Meeting of Hospital Protocol Working Group
March 8, 2012
3:00PM – 4:15PM

In attendance:

Chair: Ryan Fritsch, lawyer

Deputy Chief Mike Federico, Toronto Police Service
Uppala Chandrasekera, CHMA Ontario
Zoltan Fekete, Investigator, Public Guardian and Trustee
Irina Sytcheva, Schizophrenia Society of Ontario
Kristen Cleary, CAMH
Keith D'Souza, CAMH
Melissa Propoky, OHA
Don Wasylenki, Acute Care Alliance

Staff: Sandy Adelson, Senior Advisor, Toronto Police Services Board

Regrets: Jennifer Chambers
Laurence Wolfson
Diana Korn-Hassani

**Action items are noted in bold**.

Introductions

Ryan started the meeting by having all participants introduce themselves. Don noted that the ER Alliance is now called the Acute Care Alliance.

D/C Federico noted that Staff Sergeant Joanne Rudnick has been transferred to a Division where there is an MCIT in operation, so we have not "lost her" in terms of dealing with mental health issues. He said that we would have a new member of the Sub-Committee, S/Sgt. Steven Pipe, who carried the portfolio in community relations some years ago. He said that there would be no loss in continuity.

Minutes of January 23, 2012

D/C Federico had a suggested change on page two of the Minutes in the paragraph starting with "Ryan commented..." He said that the reference to a person being "admitted" should be changed to "when the hospital takes charge of a person." Sandy said that she would make that change in the Minutes.

**Sandy to make correction to January 23, 2012 Minutes**

Melissa asked about whether Glenna Raymond from Ontario Shores Mental Health Sciences would be attending the meeting. Sandy noted that she had been contacted and that she was joining the Working Group but was not able to attend this meeting.

Ryan noted that the reconstituted Working Group met for the first time a month or a month and a half before (note: a previous Working Group had met on a number of earlier occasions.)

Review of TPS Draft Protocol

D/C Federico said that the draft protocol discussed at the last meeting was developed by ER directors. Dr. Olive, in consultation with the Toronto Police Service worked on this but it was primarily written *by* hospitals *for* hospitals to govern the rules with respect to police admissions. He said that this protocol was then canvassed with Unit Commanders as some details require local input. He said that this was *not* an agreed-upon MOU but rather, a set of principles that hospitals can choose to follow; they are more of a suggestion regarding how hospitals can manage. He said that the hospitals involved in drafting this were St. Joe's, St. Mike's and CAMH.

D/C Federico said that this was not a binding protocol but more of a set of best practices. He said that it is uncertain whether hospitals city-wide will take up a standard protocol.

He said that with respect to the MCIT program, there is a precise MOU. He said that the local hospitals have been working with the local divisions over the years to manage issues with respect to patient transfers. He said that there is mutual agreement that the point of transfer can be an area of vulnerability for the individual as well as possible liability for the hospital. D/C Federico emphasized that the ER Directors document should not be called a protocol.

Don said that "guideline" is a good way to describe the document drafted by the ER Alliance (now the Acute Care Alliance). He said that this is not seen as official on the hospital side.

D/C Federico said that officers stay until the hospital advises them that they have taken charge of the individual; this may happen in the ER or in another room. He said he met with the MCIT teams today and the issue of transfer to hospital is even an issue for them and they have a mental health worker.

Ryan asked what the issue is that we are trying to address here. He asked whether we are trying to set up a standard policy. He said that he knows there is a public concern about not wanting to hold people for hours. He also raised some of the LHIN "upstream" issues – who are the target users and can we offer services to keep them out of the ER in the first place?

Ryan said that we need a roadmap: what is going on out there and how do we avoid duplicating what others are doing.

Members of the group expressed an interest in seeing the draft protocol that has been developed. Kristen Cleary handed out copies of the document. She said that the LHIN guideline developed by Dr. Ovens is the same one we are talking about. She said that she sits on the Community Police Liaison Committee (CPLC) for 52 and 14 Divisions and that her ER has had this protocol in place for a year and half.

Current Situation

Ryan said that we need to get a sense of what exists right now.

D/C Federico said the Service has a series of procedures which govern interaction between police and emotionally disturbed persons. In addition, we have the *Mental Health Act* which requires police to take individuals to the nearest psychiatric facility. He said that the officer must remain at the psychiatric facility until someone takes charge of the individual.

