HSJCC Info Guide

Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario

Provincial Human Services and Justice Coordinating Committee

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Contents

Executive Summary

The purpose of this Info Guide is to assist police services and hospitals in Ontario to reduce emergency department wait-times for police officers who are accompanying individuals experiencing a mental health crisis. The Info Guide provides an overview of the key issues relating to mental health apprehensions and police accompanied visits to the emergency department. In addition, the strategies for establishing effective police-emergency department protocols are highlighted as well as an inventory of protocols and resources from across Ontario.

The information contained in this document was compiled through a call for information which was distributed through the HSJCC Network to municipal and provincial police services, hospital staff, and providers of community mental health, addictions and other human services across the province.

Clear, consistent communication is the key to reducing wait-times

A central theme emerged from the survey responses – the need for clear and consistent communication with respect to mental health apprehension situations. Police officers, hospital staff and community care providers identified several strategies for reducing wait-times for police accompanied visits to the emergency department (ED), including:

- ✓ Building strong relationships between police services and hospitals;
- ✓ Providing cross-sectoral training for police services and hospital staff about mental health apprehension situations;
- ✓ Calling ahead to the ED when a police officer is on route with a person experiencing a mental health crisis;
- ✓ Establishing clear lines of communication upon arrival at the ED;
- ✓ Utilizing a mental health screener form to communicate information about the circumstances and observations about the person in crisis;
- ✓ Arranging a quiet room for police accompanied visitors to the ED;
- ✓ Having adequate staff support to manage mental health crisis situations in the ED;
- ✓ Designating a liaison in the ED to work directly with police officers when they arrive with a person in crisis;
- ✓ Establishing a written agreement between police detachments and hospitals that sets out procedures, expectations and respects patient rights;
- ✓ Conducting routine monitoring and evaluation of the protocol in place, and making changes as necessary; and
- ✓ Ensuring person-centred care.

Background and Purpose

The purpose of this Info Guide is to assist police services and hospitals in Ontario to reduce emergency department wait times for police officers who are accompanying individuals experiencing a mental health crisis. The Info Guide provides an overview of key information contained in protocols devised and implemented by police services, emergency department staff and community service providers. The Info Guide also provides an inventory of protocols from across Ontario that work to reduce emergency room wait-times for police.

This Info Guide was developed by a working group of the Provincial Human Services and Justice Coordinating Committee (HSJCC). The HSJCCs were established in response to a recognized need in the province to coordinate resources and services, and plan more effectively for people who are in conflict with the law. Priority consideration is for people with a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, and/or fetal alcohol spectrum disorder.

The information contained in this document was compiled through a call for information which was distributed through the HSJCC Network to municipal and provincial police services, hospital staff, and providers of community mental health, addictions and other human services across the province.

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Police in the Emergency Room: An Overview of the Issues

Police officers, by virtue of their role as emergency responders, are often the first to arrive on the scene of a mental health crisis, and they often accompany individuals to the emergency room. Police officers and emergency room staff can offer unique insight about how to make the emergency room more efficient for all, both in terms of reducing wait-times for police officers and increasing care for the person in crisis.

Through the call for information survey that was administered through the HSJCC Network, municipal and provincial police officers, hospital staff, and providers of community mental health, addictions and other human services across Ontario identified several key issues that affect police interactions in the hospital emergency department (ED).

Increasing wait-times

Survey respondents identified numerous service dynamics that can result in extensive delays for police accompanied visits to the ED:

- Many regions of the province have crisis intervention services that provide support to individuals experiencing a mental health crisis in the community. Crisis intervention services are often effective in diverting individuals away from the ED and redirecting them to appropriate care in the community. However, in most regions of the province, crisis intervention services are only available during daytime or evening hours, thus increasing the pressure on the ED during nighttime. A community care provider stated, "There are staffing issues with mental health crisis support, because there is nobody working from 11pm to 7am."

- The sheer high volume of cases in the ED in both urban and rural settings in Ontario results in countless delays in the ED, ranging from wait-times of 2 – 8 hours for police accompanied visits. One police officer from a rural northern community stated, "I personally have had to wait in the ER for as long as 34 hours before the hospital would admit the patient." Similarly, an ED staff person stated, "It takes time to assess if the person requires hospitalization especially with competing priorities in the ER. The physician needs to be available, security staff need to be free and we need a spot for the patient."

- Upon arriving at the ED, mental health apprehension clients are often given a low triage priority when compared to clients experiencing physical traumas. Conducting the mental health assessment itself may only take a few moments; yet, hours can be spent in the ED waiting for a physician to conduct the assessment. A police officer stated, "I waited over 6.5 hours about a month ago, and it took the doctor less than a minute to 'form' the patient."

- Police accompanied visitors in the ED often face delays in being admitted to the hospital due to a shortage of mental health in-patient beds available at the hospital; and in more rural and northern areas of the province, the number of available mental health in-patient beds within the regions are even fewer. A police officer from a rural

area stated, “Once a bed is secured, the police have to transport the patient. The cost of transport is incurred by the hospital which is about $1,000 – $2,000 depending on how far we have to go. Sometimes we even have to provide security until the transfer can be made.”

- The “revolving door” also occurs in the ED. Police officers may accompany a mental health apprehension client to the ED; yet once the individual is examined by the physician, the individual may be released back into the community because they did not meet the criteria for involuntary admission to the hospital. Once released, the individual may not be connected to appropriate community mental health and addictions services, and as a result, a few days or even a few hours later, the police officers may reencounter the individual in the community. A police officer from a rural community stated, “The mental health hospital closest to us is 1.5 hours north and another is 2.5 hours south. The frustration for our officers occurs when we escort a client all the way to the ER only to have the doctor release them.”

Impact on police services

Police officers who responded to the survey spoke about their experiences when they arrive at the ED:

- Police officers are frequently asked to play the role of security guard for clients who maybe decompensating in the ED. Often, police officers are requested to remain with the client until the individual is admitted to the in-patient mental health unit. These types of situations cause police officers to remain at the hospital for extended periods of time. A police officer stated, “Often, but not always, police are left with the patient for long periods of time before the patient is even assessed, such as taking vitals, etc., then even longer for the patient to be admitted into the psychiatric unit.”

- Extended wait-times can be quite costly as two police officers are often required to accompany an individual to the ED. This can also result in public safety issues because multiple police officers are waiting in the ED instead of being out on patrol ensuring the safety of the community. A police officer stated, “The biggest challenge for us is, once two officers are required at the hospital, that only leaves one officer on the road, and we must attempt to call another officer in from home.” These situations left the police officer wondering, “EMS can bypass the waiting room of the ER, so why can’t police do the same?”

Impact on the emergency department

ED staff who participated in the survey spoke about their experiences responding to police accompanied visits to the ED:

- The ED tends to be a busy and crowded place; and often, there is a lack of private space and a quiet room is rarely available. Police accompanied visitors to the ED would benefit from having privacy and a quiet space; however, for many hospitals, space is very limited and a quiet room cannot be made available to the client. An ED staff person stated, “There is such a lack of ER space to place those in custody in a private room and out of the public eye.”

- Many hospitals in Ontario do not have a Security Department therefore are not well equipped to manage high risk crisis situations; as a result, these hospitals rely on police officers to provide security in the ED. For the hospitals that do have security guards on duty, often it is unclear when the guards are permitted to take over custody of a mental health apprehension client. An ED staff person stated, "We have had some difficulty with security taking over custody of the patient, leaving officers standing by at the hospital for hours. Not sure about when and if the hospital security can continue the apprehension on behalf of the police."

