticipated that the expert participants can illuminate unique strategies for working in their particular communities which may facilitate strategies for HSJCC's operating in other Ontario communities. This study hopes to additionally facilitate the illumination of potential new directions for more comprehensive policy research.

Section 2

Methods

2.1 Methods

Quantitative analysis, supplemented by some qualitative input was utilized to conduct this study. An electronic survey was devised and distributed to five HSJCC's. The survey, contained in Appendix C, was developed using *Survey Monkey* and secured by *VeriSign* for the utmost in privacy protection. The survey contained 19 questions. Some questions were more structured and others provided for personal ideas/experiences/input, and were intended to answer the researcher's questions of interest. The survey was designed so that respondents could answer, one, some, or all of the questions, and could exit the survey at any time without submitting any information whatsoever. A pre-test was sent to four of my colleagues, two nurses, one social worker, and one police constable, who are not involved in nor have knowledge of HSJCC's. The pre-test was implemented ensure the survey could be accessed through the survey link and for the purpose of ensuring a clear understanding of the questions. The pre-test participants did not identify any necessary revisions, advised that they felt the questions were clear, and were easily able to access the survey link. The survey provided for total anonymity of respondents because email and IP addresses were not collected. The researcher never accessed any of their email information as the Chairs and Co-chairs of the selected HSJCC's were asked to distribute a letter to their memberships via email (Appendix B) on behalf of the researcher. The letter

(Appendix B) explained the purposes of the study, discussed confidentiality/anonymity and provided a link that could be copied and pasted into the address bar of a web browser. In the letter, potential respondents were advised that they could forward the survey link via email to a location of their choice to ensure they could complete the survey in complete privacy and comfort.

Given the convergence of various organizations and policies, the distant geographical locations of the Committees, any data would prove very difficult to collect using another method. Additionally, given the sensitive nature of the topic, recruitment of participants may have been more difficult if the anonymity granted through this method could not be guaranteed. Utilizing other methods, such as focus groups, face-to-face or telephone interviews for example, would not ensure participant anonymity and therefore may have yielded skewed results due to the potential discomfort caused by answering some of the questions.

2.2 Sampling and Selection of Participants

Purposive sampling was utilized for this study. In purposive sampling, researchers draw on their own knowledge of the subject to identify participants with characteristics likely to have knowledge in the subject area of investigation. The researcher surmised from experience that the highest concentration of forensic clients might be found in areas containing the most social services available to them, including shelters/hostels, meal programs, probation and parole, corrections, and income supports, etc. Given that research also suggests those with serious mental illnesses are over represented in correctional facilities, and it is the recidivist population of interest to HSJCC's, it was surmised that upon their release, they may take up residence in the areas where the correctional facilities that housed them are located. Areas with correctional

facilities and psychiatric hospitals tended to have an abundance of social, psychiatric, and correctional services available. It was further surmised that the forensic cases encountered by HSJCC members in these types of areas may encounter unique complex cases in greater volumes than those in other areas. The researcher thought that in these areas, this greater volume of clients and complexity might provide for greater diversity in HSJCC members' experiences with organizational and provincial policies.

Selection of the HSJCC's to participate in the survey was therefore based on the following criterion: 1.) Committees were located in areas where large psychiatric hospitals exist that also contained forensic units; and 2). Committees were located in areas where federal and provincial corrections institutions were located. These criterion yielded a list of four regional Greater Toronto Area (GTA) Committees (Toronto, Durham, York, and Peel) and two local GTA Committees (South Toronto and Scarborough) located within the Toronto Regional HSJCC; Frontenac County local HSJCC from the South East HSJCC region, Hamilton from the Central South HSJCC region, Thunder Bay from the North West HSJCC region, and Simcoe-Muskoka Regional Committee containing Penetanguishene that did not list local Committees. Although the city of Ottawa also met the criterion, a local HSJCC could not be located. Frontenac is located in the Ottawa and Kingston areas. Given that Penetanguishene is one of only three maximum secure forensic facilities in Canada and met the other two criteria, the Simcoe-Muskoka regional HSJCC was selected for this unique quality. The Toronto local Committees, Durham, York and Peel regional HSJCC's were placed into a container and South Toronto was drawn out as a representative from that area. Therefore, the five HSJCC's selected from which respondents to the survey were recruited are as follows: Toronto South, Hamilton, Thunder Bay, Simcoe-Muskoka, and Frontenac.

An e-mail list of regional and local Chairs and Co-chairs of HSJCC's is public and was obtained from the HSJCC website. The list provided contact information for these persons in

the regions selected above. The researcher contacted them initially by phone to discuss the project, and their interest in participating, then forwarded the email to them for review and potential distribution to their respective HSJCC members (Appendix B). The letter requested that they let the researcher know via email when the survey had been distributed and how many members received the letter so that response rates could be calculated.

2.3 Analysis, Limitations and Ethical Considerations

Due to the limited scope and voluntary nature of this research, it was not possible to obtain opinions from every HSJCC member solicited and therefore every opinion is not represented. Individual communities are unique in resources and therefore, the research results/conclusions need to be very carefully considered when trying to apply them to other Ontario HSJCC's. Although it is anticipated that other Committees experience similar contradictions/impacts, only five Committees were selected to participate in this study. In addition, volunteer biases, systematic biases, and the small number of participants prevented the results of the study from being externally valid. The results also lacked internal validity as there was no definitive way to determine that the existence of the five HSJCC's, legislation, and organizational policies were the only barriers to effective and open communication.

Ethically, it was anticipated that some participants might experience discomfort with completing the survey. It is generally recognized that addressing issues with policies is a type of intervention and participants need to be aware of their rights via informed consent (IEC, 1999). Rights issues including confidentiality and anonymity were addressed in the Participant Recruitment Letter contained in Appendix B and were addressed at the outset of the survey.

Given that the participants were volunteers, and the subject matter is their area of interest and expertise, any harm to participants was unlikely.

Ethics approval was provided by the McMaster University Ethics Board on September 30, 2008 under certificate 2008-129.

2.4 Survey Results

The survey was distributed to the respective HSJCC's on October 15, 2008 as outlined. The deadline for completing the survey was November 9, 2008. One committee immediately volunteered to participate and distributed the survey as requested to its thirty-eight members. Two other committee representatives corresponded via email with interest in reviewing the survey and considering it for submission. No other correspondence from the committees was received. Therefore, if responses were received from only one of the five committees who confirmed its distribution, of the thirty-eight committee members to whom the survey was confirmed as distributed, 26.3% or ten participants started and submitted the survey; six members (15.8%) completed the survey in its entirety. Respondents had the option to answer only questions of their choice. All responses to individual questions are used in the analysis. It is acknowledged that it is possible that other Committees distributed the survey, but did not correspond to confirm its distribution, or with the number of members to which it was distributed.

71.4% (5 of 7) respondents had been Committee members for three years or more. 14.3% or one each of the seven respondents that answered this question each had been Committee members for one to two years and less than one year respectively. Three

respondents identified themselves as employed in hospital programs, two identified themselves as employed in developmental service agencies, one in substance addictions counselling, and one in community justice. Three respondents identified as program managers, two as program co-ordinators, and one as a clinical director.

