REVISED JULY/05

EMERGENCY MENTAL HEALTH RESPONSE PROTOCOL

Table of Contents

I. PREAMBLE:

The aim of this protocol is to provide for an integrated, effective and safe response to certain emergency mental health situations, which by necessity involve multiple community agencies. This protocol was developed with the input of the key resources that will be called to deal with individuals who are in acute mental health distress. The Emergency Mental Health Response Protocol will clarify which services the protocol participants can provide and receive from each other. The signatories to this agreement and representatives that constitute the Mental Health Liaison Committee include:

II. INTRODUCTION:

The partners involved in this protocol respond to emergencies involving individuals with suspected or confirmed mental illness and those in significant distress due to a situational crisis. These partners include:

- Cornwall Community Police Services
- Ontario Provincial Police
- Cornwall Community Hospital(CCH) – Emergency Services and the Mental Health Crisis Team (MHCT)
- Glengarry Memorial Hospital
- Cornwall S.D. & G. EMS

III. PHILOSOPHY:

We Believe:

1. That the provision of prompt assessment and treatment for individuals who are experiencing a psychiatric crisis in the community is essential to ensure a safe level of physical and psychological well-being for those individuals.

2. That prompt intervention promotes safety and support for both the individuals in crisis and others in the community.

3. That the crisis treatment begun in the community enhances the effectiveness of subsequent treatment and facilitates the individual's co-operation with the service provided and thus reduces the inappropriate use of institutional care.

4. That interdisciplinary and inter-agency co-operation in assessment and intervention is essential to provide a comprehensive, efficient and effective crisis resolution, as well as facilitating co-ordination in service delivery.

5. That people experiencing psychiatric crises in the community present unique challenges to all professional care providers and that special education and skills are necessary for this area of psychiatric service.

6. Because crisis impacts the individual and his or her social system support should be extended to the family and friends, whenever possible and appropriate.

7. That the client's natural support network is a valuable resource and should be strengthened and utilised to the greatest degree possible.

8. That the Mental Health Crisis Team will promote improved communication, understanding, good will and co-ordination between mental health service providers in the community assisting them with becoming better able to support those in crisis.

9. The Mental Health Crisis Team can promote the efficient use of services to psychiatric patients in the area served by the team.

10. That on-going community education about mental health issues is an integral part of the Mental Health Crisis Team.

11. That continuing programme evaluation is necessary to determine the usefulness of the programme in facilitating efficient and cost effective treatment and disposition decisions.

12. That research undertaken by the participants will provide valuable data for future psychiatric service planning in the counties of Stormont, Dundas and Glengarry.

IV. KEY PRINCIPLES:

- Response to people with a mental illness or in acute emotional distress should be provided by the least restrictive and least intrusive means possible and in a manner that ensures the safety of the person and others, and minimises interference with the person's privacy, dignity and self-respect.

- That there are multiple agencies in SD&G with a mandate to respond to those in mental health crisis and wherever possible they work together to provide the most appropriate intervention

- The above services will be provided in a spirit of mutual support and co-operation with the intent of sharing and easing the workload of each of the Protocol participants.

- Although the emphasis is on emergency response, this will not preclude the right of Protocol participants to request help of each other in situations where an emergency is not present.

- The participants recognise that resources are often scarce and that medical emergencies will take priority over mental health emergencies in certain situations. Every effort will be made to accommodate the other partners in these situations.

V. TARGET POPULATION:

1. Individuals 16 or older who have a confirmed or suspected mental illness and who are a danger to self or others.

2. Individuals 16 or older who are in a crisis situation causing significant distress and who require an emergency/urgent response.

3. Senior citizens who appear to be suffering from a form of dementia and who appear not to be receiving support services.

VI. SERVICE PRIORITIES:

1. To give highest priority in responding to those who present at risk to the security and safety of themselves or others due to a mental health emergency. For example: suicidal/homicidal individuals, bizarre behaviours, etc.

2. To provide 24 hour a day response capacity

3. To provide direct face-to-face intervention.

4. To support those individuals/agencies acting as first responders to mental health emergencies (e.g. – ambulance, police, families, crisis lines)

5. To share expertise and provide advice.

6. To offer clear access to services for those experiencing a mental health emergency.

7. To facilitate a co-ordinated community response system for those experiencing a mental health emergency that supports reciprocal service agreements between service providers.

