Parole /CSC Referrals to the Sexual Behaviours Clinic (SBC)

Purpose of the referral:

- The SBC **only** offers sex drive reducing medication consultation and follow-up to patients referred to us from CSC.

Who can make a referral?

- Parole officer

Note: referrals must have a physician and their OHIP billing number included as well as a CSC Mental health Nurse contact to provide additional medical collateral information.

Important to note:

- We only accept referrals for patients who score 1 and above on the STATIC-99R.
- Assessment for sex offender specific treatment services are only available if the client/patient has completed all treatment available to them through CSC, and if CSC has deemed they are no longer in need of treatment and the client/patient is self-identifying a need for more treatment.

The SBC **DOES NOT** offer services to people:

- With pending sexual or sexually motivated offence charges.
- Appealing a sexual offence conviction.
- Seeking a risk assessment or a parenting capacity assessment.

Referrals must include:

- ☐ Complete all pages of this referral package
  - ☐ CAMH referral form
    - On Page 1 under Referring Provider Information include a Psychiatrist, Physician or Nurse Practitioner and their billing number
    - On page 2 under reason for referral put, “assess for treatment with sex drive reducing medication.”
  - ☐ Legal History
  - ☐ Phallometric consent form
  - ☐ Bi-directional consent form
- ☐ Criminal Profile
- ☐ Standard Profile
- ☐ CPIC
- ☐ Programs reports (sex offender specific)
- ☐ Any psychological risk assessments that are on OMS
- ☐ Any court psychiatric reports that are on OMS.

Identify if any of the documents are not available/ do not exist: _____

How to submit your referral?

- ☐ Send completed referral package and all required documents to sbc@camh.ca
- ☐ Include In the subject line **SBC Referral – OFFENDER’S FIRST AND LAST NAMES AND FPS#.**
- ☐ CC the appropriate Mental Health Nurse on the email. They will follow-up and send the medical portion of the referral.

If you have any questions about making a referral, please call 416-535-8501 Ext: 32510 (intake coordinator) or Ext: 34886 (Administrative Secretary).

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D0359A

Patient ID Label

(For CAMH use only)

CAMH REFERRAL FORM

Date of Referral (DD/MM/YYYY):_____

PATIENT INFORMATION

Clear Content

Legal Name
First Name: Last Name:

Preferred Name (If applicable)

Date of Birth (DD/MM/YYYY):

Gender:
☐ Female ☐ Trans Woman ☐ Two-Spirit ☐ Gender fluid ☐ Non-binary
☐ Male ☐ Trans Man ☐ Genderqueer ☐ Androgynous ☐ Other: _____

Health Card Information:
Health Card #: _____ Version Code: _____ Expiration Date (DD/MM/YYYY):_____
If the patient does not have a Health Card, please provide their Mother's Maiden Name: _____

Patient Address:
Address: _____
City: _____ Province: _____ Postal Code: _____ Unit #: _____

Is there a need for an interpreter? ☐ Yes ☐ No If yes, please specify which language:_____
Are there any accessibility concerns? ☐ Yes ☐ No If yes, please specify:_____

PATIENT OR DELEGATE CONTACT INFORMATION

Clear Content

By listing telephone numbers or an email address below, the referral source confirms that the patient consents for CAMH to call/ email them regarding this referral. CAMH will refrain from communicating unrequired personal information until consents are verified.

Patient/ Delegate Telephone Number(s)/ E-mail Address (Specify type: home, office, cell, etc.)

Contact information below is for: ☐ Patient ☐ Delegate If Delegate, please specify relationship to patient: _____

Type: _____ **Tel #1**:_____ Consent to voicemail messages: ☐ Yes ☐ No

Type: _____ **Tel #2**:_____ Consent to voicemail messages: ☐ Yes ☐ No

E-mail Address: _____

CUSTODY STATUS (For youth under the age of 16)

Clear Content

Custody Status:

☐ Joint Custody (Please fill out contact information for both guardians)
☐ Sole Custody (Please fill out contact information for the sole guardian)
☐ Lives with both parents/ Married/ Common Law (Please fill out contact information for both guardians)
☐ Other (e.g. CAS), please specify: _____

