

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

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Part 1: Introduction

Neither the mental health system nor the law enforcement system can manage mental health crises in the community effectively without help from the other (Lamb et al, 2002).

This report closely examines one step in the journey of a suicidal individual through the Emergency Medical System in Ontario: The interaction between police forces and hospital emergency departments in Ontario during the period between apprehension of the patient and the police officers' departure from the hospital. In particular, this paper seeks to answer three questions about day-to-day practice (as opposed to theoretical or study conditions):

- What is working well?
- What is not working well?
- What improvements are necessary?

Rather than "how SHOULD these systems work together", this paper seeks to answer the question "how do these systems REALLY work?" by focusing on the nature of the everyday relationships and the stresses and strains at the interface between the law enforcement and hospital systems.

1.1 The Extent of the Problem

Suicide is a complex set of behaviors that exist on a continuum from ideas to action [Mayo Clinic]. Though not a mental illness itself, suicide is a potentially devastating consequence of many psychiatric disorders (affective disorders, substance use disorders and schizophrenia are most commonly associated with suicidal behavior), as well as medical disorders (and the medications used to treat them). Suicide can also be a consequence of conflicts and losses (e.g. disruption of an important relationship) particularly in those individuals already vulnerable due to social isolation, limited social support, and/or a psychiatric disorder. Common to all patients with suicidal behavior is intense mental pain and anguish characterized in part by depression, hopelessness and helplessness, and a feeling that life is unbearable (See Table 1 below).

Suicidal behaviour is an important, recognized, and preventable public health problem. Across Canada, suicide is one of the leading causes of death in both men and women from adolescence to middle age (Health Canada, 2002). In 1998, for example, suicide accounted for one-quarter of all deaths among individuals aged between 15 and 24, and 15.9% of all deaths among individuals 25-44 years old (Health Canada, 2002). On average, three people die of suicide and self-inflicted injuries every day in Ontario (CIHI, 2001). Suicide is third among causes of potential years of life lost among men, and sixth for women (Health Canada, 2002).

The actual number of suicide deaths may be considerably higher, because of difficulty assessing whether a death was intentional, or because information about the nature of the death becomes available after the death certificate was completed.

The figures for suicide *attempts* are considerably higher. It is estimated that 11.5% of the population will consider suicide in their lifetime, and 3.6% will attempt it. Nine percent of all adolescents report having made at least one suicide attempt (Health Canada, 2002).

Table 1. Patients At High Risk Of Suicidal Behaviour [WHO, 2000]

Individual and sociodemographic factors:

- Psychiatric disorders (generally depression, alcoholism and personality disorders);
- Physical illness (terminal, painful or debilitating illness, AIDS);
- Previous suicide attempts;
- Family history of suicide, alcoholism and/or other psychiatric disorders;
- Divorced, widowed or single status;
- Living alone (socially isolated);
- Unemployed or retired;
- Bereavement in childhood.

If the patient is under psychiatric treatment, the risk is higher in:

- Those who have recently been discharged from hospital;
- Those who have made previous suicide attempts.

In addition, recent life stressors associated with increased risk of suicide include:

- Marital separation;
- Bereavement;
- Family disturbances;
- Change in occupational or financial status;
- Rejection by a significant person;
- Shame and threat of being found guilty.

1.2 Method

Information was drawn from three groups of sources:

1. Literature Search

Literature search was conducted through Medline and relevant articles were reviewed. Books, articles, opinion pieces, and suicide policy statements by organizations in Canada, USA, and other places in the world (notably England, Australia and New Zealand) were also reviewed. These were culled through Internet searches (primarily Google) and suggestions offered by correspondents in the course of data collection through Medline.

2. Stakeholder Survey

Responses to a survey from police, community mental health services, hospital services, and families, turned out to be a rich lode of information and experiences, and form the core of this report.

3. Inquests Reports

Inquest Recommendations from cases involving suicides were requested from all ten provinces and territories.

1.3 The Most Important Page Of This Document

When you go to heaven,
you'll find that most of the front seats
are occupied by people
who weren't such big shots down here.

Attributed to Louis Safian

The survey and inquest recommendations to follow -- the bedrock of this report -- contain a fair amount of criticism. And the subjects of such criticism, in reading what is to follow, may react as did a crisis worker who reviewed a draft of this paper:

Don't misunderstand me when I say this, but, this was exhausting to read. Nothing to do with the style, just the seemingly limitless number of criticisms from stakeholders, misunderstandings of the MHA (primarily from the police).

I'm sure my reaction comes primarily from working in the field for so many years and feeling, as you described very well, helpless and essentially burned out...

Also, reading all the comments in the first half -- given that our program provides above average care, it was difficult to feel so criticized by the police when they refer to "crisis workers" etc.

I wish to make clear that the recommendations of this document are all predicated on the belief that those on the front line of service delivery -- police officers, doctors, nurses, crisis workers, psychiatrists, community mental health clinicians -- are committed to excellence in their chosen field, and give their best effort each day to serve the public (whether "client" or "patient").

To all these individuals -- who will occupy the aforementioned "front seats" above -- this document is dedicated, in the hope that the frank observations recorded herein, and the recommendations that come from them, will help to make available the resources and cooperation they need.

Part 2: Review of the Literature

2.1 Police

The rationale for the police to intervene in the lives of persons with mental illness derives from two common-law principles: the power and authority of the police to protect the safety and welfare of the community, and the state's paternalistic or *parens patriae* authority, which dictates protection for citizens with disabilities who cannot care for themselves, such as those who are acutely mentally ill. Often both principles are involved when police are dealing with persons with mental illness who pose a threat of danger to the community or to themselves (Lamb et al, 2002).

With regard to the role of the police in mental health emergencies, the police are acknowledged as "front-line mental health workers" (Matheson, 2002), and are

...Typically the first and often the sole community resource called on to respond to urgent situations involving persons with mental illness. They are responsible for either recognizing the need for treatment for an individual with mental illness and connecting the person with the proper treatment resources or making the determination that the individual's illegal activity is the primary concern and that the person should be arrested. This responsibility thrusts them into the role of primary gatekeepers who determine whether the mental health or the criminal justice system can best meet the needs of the individual with acute psychiatric problems (Lamb et al, 2002).

In Ontario, police can bring an individual to hospital either voluntarily (in which case police are not legally obliged to stay), or involuntarily, through apprehension under the Mental Health Act. If the latter, they usually must remain for an orderly transfer of custody to the hospital.

The literature clearly documents two overarching frustrations of the police at this interface between police and hospitals – the interface which is the focus of this report: First, there may be long waiting periods in the hospital ER until the apprehended individual is assessed. During this wait, the officers are obliged to stay with the patient, and the officers are unavailable for other duties (Lamb et al, 2002; Matheson, 2005).

Second, after all the waiting...

Mental health professionals may question the judgment of police officers and refuse to admit the person, or they may quickly release a person who just a short time earlier was thought by the police to constitute a clear menace to the community (Lamb, 2002).

.... This revolving-door situation means that police officers encounter many of the same individuals again and again in the community (Matheson, 2005).

Police often perceive they are unwelcome and their observations and opinions are not valued or dismissed. This experience is not restricted to North America:

In the UK, police reported that they were not treated professionally and that the medical staff did not always consider or make use of their knowledge of the individual and the situation... (Adelman, 2003)

Police generally have a more collegial relationship with health care staff of mobile crisis teams. There are four basic models for mobile crisis teams (Lamb, 2002):

(1) [The "Memphis Model:"] Police officers with special mental health training...provide crisis intervention services and ... act as liaisons to the mental health system.... This

model places a heavy reliance on psychiatric emergency services that have agreed to a no-refusal policy for persons brought to them by the police... .

(2) Mental health consultants who are not police officers are hired by the police department. These consultants provide on-site and telephone consultations to officers in the field.

(3) Psychiatric emergency teams of mental health professionals who are part of the local community mental health service system but have developed a special arrangement with the police department to respond to special needs at the site of an incident.

