C.O.A.S.T. Guide to Sharing information with Police and Dispatchers in Police Communications

1. Legislation pertaining to circumstances necessitating/permitting client-unauthorized personal health information sharing

Simply, Health Information Custodians (HIC's) are defined in Ontario's 2004 Personal Health Information Protection Act (PHIPA), as **anyone having care and control of personal health information**. It is legislated in this *Act* how HIC's are required to use, disclose, and protect the personal health information of others to which should be strictly adhered. However, provisions for the client-unauthorized sharing of personal health information are set out as follows:

> A health information custodian may disclose personal health information about an individual if the custodian believes on **reasonable grounds** that **the disclosure is necessary** for the purpose of **eliminating or reducing** a significant **risk** of serious bodily **harm to a person or group of persons**. PHIPA, 2004, c. 3, Schedule A, s. 40 (1).

As professionals, we are also governed policies set out by our Colleges and St. Joseph's Healthcare which are consistent with the PHIPA legislation. The Regulated Health Professions Act, S.O. 1991 (RHPA) is legislation that governs all registered health professionals and Colleges including but not limited to nurses, occupational therapists, psychologists, respiratory therapists, midwifery, massage therapists, dentists, medicine, audiologists and language pathologists, pharmacists, etc. Likewise, pertaining to the client-unauthorized disclosure of personal health/personal information, the RHPA Chapter 18 S. 36 (i) states such disclosure is permitted:

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

Similarly, professional College ethics and principles are consistent with the legislation. The Ontario College of Social Workers and Social Services Workers (OCSWSSW, 2008), for example, states the following:

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

C.O.A.S.T. employs social workers, nurses, and occupational therapists as Adult Mental Health Workers. Each respective discipline can refer to their specific Colleges in addition to the legislation for principles/ethics dealing with confidentiality.

2. So, what client-unauthorized information should we share with Police and Police Dispatchers?

Both Police and C.O.A.S.T. strive to preserve human life. Some C.O.A.S.T. clients can perceive themselves as non-clients, and are non-collaborative with treatment producing a lack of insight about their safety and the safety of others in the context of psychosis and impulse control disorders. C.O.A.S.T. can have information from families/significant others, community members, health professionals, and clients themselves when well for example, that may have occurred in other jurisdictions/countries or in hospitals, that may not be available to police or other authorities. Such information may for example, be related to sexually/physically assaultive behaviours, thoughts of harm to others, or past suicide/pseudo-suicide attempts/ideations that may be relevant to the protection of the client, police and/or community members. Such information may also include communicable disease information that may facilitate protecting 911 responders from harm.

Police responding to emergent 911 situations rarely have the opportunity to collect such information prior to attending these calls due to the expediency with which they must respond. Police often do not have any demographic

information about clients other than an address to attend when responding to calls until after they are on scene. Since C.O.A.S.T. can be a valuable source of information Police can not access through police information systems and often has information also gathered from police information systems, they are encouraged to call C.O.A.S.T. for support in situations where they suspect mental health issues are promoting the difficulties necessitating an emergency response. For Police C.O.A.S.T. can sometimes be considered the "one-stop-information-shopping" phone call about relevant mental health data they may need to rapidly access to assess risk to themselves, individuals, and community members.

The legislation outlined above indicates our professional obligation should be to share any information necessary to **reduce, protect, or eliminate potential risk of physical harm** to a **person or group or persons**. You would need to share the same information whether you initiated a police response via 911 or police contacted C.O.A.S.T.

Defining an understanding of who we need to protect

Person or group of persons:

Police, the subject individual, C.O.A.S.T. staff and other healthcare providers, landlords, superintendents, tenants, families, significant others, and any other community member need to be protected/safeguarded from potential harm.

Defining an understanding of circumstances warranting protection

Potential

At C.O.A.S.T. we are deemed **experts at assessing risk in the context of mental health and illness**. This means that we understand psychiatric illnesses/disorders as defined in DSM-IV-TR, their respective symptom presentations, and what risk these diverse individual and combined symptoms may present to individuals and community members in addition to what course of action might be best in each individual circumstance. Given this, we are able to determine when persons present a potential risk to themselves and others. There is **never an absolute;**

rather we can reasonably predict an outcome based on particular types of symptoms, intervention or non-intervention. We are concerned specifically with the **potential risks to someone's physical safety in the context of symptoms of DSM-IV-TR defined psychiatric disorders**.