1. Guardian Name:_____
   Telephone: _____
2. Guardian Name: _____
   Telephone: _____

REFERRING PROVIDER INFORMATION

Clear Content

Name
First Name: Last Name:

Billing Number:

Please select one of the following:
☐ Family Physician ☐ Psychiatrist
☐ Nurse Practitioner ☐ Other: _____
☐ Methadone/ Suboxone Provider

Referring Provider Address:
Address: _____
City: _____ Province: _____ Postal Code: _____ Unit #: _____

Telephone: **Fax:** **Email:**

Does your patient currently have a psychiatrist? ☐ Yes ☐No ☐ Unknown
If yes, please indicate the name of the psychiatrist, First name:_____ Last Name:_____
If yes, is the patient's current psychiatrist aware of the referral? ☐ Yes ☐No
If no, please indicate why: _____

****If the patient has a psychiatrist it is preferred the referral comes from them. Alternatively, please attach consultation notes****

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Patient ID Label

(For CAMH use only)

Patient Name: _____

1. REASON FOR REFERRAL

Clear Contents

Please indicate the primary reason for referral (specify current symptoms, presenting problems and history)

** Individuals requiring psycholegal assessments who are referred by the court, legal counsel or other third parties should be referred to the psycholegal clinic. Note there is an alternate referral process for this clinic – details can be found at www.camh.ca **

Please select the service you're seeking for your patient:

- ☐ Psychiatric Consultation
- ☐ Diagnostic Clarification
- ☐ Treatment Recommendations
- ☐ Medication Review
- ☐ Specific Treatment (e.g. CBT):
  _____
- ☐ Addictions Treatment
- ☐ Other: _____`
- ☐ None of the above

2. SUBSTANCE USE (indicate current substances, amount, frequency of use, etc.)

Clear Content

3. RISKS AND SAFETY CONCERNS

Clear Content

This information is used to optimally plan for the patient's first appointment and to ensure their safety and the safety of our staff.

Risk:	Yes	No	If yes, when (DD/MM/YYYY):	Details:
Suicide Attempt/ Ideation	☐	☐		
Deliberate Self-harm	☐	☐		
Violent Behaviour/ Safety Concerns	☐	☐		
Legal Involvement	☐	☐		
Fire Setting	☐	☐		

*****If any of the above risks and safety concerns are selected, you are REQUIRED to provide additional details*****

4. MEDICATION (both psychiatric and non-psychiatric medication)

Clear Content

Medication	Current	Dose	Frequency	Response & Adverse Effects
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

5. AGENCIES, HOSPITALS OR THERAPIES INVOLVED WITHIN THE PAST TWO YEARS

Clear Content

Organization	Describe Involvement

6. RELEVANT MEDICAL/ DEVELOPMENTAL HISTORY (e.g. disabilities, intellectual delay, autism, allergies, endocrine, neurological, respiratory, cardiac, metabolic or other issues)

Clear Content

Completed by:

_____ (Print name & credentials)

_____ (signature)

Date: _____ (dd/mm/yyyy)

Forms completed electronically should be printed, signed and faxed to CAMH.
Please fax referral to Access CAMH at 416-979-6815
Please review instructions included (also available at camh.ca/referralform)
Website: camh.ca

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Legal History
Sexual Behaviours Clinic (SBC)

Client/Patient name:____________________________**DOB:** ____________________________________

Reminder to complete the Access CAMH referral form located here:
electronic form and attach this package to it.

****Please TYPE and answer ALL questions****

(Failure to do so may result in referral being delayed or refused).