8. To respond to emergencies by offering solutions for immediate resolution of the situation. Resolving the underlying problem will often require referral to other programs or agencies.

VII. RESPONSE LEVELS:

The following response level categories will be used to ensure that each agency is defining mental health situations in the same way.

1) Emergency Response – High Risk

An emergency response is required where there is an actual or potential risk that a person's life is immediately threatened, such as in the case of a suicide attempt, homicide or an overdose of harmful substances. This would also include situations where an immediate response is required in order to prevent loss of life. Most emergency situations require police and ambulance only. However, there are cases, such as imminent risk of suicide, where the MHCT may be called to intervene in order to assist the client in understanding the need for service.

The MHCT will not routinely go to situations that are at this level where the patient's medical stability is the primary concern. However, the team will assess the client in the respective emergency room if requested by the ER physician. The team, in these situations, will provide immediate response if the patient is medically stable, the risk is related to mental health issues and the team is required to provide on-site intervention in order to facilitate treatment.

2) Urgent Response – Moderate Risk

An urgent response is required for a person who:

a) Exhibits evidence of acute mental illness accompanied by:
   - Agitation
   - Distress
   - Impulsively
   - Unpredictability
   - Propensity of destructive acts; or

b) Has attempted or threatened suicide; or

c) Is unable to be contained safely in a care or support situation in the community, (for example, they are wandering or confused); or

d) Sedation has been administered to enable safe transport; or

e) There is a need to use approved mechanical restraint for safe transport.

Depending on level of risk determined the client might be followed up by MHCT or referred to CCH Emergency Room (ER) for assessment/treatment. (If there are no safety factors police/ambulance will be cleared from the call and MHCT will transport or arrange transport to the appropriate facility).

When this type of patient presents in emergency independent of other service providers, the triage nurse can call the MHCT to attend to provide assessment and recommendations. This will usually occur once the ER physician has medically examined the patient.

3) Routine – Low Risk

a) Symptoms of psychological and social problems that disrupt activities.

b) Behavior or a pattern of symptoms that may lead to additional problems, become more difficult to change, or urgent problems in the future (but not immediate future).

c) The person is competent, knowledgeable and familiar with the current problem or issue, and based on that knowledge is comfortable and willing to wait for a convenient appointment.

d) Clients who need additional support to prevent the onset of a more acute situation and are agreeable to follow-up by the crisis service.

e) Patient transfers between facilities of stable patients.

The police may choose to call the MHCT on these types of calls during service hours or may choose to fax a routine follow-up for the following day.

The Emergency Departments can contact the MHCT to provide assessment in the ER or to follow-up with the individual upon discharge.

VIII. ROLES and RESPONSIBILITIES:

All Parties Agree:

- That in-service training on topics specific to each participant's expertise will be routinely provided to one another to better serve clients with mental health problems in SD&G.

- To be part of a Mental Health Advisory committee and to meet on a regular basis to discuss local issues regarding the interaction between services and discuss and resolve problems that may arise.

1) Role and Responsibility of Police:

a) The police will endeavor to notify the appropriate hospital as soon as possible regarding a patient they have taken into custody for examination under provisions of the Mental Health Act (MHA) to provide information to the hospital and to prepare them for the arrival of the patient.

b) Patients will be taken directly to the CCH Emergency Room whenever a patient is under a Form 1 MHA or when the patient has been assessed as needing psychiatric assessment and the patient is deemed medically stable. Whenever the police are unsure of the medical stability of the patient they should request the back up of the ambulance service or take the individual to the nearest emergency room.

c) Police will remain with patients transported to the ER for evaluation under section 17 of the Mental Health Act **for a period of up to *one hour* unless** other medical emergencies in the ER make this time frame unrealistic. The transfer of responsibility to the hospital occurs when the patient is admitted to the inpatient psychiatric unit, therefore the police will be informed immediately when the decision to admit or discharge has been made. Police will communicate regularly with the ER team leader or delegate about any delays in the transfer of responsibility to the inpatient psychiatric unit. Police will remain in the ER if specifically requested to assist with an agitated, aggressive or volatile patient.