Impact on the individual in crisis

Survey respondents shared their observations about the impact that police accompanied visits and ED service dynamics have on the individual in crisis:

- Police accompanied visits to the ED increase the stigma of mental health conditions. The apprehension by the police officer, which often involves the use of handcuffs, can increase anxiety and exasperate the condition of the person in crisis. Waiting for prolonged periods of time in a crowded, busy ED can further compound this experience. A police officer stated, "Persons suffering from mental health conditions are not happy to be in police custody and often do not understand why they are there. The stigma of being seated in an ER under police guard, often in restraints, adds to the stress of the situation." Similarly an ED staff person stated, "There is perceived stigma created by having police officers wait with individuals with mental health concerns – this reinforces the notion that they are *dangerous* when that is not true."

- The privacy of the mental health apprehension client is compromised as they are restrained and seated inside the waiting room of the ED alongside others clients waiting their turn; this further increases the stigma of mental health conditions. A police officer stated, "Having a handcuffed person sitting in the same area as families awaiting treatment makes it very uncomfortable for everyone involved."

- With mental health apprehensions, ED staff are frequently not able to get an accurate history from the client because the individual can feel uncomfortable speaking freely in front of the police officers. An ED staff person stated, "The issues arise prior to arriving at the ER. How individuals are addressed and transported to the ER will have a major impact on the handoff. Sometimes it's so hard to get a history from the patient when they feel they're not able to speak freely with police on the scene."

- In some rural and northern areas of the province, clients often do not have access to transportation to return home after the police accompanied visit to the ED. After the mental health assessment is completed and the client is discharged from the ED, some clients do not have the means to access transportation to return to their homes. A community legal service provider stated, "Clients have told me about being taken all the way to another town to the hospital with no ride home and having to stay in a shelter until someone can go pick them up."

Strategies for Implementing Effective Police-Emergency Department Protocols

A central theme emerged from the survey responses – the need for clear and consistent communication with respect to mental health apprehension situations. Police officers, ED staff and community care providers identified several strategies for reducing wait-times for police accompanied visits to the ED, including:

- ✓ Building strong relationships between police services and hospitals;
- ✓ Providing cross-sectoral training for police services and hospital staff about mental health apprehension situations;
- ✓ Calling ahead to the ED when a police officer is on route with a person experiencing a mental health crisis;
- ✓ Establishing clear lines of communication upon arrival at the ED;
- ✓ Utilizing a mental health screener form to communicate information about the circumstances and observations about the person in crisis;
- ✓ Arranging a quiet room for police accompanied visitors to the ED;
- ✓ Having adequate staff support to manage mental health crisis situations in the ED;
- ✓ Designating a liaison in the ED to work directly with police officers when they arrive with a person in crisis;
- ✓ Establishing a written agreement between police detachments and hospitals that sets out procedures, expectations and respects patient rights;
- ✓ Conducting routine monitoring and evaluation of the protocol in place, and making changes as necessary; and
- ✓ Ensuring person-centred care.

Building strong relationships

An essential first step to reducing ED wait-times is to build strong relationships between police officers and ED staff. Building strong relationships opens the door for clear and consistent communication. It is important that the relationship building occurs at both the senior management level (i.e. between the Chief of Police and the CEO of the hospital) as well as at the front-line staff level (i.e. between front-line police officers and ED staff). Establishing a joint police-hospital committee that meets on a regular (at least quarterly) basis with the purpose of reducing wait-times for mental health apprehension situations in the ED is recommended.

A police officer stated, "When positive professional relationships exist between police and the health facilities, the process works much better. Often, a positive professional relationship needs to exist with higher level representatives of each agency." Similarly, an ED staff person

stated, “We formed a working group co-chaired by the Director of Mental Health and the Police Inspector. The working group is comprised of ED managers, physician leads, mobile crisis team managers and staff, and others as needed. The working group identified the problems and committed to identifying the solutions.”

Providing training

Providing routine, comprehensive, inter-sectoral training to police officers and ED staff regarding mental health apprehension situations is another strategy for increasing communication and reducing wait-times for police accompanied visits to the ED. For police officers, specialized education programs, such as Crisis Intervention Training (CIT), offers de-escalating training and provides information on the different types, symptoms and behaviours associated with mental health and addictions conditions, and identifies the role of community mental health providers and hospitals in assisting individuals experiencing a mental health crisis. In like manner, training for ED staff increases awareness and understanding about the role and responsibilities of police officers with respect to mental health apprehensions.

A police officer stated, “CIT trained officers seem to be able to more clearly articulate their grounds for apprehension and need for admission.” Similarly, another officer stated, “Communication improves when police and health providers have an understanding as to the responsibility of each agency and what each agency can and cannot do. Police cannot detain individuals without charge for an extended period of time.”

Calling ahead

Another strategy that was recommended by police officers, ED staff and community care providers is to call ahead prior to arriving at the ED. When police officers are on route to the ED, it is best to call ahead to inform ED staff that a mental health apprehension has taken place and police officers will be arriving at the ED with the individual. This information allows ED staff some additional time to adequately prepare for the incoming client.

A police officer stated, “It is good practice to have our Dispatch call ahead and advise hospital staff in advance that a patient will be arriving. This allows the hospital staff time to prepare or redirect the patient prior to police arrival. We often contact a crisis nurse at the hospital to inform them that a patient is coming and share some information about the situation so they know what to expect.” Similarly, a community service provider stated, “As soon as our Crisis Services is paged, we respond via telephone to the emergency room to gather information and give them an ETA of our arrival, which is usually within 15 minutes.”

Communicating upon arrival

Providing detailed information to the triage nurse is another strategy for reducing wait-times for police accompanied visits to the ED. Establishing communication upon arrival and sharing detailed information with ED staff can expedite the process and can assist ED staff to provide adequate care to the person in crisis. Furthermore, establishing communication upon arrival can help determine the length of time that police officers are required to remain at the hospital.

A police officer stated, "A successful approach to reducing wait-times for police have been to provide as much detailed information to the triage nurse when registering the patient. This can sometimes provide details required to get a quicker response from the doctor and make their assessment of the patient easier." Similarly, another police officer stated, "It's important to communicate with the staff (nurse/doctor) as soon as possible in hopes that a solution can be determined on whether police are still required to be present. It's good to continuously seek clarification or answers as to what or when the next step is to occur."

Using a mental health screener

An effective strategy that was highly recommended by police officers, ED staff and community service providers is the use of a communication tool such as a mental health screener form. This type of form is often developed in joint partnership between police officers and hospital staff. The form is completed by a police officer upon conducting a mental health apprehension and identifies key information about the person experiencing a crisis, including the circumstances of the apprehension, any relevant history about the individual, any specific behaviours or symptoms that were observed, and the rationale for conducting the apprehension. A police officer stated, "Using the mental health screening form has really helped our officers to identify their reasons for the apprehension and it also provides the hospital staff with important information about the patient."

Having a quiet room

Designating a quiet room inside the ED for police accompanied visitors is another recommended strategy. Having a quiet space for individuals experiencing a mental health crisis can reduce the stigma associated with mental health conditions. The quiet space provides privacy for the individual and offers shelter from the watchful eyes of other patients in the ED. A quiet space can also provide safety and security for the individual in crisis.

A hospital staff person stated, "We now have 2 quiet rooms in the emergency department for better monitoring of mental health patients." Similarly, a police officer stated, "The hospital in our area has improved process whereby they now have a separate dedicated area for mental health assessments that is very secure."