_ _

Referral Eligibility

1. Reason(s) for Referral:

   ☐ Assessment ☐Treatment ☐Sex drive reducing medication ☐Phallometric testing

2. If treatment is recommended, will this patient be attending the SBC for treatment?

   ☐Yes ☐ No

3. Is the patient appealing their conviction? *Note: we **do not** accept referrals when the patient is appealing their conviction:*

   ☐Yes ☐No

4. Does the patient have outstanding legal charges (i.e. charges with no disposition)? *Note: we **do not** accept referrals for outstanding charges that are **sexual** in nature:*

   ☐Yes ☐No

If yes, describe:

5. STATIC 99R score:____

6. STABLE 2007 score:____

Current Conviction(s)

7. List out current conviction(s): ____

8. Length of custodial sentence: ____

9. Date of release from custodial sentence: _____
(dd/mm/yyyy)
10. Length of probation sentence: _____
11. Date probation will be completed: _____
(dd/mm/yyyy)
12. Number of victims: _____
13. Age(s) of victims: _____
14. Sex of victim(s): _____
15. Relationship to victim(s): _____
16. Has the patient lived /cohabitated with a romantic partner for 2+ years: ☐Yes ☐No
17. Description of index offence:

Include details on what, when and on how many occasions it occurred. For charges related to Child Sexual Exploitation Material (CSEM) include the number of images/files and age/sex of victims.

Attach a separate page if you run out of room.

Prior Offence(s):

18. Is the patient a first time offender?

☐Yes ☐No

If no, based on the official criminal record list **all** prior charges and convictions (including non-sexual offending, withdrawn, dismissed, acquitted, and not guilty findings):

	Disposition Date (dd/mm/yyyy)	Offence	Disposition
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

If you require more room, please attach an extra page.

Detailed summary of past offence(s):

19. Provide a detailed summary of all sexual, sexually motivated, and violent prior offending behavior, including convictions and withdrawn/dismissed charges:

Attach a separate page if you run out of room.

Previous Treatment Information:

20. Has the patient previously been involved in assessment or treatment specific to sexual offending?
    ☐Yes ☐No

If yes, with whom and when:

_____

_____

Attach any relevant assessment report / treatment summary report to referral (if appropriate).

21. Is the patient **currently** involved in treatment specific to sexual offending?
    ☐Yes ☐No

If yes, with whom and when is the expected end date?

_____

_____

Additional Information

22. Please share any other significant information that you think would be helpful for us to have (i.e. mental health concerns, Developmental Delay, risk level, substance use):

Attach a separate page if you run out of room.

Form completed by: _____Date: _____

Virtual Appointment Scheduling

A virtual appointment requires the patient to have access to:

- A smart phone / tablet / computer with a camera and microphone
- Access to a strong internet connection
- A private space for approximately 2-3 hours

Can this patient attend a virtual appointment?

☐ Yes
☐ No

If yes, provide an email for our staff to connect directly with this patient to schedule the initial assessment.

Email for patient: _____

This email will be used to send:

- Appointment details
- Virtual appointment link
- Registration forms and assessment consent form

Patients who are unable to attend a virtual appointment

Our staff will connect with you, the referral source, directly when we are ready to schedule the initial assessment. You will be provided with an appoint date and time, required forms and directions to give to the patient to attend an in person appointment.

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Sexual Behaviours Clinic

Consent for Service (Assessment)

Client Name (please print): _____

Clinician Providing Service: _____

Why This Assessment Is Being Done

We are doing this assessment to understand if you might have a sexual disorder or other mental health concern. Based on what we learn, we might suggest more treatment or testing. If needed, we may also say something about your risk of committing future violent or sexual offences.

What the Assessment Includes

You'll have at least one interview where we ask questions about many things, including:

- Your family and childhood
- School and work
- Relationships and sexual history
- Use of substances, gambling, or criminal behavior
- Physical and mental health

You might also be asked to do a test called **phallometric testing** (a test that measures sexual arousal). If this is suggested, we'll explain it first, and you can choose whether or not to do it. If you do the test, the results will be part of your report.

Confidentiality (Keeping Your Info Private)

We do our best to keep your information private, but there are some exceptions:

- A report will be written and shared with the person or agency that referred you (like a doctor, probation officer, or lawyer).
- You give permission to share it.

- A court orders it.
- We believe you are at risk to harm yourself or someone else.
- You say something that suggests a child has been, or is at risk of being, hurt or neglected.
- Someone in a long-term care or retirement home is being abused or neglected.
- You talk about sexual abuse by a healthcare worker.
- Our professional College reviews our work.
- You talk about a serious crime that hasn't been reported before (if you're on probation/parole, your probation officer could share this with police).