(4) Teams composed of both specially trained sworn police officers and mental health professionals employed by the local community mental health department.

2.2 Suicide Risk Assessment

One source of conflict between police and hospital ER services is disagreement about the patient's degree of suicidal risk. Typically, the police bring an individual they believe to be at high risk of suicide to an ER, but the ER physician discharges the individual.

The state of the art of suicide risk assessment can be stated simply:

Clinical assessment remains the essential element of suicide risk assessment (Links and Hoffman, 2005).

Rating scales may inform or guide interview questions, but no rating scale or questionnaire is a substitute for the clinical triad of interview, mental status examination, and collateral information, followed by a clinical formulation and risk assessment.

The key role of collateral information, a point germane to our coming discussion, is supported by practice guidelines:

Although obtaining collateral information is useful with all suicidal individuals, in the emergency setting such information is particularly important to obtain from involved family members, from those who live with the patient, and from professionals who are currently treating the patient. Patients in emergency settings may not always share all of the potentially relevant aspects of their recent symptoms and their past psychiatric history, including treatment adherence. In addition, most psychiatrists who evaluate patients in emergency settings do not have the benefit of knowing and working with the patient on a longitudinal basis. Corroboration of history is particularly important when aspects of the clinical picture do not correspond to other aspects of the patient's history or mental state (American Psychiatric Association, 2003).

These practice guidelines make particular mention of the patient brought by police:

The process by which the patient arrived at the emergency department can provide helpful information about his or her insight into having an illness or needing treatment. Typically, individuals who are self-referred have greater insight than those who are brought to the hospital by police or who reluctantly arrive with family members. For individuals who are brought to the emergency department by police (or as a result of a legally defined process such as an emergency petition), it is particularly important to address the reasons for the referral in estimating suicide risk (American Psychiatric Association, 2003).

Obtaining information from the police is mandated in Ontario's Mental Health Act, under Section 7, "Taking into Custody by Facility":

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.

2.3 The Unpredictability Of Suicide, And What The Courts Expect From Doctors

Demographic, diagnostic, and other factors identify groups at increased *risk* for suicide, but "we do not possess any item of information or any combination of items that permits us to identify to a useful degree the particular persons who will commit suicide (Pokorney, quoted in Goldney, 2005)." Put more bluntly, "the assessment of suicide risk does not mean *prediction* of risk, because the latter is not yet possible (Goldsmith et al, 2002)."

Some of the reasons are summarized by Slavney (1996):

One problem is that the risk factors identified in long-term epidemiological research may not be useful in the prediction of short-term individual behavior. Knowing whether or not a patient belongs to a high-risk group (actuarial information) is less helpful than knowing whether or not he intends to take his life (clinical information). Similarly, knowing what might happen in the next year is less helpful than knowing what has happened in the last week.

Prediction is difficult even when recent events are taken into account. Stressful circumstances are frequent in the weeks and months before suicide, but they have little value as warning signs. Although suicide is associated with unhappy relationships in the young, financial concerns in the middle-aged, and medical illnesses in the elderly, many people have such troubles and never take their lives.

Another methodological problem, then, is that suicide is uncommon, even among those belonging to groups at increased risk. Although suicide attempters in the first year after self-injury are much more likely than members of the general population to take their lives, only 1% of them actually do so. With a behavior as rare as this, it may be difficult to identify those few individuals whose risk will be realized.

The effect of a low base rate on suicide prediction has not been overcome by the use of scales derived from multiple risk factors. The difficulty in designing such instruments has been to strike a balance between sensitivity and specificity: if the former is emphasized (in order to reduce fatalities), there are too many false positives; if the latter is emphasized (in order to reduce unnecessary treatment), there are too many false negatives. Suicide prediction scales are valuable because they remind clinicians to inquire about the behavior, but they omit considerations (e.g., religious beliefs) that make it unlikely.

Thus the clinical goal for the ED physician's suicide risk assessment is "not to predict suicide, but rather to place a person along a putative risk continuum, to appreciate the bases of suicidality, and to allow for a more informed intervention (Links, 2002)."

The courts have recognized the impossibility of predicting who will suicide, and expect clinicians only to use reasonable prudence that other professionals would exercise in similar circumstances (Goldsmith et al, 2002).

The courts have long recognized that medical practitioners are not expected to be infallible in their predictions as to human behavior. As one court put it, all who are called upon to predict human behavior recognize the near impossibility of doing so with confidence. If an attempt at suicide may be said to establish an error in judgment on the part of anyone assessing the risk of that event who does not anticipate it, then errors in judgment are endemic in the assessment of the risk of suicide. Even the best judgment of a skilled psychiatrist will frequently be wrong. As a result, the courts will distinguish between the breach of a standard of care and a mere error in professional judgment,

recognizing that mistakes can happen and they are often.... only identifiable in hindsight (Miller Thomson LLP, 2002).

2.4 Effective Interventions

The low base rate of suicidal behaviors makes it “virtually impossible, at the very least with conventionally available resources, to mount the huge studies that would be necessary to have sufficient statistical power to demonstrate differences in outcome of different treatments, even if it was ethically possible to do so” (Goldney, 2005). It is no surprise, then, that “no one has demonstrated an enduring causal relation between purposeful interventions and reduced suicide rates” (Thompson, 2005).

This should not lead to therapeutic nihilism:

About all we can say now is that there is an absence of evidence for a positive effect—which is a different thing. That is, we do not know the effect on suicide rates of removing all psychiatric services.... It is highly likely that several societal and service factors keep the “resting level” of suicide from being higher; these include the work of psychiatrists and other mental health professionals, family support, community organizations, social structure, and perhaps, random acts of kindness (Thompson, 2005).

Interventions focused on treating well-known suicide risk factors should reduce the risk of suicide. Links and Hoffman (2005) note psychiatric disorders are “almost universally found in victims of suicide.” The presence of a psychiatric or substance use disorder is second only to a history of previous suicide attempts in the elevation of lifetime suicide rate.

Table 2: Lifetime Suicide Rates (APA, 2003)

	Estimated Lifetime Suicide Rate (%)
General population	0.72
Previous suicide attempt	27.5
Major depression	14.6
Mixed drug abuse	14.7
Bipolar disorder	15.5
Dysthymia	8.6
Obsessive-compulsive Disorder	8.2
Panic disorder	7.2
Schizophrenia	6.0
Personality Disorders	5.1

Further, there is evidence for the benefit of some interventions in specific subpopulations at risk (Links and Hoffman, 2005), e.g.:

- Clozapine for individuals with schizophrenia at high risk for suicide.
- Lithium as maintenance therapy for patients with bipolar affective disorder at risk for suicide.
- Intensive intervention with dialectical behaviour therapy, cognitive-behavior therapy, or problem-solving therapies for patients with recurrent suicidal behavior.

Psychiatric Hospitalization

Hospitalization, by itself, is not a treatment. Rather, it is a treatment *setting* that may facilitate the evaluation and treatment of a suicidal person (American Psychiatric Association, 2003). The decision to hospitalize a patient at risk for suicide is complex and involves not only a suicide risk assessment, but also consideration of other factors, such as possible negative effects (disruption of employment, financial and other psychosocial stress) and willingness to cooperate with treatment.

There is no empirical evidence that psychiatric hospitalization reduces the incidence of suicide in the long term (American Psychiatric Association, 2003), and in some situations (particularly some personality-disordered patients), hospitalization can be regressive or counter-therapeutic (Lambert, 2003).

The literature on police/mental health liaison, however, cites ready access to mental health services (including, but not limited to, hospitalization), as key to the effective functioning of most models of collaborative care:

... Ideally, police and mental health systems would develop a no-reject policy, meaning that if a police officer needed support from the mental health system – for instance, if he or she felt there was a need for a hospital bed – then there would be some guarantee that the services would be available. Particularly when people have concurrent disorders and other serious and complex needs, the no-reject or no-refusal feature is identified in the literature as a characteristic of an effective plan. Having access to a specific program for dealing with concurrent disorders, notably mental illness and addictions, is also seen as a characteristic of an effective program. Having these options makes it more likely that police will divert people out of the criminal justice system and into the mental health system when they perceive that a person is at risk.