Having adequate staff support

An essential requirement for reducing wait-times is to have adequate staff support in the ED, for both hospital staff and police officers. It is crucial that the ED has the staffing capacity to provide services in a timely manner, including adequate staffing of physicians to conduct mental health assessments, nurses or crisis support workers to provide counselling to the person in crisis, and adequate security staff that may be able to assist with mental health apprehension situations. For police services, it is equally important that additional officers are made available if they are needed in the ED to help manage a high-risk crisis situation.

A hospital staff person stated, "Proper staff is now on hand at our hospital to diagnose mental health-related patients. Hospital security attends in a timely fashion and takes possession of the patient allowing police to leave." A police officer stated, "We have implemented a system where after two hours of waiting, the hospital then defaults to a system where they enter into

a 'paid duty' arrangement with the police detachment to provide security. An additional police officer is called to the hospital to provide security as needed, thereby releasing the on-duty uniform officers to return to their regular duties."

Designating a liaison

Utilizing a designated liaison to coordinate mental health crisis situations in the ED is another recommended strategy for reducing wait-times for police accompanied visits. A designated crisis coordinator in the ED can be an asset to ED staff as well as police officers in terms of establishing clear communication. The designated crisis coordinator can also provide services and supports to the individual experiencing a mental health crisis, including conducting an initial mental health assessment, providing counselling services, and connecting the individual to appropriate resources in the community.

A police officer stated, "The hospital in our region employed an emergency room coordinator and they made many steps forward. It was easy communicating any concerns when there is one liaison person so closely connected to the ER." Similarly, a community service provider stated, "At our hospital, a mental health crisis worker is available to respond directly to police calls for service. The crisis worker has the capacity to assess the individual at the point of contact with the police and assist in ED avoidance by providing follow-up, support and referral to community services. The aim is to provide appropriate client service as well as reduce the number of times police are going to the ER with clients."

Establishing a written agreement

Establishing a written inter-agency agreement between police services and the hospital is another essential strategy for reducing ED wait-times. The most effective inter-agency agreements are those that are developed in partnership with police officers, hospital staff and relevant community service providers, such as crisis support, emergency medical services (EMS), community mental health agencies and other key stakeholders.

The jurisdictions for police services are often much broader than the catchment area of a hospital; as a result, police officers may accompany individuals in crisis to multiple hospitals within their jurisdiction. Therefore, it is recommended to establish a citywide or region-wide protocol rather than having a unique agreement for each hospital setting. Having a citywide or region-wide protocol ensures that all key stakeholders are working collaboratively to reduce wait-times for police accompanied visits to the ED.

A written protocol also ensures that patient rights are protected. By setting clear procedures and expectations between service providers, patient rights can be woven into daily practices. Rights protections thus become a normal part of the process rather than being marginalized or unacknowledged.

A hospital staff person stated, "We have been able to encourage our local police service to call the crisis centre while on route and advise of who is being transported. We have established a protocol between the crisis centre and the ED based on the CTAS triage rating scale, and have a 15-minute or less response time. Unfortunately our catchment area encompasses 7 different police detachments and getting consistency is difficult."

Conducting routine monitoring

Once a protocol and written agreement is in place in a city or region, it is recommended to conduct routine monitoring and evaluation of the protocol to celebrate the successes, identify the challenges, and discuss solutions on an ongoing basis. A hospital staff person stated, "We have discussions about challenges and successes with police colleagues at regular (quarterly) meetings between the hospital (Mental Health Unit, Emergency Department, Security Services) and 3 police forces. This keeps our system going."

Crisis Planning

Crisis planning is another effective tool for ensuring person-centred care, reducing wait-times for police accompanied visits to the ED, and can often facilitate ED diversion. Crisis planning offers a way for individuals with mental health, addictions and other human service needs to establish a plan of action in preparation for periods of illness. Crisis plans provide time-tested strategies for de-escalating crisis situations and provide the tools for reducing triggers. These plans have the added value of giving individuals the ability to control the care they receive when they may be unable to effectively communicate, outlining specific treatments and medications that have either mitigated or aggravated such experiences in the past.

A survey respondent from a community service agency stated, "It's important to make use of crisis plans that outline what the person's needs and sensitivities are – how they communicate, current medications and how to make use of support staff or family. Do not assume the person understands what is happening – their cognitive delay may not be evident."

A crisis plan opens the lines of communication between the individual and others about their needs and concerns, and protects the individual from unwanted or harmful interventions or treatments, or interventions they know to be ineffective to their care. Crisis plans are designed to keep the individual at the centre of care, even during times when they may have difficulty communicating their needs to others. Crisis planning is developed by the individual in collaboration with family, service providers, peer support, and others the individual may choose to assist in the process, to form an effective and respected document that can be used in times when a person is unwell.

Every crisis is different and individual plans vary by necessity. A crisis plan is developed by an individual in wellness and is used by others involved in a person's life, their loved ones, friends, supporters, health care professionals and others who may come into contact with the individual during emotional distress such as the police and EMS. Families, service providers and others can also help develop crisis plans that form an effective and enforceable legal document that can be used in times when a person is unwell.

Recovery from personal crisis or health crisis may be impeded by trauma, circumstance or anxiety. An effective crisis plan can reduce exposure to personal risk, including the impact of substance abuse and addictions. There are many complicated elements concerning privacy when discussing the disclosure of personal information. This is only made more so during times a person is experiencing a crisis. Given the nature and confusion of those in a crisis state, developing and maintaining a crisis plan that includes provisions dealing with privacy is crucial.

Wellness Recovery Action Plan (WRAP)

One example of a crisis plan is the Wellness Recovery Action Plan (WRAP). WRAP is a tiered approach to crisis planning, beginning with a daily maintenance section in which elements that are known to promote wellness are listed. In a separate section, known triggers are recorded, thus clearly identifying situations/things that should be avoided if possible; and early warning signs that may signal a transition to a state of crisis are outlined in a third

section. These documents empower the person experiencing a mental health crisis to recognize when they may be losing control, and act as a helpful resource for regaining stability.

For those times when maintenance tools are not enough to moderate a crisis, there are two further sections. The first focuses on the symptoms that one might encounter when the situation deteriorates. These are especially helpful for knowing when to seek help from family or friends as a crisis is developing. The last section is the crisis plan itself. This section includes the following information:

- Symptoms that signal the need for intervention
- Primary and back-up designates with contact information who will take action on behalf of the person in crisis
- Contact information for the team of professionals with whom the person works
- Medications that are currently being taken, those that might help, and those that have been unsuccessful in the past
- Both preferred treatments and those that should be avoided
- A plan for in-home care
- Acceptable and unacceptable treatment facilities
- Helpful actions that can be taken by others
- Unhelpful actions that should be avoided
- Instructions on when the plan is no longer necessary

Providing that the person in crisis is not an immediate danger to themselves or others, loved ones have guided instructions on how to react in situations that might otherwise result in a call to police services. For instance, a plan may prioritize the involvement of a Mobile Crisis Intervention Team (MCIT) instead of the potentially stigmatizing experience of a police intervention. Crisis plans also allow a family member or friend who is calling for police intervention to clearly identify the situation as a mental health crisis. In those cases where police involvement is deemed necessary, a crisis plan like WRAP can provide police officers with information that may otherwise be unavailable, such as a list of medications and a brief case history of the person in crisis. This can assist police officers in their decision-making, which may expedite consultations with ED staff or result in diversion to community services.

While an individual's WRAP documents are detailed and may be stored in a binder, crisis plans can also be written on a card that is kept on person at all times.