Seven respondents provided information about how they became involved with their HSJCC. Of these, five respondents were invited to join their committee due to needs for particular sector representation such as those affiliated with addictions agencies specific to criminal justice, dual diagnoses/developmental disabilities, and youth criminal justice. One respondent sought out the committee due to the “great work” they encountered through their experience in participating in another HSJCC in different region.

Of seven respondents who answered this question, most seemed to be guided by several policies when planning for client management, individual and community safety as members of their HSJCC. These policies included organizational policies (85.7%), other policies (57.1%) including Youth Criminal Justice Act, Child and Family Services Act, Developmental Services Act, and “foremost the safety of the client and community”, Mental Health Act (42.9%), PHIPA (42.9%), Healthcare Consent Act (42.9%), confidentiality agreements signed for the purpose of participating in their HSJCC (42.9%), and professional college guidelines (14.3%).

Informed by the policies that guide their HSJCC work 85.4% of seven respondents to this question perceived a right/obligation to share information about specific non-collaborative clients in cases where imminent danger to the client or others was perceived. 71.4% agreed they would need to share such information in instances where potential danger to the client or others was perceived. 57.1% stated they would share confidential client information if the client were unable to care for themselves. One respondent stated they have a release of information on

their intake forms to share information with probation officers as part of their case management strategy and one stated they would never share information without the consent of the client or the client's next of kin.

The Ontario Government suggests that the inter-ministerial goals of HSJCC's are to come together to discuss prevention, system design, crisis and community intervention planning, court assessments, and case management, promoting that HSJCC's find "local solutions to local problems". To enable cross-sector collaboration and joint communication the government states that inter-ministerial, community services, inter-agency working communication agreements, and information sharing protocols have been devised. Respondents were asked if they feel such agreements safely grant them permission to freely share information about specific clients at HSJCC meetings to plan for community management of their clients despite the policies and guidelines they noted above as informing their work. Of seven respondents that answered this question, 71.4% stated they felt protected by the government's agreements in achieving their goals. 28.6% stated they do not feel protected by these agreements. In answering the question why they feel protected or why they do not feel protected answers were as follows: a) two respondents stated they did not believe all committee members were completely aware "of said policies/guidelines/regulations," and how these beliefs may restrict the sharing of information; b) one respondent stated, "I'm not sure if these agreements can supersede legislation" and c) one respondent stated, "still requires consent of the client/next of kin."

Three of seven respondents felt that these policies and guidelines directed them adequately and safely in making decisions about sharing information about HSJCC clients. Two respondents felt that the policies/guidelines seem to contradict one another which make them feel uncomfortable and unprotected regarding decision making about what information they may or may not share, whether is it ethical and/or lawful to share information about clients

with other HSJCC and community members instrumental in executing client management plans. Of those that felt some discomfort with the decision making process regarding information sharing 28.6% (2 of 7) stated that reassurance from government/college/organizations that they are protected from liability would ease their discomfort. 28.6% (2 of 7) agreed that clarification of policy interpretation would ease their discomfort. 42.9% (3 of 7) stated although they did not answer feeling uncomfortable with decision making, they did not fully understand the policies. One respondent stated they would only share information with the consent of the client or the client's next of kin.

Seven respondents provided information about their understandings of potential consequences that may be imposed should they breach privacy/information sharing policies, regulations, and/or guidelines included the following: civil litigation (71.4%); suspension from employment without pay (28.6%), required to pay a fine (28.6%); termination from employment (14.3%); suspension from employment with pay (14.3%); and termination from professional college membership (14.3%). 28.6% of respondents answered that they did not know what potential consequences might encompass. No respondents thought that their professional college membership could be terminated and no respondents thought that they could be incarcerated. Three respondents answered "other" (42.9%). One respondent stated that they felt consequences would depend on the severity of the breach and the intent behind it. Two respondents thought some form of warning or "professional censor" might be a consequence. Of these consequences six respondents provided answers about the most important consequence for them to protect. Safeguarding against civil litigation, "my employment", and their professional license were identified. Two of six respondents stated they were uncertain what was meant by "protect" in the question but would not like to see employment termination as a consequence when persons are acting in "good faith." Of seven

respondents all denied ever having been the subject of an inquiry due to breach of confidentiality.

85.7% of seven respondents believed that sharing more or different types of information about their HSJCC's non-collaborative forensic clients would enhance their committee's ability to manage clients more effectively to promote community and individual safety, while 14.3% disagreed. Of the respondents who agreed that sharing information would be advantageous the following comments were provided:

any information that provides an opportunity to plan creatively to protect the individual, family, and community; the identified needs or plan of care for a client; information of the whereabouts, status of incarceration, which agencies are involved and needs that may be addressed by others participating in the Committee; only what is relevant and needed at the time for decision making; Past mental health/criminal history. Current diagnosis and prognosis. Current legal issues. Current 'capacity' assessments. Current financial information.

One respondent stated no information should be shared.

Seven respondents agreed that they might need to share information about clients with others in the community. However, four of these seven respondents cautioned that they would need the consent of clients or substitute decision makers unless the client were perceived to be in crisis or potentially dangerous to themselves or others. Of committee members that felt they would like to share information with members of the community, mobile crisis services ranked the highest at 85.7%. Others included psychiatric emergency services and police (71.4%); other community mental health services involved with clients (42.9%); probation and parole, Ontario Review Board, family/friends/significant others (28.6% each); and courts/court diversion (14.3%). 14.3% stated they would not share information.

Two of three respondents stated that their committee has made particular successes despite the potential contradictions and/or barriers. One of these three respondents shared that

their HSJCC was able to implement court diversion, education, and case resolution for a client. Another respondent stated that the committee has been a mechanism for closing gaps between services from hospital to community, and from jail or court to hospital. Two of five respondents stated that they felt it would be important that others know that their committee is dedicated to problem-solving about individual clients and devising practical solutions. Their solutions are implemented quickly and effectively. They noted that their committee is not one that debates theoretical systems analysis, issues, or how to collaborate, but one of action.

Section 3

Discussion

The results of the survey highlighted that the Committee is comprised of the appropriate/desired inter-ministerial stakeholders identified by the government as needing to come together to discuss their common forensic clients. The respondents identified themselves with backgrounds/employment in criminal justice, hospital psychiatric programs, hospital based community psychiatric programs, community based mental health programs involving those with developmental delays, addictions, general counselling, those assisting persons in transition from incarceration to community, and youth criminal justice. The majority of respondents were quite experienced as members of the Committee having contributed their time for three years or more. The respondents stated they are trying to manage this population, seemed dedicated, and quite proud of their Committee's accomplishments.

The survey was designed to answer questions about how the obligations of the committee might be impacted by a convergence of privacy policies from professional colleges, legislations, and organizations. It was surmised that given the convergence of the various legislations and policies involved, some significant confusion pertaining to policy interpretation about the client-unauthorized sharing of information among Committee members would be evident regardless of the governmental service agreements that have been devised to facilitate the free sharing of information about common forensic clients – the information needed for HSJCC's in planning for client and community management and the promotion of public safety.