A range of strategies has been developed to deal with this issue. In some cities, police programs have preferred status in hospital emergencies. One defining characteristic of the [Memphis] CIT program is that if a person requires hospitalization, officers can leave consumers at the hospital within 15 minutes of arriving, as set out in Memoranda of Agreement that exist between the Memphis police and the University of Tennessee Medical Center. There is a no-refusal policy in place at the medical centre, so that if officers have assessed and defused a situation and decide that the individual is in need of treatment, the Center accepts responsibility for ensuring that the person's needs are met. The medical centre also has an agreement with the state hospital not to refuse any patient that meets minimum commitment criteria (Adelman, 2003).

Rhodes describes another strategy:

In a study of persons admitted to hospital for the first time for deliberate self-harm, those in the treatment arm were offered a “green card” upon discharge, which stated that a doctor was available at all times and encouraged the subject to seek help at an early phase of problems by either calling or going to the emergency room for potential inpatient admission....

After 1 year, the proportion of repeaters in the experimental arm was lower than in the control group (5% versus 11%), and this difference was statistically significant when persons who made serious threats were included (5% versus 13.5%). Interestingly, only about 15% used the green card for a total of 19 times, and 15 of these contacts were by phone (Rhodes, 1998).

It should be emphasized that “no refusal” refers to access to services in general, not solely to whether the patient is hospitalized.

2.5 Conclusions

- (1) Police, by virtue of their role as first-line responders to patients in crisis and their powers to apprehend under the Mental Health Act, have a role in the mental health care system.
- (2) Suicidal behavior is essentially unpredictable. Clinical assessment of suicidal risk remains the standard of care.
- (3) Such an assessment requires diligence in obtaining collateral information.
- (4) Police who bring a patient to the ER, though a logical source of collateral information, often perceive their input as unwelcome and undervalued.

Absent from the literature are studies closely examining the interaction between the apprehending police officers and the hospital staff conducting the suicide risk assessment. This is the focus of the stakeholder survey discussed in the next section.

Part 3: Survey of Stakeholders

3.1 Introduction

The core of this report consists of responses to a survey from three groups of stakeholders:

1. **Police:** Responses were solicited through a nationwide Police-Mental Health email list, and through direct mailings to Chiefs of Police in Ontario.
2. **Community mental health services:** The survey was mailed (or emailed) to all Ontario offices of the Canadian Mental Health Association (CMHA).
3. **Hospitals:** The survey was mailed to chiefs of Emergency Departments, and chiefs of Psychiatry departments, of all Ontario hospitals.

Additional groups surveyed but for which few responses were received:

- Patients and families (through a nationwide suicide-survivors mailing list).
- Ontario Crisis or Distress Lines.
- Ambulance Services (EMS) in Ontario.

Recipients of the survey were encouraged to distribute copies to other interested parties. To facilitate this, a copy of the survey was posted on the Internet (but not listed in search engines).

The survey:

"Thinking of the relationship between **police departments** and **hospital emergency services** in your community with regard to the suicidal individual,

1. What is working well?
2. What problems remain?
3. In what ways could current policies and practices be improved?
4. What new policies, practices and resource are needed?

Respondents were asked to write in their responses. Most responses were either emailed or faxed to me. Follow-up for clarification, where necessary, was done by email, fax or telephone.

Each issue or concern identified by a respondent was treated as a distinct data point, and then collated under relevant topics. Since many surveys included more than one response per question, the total number of responses for any question is greater than the number of surveys received.

Answers for questions 3 and 4 are combined in the following analysis, as most respondents did not make a distinction between *current* and *new* policies and practices. Respondents rarely duplicated the content of their response in both questions 3 and 4.

Number of Surveys Returned:

Police	170 responses*
Emergency Departments	16 (3 from Toronto)
Psychiatry Departments in Hospitals	8 (2 from Toronto)
Psychiatrists	5 (2 from Toronto)
CMHA	11
Family members and others	4
EMS	3

* Includes 54 individual surveys, and 1 summary report from OPP Peel collating 116 individual surveys

Responses from all Police, E.D.s, Psychiatry Departments and CMHA were often noted to be the product of contributions from many individuals. Thus, the total number of *individuals* contributing to the survey is greater than the total number of survey responses.

About the data which follows

The survey responses are presented below. Respondents were grouped into three main categories:

- Police
- CMHA
- Hospital (includes psychiatrists, psychiatry departments in hospitals, and Emergency Department respondents)

Each stakeholder group's response to Question 1 ("what is working well?") and Question 2 ("What problem remain?") is presented. Then, each stakeholder group's combined response to Questions 3 and 4 (recommendations for change) is presented. For each question, a summary of responses, in both tabular and pie-chart forms precedes the actual responses.

Fewer responses were received for the remaining two categories of

- Family members and advocates
- EMS

Where available, responses for these groups are presented, though numbers were too few to warrant tabular or pie-chart presentations as well.

All responses, except where noted, are reproduced verbatim. I have editing for brevity where necessary, deleted identical responses, and removed identifying information. There is a lot of material here, but I encourage the reader to study the verbatim responses as well as the summary information. Respondents were encouraged to provide details of their views and experiences, and their responses convey a sense of immediacy and thoughtfulness that is inevitably lost in tabulations.

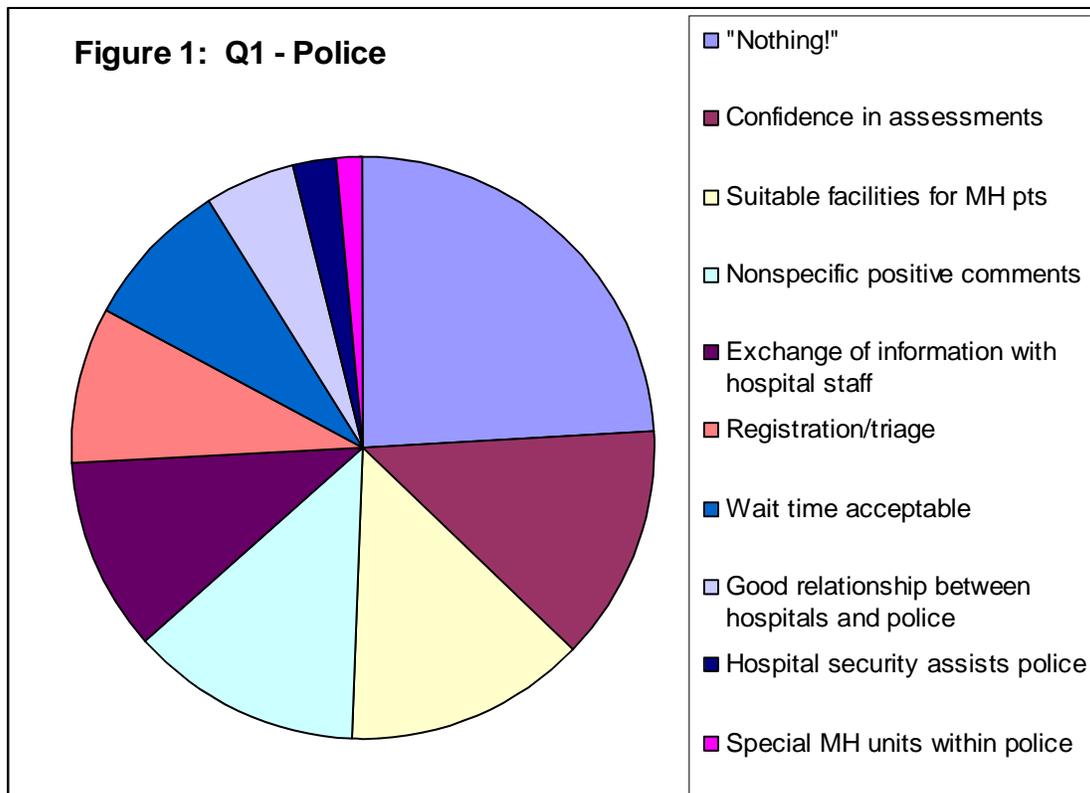
Abbreviations:

MCIT	= Mobile Crisis Intervention Teams (a.k.a. Mobile Crisis Teams)
MH	= Mental Health
MHA	= Mental Health Act
PHIPA	= Personal health Information Privacy Act
SMI	= serious mental illness
"formed"	= shorthand for "placed on a Form 1"

3.2 Police Responses

3.2.1 Q1 “What is working well?” 158 responses

<i>Category of Response</i>	<i># Responses</i>	<i>% of Total</i>
“Nothing”	38	24.1
Confidence in assessments	21	13.3
Suitable facilities for Mental Health patients	21	13.3
Nonspecific positive comments	20	12.7
Exchange of information with hospital staff	17	10.8
Registration/triage	14	8.9
Wait time acceptable	13	8.2
Good relationship between hospitals and police	8	5.1
Hospital security assists police	4	2.5
Special Mental Health units within police	2	1.3
	158	100 %



"Nothing"

In 38 surveys, the response to Question #1 consisted of the single word "Nothing".