The **subject individual's** physical safety is concerned with instances of
a). **Potential Inability to care for themselves in the context of mental illness symptoms:** Such instances might include, but are not limited to, instances where for example, persons who are non-compliant with medications for physical health problems such as diabetes, thyroid, heart conditions, etc. can encounter life threatening circumstances due to their non-compliance, significant weight loss and/or physical deterioration caused by lack of consumption of food or fluids, living in squalid conditions causing health risks, etc. The potential for physical risk must be assessed on a case-by-case basis including historical factors, current symptom presentation, and the person's likelihood for improving these circumstances independently in the community with particular supports such as psychiatric medication compliance, etc. An example may be where due to lack of psychiatric medication compliance a person believes all medications are poison and will kill them so they cease medications for serious medical problems as well.

b). **Potential Harm to self in the context of mental illness symptoms:**
These may include but are not limited to, historical and present suicidal ideation/suicide attempts, the seriousness of historical attempts, anticipation of rescue/expectation of death after an attempt, substance use, psychosis, paranoia, or continually placing oneself in risky situations where the consequences can not be understood or anticipated by the individual.

Physical safety also includes the safety of others . . . . . .
c). **Potential Harm to others**
These instances may include direct threats, assessment of current and historical instances of violence, past forensic admissions, assessment of criminal history, paranoia, delusions of replacements and imposters, suicide-by-cop, communicable diseases such as the Hepatitis group and HIV where fluid precautions need to be exercised with care by emergency responders, etc.

Defining an understanding of what information we should share

Taking together the potential risks outlined above, we should share any pertinent information relative to these protections with police and police dispatchers when receiving police and police communications calls. We assess the situations individually based on the historical information maintained in our databases and our risk potential expertise given the current situation and mental health concerns known to us with information provided by HPS employees on scene/receiving 911 calls. We should always **err on the side of caution and safety** in an attempt to ensure the security of everyone involved. We would only be liable to share health information in the case of malice. As long as we believe we are acting to safeguard others, we would not be considered malicious by any court.

In ensuring personal health information protection of the subject individual we must **consider what information is actually needed and is useful to police at the scene**. For example, they may not need to know a specific psychiatric diagnosis or medications because they may not understand what the diagnostic information means or what medications are used for. Rather, they may simply need to know that last time the person acted this way, the person behaved in a particularly dangerous way. For example, they tried to grab the officer's gun, or attacked police, or were cowered in a dark corner of their home with a weapon because they believed the aliens were coming to get them, or were perched on their balcony ready to jump, or …. They need to know specifics conveyed to them in language they can understand and can help them. They may need to know if medications are used for psychiatric or medical reasons because of the way they have found a person. **Consider what information is necessary, pertinent and useful to each individual situation.**

3. Sharing information with C.O.A.S.T. Police Officers/Relief Officers

C.O.A.S.T. Police/Relief Officers should have all the information that you have about the history of the person and presenting problem in order that you can plan as a team, the best manner to approach the outreach call. Again, the officer

may not need to know the name of each medication a person should take as these may not mean anything to the officer. However, the officer may need to know that the person has a pace-maker or heart condition for which they should take medications. The officer may need to know that the person has a psychotic disorder. Educate the officer about the symptoms and what these symptoms may mean for your safety, the officer's safety, and the safety of others in carrying out the call. The more education we can provide to the officer about our client population, the more the officer will understand about what they may or may not encounter in carrying out the call **safely**. The officer may need to do some further investigation from a police perspective in order to plan to **carry out the police-civilian call safely**. C.O.A.S.T. police officers need to be asked to be sensitive to facilitate reducing stigma and difficulty for our clients. It is our job to educate them in this regard. While we know that police can report anything they see or hear during our mobile interaction with the client, ask the officer to be careful not to put any potentially stigmatizing information in their reports. Shorter officer reports sometimes results in better outcomes for our clients. If police are able to at least report that we have for example, attended and apprehended a person, for reasons defined in Section 17 of the Ontario MHA briefly articulated with necessary safety precautions identified, when uniform police encounter the person in another instance, they will likely call us for first hand information which usually better serves our clients needs. You can talk with the officer about what their report might contain and attempt to negotiate and educate while doing so. For example, it may not be necessary to disclose in a police report that a person is positive for specific stigmatizing communicable diseases. Rather, an alternative reporting method you could discuss with the officer police might entail the officer flagging the person in police databases for other police encountering them is to simply state that "universal fluid precautions" should be taken. Assess the officer's comprehension of medical and psychiatric language. The language you use to communicate with the officer should be such that you end up with a common understanding of the client situation you are about to encounter. Remember you can never tell the officer what to put in their report. However, by providing education to the officer about the client population C.O.A.S.T. services it is hoped that the officer will keep the client's best interests in mind.

4. Managing Telephone Police/Dispatcher Inquiries

4-i). When receiving a police call, try to subtly determine the reason for the call … Are mental health concerns expected? Why? What's happening there?
Sometimes we are contacted by police/dispatchers and the question posed is **"Do you have this person in your data base?"** There is no need to become defensive or demanding here. There is no need to tell them you CAN NOT provide them with the information being requested UNLESS they tell you why because health information is confidential. It is often useful here to simply start a conversation by stating, "While my computer is working to search that name, can you tell me what's happening with John Doe?" Begin to explore the situation and assess the reason for the information request.