Crisis Cards

Those developing a WRAP Crisis Plan may also choose to develop pocket-size cards which may be used in the event of a mental health crisis. These cards are an effective way to communicate to first contact/responders such as friends, health care providers, EMS, police or others should an emergency ever arise and an individual becomes unwell.

The card also allows space for an individual to supply any information they wish and to request specific actions to be carried out. The individual can share as much or as little

information as they want that identifies the practical help they need in a crisis. This could include:

- Name and addresses of supporters the individual would like contacted which may include both informal and formal supporters
- Current care and treatment plan
- Recognition of what helps or does not help in crisis
- Recognition of self-management techniques

Sharing the Crisis Plan

The key to the success of crisis planning is communication and relationship development. This will include trusted supporters identified in the individual's crisis plan and may include health care providers such as a psychiatrist, family physician, case manager or other community supports, mobile or telephone crisis support and the police. An individual may choose to share all or part of their crisis plan and may choose different parts of their crisis plan to share with different contacts in their life. For example, an individual may choose to share their entire WRAP with their health care team, but may choose to only share the section on helpful interventions with the police. It is an individual choice to share personal health information and the individual needs to understand their rights around sharing the information that may be maintained on a database, particularly when sharing with individuals or organizations who are not bound by personal health information legislation. The goal of crisis planning is to develop relationships, that when needed, provide an effective provision of crisis support.

For more information about the Wellness Recovery Action Plan (WRAP), visit:
http://www.mentalhealthrecovery.com/wrap/

http://psychcentral.com/library/id239.html

For more information about crisis plannig, visit:
http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/concurrent_disorders/a_family_guide_to_concurrent_disorders/crisis_and_emergency/Pages/creating_crisis_plan.aspx

Children and Youth

Survey respondents from the policing sector, hospital setting, community mental health, addictions and other human services organizations identified several key issues that affect police interactions in the ED specifically relating to children and youth:

- Police accompanied visits to the ED involving children and youth typically experience longer wait-times when compared to adult visits. A police officer stated, "There are much longer wait times for children apprehended under the *Mental Health Act*. The reason we're often given is that it's a result of no beds being available for this age group or no paediatric staff or physicians available." Similarly, a community service provider stated, "The ER doctors have been hesitant to form children. Partly due to the lack of availability of paediatric beds, and the age of the child. They cannot put children in the psychiatric ward because of their age, and it is often not appropriate to put them in the paediatric ward. So they are turned away and dealt with on an outpatient basis."

- Situations regarding children and youth not only involve police and the ED, they also involve parents and guardians, and typically involve additional agencies, such as community children and youth service providers and the Children's Aid Society. Having multiple stakeholders involved in the situation often leads to a breakdown in communication. A hospital staff person stated, "There are specific challenges with children and youth. It can take 3 times as long to assess this age group. Often group homes are unable to manage children with behavioural issues and there is a lack of effective community care plans for these children. This age group can be more complicated with having to consult with parents, guardians, the school and CAS, etc."

- There is a lack of accessible mental health and addictions-related services for children and youth often resulting in longer wait-times in the ED. Often, police are requested to accompany the child/youth to another hospital to access appropriate services. An ED staff person stated, "Emergency room issues for children and youth are based mostly on availability of services. Our hospital does not see children and the nearest facility that does deal with this population is just over an hour away and it is difficult to arrange for an expert assessment during off hours. Also to get a young client admitted to an out of town facility has the added challenge of transportation when often police and/or ambulance are reluctant to leave the area. Occasionally the young client will be forced to remain in the ER overnight to wait until either paramedics or police are able to provide day staff personnel to make the transfer." Similarly, a police officer stated, "ER doctors typically will not make Form 1 assessments on persons under 16, they usually call in outside children's service agencies or a child psychologist to do the Form 1 assessment. This can greatly increase time spent at the hospital."

- For hospitals that do provide mental health and addictions-related services for children and youth, often these services are only available during daytime hours. A hospital staff person stated, "We currently have no ER crisis response for children and youth when brought in. The children's mental health agency in the community provides telephone response overnight as required but does not come into the hospital. We are currently trying to address this gap internally by providing after hours

assessments through our Adult Crisis Centre and then provide a follow up the next business day by our hospital's child and youth workers."

- Police accompanied children/youth in the ED often face delays in being admitted to the hospital due to a shortage of paediatric beds available within the hospital or within the region. A police officer stated, "There is only one child/youth psychiatrist at our local hospital. The doctor is often busy with other duties and/or unavailable. This increases wait-times for officers at the hospital. Our jurisdiction does not have a facility to care for children/youth suffering from mental illnesses. The closest facility is a short drive away but often does not have available beds. If a bed is not expected to become available anytime soon then other neighbouring facilities will be contacted to determine their available beds. And then we have to make the transfer."

- Stigma and discrimination is another significant issue facing children and youth visitors to the ED. Often, negative stereotypes are associated with children and youth, especially those with mental health and addictions-related conditions, and as a result, their care is compromised.

  A community service provider stated, "Children and youth have basically been dismissed as making up symptoms and are treated as if they are not in the room. I have observed children and youth spoken to by social workers, nurses, physicians and psychiatrists with patronizing, condescending attitudes and with the assumption that the patients are just wasting time. Children and youth have very real fears and traumas that are not easily articulated by conventional methods, such as verbal description. They need to be offered alternative means of communication, through expressive arts, music, writing, or drawing. They respond best to less formal, less intimidating methods."

  Similarly, a police officer stated, "Youth are often treated as less of a priority than adults. A recent example occurred in our local area where police took a 12-year-old boy who was attempting to commit suicide to the local hospital for help. The hospital did not weigh the information from the police appropriately. The patient was released against the wishes of the police. The 12 year old killed himself a few days later. There has been no review that has involved the police."

For more information regarding children and youth mental health, visit:
http://www.kidsmentalhealth.ca

Racialized and Aboriginal Communities

The issues affecting police accompanied visits to the ED involving individuals from racialized and Aboriginal communities was highlighted in many of the survey responses from police officers, ED staff and community mental health, addictions and other human service providers:

- Many survey respondents observed that racialized and Aboriginal groups were over-represented in police accompanied visits to the ED.

  An ED staff person stated, "The challenges that these groups face include (but not limited to): poor community follow up, unable to afford or pay for service, housing and income issues which contribute and add to further marginalization of these populations, poor access to primary care providers or inability to follow through with appointments results in more visits to the ED which may have been handled in outpatient services. Many of these clients lived on the streets, which makes them more visible to police and therefore may be brought in by police more often. The challenge with some of these clients is the ED becomes a 'revolving door.' The inability to access services in community for a multitude of reasons results in an over-reliance on the ED."

  Similarly, a police officer from Northern Ontario stated, "Aboriginal people are overrepresented as *Mental Health Act* apprehensions in North Western Ontario. There is often a cultural and language barrier and stereotypes with all agencies and people involved. The support required and social services needed to provide assistance instead of emergency rooms is very limited. Social agency support is required to eliminate the *Mental Health Act* 'revolving door.'"

- Language barriers and the lack of interpreter services available is a significant issue facing racialized individuals. An ED staff person stated, "Our catchment population contains many individuals of South Asian decent. We often see language barriers affecting the ability for a parent to communicate their child's behaviour or their safety concerns properly. In these situations, the provision of crisis support services that are sensitive to language and culture would be helpful."

- Significant barriers are created for racialized and Aboriginal communities due to the lack of culturally appropriate crisis services in both the community and the ED. A police officer stated, "Our community is in close proximity to the largest Six Nations Reserve in Canada. There are a high proportion of individuals with addictions and mental health challenges that use the ER and police services. Despite our close proximity to the Six Nations, there are significant barriers to providing appropriate, sensitive, inclusive services for these clients by informed, knowledgeable health care professionals."