The convergence of policies and confusion in policy interpretation were evident in the participant responses. For example, 85.7% of the policies presented in the survey affected the respondents, in addition to other policies/legislations that were not identified in the survey list but pertained to youth criminal justice, families, and those with developmental disabilities.

Some participants responded throughout the survey questions, that regardless of the dangerousness of circumstances they would never share information about clients without client or next of kin/substitute decision maker consent. The majority of respondents would share information in situations of imminent danger to the client or others, while some would share information about potential danger and a client's inability to provide self-care. The respondents stated they would like to share information about clients without client consent among themselves and with various community service providers to enhance better client management. However, apprehension was detected in their answers. They identified that they believed particular consequences such as civil litigation and/or loss/suspension from employment/professional licences may be imposed should they breach the privacy of a client. Hence, it seems plausible here that if they shared client-unauthorized information they may later regret such a decision if a client or employer discovered their action(s) and imposed consequences.

These answers give cause for concern because in reviewing the legislation provisions set forth conditions advising when and how it is legally responsible to share client-unauthorized information. Thirty percent of respondents were employed in hospital or hospital based programs and 100% identified themselves as managers, clinical directors, and program co-ordinators. All work in some manner with forensic clients and the majority would likely be

defined as health information custodians¹³ as identified by PHIPA, thus would be governed by the following:

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. PHIPA, 2004, c. 3, Schedule A, s. 40 (1).

Similarly, The Ontario College of Social Workers and Social Services Workers (OCSWSSW), for example, specifically directs its members to report to appropriate authorities concerns about potential injury to clients or others which it states supersedes organizational directives:

Unauthorized disclosure is justified if the disclosure is obligated legally or allowed by law, or if the member believes, on reasonable grounds, that the disclosure is essential to the prevention of physical injury to self or others. (OCSWSSW Principle V, Confidentiality)

The Regulated Health Professions Act, S.O. 1991 (RHPA) is legislation that governs all registered health professionals and Colleges including but not limited to nurses, occupational therapists, psychologists, respiratory therapists, midwifery, massage therapists, dentists, medicine, audiologists and language pathologists, pharmacists, etc. Organizational and Professional College policies should be consistent with PHIPA and RHPA legislations. Likewise, pertaining to the client-unauthorized disclosure of personal health/personal information, the RHPA Chapter 18 S. 36 (i) states such disclosure is permitted:

If there are reasonable grounds to believe the disclosure is necessary for the purpose of eliminating or reducing significant risk of serious bodily harm to a person or group of persons

¹³ Defined in PHIPA as anyone having care and control of personal health information. PHIPA, 2004, c. 3, Schedule A, s. 3 (1).

Other legislations such as The Police Services Act, R.S.O. 1990, Ministry of Correctional Services Act, R.S.O. 1990, make similar or even broader provisions for the unauthorized disclosure of private personal information about clients (prisoners and the like).

HSJCC's work primarily with clients who are recidivist in the context of symptoms of serious mental illness and who are non-collaborative with treatment plans, who therefore, based on their history, are likely to re-offend, hence there is a reasonable expectation that they likely to cause some type of harm to others in society. The legislative provisions for the unauthorized disclosure of personal information/health information outlined above cite eliminating, reducing, and preventing serious bodily harm or injury to a person or group of persons as reasonable and authorized grounds to disclose the information in question to others. Planning for how to prevent re-offenses and reduce the inevitable likelihood of societal victimization perpetrated by forensic clients seems then, to fall within the parameters for reasonable unauthorized disclosure of confidential information set out in these legislations.

One might conclude that Committee members would not be breaching any privacy or legislative policies pertaining to the client-unauthorized disclosure of personal and personal health information for the purposes of managing the behaviours of this challenging population. Rather, legislation seems to support these kinds of conversations between Committee members and with other stakeholders in the community deemed instrumental for devising and implementing client management plans intended to protect society. These provisions seem juxtaposed in protections for individual HSJCC members from any potential consequences given their intentions are in good faith, without malice or personal gain.

It follows then, that 100% of respondents could be unaware that the client-unauthorized disclosure of personal/personal health information is legally permissible and responsible given

the nature and intent of the Committees. However, I have been employed at several agencies/hospitals over the past few of years including CMHA Halton, Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, Joseph Brant Memorial Hospital, and others. Privacy legislation and the safeguarding of patient/client information has been a consistently contentious topic for management and healthcare information custodians at all of the agencies where I am or have been employed. In my experiences, fear of retribution for the unauthorized disclosure of patient/client information seems deeply entrenched in employees of these organizations. I expect, based on my own experience, that privacy legislation would be equally contentious and confusing for those persons involved in HSJCC's and their respective employers, particularly given the mass convergence of policies from different ministries, educations, and disciplines. As anticipated, these respondents' understanding of these policies seems ambiguous at best and consistent with my own personal experiences.

What respondents indicated was that they believed their Committee members were not adequately informed of the policies, regulations, and guidelines and that their lack of knowledge may "*restrict the sharing of information.*" A respondent indicated that they did not believe the inter-ministerial agreements could supersede legislation. Respondents stated, "*I simply just do not know exactly what the policies are;*" and "*I simply do not know the policies in great detail.*" Some respondents believed there could be serious personal consequences to them if they disclosed unauthorized client information at HSJCC meetings and with instrumental community stakeholders in the context of possible misinformation or lack of information.

So what, you might ask. So what if Committee members might be apprehensive about freely sharing information about common forensic clients in planning for their community management at HSJCC meetings? So what if they may not have a clear understanding of the policies and regulations which guide them? The answers to these questions may have very

serious implications for the protection of society. What seems to warrant examination is how and why people make decisions in conditions involving potential ambiguity, risk, and regret.

In decision making studies, ambiguity is defined as an unknown distribution of outcome probabilities. Risk is defined as an outcome which is unknown, but a situation in which at least one probability is known. Gambling is a common example of risk where the outcome is unknown but one's prospects of either winning or losing one's wager is known (Lauriola, et al., 2007; Lauriola and Evans, 2001 (a); Edwards, 1997; Kahneman & Tversky, 1979). Studies regarding risk/ambiguity aversion have consistently reported findings that suggested risky decision making and decision making under ambiguity are influenced by factors such as one's perceptions of benefits and costs, personal tendencies to seek or avoid risk/ambiguity, and individual risk/ambiguity tolerance (Lauriola, et al., 2007; Lauriola and Evans, 2001 (a); Edwards, 1997; Kahneman & Tversky, 1979).

There are many ambiguity, risk, and regret aversion studies (Lauriola, et al., 2007; Reb, 2005; Zeelenberg and Beattie, 1997, and others). These studies suggest that persons are thought to purposefully avoid decisions involving risk and ambiguity due to the negative emotions that could be associated with making a decision which will later be regretted because better choices would have resulted in a more desirable outcome and elicited positive emotions. These studies indicate that regret has some underlying presuppositions. For example, regret is considered an aversive emotion producing a desire to avoid it. Regret is considered anticipatable and anticipated regret is considered a function of one's personal abilities to predict undesirable outcomes. Further, the intensity of anticipated regret is associated with outcomes driven by comparisons involving what might have been if a better/alternative had been chosen. Finally, negative feedback from others which elicits regret, shame, and self blame about decisions often explains risk and ambiguity avoiding behaviours. Zeelenberg and Beattie's study (1997)

indicated that anticipated feedback on decisions profoundly affected one's decision choices. The study suggested that even when there is a strong personal preference for a particular decision choice, anticipated regret might drive a person toward another choice because people are motivated to minimize regret and aversive emotions. Zeelenberg and Beattie (1997) suggest there is room for debate about anticipated regret sometimes resulting in bad decisions.