Psychiatric expertise, quality of assessments

Having multiple qualified persons examining MH patients has assisted Police in demonstrating need for further assessment of MH patients.

Having MH workers on staff has been an appropriate move by the hospitals to assist with the assessment of MH patients that are brought to the emerg.

Doctors are willing to admit people overnight for observation, which decreases recidivism.

Doctors are available 24/7 to assess people.

On facilities

Schedule 1 hospitals are equipped with proper seclusion rooms and surveillance cameras for emotionally disturbed or suicidal people.

...Usually room in the two rooms provided for MHA patients.

The hospitals quickly have a room available in the emergency area for the patient and a nurse is in quickly to take the preliminary info.

Triage nurses recognize that when officers have concerns about a "violent" person, rooms are being prepared in advance of arrival.

On waiting time and prioritization of mental health cases

A quick assessment by hospital leading to issue of Form 1.

Having social workers on standby at ERs greatly assists officers who attend the hospital with an EDP. [*Writer later clarified this comment as follows: Social workers can act as a 'go between' for the Police when dealing with hospital staff, or provide additional support by means of arranging alternatives to detention, or to provide some type of follow-up or home visits*].

For the most part, police do not have to wait to see a Doctor. Medical staff is very accommodating and typically meet with officers and take the time to assess our subjects quickly.

If a person is displaying obvious mental health problems then the hospitals will take them without too many problems.

SOME doctors take mental health apprehensions with some sense of priority.

Hospitals are attempting to have police with MHA patients at the top of their list when they attend the emerg.

Having a triage nurse attend for the initial assessment, I find, expedites the assessment for the Doctor and decreases the time spent at the ER for the Police.

What works well is when hospital staff is notified police are bringing in MHA person and see to it that Crisis nurse or doctor sees MHA person ASAP. It would be nice for MHA person to be then turned over to hospital security in order to free up officers.

On the overall working relationship with hospitals

Joint mental health crisis committee involving hospital admin, ED managers, CMHAs and local police agencies.

Communication between higher-level managers at the hospitals and police service has increased significantly in the recent days due largely in part to the creation of a Mental Health Liaison Officer position.

Any formal or informal working relationship between a hospital and a police service is invaluable when it comes to addressing problems that arise.

PALCs (Police Ambulance Liaison Committees) are very effective in 'nipping problems in the bud' when procedural or personnel conflicts arise.

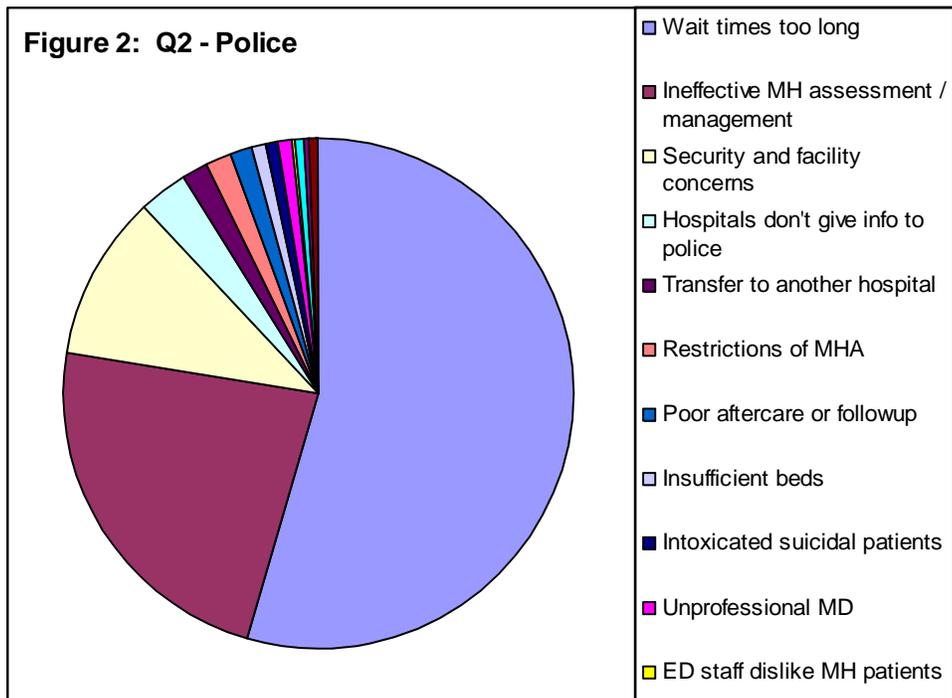
Although there is no written protocol, there is a clear understanding between hospital management and detachment supervisors as to what course of action is to be taken in cases involving mental health patients.

3.2.1 Police responses to Q2: “What problems remain?” 235 responses

“Though we are now being invited to the table to help assist in alleviating the present problems, [there is still a] need for services to understand that we are the common denominator with all services.

“I could go on and on; however, I haven’t the time for something that I feel will not improve over the course of my time left with the OPP.”

Category of Response	# Responses	% of Total
Wait times too long	128	54.5
Ineffective MH assessment / management (includes 29 responses citing hospitals ignoring police input)	54	22.9
Security and facility concerns	25	10.6
Hospitals don't give info to police	7	3.0
Transfer to another hospital	4	1.7
Restrictions of MHA	4	1.7
Poor aftercare or follow-up	3	1.3
Insufficient beds	2	0.9
Intoxicated suicidal patients	2	0.9
Unprofessional MD	2	0.9
ED staff dislike MH patients	1	0.4
ED staff dislike police	1	0.4
Police presence aggravates patients	1	0.4
Doctors unfamiliar with MHA	1	0.4
	235	100 %



Wait times

[Some respondents cited waiting times of "between 1 and 4 hours", "up to 6 hours", "8 hours", and "up to an entire 10 hour shift."]

If the police bring them in, it is because they meet the criteria for arrest and assessment under the Mental Health Act. To make the police wait around hours until a decision is reached is a taxing drain upon our resources that also has public safety issues.

TIME, TIME, TIME, TIME, TIME....

After Police deal with the MHA patient, then we WAIT to see emerg physician, then if the patient is formed, we transport to facility where we again WAIT to see if patient is accepted by psych.....

I have no problem with the process, and our time has been cut in half from 15 years ago, but it is still a lengthy process that could be shortened.

Police continue to watch patients who have been formed by the hospital as the hospital fails to have enough staff on hand.

WAY TOO LONG OF A WAIT! There's absolutely no need for us to wait so long to be seen by crisis team. When they finally see the person, I see that the decision-making is more on whether a bed is available but not true need for the individual.

"Night shifts:" If a patient is brought into a Schedule 1 facility after the Crisis Teams have gone for the evening, the officer is left to baby-sit the patient until the hospital accepts them. With the constraints that the emergency departments face they will often leave the patient in the custody of the officers until the Psychiatry department comes back in for shift. NOT ACCEPTABLE!