  With regards to this issue, an ED staff person from Northern Ontario stated, "Our geographical area has a high number of Aboriginal individuals and a high number of Aboriginal support services. The challenges have been with the lack of knowledge regarding their culture from the crisis services and emergency room staff. We have

recently been involved with the local mental health agency, police services and EMS to talk and discuss how we can service this population better. We have been given the names of two Aboriginal Healers who would be able to provide cultural support at the time of a crisis. As crisis workers, we have agreed to ask the individual if they want cultural and spiritual support present when doing assessments."

- Stigma and discrimination are another significant issue facing racialized and Aboriginal populations who are involved with police accompanied visits to the ED. Due to racial profiling and negative stereotyping, the level of care provided to these populations is compromised.

  A police officer stated, "These patients may be treated differently in the emergency department i.e. their medical problems may be downplayed or overlooked." Similarly, an ED staff person stated, "My experiences have led me to see that individuals of non-white Anglo-Saxon backgrounds, of every minority, but particularly Aboriginal populations, are treated almost as if they are non-human. There is a basic disregard for their needs and less sensitivity to cultural variances and relationships with power and authority."

  A correctional service provider stated, "As per statistical information, Aboriginal people are over-represented in Corrections, therefore it is likely the number of ER involvement may be a higher number of Aboriginal people. Also, many Aboriginal people live in remote communities with minimal services available to them upon release from hospital i.e. mental health, addictions, support workers, fly-in probation supervision for remote communities, thus increased possibility of repeated incidents when no other supports are available. If legal charges derived from incident leading up to attending the ER, there are longer court remand dates for Aboriginal people due to court schedules for remote communities. There are limited discharge plans for Aboriginal people once released from custody, as there are limited resources in their home communities, thus increasing the possibility of recidivism. An Aboriginal person with a mental health or addictions condition may be referred and have access to mental health support systems while incarcerated but limited upon release in their remote community, thus increasing recidivism and the need for repeated police ER response."

Community of Interest on Racialized Populations

The Provincial HSJCC worked in partnership with the Community of Interest (COI) on Racialized Populations and Mental Health and Addictions to investigate the issues facing racialized individuals who access the ED. The COI hosted a Think Tank forum on this topic in Toronto in March 2013. In addition, a literature scan and backgrounder was developed; as well, two consultations were conducted with persons from racialized communities with direct lived experience using the ED and service providers from community-based mental health organizations who were familiar with the needs of racialized communities and their reasons for arriving at the ED.

The COI Backgrounder document stated that there is little Canadian research available about the links between police, racialized populations and the ED. The COI highlighted a study published by G. Eric Jarvis, M.D., et al. in 2005 which suggests that racialized individuals

hospitalized with psychosis are more likely to have been brought to the ED by police or ambulance. The study concluded that Afro-Canadians admitted to the hospital with psychosis are overrepresented in police and ambulance referrals to emergency psychiatric services.

The COI Consultations revealed that racialized ED service users are living on the margins of an already marginalized social group (i.e. person with the lived experience of mental health and addictions issues). Narratives from both service-user and service-provider consultations revealed that they were often doubly stigmatized and marginalized by the health care system and other systems, such as the criminal justice system, both as people with mental health conditions and addictions, *and* as racialized persons. The consultations also revealed that lack of availability of services and supports exacerbates the use of the ED.

For more information about the Community of Interest on Racialized Populations and Mental Health and Addictions, visit:
http://eenet.ca/the-racialized-populations-and-mental-health-and-addictions-community-of-interest/

Relevant Legislation and Patient Rights

In Ontario, several legislation govern police mental health apprehensions and interactions in the ED. Below is a discussion of two relevant pieces of legislation: the *Mental Health Act*, which permits the police officer to apprehend the individual experiencing a mental health crisis and accompany the individual to the ED, and the *Personal Health Information and Protection Act*, which governs the communication of health care information and impacts on communication strategies between ED staff and police officers.

Mental Health Act and Apprehensions

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

> Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,
> (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
> (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
> (c) has shown or is showing a lack of competence to care for himself or herself,
>
> and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
> (d) serious bodily harm to the person;
> (e) serious bodily harm to another person; or
> (f) serious physical impairment of the person,
> and that it would be dangerous to proceed under Section 16, the police officer may take the person in custody to an appropriate place for examination by a physician.

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

The *Mental Health Act* details five additional conditions under which police officers are permitted to apprehend individuals:

- Under Section 15, police officers may apprehend an individual who is the subject of an application for psychiatric assessment (Form 1). This section permits police officers to apprehend the individual subjected to a psychiatric assessment for a period up to seven days, including the day the assessment was issued, and take the individual to a psychiatric facility.

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

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

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

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

Mental Health Act and Restraint

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

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

The "prescribe manner" for a facility to take custody is given in Regulation 741:

> 7.2(1) Where a person is taken to a psychiatric facility under Section 33 of the Act, the officer in charge or his or her delegate shall ensure that a decision is made as soon as is reasonably possible as to whether or not the facility will take custody of the person.

While police have broad authority to maintain custody, the *Mental Health Act* prescribes specific conditions and limitations on health care facilities to detain and restrain persons in their custody. These procedural safeguards are found in Sections 6 and 14 of the *Mental Health Act*:

> 6. Nothing in this Act shall be deemed to affect the rights or privileges of any person except as specifically set out in this Act.
>
> 14. Nothing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient.

Until a "person" has been assessed for admission as a "patient," the health care facility may not have the legal authority to detain, restrain, or otherwise use force in taking custody of the person. Such measures may only be used once a person is subject to a formal application for

psychiatric assessment (Form 1). Once a person has been subject to a Form 1, the *Mental Health Act* then gives the facility authority:

> 15(5)(b) to detain the person who is the subject of the application in a psychiatric facility and to restrain, observe and examine him or her in the facility for not more than 72 hours.

Persons assessed on a Form 1 have a right to know the reasons for their detention and to know of their right to counsel. Facilities who fail to advise persons of their rights (usually through delivery of a Form 42) risk restraining and detaining the person without lawful authority.

To avoid violating patient rights and freedom from unlawful detention, it is recommended that any ED Apprehension Protocol clarify the transfer of custody with clear procedures and expectations for each service provider. This could include guidance around:

- Elevated triage priority to ensure that persons apprehended under the *Mental Health Act* are quickly assessed, and that a decision to take custody is made as early as possible (and so in compliance with legislation);
- Early physical assessment of the apprehended person to facilitate their formal admission as a patient;
- Provision of supervised or monitored quiet rooms without locks;
- Training for hospital security on the limits of their detention and restraint powers, and alternative measures that may be used;
- Training for hospital staff and security on the legal rights framework, de-escalation techniques, and human rights accommodations, especially communication;
- How to assess and triage apprehended persons who are unable or unwilling to communicate; and
- Clear procedures around the provision of the Form 42 and the availability of peer support and advocacy services.

To access the Mental Health Act, visit:
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm

For a detailed summary of other legislation and policies that affect police officers' interactions with the health care system, refer to Section 3.2 of the HSJCC report *Police & Mental Health: A Critical Review of Joint Police/Mental Health Collaborations in Ontario* (2011) at: http://www.hsjcc.on.ca/Provincial/Police%20and%20Mental%20Health%20Project/Police%20and%20Mental%20Health%20-%20A%20Critical%20Review%20of%20Joint%20Police-Mental%20Health%20Collaborations%20in%20Ontario.pdf

Personal Health Information and Protection Act

In Ontario, health information is protected by *the Personal Health Information and Protection Act*, 2004 (PHIPA). Section 4 of the Act states that personal health information includes any identifying information about an individual, in oral or recorded form, as it relates to their physical or mental health. Under Section 3 of PHIPA, only a "health information custodian" can have custody or control of personal health information as a result of, or in connection with, performing the person's or organization's powers or duties.