Fessler (2001) postulates that shame-pride biases are part of cost-benefit analyses persons consciously or subconsciously employ while engaging in decision making processes. Fessler describes the following as conditions involved in the manifestation of shame: self-knowledge that one has violated a social norm, self-knowledge of failure, another person's awareness of one's failure, one's knowledge that another is aware of their failure, one's beliefs that the other harbours hostility toward them for their failure or overtly displays hostility toward them for their failure, and thus the aversive emotion *shame* is produced. Conversely, pride fulfils a social norm, self-awareness of one's success, other's awareness of one's success, one's self-awareness that others are aware of their success, and a positive appraisal of one's decision is received by others eliciting the desirable and gratifying emotion, *pride*. Fessler (2001) asserts that given the central role of emotion in motivating action, it is unlikely that individuals make decisions without the influence of emotions. Thus, the objective of decisions would be pride and the manifestation of positive feelings which produces benefits to individuals, while the anti-objective would be eliciting negative emotions such as shame perceived as costly.

A Bettman et al. study (1998) identified some potentially conflicting motivating factors in problem solving for decision making that included maximizing accuracy, minimizing cognitive effort, minimizing negative decision making emotions, and maximizing the ease with which decisions can be justified to others whom a decision maker may be accountable. Tetlock (1992) argues that people will often make decisions by deferring to the preferences of those who hold

them accountable, thus minimizing cognitive effort, maximizing their potential for accuracy, and reducing potentially negative feedback and emotions which could otherwise be associated with their own individual decisions.

In sum, decision making literature indicates that people are likely to make decisions that elicit positive emotions, are consistent with social norms, are perceived as accurate, consume less cognitive effort, and are consistent with decisions of those to whom they are accountable such as employers and regulating bodies. People predominantly appear to seek to avoid decisions involving risk and ambiguity which might result in eliciting aversive feelings for them, may be perceived as potentially regretful, and decisions which might result in producing feelings of shame. People particularly seem to avoid decisions that may result in the potential for negative feedback from others. They also can be dissuaded from decisions that are contrary to their personal preferences if they perceive an alternative decision may minimize the potential for regret.

Pertaining to HSJCC survey respondents and using this analysis, ambiguity seems it may be related to their lack of knowledge of policies in addition to misperceptions that consequences could be imposed should they make regrettable decisions and choose to engage in client management conversations with HSJCC members and fundamental community partners involving client-unauthorized information disclosure. Risk might be defined as their beliefs that aversive consequences will be imposed for the disclosure of client-unauthorized information. They may believe that should it be revealed that they shared client-unauthorized information they could be terminated from their paid employment or, for another example, the subject of civil litigation. Choosing to share the information could then result in negative emotions related to such a decision.

It follows from the studies in decision making outlined here, that HSJCC members therefore may be likely to protect themselves from making decisions which could result in any regret. Deciding not to share information has thus far seemed not to produce any negative outcome them. Deferring their decisions to their beliefs of consistency with their contentious privacy policy beliefs seems quite reasonable. They therefore are likely to repeat the same decisions about not sharing client-unauthorized information which may have been proven to afford personal protection to them; it is not an aversive decision from their perspectives.

The potentially erroneous privacy policy belief systems of these respondents set out thus far highlight a latent conflict in agendas between the government's directions to HSJCC's, and the individual Committee members. The government's objectives in mandating these Committees seems to be to provide the public with the appearance of social protection through the reduction of crisis incidents – the victimization of unwitting members of society – perpetrated by forensic clients. Volunteer HSJCC members meet to attempt to strategize about how to accomplishing this objective. These respondents identified a desire to be able to freely share information about forensic clients among themselves and with community stakeholders deemed instrumental in implementing client management plans. However, due to perhaps erroneous privacy policy beliefs, it seems they may have decided to maximize protection of themselves which may have the impact of compromising the protective intent of the policy. If society is not protected due to Committee members' self protection behaviour, and a serious crisis event occurs, given Ontario's government has provided legislation that seems to facilitate the kind of communication it has requested of HSJCC's, who will be accountable for the tragedy? Although the government has not concisely articulated any client-unauthorized disclosure rules to these Committees, when faced with actual public adversity, government may defer blame to HSJCC's. What then?

Some respondents believed they need to protect personal information about forensic clients at all costs if consent can not be obtained. This begs the question about whose rights are being upheld. It has already been proposed that erroneous belief systems may contribute to decisions made not to share client-unauthorized information with anyone. In deciding this way, individuals seem to be exercising an anticipatable self-protection while simultaneously upholding the rights of their forensic clients which raised the following questions for me. Are non-collaborative, non-insightful forensic clients whose thoughts are significantly disordered, whose past history has demonstrated a pattern criminal re-offending in the context of symptoms of serious mental illness truly capable of making the best self-care decisions? Would non-collaboration, recidivism, violation of others, and incarceration be accurately reflective of a forensic clients' choices? At what risk, and to whom and under what circumstances, should strict constructs of privacy be upheld?

Some respondents identified that they were uncertain that the directives to HSJCC's by governments facilitated through working agreements could supersede legislated policies. Perhaps by virtue of the fact the government stated these inter-agency working agreements were devised, implying they are needed, this gave rise to the notion that there would be contradictions in privacy policies amongst a convergence of ministries. Regardless, respondents indicated that they might feel better about client-unauthorized information provision if reassurances from the policy makers that they are protected from personal liability were provided. Additionally they agreed that clarification of policy interpretation could facilitate the needed sharing of information. Some respondents stated that although they did not experience difficulties with their decisions whatever those may be, they still acknowledge a lack of clear policy understanding.

In the context of these questions, the potentially conflicting agendas identified, and these respondents' survey answers, education about legislation and policies might be a key component to enhance functionality of HSJCC's. This might consist of devising something simple like a Guide-to-Client Information Sharing for Human Service and Justice Coordinating Committee Volunteers. Such a guide might concisely set out links for web-available legislations and sections that volunteers can refer to pertaining to client-unauthorized information disclosures, contain frequently asked questions about privacy legislation, common interpretations of privacy policies, individual protection from liability standards, and thank them for participating in these Committees. It might also take the form of a short podcast conveying the same information using the voices of regulators and legal experts to allay fears of participants and to reassure them that although they have undertaken an important, very difficult, and challenging task involving social protections under contentious and confusing conditions, they are protected by law, regulation, and convention from personal and professional liability.