c) Police Officers will assist the staff of the MHCT, ER and Psychiatric Inpatient Unit as requested in order to assist with physically aggressive patients who pose a danger to staff or other patients. The privilege of this assistance should not be abused by hospital staff and is subject to periodic review.

d) When necessary police officers will provide stand-by assist to the MHCT and that as soon as safety is determined the police will be freed up if not required for duties under the MHA.

e) Police acknowledge the limited ambulance resources available to the community in the evening hours and as such will transport clients to the Schedule One Psychiatric Facility whenever appropriate for them to do so. It is appropriate to do so when the police have been involved in the call (MHA) with a medically stable individual whom they have transported to hospital.

f) When the police are called to assist with a MHA call, every effort will be made for the MHCT to be contacted before bringing the person to the hospital to determine if the situation can be dealt with outside of ER.

2) Role and Responsibility of MHCT:

1) That the MHCT will assist the police/ambulance/ER as requested in crisis situations with acutely disturbed mental health patients in the community and priority will be given to police, ambulance and ER calls for assistance.

2) Pages for assistance will be responded to within 5 minutes of receiving the page. The MHCT will then give an estimated time for assistance.

3) That the MHCT will provide next day assessment and short-term follow-up to clients seen by police/ambulance/emergency room when the MHCT is not available. These situations must not be urgent in nature and for clients who do not require immediate assessment/hospital admission.

4) That the MHCT will provide consultation to police, ambulance and the emergency departments with regard to heavy service users and assist to develop a management plan.

5) That if the MHCT recognizes the need for both police and ambulance assistance, then both services will be contacted concurrently and arrangements made to meet at a common location. The parties will consult regarding roles and best mode of transport for client.

6) The MHCT staff has a team vehicle and can transport clients. This applies in situations where the person does not require active monitoring or medical care and there are no perceived risks to the workers or to client safety.

3) Role and Responsibility of CCH Emergency Department

a) That ER Physician will consider a potential involuntary admission a medical emergency. The ER Physician should see such a patient as soon as possible but (at the maximum) no more than 1 hour after arrival. That all parties recognize medical trauma situations will be always the highest priority for triage.

b) That the CCH on-call psychiatrist will be available to both Glengarry Memorial and Winchester District Memorial Hospital emergency departments for telephone advice about mental health patients requiring a Schedule One facility admission. The psychiatrist may request the assistance of the MHCT in these situations.

c) That the ER will work in cooperation with the psychiatric inpatient unit to ensure that those admitted patients that cannot be immediately transferred to this unit will be monitored through hospital resources. This will be done in order to expedite the transfer of custody of the patient from police to hospital unless a risk to the safety of staff or patient is identified that requires police stand by assistance. The ER Team Leader or delegate will communicate regularly with the police about timeframes for transfer to the inpatient psychiatric unit.

d) That CCH ER will accept direct transfers from all areas of SD&G of patients assessed in the community to be medically stable and in need of psychiatric

admission in order to provide continuity of care for the patient and reduce duplication of resources and assessments.

e) Those clients who present in the off hours (0100 – 1200) and do not require admission will be referred to the MHCT for urgent follow-up (within 24 hours) when appropriate to do so.

4) General guidelines for Police/ER/MHCT interactions:

1. The CCPS / OPP would notify the MHCT via the pager system that they are in the process of dealing with a mental health situation. MHCT will inquire if this is a situation that can be handled through a mobile visit.

2. On arrival at the hospital, the triage RN would assess the client's needs. The triage nurse will then advise the ED physician of the client's arrival. If the client is medically stable, the nurse will request a referral to MHCT in order to expedite the length of stay for police.

3. If the disposition of the triage RN is such that the ED physician should first see the client, MHCT can then be called later at the physician's discretion.

4. If the triage RN's assessment is such that the MHCT can be involved prior to the client being seen by the ED physician, the triage RN would consult with the ED physician re this decision. The MHCT will then be paged to begin the intervention and assessment.

5. In #4 The triage RN, MHCT and the police will determine the safety needs of the situation prior to the MHCT assessment. As well, transportation needs post assessment will be determined at this point.