Remember, Police are not healthcare professionals and do not know the regulations we are subject to any more than we know their job and the regulations they are subject to. We need to help protect each other to promote the safety of all involved to promote the safety of individuals and the greater community. Always be courteous and respectful.

4-ii). **Police/dispatchers are not calling to manipulate personal health information about people for from us – there is a reason they are calling us and it is our job to respectfully determine what that reason is and how we might best collaborate with them.**

Through this conversation you are assessing the situation at hand. The reason for the request for information most often becomes quite apparent. While engaged in the casual conversation, and assessing the current situation, you can be reading the client's file for historical and diagnostic information if one exists. You may need to check for alternative spellings, etc. You should always check the Old COAST Log as well. The casual conversation allows you to explore the potential risk factors and determine what information should be provided if any.

What is the outcome of your assessment in 4-ii?

4-iii-a). **You have made a determination you need to share client unauthorized information.** If you determine that the situation meets the criteria for client-unauthorized information provision, ensure you are providing useful information in language that any lay person can understand. Often police/dispatchers do not know what information they need or are requesting. Rather, they are hoping we can shed some light on a complex situation. Clinical terminology is not going to be useful to police at the scene.

Keep it simple. Many Police and Dispatchers have limited or even no medical training. Many Police are newer recruits. We need to educate Police about mental illness and risk factors to reduce stigma and streamline the assessment process.

4-iii-b). **You have made a determination you can not share any information about the person in question who is found in our database**. You may say something like, "You know, I don't think there's anything here that's going to be helpful to you. Can I call John Doe for you /Can you put John Doe on the phone (if police on scene and calling) and see what I can find out? Maybe we can settle him out then police won't need to attend/or can leave the scene. I can call you back/tell you at the end of our conversation and let you know." This response is most often met with relief on the part of the dispatcher/police officer who welcomes your intervention. Once you have further assessed the situation with the person, if you determine a police response is most appropriate/we should attend/person needs to go to hospital, Barrett Centre or other, you will be able to share with the dispatcher/police officer/community service provider what information is necessary for you to provide given the circumstance(s).

4-iii-c). **You have made a determination you can not share any information about the person in question because they are not found in our database**. Assess the safety of the person presently and determine what the best response might be. Are there mental health issues? Sometimes the officers have some difficulty articulating what they are seeing. We need to be diligent at asking the officer questions. Ask them what they think about the situation and assess their comfort

level. Can you help by talking to the person or complainant at the scene? If the person can be safe, offer for our team to attend when we become available which may take a day or two, or if available maybe we can assist them personally on scene. Ask Police at the scene to forward the report to C.O.A.S.T. if we do not attend so that we can follow-up the situation.

4-iv). If you are uncertain how to proceed in any call you are triaging, put the caller on hold or ask if you can call them back while you consult with your colleagues about how to best manage the call.

4-v). **Share necessary information with police about missing persons** such as contact names and phone numbers contained in our database, previous addresses/locations, potential for violence and/or suicidality, and frequently visited places to assist the officer's search. Finding them safely is what we strive for. Someone took the time to report the client missing and is worried about the client. Often the officers do not have much in the way of information because our clients can be transient and elusive. It is usually helpful to the officer so the officer can report the person "found" and hopefully "safe." The quicker the person is found, the more likely it is they can be protected. It is also useful for us to know that our clients are "missing persons" in case we obtain information about them in other ways and then we can report that information to police to follow-up.

5. When we absolutely do not share information with Police

5-i). Sometimes we receive requests from, for example, detectives or other police investigators who are investigating a criminal matter involving a potential client. They review the police databases obtain information that we have visited their suspect. They call us. **We do not share client information for the purposes of prosecuting a person** without a subpoena unless otherwise prescribed by law. **We do not attend to visit clients at the request of police for example, to gather evidence for their case**. *We attend only for the purposes of mental health assessments*. Any such information we have or would gather would not be admissible anyway because it was gathered under the guise of a mental health

assessment not to mention it would surely damage any rapport and trust we build with our clients.

5-ii). Sometimes, although very rarely, we receive requests for information from officers about their family members, neighbours, friends, etc. **We do not share client's personal information with police for personal reasons** any more than we would share with someone who makes the request who is not a police officer.

5-iii). **We never give client names or diagnostic or potentially diagnostic information over the police radio**. It is not secure. **Remind the officers you work with of this.** If uniform officers radio the C.O.A.S.T. officer you are working with and ask for such information, ask the requesting officer to call you or obtain a phone number where you can reach the officer in the field.

6. Remember this is only a guide to sharing information with police and police personnel. We do not work in a black and white environment at C.O.A.S.T. Our environment tends to be rather grey at times. We must use our clinical judgment when making decisions about what information we need to share with police on the merit and circumstances of each situation.