Section 4

Summary, Limitations, and Concluding Reflections

4.1 Summary

After reviewing the evolution of policy amendments in mental health legislation in Ontario over the past several decades, situated in the Canadian context an understanding of how forensic clients have come to reside in Ontario communities was facilitated. The conditions presently constituting reasonable grounds to enforce involuntary commitment and treatment of forensic clients were discussed. However, it was identified that difficulties managing the forensic client population continue to exist. Forensic clients were defined for the purposes of this research as those adult persons with mental disorders¹⁴; who are non-collaborative with treatment plans¹⁵; reside in Ontario communities; and who repeatedly interface with the criminal justice system, but are not necessarily supervised by the ORB. This research turned focus to the work of HSJCC's, an initiative mandated by the Ontario government which seems to provide the public with the appearance of a social protection mechanism for the significant social violations this small population of Ontarians has the potential to perpetrate. Examples of such violations were provided.

¹⁴ Organically based psychotic disorders found on Axis I and cognitive impairment found on Axis II (DSM-IV-TR) such as schizophrenia, schizoaffective disorder, bi-polar affective mood disorder, concurrent disorders, and dual diagnoses

¹⁵ Medication adherence, CTO's and/or designated out-patient supports

After attending a local HSJCC meeting, I noted that considerable privacy policy interpretation confusions seemed inherent among committee members who needed to make decisions regarding client-unauthorized information provision for the purposes of devising community management plans. Given the various ministries, educational backgrounds, and disciplines mandated to meet to carry out the government's directives, the confusion noted seemed predictable. My own employment at several agencies/hospitals over the past few of years in various Southern Ontario communities emphasized privacy legislation and the safeguarding of patient/client information, as consistently contentious topics for management and healthcare information custodians. In my experiences, fear of retribution for the unauthorized disclosure of patient/client information seemed deeply entrenched in employees of these organizations. I expected then, that privacy legislation would be equally contentious and confusing for those persons involved in HSJCC's and their respective employers, particularly given the mass convergence of policies. As such, the following research question was devised: **How do organizational policies, privacy and human rights legislations impact/contradict professional members of HSJCC's in relation to the Ontario government's recommendation to freely share information about clients to collaborate on planning for community and individual safety?**

A qualitative research study was devised to answer my research question. A survey was developed and electronically distributed to five Ontario HSJCC's to gain preliminary insights into the research question. The participant request letter and survey are contained in Appendices B and C respectively. Although responses were gathered from a small group, as anticipated, these respondents' understandings of these policies seemed ambiguous at best and consistent with my own experiences. Their lack of understanding of the policies seemed to contribute to their decisions not to share client-unauthorized information within the Committees and outside the

Committees with community partners deemed potentially instrumental in client management planning. Decision making studies in conditions involving ambiguity, risk, and regret were utilized to support the manners in which Committee members may have arrived at their decisions not to share client-unauthorized information. It was proposed that their decisions may have been rooted in self preservation given their beliefs that undesirable consequences could be imposed should they make potentially regrettable decisions to share client-unauthorized information in compliance with government directives.

However, it was learned and illustrated that privacy policies make provisions for the disclosure of client-unauthorized information, which seemed ambiguous to this group of respondents given the mass convergence of policies with which they work. Preconditions for such information provision include eliminating, reducing, and preventing serious bodily harm or injury to a person or group of persons. Planning for the prevention of re-offenses and reducing the inevitable likelihood of societal victimization perpetrated by forensic clients seemed then, to fall within the parameters for reasonable unauthorized disclosure of confidential client information.

If HSJCC members are not freely sharing the client-unauthorized information required for devising client management plans with each other and with community stakeholders who need to be involved to protect society, and because their decisions may be rooted in self-preservation due to erroneous policy beliefs, it follows that they may not realize their full potential and functionalities to protect society compromising the protective intent of the policies consistent with government directives. Their potentially erroneous beliefs may be inhibiting their utilization of valuable resources and knowledge which could enhance their planning abilities and promote the protective policy intent. Several questions were raised with regard to whose rights and at what costs such information deficiencies could pose. Two suggestions were

made about how volunteer HSJCC members might be more effectively educated about legislation regarding privacy policies and their functions including a written guide and a podcast.

4.2 Limitations

This study has many limitations that I have been able to identify. One must be careful not to draw any conclusions from such a small sample size, resulting in the tentative nature of the discussion involving the survey results. Additionally, constructs that were surmised by me as potentially impacting client-unauthorized information provision decisions in the designing of the survey were utilized rather than undefined constructs that solicited predominantly open-ended feedback. No questions directly solicited open-ended feedback about how respondents arrived at their decisions and therefore, no specific information about decision-making processes was gathered, but rather implied from research on decision making. Consequently, it is important to note that these decision-making studies may not actually reflect how this particular group of respondents made decisions or what decisions were made to share or not share client-unauthorized information. The answers reflect only their belief systems about when client-unauthorized information might be shared. The survey questions only solicited information about constructs designed to explore potential reasoning processes through potential belief systems. Clearly other factors may impact how persons made/make decisions such as individual tolerances for decisions involving ambiguity, risk, and regret. Moreover, given some respondents identified that they were not clear about the directives involved in privacy policies some respondents may not have perceived any of their decisions as involving ambiguity, risk or regret.

Furthermore, respondents identified that they were unclear about what was meant by “protect” in question 6, although seemed to reflect my intent in asking it in their open-ended responses. Although a pre-test was sent to four of my colleagues who are not involved in

HSJCC's and did not identify any misunderstandings in their feedback to me, a more thorough explanation of "protect" may have yielded richer results, particularly given there seemed to be a lack of understanding in policies.

It must be noted while discussing limitations that in my work in crisis intervention with this population I have rather strong opinions about my beliefs which involve a resolute contention to share information about this particular group in order to plan for managing this group. My opinions are derived from my own familiarity with the group's potential for extremely traumatizing violations of community members. I am too familiar with the devastations of families, friends, and strangers alike that can potentially be left in their wake. My beliefs are rooted in observation and psychiatric ideations that it is largely due to the lack of insight that can be produced by the symptoms of serious mental illnesses, which can produce significant disorder in thoughts and behaviours that make this group non-collaborative with treatment plans. I have witnessed the positive individual and community outcomes supported in literature and studies, such as the mandated five year review of CTO's, for this group associated with the intervention of pharmaceutical therapies and community supports. My insights are additionally derived from observations that we can manage and monitor this non-collaborative population when communication is not perceived as an obstacle. Given my opinions it is possible that the study design may have had the impact of influencing the respondents' answers by shaping their thinking and is therefore subjective in nature.

Together, these limitations may be insightful for planning more comprehensive and objective research about these Committees.

4.3 Concluding Reflections

Given these identified limitations, it is noteworthy here to identify that the study was designed to gather only preliminary insights and to be manageable as Master's level research. In meeting these goals, the research seemed to me to be successful. The primary insight identified was ambiguity in notions of policies for this group of respondents. If these respondents identified uncertainty in understanding privacy policies, it seems reasonable to assume that there are other members of Ontario's HSJCC's who are at least equally as uncertain about their roles and responsibilities guided by privacy policies, particularly given these Committees work with an enormous amount of policies with which other members may not be familiar due to the convergence of ministries, educations, and disciplines.