6. Once the assessment is completed, MHCT will make a full report to the ED physician for disposition. The Police will be kept abreast at all stages of the process.

5) Role and Responsibility of the Winchester District Memorial Hospital and Glengarry Memorial Hospital Emergency Department:

a. That ER physician will consider a potential involuntary admission a medical emergency. The ER physician should see such a patient as soon as possible but (at the maximum) no more than 1 hour after arrival. That all other parties recognize medical trauma situations will be always the highest priority for triage.

b. That police will transport patients requiring Schedule one facility admission, but if sedated the patients will be transported by ambulance.

c. That patients not requiring Schedule one facility admission but who require mental health follow-up may be referred to the MHCT for that follow-up.

d. To assess patients who require medications in order to stabilize them enough to remain in their home and provide treatment to those who need medical stabilization prior to transfer to the Schedule one facility. Those who are medically stable and require psychiatric admission will be taken to the Schedule one Facility instead of the local ER.

e. The local patient will be served, as much as possible in their local communities and that there is recognition that the relationships they have with local hospital staff are valuable. However clients should be encouraged to seek support and assistance by accessing the crisis line or mental health crisis team to reduce inappropriate use of these ER departments.

f. Where a person requires transport from one hospital to another, the hospital transferring the patient will make all the arrangements for transportation and will notify the receiving hospital in advance of the need to transfer. If ambulance transport is required, the request for an ambulance will be prioritized in accordance with the response categories previously described.

6) Role and Responsibility of Cornwall S.D. & G. EMS:

a) If, on arrival at the location, the ambulance service responding to a call believe the person appears to have a mental illness but does not require immediate transport to a hospital, they will contact the MHCT to assist with assessment and most appropriate management of the patient

b) If the person appears to be mentally ill and requires hospital treatment but refuses to be transported by ambulance, the police will be called and will either transport client or assist the ambulance service in the transport.

c) To ensure their safety, Form 1 MHA patients who have been sedated will require ambulance transport.

d) Ambulance paramedics will call the police if they determine they cannot provide transport without assistance.

7) Role and Responsibility of the Mental Health Crisis Line:

a) The DCO will provide a bilingual public crisis phone service for those people experiencing a mental health crisis. The DCO will have the capacity to screen and refer clients on to more specialized resources such as MHCT, Ambulance and Police.

b) The DCO will provide support to those people in crisis in our community, including those that require regular ongoing support in order to prevent a more acute crisis requiring more intensive resources.

c) DCO will determine the most appropriate resource to respond to emergency and urgent mental health situations (for example, ambulance for a medical emergency such as an overdose).

d) DCO will make referrals for others whose crisis is not an urgent mental health crisis but rather one that requires the support of other local resources such as transition houses and alcohol and drug resources as examples. The MHCT may be consulted re local resources.

IX. MONITORING AND EVALUATION:

The services provided under this protocol will be monitored and evaluated by each partner on an annual basis.

X. CONFLICT RESOLUTION:

Disputes around accessing services, ethical issues, roles and responsibilities, perceived breach of the protocol, changes arising from organizational restructuring, Ministry policy, funding changes or anything that requires adjustment of protocols, and inter-personal conflict or any dispute arising from or as to the interpretation or application of this protocol shall be resolved by the parties in accordance with the following procedure.

- Individuals most immediately involved must address conflicts. At their option they can request a third party to assist them, if:
- The resolution is beyond their decision making authority, or
- A mutually acceptable resolution is not reached within the timelines set out by the service providers in their operational protocols.

If this process does not resolve the conflict, the matter should be referred to the next level in the organization hierarchy for mediation and resolution.

XI. AMENDMENT and TERMINATION:

The terms of this protocol will be in effect unless the protocol is amended in writing with the consent of all parties.
This protocol may be terminated by any of the parties giving written notice to the other partners with 60 days notice prior to the termination.

XI. SIGNATORIES:

CCH – Director of Emergency Services

CCH- Coordinator of SD&G MHCT

CCH-Manager Inpatient Psychiatry Unit

Chief of Psychiatry at CCH

Cornwall Community Police

Ontario Provincial Police

Glengarry Memorial Hospital

Cornwall S.D. & G. EMS