In *Circle of Care: Sharing Personal Health Information for Health-Care Purposes*, the Information and Privacy Commissioner of Ontario (2009) describes "the circle of care." Although the circle of care is not defined under PHIPA legislation, it is a term commonly used to describe the ability of certain health information custodians to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in PHIPA. This document indicates that police officers are excluded from the circle of care.

Section 29 of PHIPA states that the individual's consent must be obtained before health information is collected or disclosed. However, PHIPA does allow exceptions to the rule concerning when health information can be shared. Under Section 40, PHIPA states that a health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

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

To access the Personal Health Information and Protection Act, visit:
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm

To access the Information and Privacy Commissioner's report *Circle of Care: Sharing Personal Health Information for Health-Care Purposes* (2009), visit:
http://www.ipc.on.ca/images/Resources/circle-care.pdf

For a detailed summary of PHIPA legislation, refer to Section 3.7 of the HSJCC report *Police & Mental Health: A Critical Review of Joint Police/Mental Health Collaborations in Ontario* (2011) at:
http://www.hsjcc.on.ca/Provincial/Police%20and%20Mental%20Health%20Project/Police%20and%20Mental%20Health%20-%20A%20Critical%20Review%20of%20Joint%20Police-Mental%20Health%20Collaborations%20in%20Ontario.pdf

To access the Office of the Information and Privacy Commissioner of Ontario, visit:
http://www.ipc.on.ca/english/Home-Page

Police-Emergency Department Protocols in Ontario

Listed below are the inter-agency agreements, protocols, policies and forms that were gathered through the call for information distributed through the HSJCC Network.

Inter-Agency Agreements

Protocol: Timmins Police Services, CMHA Cochrane-Timiskaming and South Cochrane Addictions Services: An agreement between Timmins Police Service, Canadian Mental Health Association (CMHA) Cochrane-Timiskaming Branch and South Cochrane Addictions Services (SCAS) to better serve people with mental health needs in the area. The protocol includes agreements on how to share information which includes consenting client list and support worker contact information, and providing mutual training.
http://www.hsjcc.on.ca/Resource%20Library/Policing/Timmins%20-%20CMHA-SCAS-TPS%20Protocol%20-%202011.pdf

Protocol between Collingwood General and Marine Hospital (CGMH) and Collingwood Ontario Provincial Police (OPP) regarding response to Mental Health Act incidents: A protocol between Collingwood General and Marine Hospital (CGMH) and Collingwood Ontario Provincial Police (OPP) to address safety and security concerns related to a patient currently under care for a mental health issue.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Collingwood%20Protocol%20regarding%20response%20to%20Mental%20Health%20Act%20incidents%20-%202012.pdf

Patients Brought to hospital under Mental Health Act by Hamilton Police: A draft Memorandum of Understanding between St. Joseph's Healthcare Emergency Psychiatric Care Facility and Hamilton Police outlining a policy and procedure to complete the transition of care from Hamilton Police personnel to St. Joseph's Healthcare Emergency Facility within 30-60 minutes. The policy summarizes the responsibilities specific to the police and the hospital, as well as joint responsibilities in mental health crisis situations.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Patients%20Brought%20to%20hospital%20under%20Mental%20Health%20Act%20by%20Hamilton%20Police.pdf

Mental Health Act Form 1 Protocol Between the Dryden OPP, Dryden Police Service, Northwest EMS and the Dryden Regional Health Centre: A formal agreement for cooperation and professional liaison between the Dryden OPP Detachment, the Dryden Police Service, Northwest EMS and the Dryden Regional Health Centre that addresses legislative authorities, responsibilities and the safety of medical staff, patients and police.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Dryden%20OPP%20(North%20West%20Region)%20-%20Mental%20Health%20Act%20Form%201%20Protocol.pdf

Emergency Mental Health Response Protocol: A protocol between Greater Sudbury Police Services, Greater Sudbury Emergency Medical Services and Hôpital régional de

Sudbury Regional Hospital to guide ongoing collaboration for an integrated, effective and safe response to emergency health situations, which by necessity involve multiple agencies. This protocol outlines the responsibilities of the police, EMS and the hospital and includes clear definitions of risk and instructions on transportation to the hospital and transfer of care. It also contains a form for the Greater Sudbury Police Service to use in expediting the transfer of care.
http://www.hsjcc.on.ca/Resource%20Library/Policing/Sudbury%20Emergency%20Mental%20Health%20Response%20Protocol%20-%202010.pdf

COAST Memorandum of Understanding: A Memorandum of Understanding between the Windsor Hotel-Dieu Grace Hospital, Community Crisis Centre and Essex County Detachment of the Ontario Provincial Police, which set out the conditions and procedures for the operation of the COAST Program, the responsibilities of the partnered services and to regulate the exchange of information between the partnered services. This is a detailed MOU that includes comprehensive sections on the terms and conditions of access, use and disclosure, scope of service, liability, and roles and responsibilities.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Essex%20County%20(West%20Region)%20-%20MOU%20-%202012.pdf

Lanark, Leeds and Grenville Mental Health Crisis Response Protocol: A protocol which clarifies specific services the protocol participants provide and receive throughout Lanark, Leeds and Grenville counties. This protocol includes the following sections: Target Populations; Governing Principles; Response Categories and Priorities; Monitoring and Review; and Conflict Resolution, with the bulk of the document outlining the responsibilities of the undersigned participants.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Lanark%20County%20LEAD%20Team%20Protocol%20-%202012.pdf

Inter-agency Agreement: An agreement between Hôpital Notre Dame and Hearst, Kapuskasing and Smooth Rock Falls Counselling Services to ensure a proper follow-up by the Counselling Services upon discharge of a client from the hospital, facilitating information sharing between agreeing agencies for the benefit of client's safety and wellness, and ensuring a proper follow-up by the hospital when a client of the counselling services is referred. The agreement includes detailed protocols for typical circumstances of clients crisis situations.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Hearst,%20Kapuskasing,%20Smooth%20Rock%20Falls%20Inter-agency%20Agreement%20-%202000.pdf

Memorandum of Understanding between Muskoka-Parry Sound Community Mental Health Service and Bracebridge detachment of the Ontario Provincial Police November 2003: A Memorandum of Understanding developed to familiarize the staff of both the parties regarding each other's role in the handling and treatment of individuals with mental health conditions and provide a coordinated response in South and West Muskoka area. The detailed procedures were developed in coordination with both Community Mental Health and police staff.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/MOU%20between%20Muskoka-Parry%20Sound%20Comm%20MH%20Service%20and%20Bracebridge%20OPP%20-%202003.pdf

Protocol between Police and Arnprior Hospital With respect to the Transportation of Mental Health Patients: A protocol between Police and Arnprior Hospital regarding police accompaniment and acceptance by the hospital of patients experiencing mental health issues.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Protocol%20between%20Police%20and%20Arnprior%20Hospital%20With%20respect%20to%20the%20Transportation%20of%20Mental%20Health%20Patients.pdf