Furthermore, insight into what privacy policy communication contradictions are encountered was gained. For example, some respondents identified that they were uncertain that the directives to HSJCC's by governments facilitated through working agreements could supersede legislated policies. Perhaps by virtue of the fact the government stated these agreements were devised, hence needed, this gave rise to the notion that there would be contradictions in privacy policies amongst, despite existing policies that consistently make provisions for the needed communication. Furthermore, insight into how and why Committee members believe their ability to communicate may be impaired/impacted through privacy policies was highlighted as the potential need to use self-preservation in decision making about sharing client-unauthorized information with each other and identified community partners.

Given the interdisciplinary nature of the Committees and inherent paradoxes and tensions in professions/educations it seems unreasonable that recommendations for education be made at the institutional learning levels. Police, corrections workers, nurses, physicians, psychiatrist, crown attorneys, social workers, occupational therapists, and others generally serve

communities in primary capacities that exclude this specialized group – forensic clients. Therefore it seems unreasonable for society and governments to expect that their managing them comprise a primary component of their institutional educations. It is profound really, that these professionals can come together to meet and problem-solve around a shared understanding of each other's roles and constraints in care provision for this group, coordinate services within the constraints of their roles, navigate policies, challenge their agencies, and negotiate and identify gaps in the mental health system that might permit for more comprehensive management of this complex and challenging group to promote individual and community safety. It is for these reasons that my recommendation for education at the level of the Committees themselves seems the most achievable.

Section 5

Appendices

5.1 Appendix A: Experiential Case Study

First meeting May 2006: COAST was contacted by police to assist with the assessment of a male party after police were called to restaurant in the downtown area for an uncooperative and physically aggressive male. Police arrived and staff at the restaurant had the male physically detained on the ground. Staff explained the he started smoking in the restaurant and was asked to take it outside. He was escorted from the restaurant twice. The third time he approached the restaurant he was yelling nonsensically, pushing, and shoving staff to gain entry to the restaurant. Police noted that he appeared significantly agitated, was talking to himself, and behaving in a paranoid manner. He wanted to return to Etobicoke and had enough money to take a bus (\$100). However, police maintained concerns about his ability to travel alone safely. Our team attended the GO Station to assist in assessment with police.

Previous COAST records indicate that the client arrived in Canada from India in 2001. He was charged with sexual assault and became involved with the Halton Canadian Mental Health Association Court Diversion Program. He was incarcerated at Maplehurst Correction Facility in Milton for this offense. He was released from prison and has been psychiatrically un-medicated for 13 months. His housing arrangement in the Halton area fell through and he was sent to Hamilton to reside at a men's shelter. CMHA Halton indicated that he experienced difficulty

with women in authoritative positions. COAST has no further information about where he had been living since that time. However, our records indicate an intention on behalf of Halton CMHA to transfer his file to CMHA Hamilton Court Diversion. Police check indicates that he is presently wanted in the Province of Quebec for an undetermined reason.

He appeared somewhat older than his chronological age. He was dressed appropriately for current weather conditions, but, was wearing two pairs of pants. His clothes were quite dirty. His hygiene was poor (greasy hair, body and foot odour). Posture was upright, but gait was somewhat unsteady, consistent with alcohol consumption. He made eye contact. However, it was often prolonged, intense, and uncomfortable. Some psychomotor agitation was noted. He was unable to remain seated, getting up after being asked to remain seated. He was wringing his hands and tensed up several times while conversing. He engaged easily, and shared information spontaneously. However, he seemed to be a poor historian. His speech was somewhat monotone, yet pressured, and slurred. He reported his mood as 'scared of that Don guy'. It is unknown who Don is. His affect was somewhat restricted. Inappropriate laughter was noted. Thought process was disorganized and illogical. He answered questions such as, 'when did you arrive in Hamilton?', by stating, 'I'm a son of a bastard'. His thought content was observed to be grandiose and somewhat paranoid. He advised us that he has 'billions of dollars' and believes 'Don' stole this money from him. He believes that 'Don' follows him from city to city, most recently from downtown Toronto to the restaurant here tonight. He was aggressive and uncooperative at the restaurant this evening and does have a history of violent behaviour (sexual assault). He appeared to be responding to internal stimuli, talking to himself and laughing inappropriately. He experienced difficulty concentrating and attending to questions. Judgment and insight seemed poor.

Given that he has a history of violent behaviour and appeared psychotic, he was apprehended under Section 17 of the Mental Health Act and safely transported to hospital for

further assessment. He was placed on a Form 1 and detained overnight. After being provided with some sedative and antipsychotic medications, he seemed to clear enough overnight to travel safely to his intended destination and was discharged agreeing to follow-up with his family doctor upon his return home.

Second meeting, November 2007: COAST was contacted by Police Sergeant who expressed concerns for a male's mental status. It was reported that he was recently released from prison on charges of uttering threats to police. Sgt. reported that since he moved to permanent apartment building address, she has been receiving complaints about his inappropriate and frightening behaviours from co-tenants. He was reported to have been staring at persons, particularly women, like he is looking right through them, riding up and down in the elevator with each individual person. He had been reported to be wandering throughout the building inappropriately clothed - "half naked". He had been disruptive in the lobby, breaking things, and banging on the pop machine. Sgt. advised that she attended the building to try to speak to him about the complaints. However, he was not at home. She entered his apartment to assess his safety in case he was inside hurt and unable to respond. She found that he had no food or beverages in his apartment, no furniture whatsoever, some toiletries, two changes of clothes, a jacket and a pair of sneakers. These were his only possessions. Sgt. advised our team that he has an extensive history of sexually deviant criminal behaviour, and had tendencies to become threatening and assaultive due to symptoms of serious mental illness. She stated he had been incarcerated for these behaviours in the past and had charges pending. Previous COAST records support her information. Sgt. requested that we assist her with mobile assessment.

We accompanied Sgt. to the address to assess his mental status. Although he was not at home, Security Tenant was able to advise us that he was sitting in the coffee shop across the street. We attended the coffee shop and spoke with him briefly. He was sitting alone inside

without having purchased any beverage or food advising he had "no place else to go". Writer gently confronted his assertion pointing out that he does have his own apartment directly across the street. He looked confused at the questions, seeming unable to respond or participate in conversation. Given his history, he was apprehended involuntarily under Section 17 of the Mental Health Act without incident and safely transported to hospital.

He was dressed inappropriately in sandals for the 4 degree Celsius temperature and was shivering. His clothes were dirty. His hygiene was quite poor. He was malodorous. He made little eye contact, but the eye contact he did make was prolonged, intense, and uncomfortable, again. He was cooperative. However, seemed unable to share information or participate in conversation. Speech was very muted and slow, extremely minimal in quantity. His affect appeared somewhat blunted and restricted in range. He was noted to be smiling quite inappropriately while talking to the writer during the car ride to hospital. While attempting to change into a hospital gown, he seemed to perseverate over changing his clothes, putting them on, taking them off, and repeating this while staring at the clothes. He experienced some difficulty with concentration. Judgment and insight seemed poor.

He was admitted to an inpatient ward on a Form 3.