There are not enough psych. facilities (beds) to take these patients. This causes a lot of logistic problems and frustration. For the police it requires officers on duty to stay with the patient and/or other officers to be called in on overtime or on a paid duty. Sometimes police guard patients from a few hours to several days before the patient is admitted to a psych. facility.

Waiting time to be seen by a doctor is often too long. When seen it is often way too long to get a bed for the patient for his assessment which means police have to guard till bed is available. Young people have to wait the longest. Police resources are spread too thin.

In smaller communities, there may only be one to three officers providing service at a time. As a result, if an officer must transport someone to hospital and is required to wait several hours with the individual, policing levels and the ability to respond in the community are affected.

Police and the suicidal individual often must wait longer than if the individual presented to emergency on his or her own. The perception on the part of hospital staff appears to be that if the suicidal individual is in police custody, their safety, as well as that of staff and other patients, is ensured. This seems particularly true if the individual is intoxicated, aggressive or is known to emergency staff. However, having an officer waiting in emergency rather than on patrol affects the safety of the other members of the community.

Police Responses to Q2 "What problems remain?"

Inconsistent response/priority from emerg staff, physicians in particular, for mentally ill individuals apprehended by police. Not a priority for many physicians resulting in long wait times on many occasions.

Having to wait several hours while a second assessment is done at the receiving psychiatric facility even though a [mentally ill] person is being brought in on a Form 1 already signed by a qualified physician.

In one Detachment the Hospital policy is that the "suicidal person" must be seen when sober. Often that person is sober in the early hours of the morning and the hospital will not call a doctor in to see that person until a reasonable hour of the morning. Some clients then question police as to why they are being held when sober and request to see a doctor right away for assessment.

In one Detachment Emergency Room staff are not particularly friendly with police. The Detachment Commander has spoken with hospital administration in hopes of cutting down the hours officers spend waiting to see a doctor. Officers can wait upwards of 4 hours waiting for a doctor to see the subject. Attempts have been made to phone first to determine when hospital staff is ready for the police; this also has not been working. Officers understand the need for emergent patients to get priority, however it would be of great assistance for emergency workers to make attempts to get officers in with patients in a reasonable amount of time.

Ineffective ER MH assessment / management

I have yet, in two years, had a subject committed. This includes the following specific occurrences: A female who slit her wrists over a traffic ticket following first contact. She used a broken cassette tape holder to conduct this. Following evaluation, released good to go. Secondly, a female stopped for speeding, evasive not responsive. Admitted thinking about intentionally driving into a culvert to commit suicide. Evaluated, released. Thirdly, male on anti-depressants and 98mgs alcohol intentionally drove vehicle into guardrail attempting same as above despondent over recent breakup. Evaluated after breath tests; released. Fourthly, male advising two people of thoughts of suicide supposedly armed with a gun or knife. Apprehended male at service center with knife within reach on front seat, confirming information. Also admitted being upset over financial ruin and recent break up. Evaluated, released.

It is my opinion [that] the physicians are taking a calculated risk, and are in turn, putting the public at unnecessary harm. These were sure cases where, to admit for further evaluation would have been the proper course of action. We can say that the police aren't trained in evaluating to that level. Then we can look at [name deleted], where members in our detachment, were faced with having to gun down an 18-year-old male, who just left the hospital when troubled.

The demeanor of the staff, specifically, busy doctors, and the on call crisis nurse on our last apprehension, was deplorable. They were more concerned with which agency was going to transport the subject if admitted, than the actual health of the subject (male with knife). The nurse attempted to have police transport to a [psychiatric facility] to have male evaluated, quoting the fact that the original information came from [that location]. The Mental Health Act was recited to the nurse, who in turn, relayed this information to the doctor, that the police are obligated to transport to the nearest facility for evaluation, that being [another location]. Both the doctor and the nurse were less than receptive. In fact, the doctor had absolutely no conversation with the officers, until after the evaluation where he stated "He's good. I'm happy," or words to this effect.

Patients brought in by police for bona fide reasons under the Mental Health Act are being released after what appears at least to this lay person [as] insufficient assessment. [Recently] we had to deal with the aftermath of a suicide because the patient was released from hospital after being brought in by officers the night before. This was the second time that the patient was taken to hospital for assessment following a suicide threat/attempt. Often the patient is not even seen by a psychiatrist and is released based upon the assessment of a lesser-trained professional. More often than not, this appears to me to be the case because there are no beds available to deal with the patient.

Often by the time the patient is examined he/she has calmed down and is no longer exhibiting the behaviour, which was the cause of his initial detention. The patient is therefore not admitted to hospital leaving police to return the patient, usually to the location where the initial stressors were, and may still be present. Police officers often feel that because they are responsible for, and have to remain with, the patient until admission that examination of the patient takes a lower priority.

Individuals with mental health issues may not receive the assessment and treatment needed because it is often faster to hold someone in custody rather than have the individual assessed by a doctor in emergency. In some situations, the standards, policies and procedures of police and emergency are incongruent. If a doctor makes the decision not to form or admit a suicidal individual, this does not mean that the police's role with that individual is completed. In many cases, police are often left with the task of deciding the most appropriate course of action to address the situation and the individual's safety. If a lack of resources or knowledge about local resources exists, police custody may be the only feasible option. However, holding a suicidal individual in police custody rarely meets the immediate needs of that individual, does nothing to address the precipitating factors or level of risk, and creates unnecessary work for police.

Local mental health professionals do not seem to use risk assessment tools relating to suicide risk. People are released from care to self-medicate. Many of the suicides we attend involve people who have had initial treatment but were not admitted to hospital.

Suicidal individual continue to be discharged just hours after they are formed regardless of how many times they repeat their attempts/threats.

In [date deleted] a 16-year-old male had used a butcher knife to threaten his parents and damage the family home. He described to the officers who responded to the call that he wanted to stab his mother in the back 'over and over and over' because he hated her so much. He was hearing voices in his head and his parents explained to the officers that they had hidden all the knives in the house and removed all flammables as he had threatened to burn the house down with them in it. He was on [5 psychiatric medications]. He had been assessed by [another hospital] and they voiced their concerns about his behaviour. The doctor who examined him put it down to his age and declined to Form 1 him. He was eventually charged with a number of criminal offences and the presiding Judge sent him to the [psychiatric hospital] for a 90 day assessment. All charges were later discharged.

The ... perception that the health care system is merely a revolving door for folks with mental health issues proves time and time again to be accurate.

CANADA is unique, for it falls short with the current interpretation of Charter Law being unable to FORCE someone who desperately needs meds, to actually have to take them...

Police Responses to Q2 "What problems remain?"

The health care system MUST go the route of public pressure, and get the word out. High risk, prone to violence, psychotic and dangerous individuals are time and time again afforded the right to write their own ticket...

The police are left to clean up the mess.

The police are called into dangerous situations, 'take care of business' and then are left to sit on the sidelines and watch as the person is again released absent treatment and enter society as a ticking time bomb...

When was the last time there was a study that indicated what we are doing with the individuals (i.e. for the most part "apprehending" under the MHA and taking them to a schedule one facility) is actually of any value? It's time to examine real alternatives that are less cumbersome to police and most of all to the clients who require assistance.

The main problem from our standpoint is that mental health issues become criminal problems because doctors appear to be reluctant to use the powers they have under the Mental Health Act. As police officers we are told that they will not Form 1 the suicidal individual because "they are just acting out", or "they are not a danger to themselves right now". Of course they are not when they are in police custody but the suicidal individual knows that if they say the right things the doctors will decline to use the Form 1 provisions. If the police report to the physician that an individual is attempting suicide after having consumed alcohol or drugs then the physician will often chalk it up to being drug induced behaviour but they fail to realize that that behaviour will continue if they are not apprehended in one way or another and then it becomes a police matter when it should be a mental health matter.

It seems that the only thing all the involved agencies are doing is protecting themselves from future suits rather than protect the individual.

Some Hospital emergency departments in the Northwest Region are staffed by locum doctors who do not understand/agree with local policy and occasionally try to circumvent it.