Protocol/Service Agreement February 2013: A detailed Protocol/Service Agreement between North Eastern Ontario Family and Children's Services, Timmins and District Hospital, and Timmins Police Service in relation to mobile crisis service intervention to address the needs of children, youth and families of the Cochrane District who require an integrated and coordinated crisis management intervention.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Timmins%20-%20Mobile%20Crisis%20Service%20Intervention%20-%20Protocol%20Service%20Agreement%20-%202013.pdf

Mental Health Act Form 1 Protocol Between Rainy River District OPP, Riverside Health Care Facilities Inc. and Rainy River District Social Services Administration Board: A protocol to provide a flexible, non-contractual, formal agreement for cooperation and professional liaison between the Rainy River District OPP and the Riverside Health Care Facilities and the Atikokan General Hospital that addresses legislative authorities, responsibilities and the safety of medical staff, patients and police. The appendix includes Paid Duty Procedures, an OPP Paid Duty Agreement form and a Transportation Decision Process flowchart.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Rainy%20River%20District%20(North%20West%20Region)%20-%20MHA%20Form%201%20Protocol%20-%202012.pdf

Template Handover Protocol for Patients brought to the ER by Police: A one-page template handover protocol developed in the Toronto Central Local Health Integration Network in collaboration between hospitals and the Toronto Police Service.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Template%20Handover%20Protocol%20for%20Patients%20Brought%20to%20ER%20by%20Police.pdf

Prescott Russell Mental Health Crisis Service Protocol for Mental Health Crisis Situations: A protocol between eleven organizations in the Prescott and Russell district developed by the standing committee of the Prescott and Russell Mental Health Crisis Service for crisis situations involving persons with mental health and/or addiction issues. This is a comprehensive 47-page document that outlines protocols for all nine participating organizations in cases of mental health and/or addictions crisis, including multiple flowcharts and diagrams to better clarify actions to be taken in such circumstances. A slightly different French version is included in the French Protocol section of this document.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Prescott%20and%20Russell%20Mental%20Health%20Crisis%20Service%20-%20Protocol%20for%20Mental%20Health%20Crisis%20Situations%20-%202003.pdf

Grand River Hospital Mental Health Manual: Crisis Accepting Custody of Patient from Police: A protocol from Waterloo Regional Police Services in agreement with Grand

River Hospital on accepting custody of a patient, which includes a Police Releasing Custody to Facility Form.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Grand%20River%20Hospital%20Mental%20Health%20Manual%20-%202009.pdf

L.E.A.D. Protocols

L.E.A.D. Team Protocol: A L.E.A.D. Team Protocol between Cornwall Community Police Service, Ontario Provincial Police (Stormont County), Cornwall Community Hospital and Cornwall Emergency Medical Service which includes a step by step description of initial response procedures of the L.E.A.D. team tailored to various. It also offers step-by-step directions for caring for individuals admitted to the Inpatient Psychiatric Care Unit, as well as, sections on Information Sharing and Disclosure; Joint Training; Insurance and Liability; Monitoring and Evaluation, and Conflict Resolution.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Cornwall%20Emergency%20Mental%20Health%20Response%20Protocol%20-%202005.pdf

L.E.A.D. Team Protocol: A L.E.A.D. Team Protocol between fifteen agencies in the Renfrew County area. The Protocol begins with a Terms of Reference for the Renfrew County LEAD team which include a Statement of Purpose, Statement of Principles, Goals, etc. There is a section on Joint Training and protocols for the LEAD Team Response.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Renfrew%20(East%20Region)%20-%20LEAD%20Team%20Protocol%20-%202007.pdf

L.E.A.D. Team Protocol: A L.E.A.D. Protocol for Lennox and Addington County based on a partnership between seven local organizations. The Protocol begins with a Terms of Reference for the Lennox and Addington County LEAD team which include a Statement of Purpose, Statement of Principles, Goals, etc. There is a section on Joint Training and protocols for the LEAD Team Response.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Lennox%20and%20Addington%20LEAD%20Team%20Protocol%20-%202011.pdf

L.E.A.D. Team Protocol: A L.E.A.D. Protocol for Lanark County which includes twelve local organizations, police services and hospitals. The Protocol begins with a Terms of Reference for the Lanark County LEAD team which include a Statement of Purpose, Statement of Principles, Goals, etc. There is a section on Joint Training and protocols for the LEAD Team Response.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Lanark%20County%20LEAD%20Team%20Protocol%20-%202012.pdf

Protocols in French

Entente de service entre Police Provinciale de l'Ontario et Service de counselling: A Protocol between James Bay Ontario Provincial Police (OPP) and Hearst Kapukasing Smooth Rock Falls Counselling Services: Programme de santé mentale, Habitat interlude, and Services aux victimes (SOAIV).
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Hearst,%20Kapuskasing,%20Smooth%20Rock%20Falls%20Protocol%20-%202012%20-%20French.pdf

Service de crise en santé mentale de Prescott-Russell: Protocole pour les situations de crise en santé mentale et toxicomanie: A Protocol between nine organizations in the Prescott and Russell district developed by the standing committee of the Service de crises en santé mentale de Prescott-Russell for crisis situations involving persons with mental health and/or addiction issues. This is a comprehensive 33-page document that outlines protocols for all nine participating organizations in cases of mental health and/or addictions crisis, including multiple flowcharts and diagrams to better clarify actions to be taken in such circumstances. A slightly different English version is included in the Protocol section of this document.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Service%20de%20crise%20en%20sant%C3%A9%20mentale%20de%20Prescott-Russell%20-%202010.pdf

Policies

East Algoma Regional Policy: This policy from East Algoma clarifies the responsibilities of Police Services in response to incidents that fall under the Mental Health Act.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/East%20Algoma%20(North%20East%20Region)%20Policy%20on%20Incidents%20under%20the%20Mental%20Health%20Act.pdf

Halton Healthcare Services Management of Patients in Police Supervision/Custody in the ED: A policy at Halton Healthcare Services for the Management of Patients in Police Supervision/Custody in the Emergency Department, directed primarily to ED staff, outlining the procedure for managing mental health patients who are accompanied by police.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Halton%20-%20Management%20of%20Patients%20in%20Police%20Supervision%20or%20Custody%20in%20ED%20-%202011.pdf

1 District - Processing Mental Health Apprehensions: A Policy directed towards the Halton Region Police Services from Halton Healthcare with the aim to expedite the processing of mental health patients who are apprehended or transported by police. This document outlines the procedures that the police can expect when bringing a patient into the ED, with some descriptions of potential recourse for officers that are experiencing longer-than-usual waits.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Halton%20-%201%20District%20-%20Processing%20Mental%20Health%20Apprehensions.pdf

The Scarborough Hospital Policy & Procedure Manual: Mental Health Services – Regional Crisis Program Accepting Custody of Patient from Police: A policy that includes the section of the Mental Health Act that describes how a facility is to take custody of a person brought in by the police. It also refers to the *Police Releasing Custody to Facility Form (TSH #845177 – (revised 2009)*, as a tool used by police and the hospital to indicate an agreement that custody has been transferred from the police to the TSH.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Scarborough%20-%20Regional%20Crisis%20Program%20Accepting%20Custody%20of%20Patient%20from%20Police.pdf

Forms

Police Releasing Custody to Facility Form: A Police Releasing Custody to Facility form from the Scarborough Hospital. This form was created to reduce unnecessary wait times that officers spend with patients in the EDs.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Toronto%20-%20Scarborough%20Hospital%20-%20Police%20Releasing%20Custody%20to%20Facility%20-%202010.pdf

Police Mental Health Apprehension Template: A Police Mental Health Apprehension Template used by Pembroke Police, Deep River Police, Ontario Provincial Police, Pembroke Regional Hospital, Deep River and District Hospital, St. Francis Memorial Hospital, Arnprior and District Memorial Hospital and Royal Victoria Hospital to provide information to ED staff on the details of mental health crisis situations. The form includes sections on appearance/behaviour; mood; thinking (which includes categories like disorganized thinking and abnormal speech); alcohol/drug use; danger issues; and medical information.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Police%20Mental%20Health%20Apprehension%20Template%20-%20Pembroke,%20Deep%20River,%20Arnprior.pdf

Police Observation Form for the Transfer of Care: A Police Observation Form for the Transfer of Care of a person with a mental health crisis to St. Joseph's Emergency Department. The form includes sections like physical behaviours; verbal expressions; history; property located on subject (like weapons or medications); and disposition.
http://www.hsjcc.on.ca/Resource%20Library/Policing/Police%20Observation%20Form%20-%20Transfer%20of%20Care.pdf

Joint Police-Emergency Department Committees in Ontario

Listed below are the Terms of Reference for inter-sectoral, collaborative committees across Ontario who are working to address police-emergency department issues; these documents were gathered through the call for information distributed through the HSJCC Network.