*additional note: MHA section 33 and Reg. 741 s. 7.2 excerpted here:*

*Duty to remain and retain custody*

*33.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. 2000, c. 9, s. 14.*

*Taking into Custody by Facility*

*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. O. Reg. 616/00, s. 6.*

*(2) The staff member or members of the psychiatric facility responsible for making the decision shall consult with the police officer or other person who has taken the person in custody to the facility. O. Reg. 616/00, s. 6.*

*(3) A staff member designated for this purpose shall communicate with the police officer or other person about any delays in the making of the decision. O. Reg. 616/00, s. 6.*

*(4) Where a decision is made to take the person into custody, the designated staff member shall promptly inform the police officer or other person of the decision. O. Reg. 616/00, s. 6.*

D/C Federico said that the Service has worked with hospitals locally to try to ensure that transfers are made as efficiently as possible. He said that this does not necessarily require a prescriptive document and may be as simple as a conversation. He said that if the

MCIT program is operating in a Division, officers will take the individual to a specific hospital. D/C Federico said that the police are a guest in the hospital so the hospital can dictate what the police do there, limited by the law and the condition of the subject. He said that instead of trying to create a protocol, it may be better to try to find a forum to urge the use by hospitals of a province- or city-wide protocol. He said that rather than our group developing that protocol, we can leave the work to the subject-matter experts who are already in the process of doing this.

D/C Federico said that there is a lot of variance across Toronto and that the ED Committee recognizes that there is no universal agency; it brought forth the LHIN proposal for other hospitals to follow. He said that our Working Group could help to create a forum to inform the hospitals about this. He said that the protocol could be about what hospitals can do to speed along assessment and admission.

There was some discussion about who should be taking on this kind of work. It was suggested that this should be a Ministry obligation but the LHIN seems prepared to do this kind of work.

Don raised a concern that there seems to be a significantly skewed distribution of apprehensions between hospitals. He said that it imposes a hardship on the busier hospitals. He said that this is an issue for the Acute Care Alliance (the Alliance). The data provided by S/Sgt. Rudnick was useful in terms of seeing how striking the numbers are. He said there could be many variables as to why police bring individuals to certain hospitals but he would like to better understand it and see some more equitable distribution.

Ryan said that ER Directors say that there may be "forum shopping," where officers assess where they will be admitted fastest and which hospitals are better resourced.

Don said that their data does not really support that though this was the traditional thought.

Kristen raised the example of one hospital that had 829 drop-offs in a year. She said that it was her impression that those hospitals that seem to accommodate police do seem to have a higher proportion of drop-offs. She also said she is not quite sure how the police calculate drop-offs. She said that the data needs to be looked at. Kristen said that she herself is not a member of the Acute Care Alliance but CAMH is a member hospital.

<u>Frequent Users Initiative</u>

There was some discussion about the Toronto LHIN "frequent users" initiative which the LHIN has asked the Alliance to undertake. They have identified a sub-group of 400

people who frequently use ER resources and have developed a pilot project to try and engage them. The hospitals involved are St. Mikes, St. Joe's and CAMH. The idea is to try to provide these people with alternative community supports and services. There will be a report to the LHIN with the outcomes.

In response to a question as to whether they were working with the police on this initiative, D/C Federico said that some of these people may have been brought in by police but more come into hospitals on their own.

Melissa talked a bit about the OHA, which has 154 institutions, including 70+ Schedule 1 institutions. She said their challenge would be providing something relevant to the GTA as a whole. She said that there is also an issue of relationships in some areas, especially remote ones; some relationships between police and hospitals are better than others. She said that the OHA supports a more principled, flexible approach that is enabling not prescriptive which can be moulded to each police service's individual approach. Melissa said she would be prepared to take this work back to the OHA Leadership Council so they can provide their input. She said that the OHA has not been engaged in this work.

Review of Provincial MOUs

Uppala said the Provincial Human Services and Justice Coordinating Committee is very interested in this protocol and would be a big advocate for this as they have done a great deal of work in this area last year. She noted that policing issues look very different in rural areas and that we need a protocol to be broad enough to be adaptable and useful at a provincial level.

Uppala provided an overview of research being done to create a standard intake/transfer form between police and the ER. The focus of this work is on communication – using language that police and hospital staff can both understand, and which is correlated with actual admissions. It includes a checklist that police can fill out on the way to the hospital.

D/C Federico noted that the Toronto Police Service Form 710 would be the comparable document for our Service.

Ryan asked whether the project that Uppala referred to would harmonize the criteria that police use and Uppala replied that it would support the police decision to make an apprehension. She said it would help to develop common language for both parties; she clarified that it does not *create* the criteria. D/C Federico added that it is not an enabling document.

Uppala then referred to the COAST Hamilton document that governs the Hamilton Police Service. She also referred to the document produced by the LEAD team in Southeast Ottawa, which takes a collaborative approach, including ambulance. In the case of the LEAD team, when an individual is apprehended, police dispatch notifies the hospital and includes such information like whether the police should use the regular entrance or an alternative one and makes connections to community mental health agencies so that they can also come to assist. She said that Chatham-Kent has a similar approach.