The police have a clear set of guidelines and procedures when dealing with a situation, while individual hospitals may have different procedures when dealing with a similar conflict. (The course of action followed at hospital 'A' may not be the same course of action followed at hospital 'B')

ER staff do not listen to police or ask police for input

...e.g. MH Patient brought in. Police not spoken to. Patient seen by doctor and released. Police not spoken to "No time." Indicated as reason.

The hospital is not interested in what the officer has to say about what they have observed or heard from the patient throughout the time the patient has been in their custody.

In past years, I have had some concern in regards to the training of crisis team members and how they determine through a single interview, if a MHA patient is a threat to themselves or someone else.

Police Responses to Q2 "What problems remain?"

Some patients are cognizant of what they have to say to get out. Often times the hospital staff will "feed" the right answers to the patient and lead them towards talking their way out of a 72 hour assessment. With some doctors, not much attention is paid to the officers' observations about the patient and, while we are certainly not mental health professionals, we do have some experience dealing with [patients apprehended under MHA] and I think it is a mistake to discount our experience.

There is ... no communication between hospital staff and police as to the status of the case and, more often than not, it takes constant badgering on our part to keep hospital staff focused on seeing a patient.

Persons lying to doctors to be released. Police advise of lies and still released.

Police officers are often treated as mere 'observers' and insignificant stakeholders when bringing in a person in need of mental health treatment.

Doctors MUST be taught and FORCED to spend time with the officers gaining insight and information into what has occurred.

IE Copper brings in whack-job, Copper waits patiently, busy Doctor arrives, FAILS to even speak with the officer and gather crucial info, and just spends 5 minutes with the now 'acting and presentable' patient who says all the right things, and walks out of the hospital...

Doctors do not take what the police advise them of regarding the individual seriously; it is putting the public at risk having these individual released into the community when they are suicidal, especially when their tendencies are escalating.

Security And Facility Concerns

Inconsistent availability of a safe room away from the regular patients, to isolate apprehended individuals.

SECURITY in hospitals absolutely pathetic! Hospitals deal with criminals, drug addicts, violent angry persons, fraudsters, deviants and on a busy night in the emerg, a 'who's who' of society's "Most Likely To Cause Pain And Suffering"...

Like a Courthouse or Jail, hospitals often see a clientele that would make any parent cringe, and run for cover hiding their children...

What do hospitals have..?? Effectively NADA! Security should be in every hospital in a high presence. Each emerg ward should have a minimum of two secure holding rooms each with video and measures to prevent escape and escalation of any volatile situation that walks in their doors...

Hospitals should be places of safety. Parents and loved ones should be able to attend an emerg ward absent the sounds, sights and smells usually associated with an [emergency] ward.

[Named hospital] does not offer any "security" in the form of a safe room (secure room with no items, instruments...etc). Also, Hospital has no security on staff to assist police with an irate or violent person. Hospital practice is to have all clients "check in" at the front desk, which raises a "security risk and risk to the general public" when the "check in" can be done once at the Emergency Department.

There are [area hospitals] with absolutely no designated areas. The Officer is expected to 'wait his turn' with the (combative, screaming, cursing) EDP in the waiting area, while sitting beside mom and pop who have brought little Johnny in to have the boo-boo on his finger looked at. Other Hospitals will have one or two 'quiet rooms' that are available for patients who are being accompanied by the police, while other hospitals 'fast track' the EDP.

Facility doors are left open for involuntary patients.

Hospitals don't give info to police

Understanding the need for police to have the most recent information to assist the victim and/or family in the recovery of these victims. Need for a more cohesive working relationship when sharing information.

When a decision is finally made regarding the status of the patient, the officer is again left out in the dark about how long the process will take, where they are going or even why they are being released.

Some doctors neglect to speak to police about what they have observed and their dealings with the person.

Often a MH patient is released with little or no information provided to police as to why the doctor has made this decision.

Sometimes people are admitted [and] are to face criminal charges when they are released. The hospital does not always call police before they release these people even though they have been requested to do so.

Transfer to another hospital

Officers are often required to escort the patient from one hospital to another facility, which causes even greater loss of officer road time. This causes a human resource deficiency in providing policing and protection in the rest of our jurisdiction.

The bureaucracy of dealing with an admitting physician who then refers the patient to a treatment facility who then decides when and if a bed or place will be available for the person.

Often times of late the hospital people are screening the patients background and if they are not from the area they are advising that the patient must be taken to their hometown because that is the treating facility. It is obvious that finances are dictating the level of service provided, not the safety of the public or the individual. In several instances in the past I have brought people in that have clearly demonstrated that they are a threat to themselves or someone else only to be told there aren't enough beds, they are not from here or I simply don't believe they are a threat. The Mental Health Act quite clearly sets out the guidelines for the police to follow yet our own medical institution is letting us down.

... [must] travel to different region to seek assistance for youth.

Poor aftercare / follow-up

Not enough follow-up is being done on repeat "clients".

Clients still are unstable but can care for themselves but once on their own they forget to take meds which puts area residents at risk, i.e.: male believed his dog was telling the aliens where he lived so he shot the dog, the firearms were seized after this event.

The government is closing homes or businesses that deal with mentally challenged people and are putting them out into the community to fend for themselves and some of these people are not able to cope with the day to day pressures of life and they then come into conflict with the law. No one is controlling their medication intake.

ED staff dislikes police and MH patients

I have personally heard hospital staff say that they hate it when police bring in a mental health patient. I also heard that it was one of the staff's... pleasure to have police wait for hours with a patient before being seen by a physician.

Another problem is the relationship between hospital staff and police. Some of the hospital staff do not like to get involved with police in fear of having to attend Court in the future. Thus, the relationship between hospital staff and police is a tense and stressful one.

Intoxicated patients

If a person has been taking crystal meth the hospital refuses to take them because of the danger these people might pose to them.

Hospital will not take people who have been drinking. They want you to take them to detox center [which] will not take them because they are suicidal so they end up in police custody. Detox center for this area is an hour away.

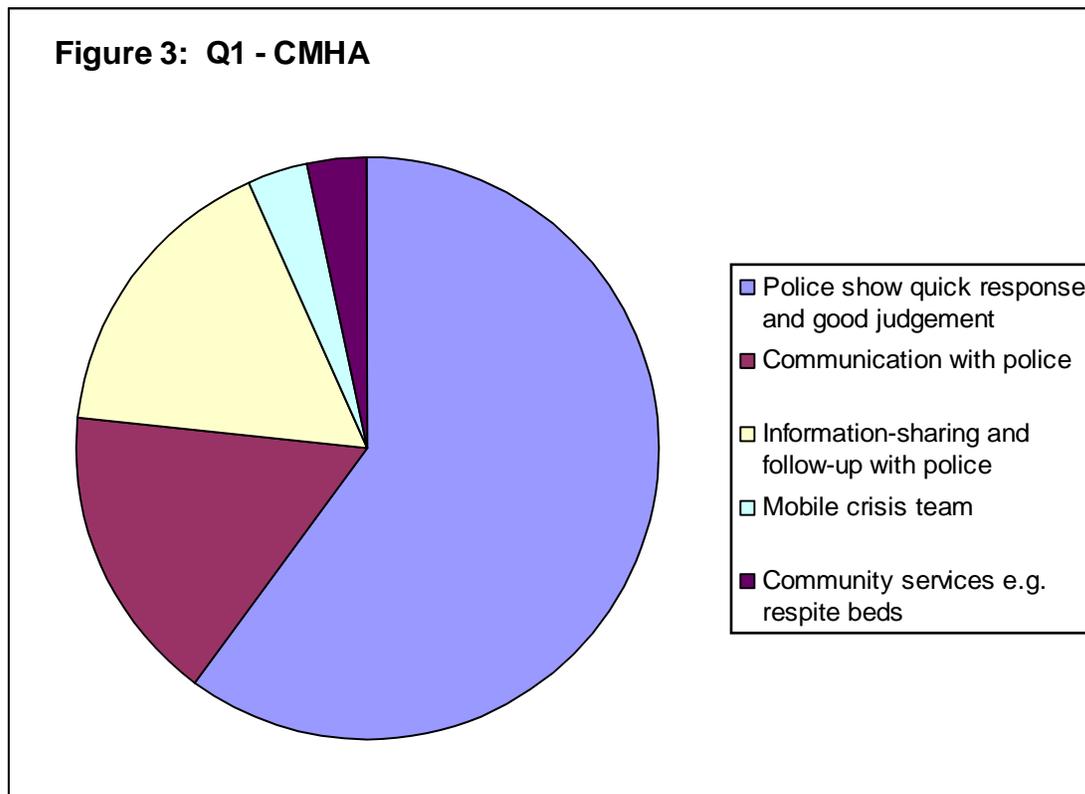
3.3 CMHA Responses

3.3.1 Q1: "What is Working Well?" 30 Responses

"...continue to have two distinct systems with minimal overlap and lack of shared knowledge..."