Scarborough Hospital Police/Ambulance/Corrections/ Hospital Liaison Committee (P.A.C.H.L.C.)
This committee provides a forum to discuss issues of mutual interest and concern for the Scarborough Hospital, Toronto Police Services (TPS) and Toronto Emergency Medical Service (EMS). Their responsibility is to provide input into Hospital initiatives that involve or impact on the TPS and EMS, identify processes that facilitate the meeting of joint goals of the Hospital, TPS, and EMS, and provide advice/assistance to resolve issues arising between the Hospital, TPS and EMS.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Scarborough%20Hospital%20-%20Police,%20Ambulance,%20Corrections,%20Hospital%20Liaison%20Committee%20Terms%20of%20Reference%20-%202011.pdf

Grey Bruce Health Network and Police Services Committee Terms of Reference: Terms of Reference for the Grey Bruce Health Network and Police Services Committee which provides a mechanism to support effective communication in order to identify and resolve issues, problems and actual and/or potential conflict situations between the hospitals and all Police Service detachments in the Grey and Bruce counties. The Terms of Reference includes sections on their Objectives; Reporting Relationships; Membership; and Meeting, Minutes and Reports.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Grey%20Bruce%20Health%20Network%20and%20Police%20Services%20Committee%20Terms%20of%20Reference%20(West%20Region)%20-%202009.pdf

William Osler Health System Mental Health, Emergency, Police and Security Liaison Committee Terms of Reference: Terms of Reference for the William Osler Health System Mental Health, Emergency, Police and Security Liaison Committee, a multi-agency, interdisciplinary body whose purpose is to promote system integration in the delivery of Emergency/Crisis services for individuals with a primary mental health and/or substance misuse disorder. In so doing the Committee will review challenging cases and develop policies, procedures and advocacy positions designed to address such issues and improve system performance.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/William%20Osler%20Health%20System%20Mental%20Health,%20Emergency,%20Police%20and%20Security%20Liaison%20Committee%20Terms%20of%20Reference%20-%202013.pdf

Resources

Listed below are resources and additional information that were gathered through the call for information distributed through the HSJCC Network.

Contact Lists

Quick Contact Guide: Developmental Disabilities in the Emergency Department: A Contact Guide based on a pilot project conducted at Sunnybrook Hospital that aims to improve care for people with developmental disabilities in the ED. The guide is meant to serve as a short, easy access guide for ED staff to connect them with resources in the developmental sector.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Toronto%20-%20Quick%20Contact%20Guide%20-%20Developmental%20Disabilities%20in%20the%20Emergency%20Department%20-%202012.pdf

Renfrew County Mental Health Crisis Team Contact Poster: A poster from Pembroke Regional Hospital that includes contact information for the Renfrew County Mental Health Crisis Team and their availability.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Renfrew%20County%20Mental%20Health%20Crisis%20Team%20-%20Poster.pdf

Flowcharts

The Crisis Response and Mental Health Assessment Flowchart: An action plan describing the triage process designed by Lake of the Woods District Hospital for police attending the ED with a person experiencing a mental health crisis.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Crisis%20response%20and%20mental%20health%20assessment%20flowchart%20-%202011.pdf

Norfolk Mental Health Information: A chart that includes contact information for CMHA Haldimand-Norfolk Branch and Community Addictions and Mental Health Services of Haldimand and Norfolk, listing the services provided; Section 17 for the Mental Health Act; a chart of popular medications and their uses in mental health cases; and a detailed flowchart for mental health crisis situations.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Norfolk%20(West%20Region)%20-%20Mental%20Health%20Information%20and%20Flowchart.pdf

Police-Community Response for At-Risk Seniors with Dementia: A flowchart for outlining coordinated action taken by community services and police in cases of crisis involving dementia.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Police%20-%20Community%20Response%20Algorithm%20for%20At-Risk%20Seniors%20with%20Dementia.pdf

Additional Information

Special Project 270: Ontario Ministry of Health and Long Term Care (MOHLTC) Other Referral Source: A project Overview of the MOHLTC Other Referral Source Project to capture whether a patient is referred to the ED by law enforcement under the Mental Health Act or by a Drug Court so as to uniquely identify these distinct patient populations to help support regional and provincial analysis.
http://www.hsjcc.on.ca/Resource%20Library/Policing/Patient%20Referred%20to%20ED%20by%20Law%20Enforcement%20-%20MOHLTC%20Special%20Project%20270.pdf

Identifying Vulnerable Seniors: An "in-the-field" Dementia Screening Tool for Police Officers: A power-point presentation introducing a screening tool that assists in the recognition of dementia in common police situations.
http://www.hsjcc.on.ca/Committees/Southeast%20Committee/Resources/2012%20HSJCC%20Disturb%20dispatch%20dementia.pdf

Police, the Emergency Department, and the Suicidal Patient: Towards More Effective Collaboration Between Police and Hospital Emergency Services in the Care of the Suicidal Patient: A 97-page report by Dr. David Gotlib, MD, FRCPC, Medical Director, Emergency Psychiatry Team, St. Joseph's Health Centre in Toronto from January 23, 2007 on the journey of a suicidal individual through the Emergency Medical System in Ontario to determine what is working well, what is not working well and what improvements are necessary.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Police,%20the%20Emergency%20Department,%20and%20the%20Suicidal%20Patient%20-%202007.pdf

The Mental Health and Addictions Acute Care Alliance: Discussion with the Toronto Central LHIN ED Network: A power-point presentation describing the background, current projects and potential areas for continued collaboration for the Mental Health and Addictions Acute Care Alliance in Toronto from April 26, 2012.
http://www.hsjcc.on.ca/Resource%20Library/Crisis%20Services/Toronto%20Acute%20Care%20Alliance%20-%20Toronto%20ER%20Stats%20-%202012.pdf

Crisis Intervention Services: A power-point presentation from Health Sciences North and CMHA Sudbury/Manitoulin summarizing their Crisis Intervention Services program.
http://www.hsjcc.on.ca/Resource%20Library/Service%20Agreements/Sudbury%20Crisis%20Intervention%20Services%20-%20An%20Innovative%20Community-based%20model%20-%202013.pdf

Contact Information

To access the Provincial Human Services and Justice Coordinating Committee, visit:
http://www.hsjcc.on.ca

To access the HSJCC Community of Interest, visit:
http://eenet.ca/the-human-services-and-justice-coordinating-committee-community-of-interest/

To join the HSJCC Network mailing list, email:
CKT_Committee@hsjcc.on.ca