If you have questions or concerns about these situations before we proceed, we can take time to discuss them.

Photos or recordings are not allowed.

Risks and Benefits

Talking about personal issues can be hard and may cause strong feelings. But this helps us understand your needs and give better recommendations.

If your assessment is done online, we use secure video—but there is still a small risk of technical problems or privacy issues. Try to join from a private space and don't use someone else's device.

Your Choice to Participate

You can stop the assessment or skip questions at any time. If you do, that will be noted in the report, which could affect how complete the results are.

Consent

I understand the assessment process, risks, and my rights. I've had a chance to ask questions, and I agree to take part. I know I can stop at any time.

Client Signature: _____

or

Signature of Substitute Decision Maker/Next of Kin: _____

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CAMH CONSENT TO PHALLOMETRIC TESTING

In order to assist in determining my sexual arousal patterns, it has been recommended that I take the penile plethysmograph (PPG). This testing is meant to evaluate my sexual interests and arousal patterns. This test cannot be used to decide my guilt or innocence regarding any specific offense I may have been accused of or committed. The benefits of this test include the possibility of determining an atypical sexual preference, which may help in beginning to discuss my sexuality. These test results may also help guide treatment and/or risk management planning.

PPG testing indirectly measures blood flow in the penis through air pressure changes in a small cylinder. The technician will help guide the placement of a small cylinder over my penis in the privacy of a dimly lit assessment room, explaining each step as it is put in place. Once the equipment is in place and secured the technician will cover my mid-section with a sheet. Occasionally during the test, the technician may enter the assessment room to make necessary adjustments of the cylinder to optimize the set up. The technician may be required to physically hold the inflatable cuff against my abdomen to ensure there is an optimal set up. Although a rare occurrence, there exists the possibility in ensuring an optimal setup, that the technician may come into contact with my genital area directly.

I understand that I may be asked questions about my sexual history and current sexual behaviours by the PPG technician. Sexual stimuli will be shown to me in a variety of forms. Commonly used stimuli can include, but are not limited to, taped verbal descriptions (presented to me over headphones), and/or still pictures (projected on a screen in front of me).

The stimuli will show nude males and females of varying ages in standing or seated poses, and/or audiotaped stories of sexual interactions between males and females of varying ages. In the test for coercive preferences, audiotaped stories may involve descriptions of force or violence. However, I may find some of the stories, as well as some of the pictures, to be offensive.

The test will take about two hours. The assessment takes place in a lab with two adjoining rooms. I will be seated in one room and the technician will be in the next room, where all the monitoring and measuring equipment is located. After I have been seated, the technician will have visual and voice contact with me using an intercom and closed-circuit TV system (focused on the upper half of my body). No video or audio recording will be made of any session without my permission/consent.

During the test, my sexual response will be monitored and recorded. I understand that I must listen to and/or watch the material presented in order to have an accurate evaluation. I understand also that it is my responsibility to cooperate throughout the entire assessment. The degree of cooperation will be included in the official report.

I understand this assessment procedure can provide detailed information regarding my sexual interests and arousal patterns. This information can later be used to more effectively evaluate and direct my treatment. The results of this test may also be used as part of a more detailed assessment of risk to reoffend sexually.

Results from my test can be used to calibrate the PPG equipment. Before results obtained from new equipment are used to make clinical decisions, they are compared with the current equipment. To collect information from the current and new equipment at the same time, the tube connecting the cylinder to the current equipment is split so it can also connect to the new equipment. I understand that:

- The process of calibrating new equipment does not change my experience in the test;
- My assessment results will be pooled with other clients results to make comparisons between the two sets of equipment;
- Only results from the current equipment will be used and reported in my assessment;
- I will not have access to results from the new equipment being calibrated.

If I have any questions about this evaluation or the information obtained from the evaluation, I will have the opportunity to talk about it with the technician during the evaluation or later with a staff member from the Sexual Behaviours Clinic.