Uppala explained that these are one-offs; the documents are all different. She said that things across the province are quite localized and that it would be helpful to have some guiding principles across the province. She said that she agrees with D/C Federico that we need to approach the issue from the perspective of hospitals.

Don asked whether it was being suggested that these forms would replace the TPS Form 710? D/C Federico replied not necessarily in Toronto. He said that if the province created a form, they would have to incorporate it under the *Police Services Act* Regulations for it to be binding on all police services. He said that the TPS created the Form 710 and would be quite prepared to modify it to reflect hospital input. He said that the trouble in Toronto is that we do not have a central unified agency to approach so we end up talking to individual hospitals. He said that if there were something that everyone agreed upon, it would be helpful. He said that the development of a particular protocol and relevant procedures would rest with the particular hospital. He said that the focus is on finding a quick and easy way to assess people.

Don stated that St. Joe's is developing a form, in conjunction with the Alliance so if this is acceptable, it might be adopted by seven hospitals.

D/C Federico reiterated that the TPS Form 710 could be modified *without* provincial approval. He said that our Mental Health Sub-Committee could create a forum to reach as many stakeholders as possible, who could then develop a protocol and principles.

Kristen asked whether police officers get directed to certain hospitals when they call in. D/C Federico replied that yes, they do, especially if they are being co-directed with an ambulance. He said they typically arrive and are informed of the circumstances of a particular hospital so they may choose to go to another one. He said they would typically go to the closest one. He noted that the TPS is an organization where people move around so if they are personally aware of great service at a certain hospital, they may choose to go there. If officers are told there is a long wait, they often leave.

Don said that the Alliance would love to see a central dispatch system so that officers could be told the best place to go. D/C Federico said that there has been some discussion with EMS about possibly accessing their re-direction system; we want to introduce subjects into the system as quickly as possible. He said that the difficulty has been finding a central forum.

Ryan asked about the existing dispatch system for coordinating diversion cases. D/C Federico said that the TPS currently does that through Reconnect and CAMH, with a one-call referral process. He said it is still a noble pursuit but is an issue of capacity and the ability to staff the line, beyond the Safe Beds as well as the community capacity to receive referrals.

Kristen asked for a clarification as she has always been told that we can't re-direct police. D/C Federico said that it is a volume-capacity issue. Kristen said, then it is more like passively redirecting them, by giving them the wait time. She said that if there is no governing body and the hospital chooses not to participate for fear that they will get too many people, then others end up getting more. She said that this is unfortunate; we need police on the roads.

D/C Federico said that we are trying to find a resolution but we also need to reflect the individuality of each institution. He said that the TPS data is not completely refined and requires us to make certain assumptions.

Kristen asked whether the wait times are based on the time of apprehension or the time of arrival at the hospital. D/C Federico said that this varies, and it depends on when each particular officer recorded this information. He said that we anticipate these variances. He said that we generally ask for the time the officer arrived at the hospital and the time they were cleared. He said that he is reasonably confident that this is a good glimpse.

Don said that the Alliance would be interested in participating in some sort of project looking at a centralized call-taking process.

Kristen said a verbal report usually works well but it is clear that some officers think they have to hand off the individual to a physician.

<u>Relevant Inquests and Case Law</u>

Ryan raised the issue of when does a transfer of custody occur – does it include the psychological assessment along with the physical assessment? He said that this is an open question. He referred to a BC case that went to the Supreme Court of Canada as well as a Human Rights Tribunal case.

Uppala noted that some ERs have a person dedicated to triaging these cases. D/C Federico said that would be a rarity here in Toronto as there are resource and capacity issues for hospitals. He said that sometimes security is provided by a private contractor.

Uppala said that there is a relevant inter-ministerial initiative that has no real authority but is funnelling the information upwards. She said a guideline would need to have a multi-pronged approach.

Melissa said that in the past, the OHA has developed overarching principles and then sample guidelines, narrowed to, perhaps, three options, which can then be minimally

customized. In this way, the OHA can monitor the work. She referred to a "mental health toolkit" which is updated regularly as well as the Leadership Council which deals with a lot of these issues. She noted that Glenna Raymond (who is now part of the Working Group) is the Chair of this group and it is meeting in 6-8 weeks. She said that this would be an opportunity to reach out to them for information and/or feedback and she is happy to take that back.

Next Steps and Other Ongoing Work

Ryan said that the Working Group should review the forms and hospital policies that currently exist.

He also said that it would be helpful to look at the work being done by Ron Hoffman (Ontario Police College), which is being piloted right now.