Category of Response	# Responses	% of Total
Police show quick response and good judgment	18	60.0
Communication with police	5	16.7
Information-sharing and follow-up with police	5	16.7
Mobile Crisis Team	1	3.3
Community services e.g. respite beds	1	3.3
	30	100

Note: Of the 30 responses to Question 1, 28 referred to some aspect of police activity, and the other two referred to mobile crisis teams and community services (e.g. respite beds). There were no positive comments on hospital ER services.



Police show quick response and good judgment

Overall the police provide a high quality service to the mentally ill person. The additional training in recent years is paying off.

Quick response by police. Police officers consistently demonstrate good judgment and skills in these difficult situations. Therefore individual is in 'better state' when they arrive at hospital.

Police respond quickly and appropriately when contacted to assist in taking a suicidal client to hospital.

Most of the officers are compassionate and informed; it is the "few" who create problems.

Police have worked well with family members and were quite appropriate. Reports of great police intervention with suicidal individual as reported by family members of suicidal individual.

Some police have an excellent understanding of mental illness and thus are more effective in dealing with mental health issues..... reduced stigma as a result of mental health training for police departments. ... [police are effective at] balancing needs for protection of our clients with criminal responsibility.

Police are being as patient as possible while incurring long waits for ER MH assessments with suicidal individuals.

Police officers and hospital staff who take the ASIST (Applied Suicide Intervention Skills Training) workshop. Broadens understanding of suicide and assessment skills. Enables us to all speak the same language during the assessment process. There is increased understanding and responsiveness from the police on the issue of suicide and it is taken seriously when services call.

Communication with police

Better coordination of services to specific situations has been seen.

Local Human Services and Justice Coordinating Committees provide a venue to discuss challenges between Justice and mental health services. Police services representatives actively participate in the committee and identify service gaps and challenges.

Collaboration on cases.

Communication and understanding with OPP has worked well; many difficulties have occurred with local police force.

Having a police mental health liaison is helpful.

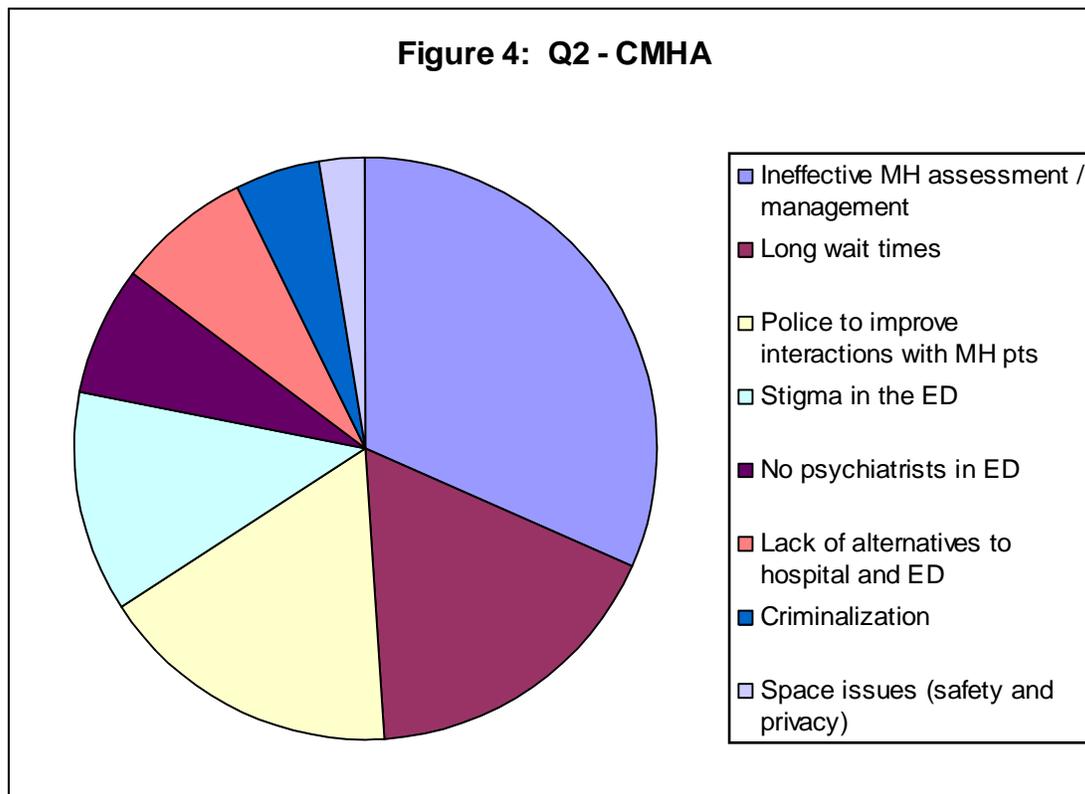
Mobile Crisis Team

Connection to a community based Mobile Team offers another level of assessment and expertise around the issue of suicide. Given the outcome of the assessment, a community based plan can be developed (which would also include the mobilization of other collateral supports if involved) to keep the person safe and at home.

3.3.2 CMHA Response to Q2: “What Problems Remain?” 41 responses

"The consumers tell us the ER is the most difficult part of the disease and treatment. They feel overwhelmed by the symptoms and the wait, [the] environment and lack of understanding and empathy at times is very difficult for them."

Category of Response	# Responses	% of Total
Ineffective MH assessment / management (includes hospitals not seeking collateral information, and not providing info after assessment)	13	31.7
Long wait times	7	17.1
Police need to improve their interactions with MH patients	7	17.1
Stigma in the ED	5	12.2
No psychiatrists in ED	3	7.3
Lack of alternatives to hospital and ER	3	7.3
Criminalization (i.e. patients taken to cells, not ER)	2	4.9
Space issues (safety and privacy)	1	2.4
	41	100.0



Ineffective MH assessment / management

On a number of occasions the ER doctor appeared to be releasing these individuals after a brief assessment without consultation with others or reading documentation. This is frustrating for police, family, justice of the peace, service providers, and the individual [who] may be apprehended more than once before a thorough assessment is completed. Once the mental health services were aware of this concern they began to monitor this and the situation appears to have improved.

Suicide threats are not taken seriously, because the person has been labeled as "borderline personality." Individuals with concurrent disorders, who present with suicidal ideation when they are high, are not assessed or taken seriously. They are often sent to detox, and are sent back out to the community with no support or further assessment. Clearer linkages and understanding are needed.

Less emphasis on beds, more on client need.

Person may be arrested under the Mental Health Act, brought in for assessment and then released by the ER physician, only to be at continued risk in the community when no referral has been made.

Physicians do not seek information from, nor provide information to, community mental health workers

ER staff needs to listen to the community mental health professionals and utilize info provided.

Ensure review of collateral info when an apprehension order was issued. The receiving hospital and doctor receive a copy of the information gathered, and [should be] expected to include the examination of the information in the process.

Information from Community Support Workers shared upfront is often not processed (or a sense of validation about this information) until hours later.