Limits to Confidentiality

- You sign a consent form for the information to be shared with someone else, for example, your family physician or lawyer;
- The information is subpoenaed or ordered by a court, where the judge determines that your record is relevant to the civil (divorce, child custody matters or a lawsuit for example) or criminal proceedings at any time;
- Members of the SBC staff have reasonable grounds to believe that disclosing your information is necessary to eliminate or reduce a significant risk of serious bodily harm to yourself or others;
- You report anything that may be a concern to the safety or well-being of children. The Ontario Child, Youth and Family Services Act requires that this be reported to the Children's Aid Society. This can include (but is not limited to) having sexual interest in children and/or a history of sexual offending against a child, and having unsupervised contact with children. If

you report previously unreported abuse against a child (and the person is still a child) we are also required to report this to child protective services.

- You report anything that suggests someone is being abused or neglected in a long- term care home.
- You disclose past or present sexual abuse by a member of a regulated health discipline. Your assessor may need to report the abuse to the appropriate professional college. The report to the professional college will (1) be done with your knowledge and (2) will include your name, only with your written consent;
- Your assessors' governing body (e.g. The College of Psychologists of Ontario) may audit files for purposes of quality assurance
- If you are under the supervision of the Ministry of the Solicitor General (provincial probation and parole), please be advised that the Ministry's policy is to notify the police if you disclose prior serious unreported criminal activity. This is not the policy of this clinic, however if you share this information to us and it is documented in your report, your probation/parole officer may be required to notify their supervisor and/or the police as a result

Consistent with CAMH policy, photographs and/or recordings of clinical encounters are prohibited without clear and express permission from each person involved (staff and/or clients), prior to the photograph and/or recording.

I understand that I may withdraw my consent or stop the test at any time. I realize that by refusing or withdrawing my consent, I may reduce the ability of my assessors/treatment providers to give the best and most effective treatment and/or assessment.

My signature below indicates that I have read this consent form, or it has been read to me, and I am agreeing to participate in this assessment. I understand the information provided in the form and have had all my questions about the evaluation answered. I also understand that data obtained in this evaluation may be used for research and/or program evaluation purposes. All personal and identifying information about me will remain confidential.

Name:_____ Witness name:_____

Signature:_____ Witness signature:_____

Date: _____ Date: _____

Do you agree to have your data anonymously used to calibrate our equipment? ☐ Yes ☐ No

Have you had phallometric testing before? ☐ Yes ☐ No

If yes, location & date of previous testing:

_____

☐ Client declines consent for phallometric testing

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BI-DIRECTIONAL CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I _____
Client/Patient Name: (Print Last Name, First Name)

hereby authorize _____ to disclose and receive personal health information

to/from Sexual Behaviours Clinic - Centre for Addiction and Mental Health (CAMH)
Name of Person/Agency Requesting/Disclosing Information

of 1001 Queen Street W. Toronto Ontario M6J 1H4
Street Address City Province Postal Code

from the records of:

_____ _____ _____
Print Client/Patient Name Date of Birth (dd/mm/yyyy) Health Card #

_____
Street Address City Province Postal Code

I consent to the following specific information to be disclosed (please check all appropriate items):

- ☐ Mental health/addictions admission history
- ☐ Medical history (including lab results, ECGs, and urine drug screens)
- ☐ Progress notes during the time period below
  _____
- ☐ Medical and/or psychiatric consultation reports
- ☐ Discharge summary
- ☐ Medications summary
- ☐ Other (Please Specify):_____

How may this information be released (choose all that apply)? ☐ Verbally ☐ Photocopy

_____ _____
Signature of Witness Signature of Client/Patient

_____ _____
Print Name of Witness (if other than client/patient, print name and state relationship)

Date: _____
(dd/mm/yyyy)

Additional Instructions: _____

This authorization may be withdrawn in writing at any time.
All Consent for Disclosure of Personal Health Information forms must be delivered to the Health Records department to be processed. An administrative fee may be applied to cover photocopying and related costs.

FOR INTERNAL HEALTH RECORDS/CLINICAL STAFF USE ONLY
INFORMATION RELEASED BY: ☐ Verbal Communication ☐ Mail ☐ Fax

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