11 Days Later: Review Board Hearing today for this particular client as client was contesting his Form 3.

His Psychiatrist was present as was his inpatient Social Worker, his lawyer and the three person Review Board Panel. This proceeding was 2 full hours in duration. Client's lawyer presented the facts that he has only one sexual assault conviction (April 2006 in Burlington) and has been compliant with his course of inpatient treatment and medications making him a worthy client to be made voluntary. However, the two separate charges wherein he sexually assaulted a 15 year old pregnant female, and again followed and attempted to sexually assault two adult females were not discussed by his lawyer and have not yet been heard in court.

Writer provided a brief synopsis of the last 18 months wherein client has become known to COAST. Full details regarding the two mobile visits and the circumstances of his apprehension under Section 17 of the MHA on both occasions were provided. He was seen in Emergency Psychiatry and on both occasions and he was admitted, the first time overnight until it was felt he was able to travel home safely after being provided with sedative and antipsychotic medications, coupled with getting a good night's sleep. The second apprehension is in question presently.

He was interested in giving his own testimony as well. During his statement, he informed everyone that he has lived a rather transient life over the last several years, residing in Mississauga, Montreal, Brantford, Hamilton, and Burlington. He was first taken to a psychiatrist when he was living in India. He was reportedly taken there by his parents because he was making claims that his girlfriend had died, but they knew of no such girlfriend. He then came to Canada in search of the dead girlfriend and he believed he saw the fictitious woman in Montreal. He stated he now realizes that she was a hallucination. His psychiatrist attested to the fact that currently there are no positive symptoms of psychosis but there does appear to be some negative symptoms of his illness. It is now felt that his illness is likely schizophrenia or schizo-affective disorder. Further observation is required to make a more definitive diagnosis. When he was admitted to hospital, he was asking for the hospital social worker's home phone number but other than that he was described as a model patient. He has remained in the locked area of the hospital unit and thus had no opportunities to leave the unit and venture into the community. His initial mental status presentation was described as "vague" and he had very little insight into his mental health issues, the need for medications or how he would be able to manage once back in the community because it does not appear that he has a family doctor or any mental health supports. When he initially came to Canada he was staying with some

friends of his family for a short period of time but was asked to leave when he became agitated and yelled at the TV for unknown reasons.

When he was apprehended by COAST 11 days ago, he was living in an apartment with no furnishings or food, and only a change of clothes. Other tenants of the building had made it known that he was acting bizarre in the building, walking around "half naked" and he was noted to be leering at the female tenants of the building. According to client, he stated he feels he does not have the skills to cook and thus frequents restaurants and buys his food already prepared. He receives Ontario Disability Support Program funds to support himself, advising he been unable to work since moving to Canada in 2001. He stated he does misuse alcohol on occasion. Concern about his ability to manage his finances was expressed and he did not have a trustee. The Review Board decision regarding the legitimacy of the Form 3 will be made within 24 hours. The results will be faxed to client's lawyer and the hospital staff by 16:00 hours tomorrow. COAST will be apprised of the outcome of the hearing by hospital staff.

The Form 3 was upheld. Writer referred his case to be reviewed by the Human Services and Justice Coordinating Committee prior to his discharge. COAST Program Manager, Terry McGurk was to keep in contact with the hospital ward regarding his progression toward discharge and discharge planning. We were advised that after the hearing he attempted and somewhat succeeded in sexually and physically assaulting a social worker on the inpatient ward.

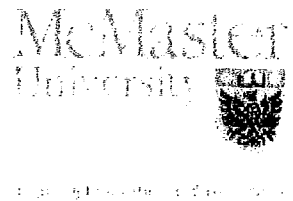
5.2 Appendix B: Participant Recruitment Letter

October 2008

To: Human Services and Justice Co-ordinating Committee

From: Sherry Beal, BA, RSW
McMaster University MSW Candidate

Re: Thesis Research



Hello HSJCC Chair Person(s):

I am a master's student in the School of Social Work at McMaster University.

This email is to let you know that your Committee has been one of five Ontario Human Services and Justice Coordinating Committees being invited to participate in a research study regarding the potential impact of privacy policies on HSJCC's. The study involves an email survey utilizing Survey Monkey. Survey Monkey ensures the anonymity of all participants. The survey is VeriSign protected and will not collect email or IP addresses of any respondents to ensure the utmost in privacy protection. The survey should take no more than 10-20 minutes to complete and is entirely voluntary in whole and in part.

This study is NOT an evaluation of any Committee, NOR does it seek to uncover, discuss, or analyze any potential policy/guideline breaches.

The study seeks to gain insight to your expertise and experiences in navigating professional, organizational and provincial privacy policies while fulfilling your role as an HSJCC member.

There is no known risk to respondents in participating in the study. However, there is a possibility that participating in the study may bring about some difficult feelings for survey respondents. For example, in thinking about policies, respondents may reflect on past decisions

they have made that may now be regretted in retrospect. Certainly, no judgment or critique is implied or intended. If participants find the questions too distressing, they may skip questions or stop their participation at any point before submitting the survey and no information will be collected.

Benefits can include the opportunity to convey ideas in a confidential manner. Your HSJCC's members may also find it important to contribute their ideas for HSJCC's, clients they serve, and the generation of more comprehensive future research.

This project is supervised by Thesis Advisor, Dr. Susan Watt at McMaster University who may be reached for additional information at (905)525-9140 Ext. 23771. This research has also been reviewed and approved by McMaster University Research Ethics Board, (905)525-9140 Ext 23142.

I am asking that you distribute this letter via email to your HSJCC members. It provides them with the details and the survey link.

How to participate:

To participate in the survey, the following link can be copied and pasted into the web address line on your internet browser to take you directly to the survey which will remain open until November 9, 2008. HSJCC members may want to forward this letter to an email address that is accessible from a comfortable location of their choice to further enhance their privacy. No one else will know whether or not you participate.

https://www.surveymonkey.com/s.aspx?sm=vLm4t5M91NWpFlnkkw_2fOMQ_3d_3d

I look forward to receiving an email from you letting me know whether or not you forwarded the survey to your HSJCC membership and hope at that time you can provide me the number of members on your Committee so that I may calculate the survey response rate for my data. If you can email me at the address listed below, I would greatly appreciate it. Thank-you for your assistance.

Sincerely,

Sherry Beal, BA, RSW

bealsl@mcmaster.ca

5.3 Appendix C: Electronic Survey

You are invited to participate in a research study regarding the potential impact of privacy policies on the work of Human Services and Justice Coordinating Committees (HSJCC). Five Southern Ontario HSJCC's have been invited to participate. This is NOT an evaluation of HSJCC's nor does it seek to uncover or analyze any potential policy breaches. This study seeks to gain insight into your expertise and experiences in navigating professional, organizational, and provincial policies while fulfilling your important role on your HSJCC. The data from this study will be used in the preparation of a Master's of Social Work Thesis, to contribute to a limited body of knowledge about HSJCC's, that may eventually benefit the clients HSJCC's serve. There is no known risk to you in participating in the study which is protected by VeriSign and is completely confidential. There is a possibility that participating in the study may bring about some difficult feelings for you. For example, in thinking about policies, the survey may elicit retrospective emotions in response to your beliefs about past practices. No judgment or critique is implied or intended. If you have any concerns you may stop participating in the survey at any time by clicking the "Exit this

survey" link located at the top right hand corner of each page, until you click the button that says you are submitting your form. Email and IP addresses will not be collected or tracked. The survey should take no more than 10-15 minutes to complete.