**Uppala to contact Ron Hoffman to determine the status of his work and whether more information can be shared with our group.**

Ryan asked whether there are any other agreements between the Toronto Police Service and other hospitals in Toronto and D/C Federico replied no, other than the MCIT agreements.

The Acute Care Alliance is currently reviewing a draft created by Dr. Silviera at St. Joe's – it is hoped that the Alliance will approve it and distribute it to 7 hospitals.
Don raised a discussion about the National Ambulatory Care Reporting System (NACRS) form, which is filled out by hospital staff when an individual registers. He said this is an overarching form that includes a field to record police apprehensions; Dr. Ovens is pushing to make this mandatory.

Uppala said that the issue is bigger than just a form – what actually happens at the hospital. She said we should focus on guidelines, issues about redirecting, and who is handling this.

Ryan said that we should **pursue the idea of a central intake or coordinating process**.

Ryan said that it would be useful to **host a forum through the TPS to discuss what everyone is doing and to get hospitals together at one table to develop best practice guidelines as the basis for a protocol with individual hospitals.**

**Uppala suggested included the OPP.**

The group agreed that we want to call these guidelines, and not a protocol.

Melissa said that having guidelines would help to foster relationships in communities where relationships between police and hospitals are at issue.

The group recognizes that the jurisdiction of the Sub-Committee and the Working Group was limited to the jurisdiction of the Board; i.e., the City of Toronto. It was agreed that we would start with Toronto and then move to work with other governing bodies.

Kristen said that much of what she was to present on has been covered. She said that it is important to maintain the integrity of clients; it is important to keep them out of handcuffs. She noted that this is a strongly stigmatized population – people make assumptions about violence and mental health. She said that police in ERs is not a good situation.

Zoltan said that he was attending on behalf of his manager. He said that the Office of the Public Guardian and Trustee is not a direct stakeholder but offers a facilitated approach, with the impetus usually being financial risk. He said they really rely on the physician in a facility for a section 15 assessment related to the individual's ability to manage finances. He said the forms should have something on them to do with the Public Guardian. He said that we need the full picture of what we might know as there are other dynamics that might put an individual at risk. He said while the primary focus is the healthcare focus, secondary to that, and still important, is the issue of finances; if these are compromised, there is a big impact.

Next Steps of the Working Group

Uppala asked whether there is a LHIN lead on the ER committee. Don said that Dr. Ovens would be the closest to that and he really pushed the development of the protocol. Don said that he is the contact for the Acute Care Alliance and Kristen said that she is for CAMH.

Melissa said that she would be happy to make contact with specific hospitals.
D/C Federico said that the TPS is consistently having discussions with hospitals but not in a central forum.

Frequency of Meetings

It was agreed that we likely need two months for Ryan to reach out to people, as noted in the Minutes.

**Ryan suggested he could reach out to broader organizations, i.e. Ontario Association of Police Services Board (OAPSBs), etc.**

**Ryan to act as co-ordinator and will work with Kristen and Don to approach the other identified groups and bring them to the table. (We are already working with CAMH and William Osler, but could approach other hospitals).**

The group also agreed it would be helpful to have a member of one of the LHINs join the Sub-Committee.

**Sandy to speak to Sub-Committee about possible contacts from LHIN**

Next meeting likely to take place in early May.

SUMMARY OF DISCUSSION

Objectives of the TPS Hospital Protocol Working Group

- Facilitate a Toronto-wide forum to coordinate the development and implementation of standardized forms and guidelines between the Toronto Police Service and area Schedule 1 hospitals to improve the transfer of Mental Health Act apprehensions to Emergency Room services
- Develop such standardized forms and guidelines by building on existing efforts (including current TPS forms/policies, individual hospital policies, and pilot projects at the LHIN and Acute Care Alliance, etc.) and in consultation with subject matter experts and researchers and persons with lived experience
- Investigate the development of a dispatch and referral infrastructure coordinated with area hospitals to more equitably distribute demand on area ER resources, expedite transfer of the apprehended person, and reduce redirects
- Consider expanding the conversation to provincial-level stakeholders once a framework is in place

Action items:

- Next meeting tentatively scheduled for May to bring together a wider table of stakeholders, particularly the area Sch1 hospitals and Toronto LHIN
- Sandy to make correction to January 23, 2012 Minutes

- Ryan to act as co-ordinator and will work with Kristen, Don and D/C Frederico to approach the other identified groups and bring them to the table (We are already working with CAMH and William Osler, but could approach other hospitals).
- Uppala to contact Ron Hoffman to determine the status of his research and whether more information can be shared with our group.
- Ryan to gather up existing documents and statistics and distribute to members of the working group in advance of the next meeting
- Ryan to work with Jennifer to bring additional voices with lived experience to the discussion
- Sandy to speak to Sub-Committee about possible contacts from LHIN