The project is supervised by Thesis Advisor, Dr. Susan Watt at McMaster University, Hamilton, ON who may be reached for more information at (905)525-9140 Ext 23771. This project has been reviewed and approved by McMaster University Research Ethics Board, (905)525-9140 Ext 23142. Benefits include the opportunity to convey your ideas in a confidential way, and to have a chance to participate in the generation of comprehensive and meaningful future research.

To further ensure your anonymity is maintained, you may chose to forward the link to this survey to an email address accessible from the privacy of your home. Your participation is entirely voluntary. Remember that you can stop participating at any time during the survey by clicking the "Exit this survey" link and none of your information will be submitted. You can choose to answer one, some, or all of the questions. After you click the "Done" button at the end of the survey, you have agreed to participate. It is important for you to understand that after you click the "Done" button, the information you submitted can not be retrieved, changed, or removed given I have no way to identify it. The information provided through this survey is secured through a password protected account and backed up on a password

protected thumb drive stored in a safely locked area of my home office.

Thank-you so much for taking your time to participate in this survey!

Sincerely, Sherry Beal, BA, BSW, RSW, MSW Candidate

1. I have read and understand the information provided about participating in this study.

Yes

This study focuses on HSJCC's non-collaborative clients and assumes that HSJCC's can have collaborative clients, although this is not HSJCC's typical client.

Non-collaboration is defined in this study as:

- Those HSJCC clients who are not generally insightful or compliant with treatment plans.

For the purposes of this study treatment plans are defined as:

- circumstances that are devised to promote some degree of mental wellness, acknowledging wellness exists on a continuum.

- As a result of the wellness facilitated by the treatment plan, it is hoped that the client's interaction with the criminal justice system can be alleviated or prevented.

- Treatment plans may include any combination of medications, residency

situations, consents to discuss them with community service providers, Community Treatment Orders, psychiatric appointments, Ontario Review Board appointments, Probation and Parole appointments, and so on. I would invite you to keep the idea of non-collaboration in mind as you move through the twenty-one questions. Some questions are multiple choice and others solicit your direct feedback. Please be careful not to provide any information that may identify you, clients, or the location of your HSJCC. Again, every question is optional to answer, so you have the opportunity to move on if you choose not to respond to a particular question(s). Should you change your mind and decide not to participate, you can simply click on the "Exit this survey" link and no data will be submitted.

Agree to participate?

1. How long have you been a member of the HSJCC in your area?

Less than one year

1-2 years

3 years or more

2. Briefly, please describe how you became involved as a member of the

Human Services and Justice Coordinating Committee? You may consider personal/professional experiences and/or community interests/experiences.

3. In your role as an HSJCC member to plan for client management and individual/community safety, what policies guide you in sharing information about specific non-collaborative clients with other HSJCC members? Please check all that apply.

Professional College guidelines

Mental Health Act

Personal Health Information Protection Act (PHIPA)

Healthcare Consent Act

Police Services Act

Organizational Policies

Confidentiality agreement signed for the purpose of communication at HSJCC meetings

Other (please specify)

4. Guided by these policies, what is your understanding about the circumstances that grant you the right/obligation to share information about specific non-collaborative clients? Please check all that apply.

Potential danger to self

Potential danger to others/society

Inability to care for self

Imminent danger to self

Imminent danger to others/society

Other (please specify)

5. The Ontario Government suggests that the inter-ministerial goals of HSJCC's are to come together to discuss prevention, system design, crisis and community intervention planning, court assessments, and case management. It is suggested that HSJCC's find "local solutions to local problems." To enable cross-sector collaboration and joint communication, the government states that inter-ministerial

communication agreements, community service agreements, interagency working agreements, and information sharing protocols have been devised. Do you think these agreements safely grant you permission to freely share information about specific clients at HSJCC meetings to plan for community management of non-collaborative clients despite the policies/guidelines/regulations discussed above?

Yes

No

Why/Why not?

6. Thinking about your HSJCC's non-collaborative clients, please complete the following statement. Please choose the one response that most reflects your own thoughts. The privacy policies/guidelines/regulations discussed above ...

-direct me adequately in making decisions about what information I can share about HSJCC clients and with whom I can share this information.

-seem to contradict one another leaving me feel unprotected about decision making regarding information sharing, and uncertain whether it is ethical and/or lawful to share information about HSJCC clients with

HSJCC members and community members instrumental in executing client management plans.

-Prefer not to answer.

-Not applicable

7. If you expressed feeling uncomfortable in the previous question what might ease the discomfort for you?

-Reassurance from government/colleges/organizations that I am protected from liability given my participation in this committee is humanitarian I care about enhancing the safety of the clients we strive to serve and the safety of our communities.

-Clarification of policy interpretation and my rights.

-Other (please specify)

8. What is your understanding of the potential consequences to you should you inadvertently breach one or more of these privacy/information sharing policies, regulations, and/or guidelines?

Please check all that apply.

Termination of employment

Suspension from employment with pay

Suspension from employment without pay

Termination from professional college membership

Suspension of professional college membership

Required to pay a fine

Incarceration

Civil litigation

Do not know

None

Other (please specify)

9. Of these consequences, which is most important to you to protect?

Please state only one.

10. Have you ever been the subject of an inquiry regarding a breach of confidentiality?

Yes

No

Prefer not to answer

11. If you answered yes to the previous question (#8), what was the outcome?

12. Do you think that sharing more or different types of information about non-collaborative HSJCC clients would enhance the Committee's ability to manage clients more effectively to promote community and individual safety?

Yes

No

Don't know

Prefer not to answer

13. What information do you think you should be able to share about non-collaborative HSJCC clients in planning for community client management?

14. With whom in the community might you need to share client information, who may be instrumental in executing non-collaborative client management plans outside HSJCC members? Please check all that apply.

I would not share information

Police

Probation and Parole

ORB

Courts/Diversion

Psychiatric Emergency Services

Mobile Crisis Services

Family/Friends/Significant others

Income supports

Case Management Services

Other community mental health service(s) involved with client

Other (please specify)

15. Are there particular successes you would like to share that you feel your HSJCC has accomplished despite the potential contradictions and/or barriers as a Committee and/or in particular client cases, without providing any identifying information?

16. Is there anything else that you think would be important to know or understand about how your HSJCC operates or your role in your HSJCC?

17. Please provide the following information. Please ensure it is vague enough that you do not reveal your identity or the location of your HSJCC.

Organization type? (e.g. hospital, probation and parole, police, corrections, city, outpatient, case management, courts/diversion, etc.)

Professional designation/position? (e.g. nurse, social worker, psychiatrist, probation officer, court diversion, crown attorney, police officer, mental health program manager, etc.)

You have completed the survey. Once you click on the "Done" button below, you have consented to share your responses anonymously for the purposes of the research outlined at the beginning of this survey. After you click the "Done" button, the information you submitted can not be retrieved, changed, or removed from the survey results given I have no way to identify it. Thank-you again for your responses.

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