Insufficient contact, e.g. Community Support Workers meeting with police officer and hospital workers to find out what can/cannot be done.

MD needs to have all info re specific individuals. All information is not necessarily known or conveyed to the assessing physician.

Long wait times

I work at a community-based mental health centre. Police do not like attending our agency when we have a suicidal client because they say they wait too long in emerg, only to have the doctor say that the patient can leave.

Wait times for clients to see doctor in ER (and the amount of time spent by police waiting with the client to see the doctor is way too long).

Police expressed concerns about long waiting times in emergency rooms. At times police may be reluctant to go to the hospital for this reason, possibly resulting in the individual being unnecessarily held in remand.

Long waits in the ER for assessment. Police have to wait with individuals in the ER (if they have been arrested under the Mental Health Act), until they are assessed by a physician. This is often a 3-6 hour wait.

Police need to improve their interactions with MH patients

Language used by an officer in responding to a situation was inappropriate or insensitive to mental health client.

While improving, police still require more and continuous education re SMI and suicidal individuals.

Method of bringing individuals to ER - - i.e. in handcuffs -- does still occur.

Unnecessary force used when police intervened in a situation where the individual is suicidal.

Some inconsistencies with the police (interpretation of reliable third-party communication and follow-up, procedures)... training needs to be consistent.

[I] have had experience with police denying assistance with attending hospital with suicidal person.... [police may be] unaware of [revised criteria for apprehension under Brian's Law] and not open to education regarding the criteria; not recognizing mental health issues as serious and/or impacting on functioning and Form 1 criteria.

At times the police provide little follow-up to the service provider.

Stigma in the ER

The hospital triage system is not effective for people with diagnosed mental health issues or for psychiatric crisis. The providers may be overburdened and have bias or stigmatize the group. Example: comments such as "You think you are sick? This guy has just had a heart attack!"

Mental health clients are "assumed" to be "a problem."

Stigma for repeat clients.

Stigma exists for clients sitting in the open waiting areas with police officers.

Overall stigma and prejudice related to mental health and people struggling with suicide.

No psychiatrists in ER

There are no emerg psychiatrists.

Current practice is often to send the suicidal person home with instructions to return the following morning to see a psychiatrist. This is inadequate and dangerous. If not sent home, individuals are reluctant to stay and are often not encouraged by hospital staff to wait.

Lack of alternatives to hospital and ER

Schedule 1 facilities are not taking patients, and the community does not have enough case management to support these individuals.

Lack of resources for community based services. [Our local] Mobile Crisis Team is a small team for [local population]. With only 1-2 staff on per shift, makes for an extremely busy shift. Individuals who cannot wait for Mobile Team connection use hospital as the only option. Mobile Team may have been able to manage these situations in the community.

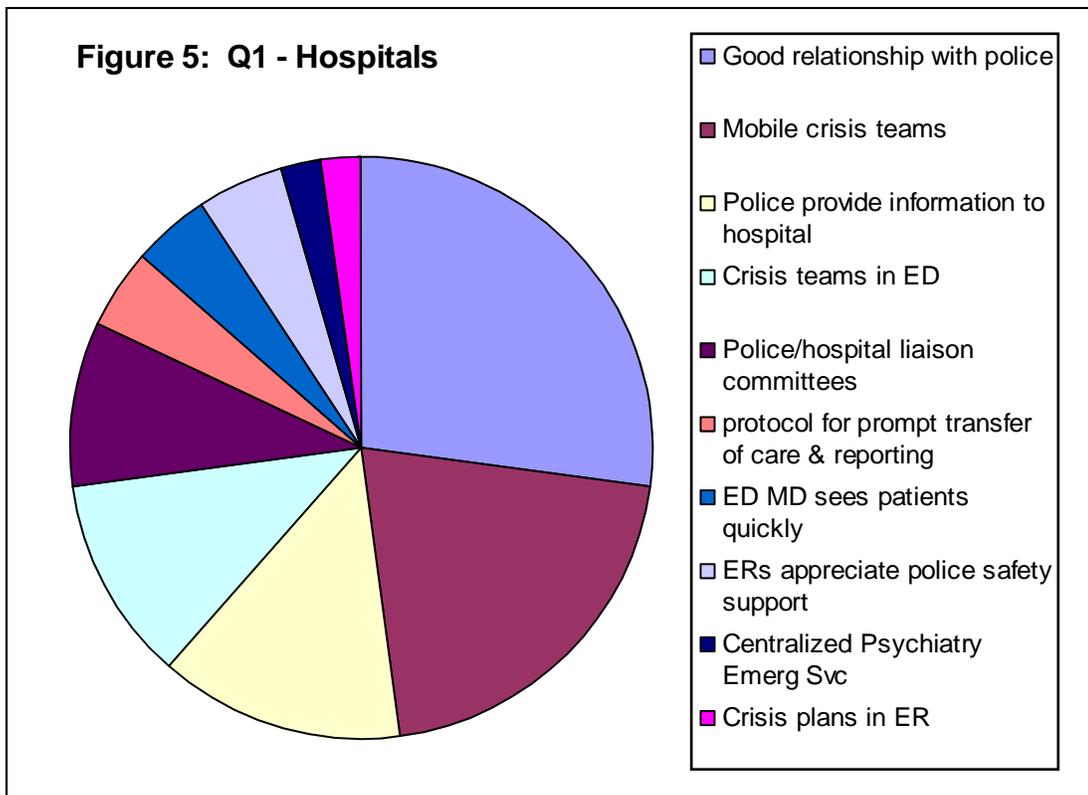
Lack of access to community based treatment services that act as an alternative to hospital. These services are often at capacity, closed for referral, and in this community are accessed after an ER assessment (which means a lengthy wait).

3.4 Hospital Responses

3.4.1 Q1: “What is Working Well?” 44 responses

When the officers are “good”, they are “great”.
When they are not, they are “terrible”.

Category of Response	# Responses	% of Total
Good relationship with police	12	27.3
Mobile Crisis Teams	9	20.5
Police provide information to hospital	6	13.6
Crisis teams in the ED	5	11.4
Police/hospital liaison committees	4	9.1
Protocol/agreement for prompt transfer of care & reporting	2	4.5
ED MD sees patients brought by police quickly	2	4.5
EDs appreciate police safety support	2	4.5
Centralized psychiatry emergency service	1	2.3
Crisis plans in ED (management plans for specific patients)	1	2.3
	44	100 %



Good relationship with police

I believe that there are no major problems in this relationship. At [our] Emergency Department I find that [police] officers are cooperative about attending with patients until emergency physician assessment. Officers appear to understand the difference between an EDP arrest and a Form 1. Officers are invariably sensitive to requests for privacy during psychiatric interviews.

Communication and response time are good locally.
Link between hospital security and police.

If we need the police, they come quickly. [Police] take suicidal patients seriously and will search seriously for Form 1 patients that have left the building.

Quick response to safety concerns about staff or patients.

We work well with local police services.

Working well. Police bring in patients well. We can form patients to our own facility. ER department works well.

Most officers who come ... are sensitive to clients needs and are cooperative with staff and ER.

We have excellent services from police. They do respond quickly for any calls of suicidal patients. They will bring them to ER, wait in ER until the patients have been assessed and/or accepted the responsibility for care by the hospital.

Excellent working relationship between police and acute care unit; this has improved a ton over the years; response time generally quite good; skill level, compassion, empathy for patients with mental health presentation has improved a lot!

Police now [bring patients] to appropriate hospital.

Best case scenario: Police officer is educated about mental illness/suicidality (especially children and adolescents), willing to arrest under MHA, willing to be part of the assessment process to include crisis worker, ER physician, psychiatrist, family etc... Transfer care/custody over to security appropriately.

Excellent response to violent patients in [our rural] ER; ER has been welcoming in terms of assessment of patient whom police are concerned about.

Police support in ER is GREATLY appreciated by all mental health workers/physicians for the violent/aggressive patient including those [who] are suicidal.

Mobile Crisis Teams (MCIT)

The local MCIT has helped tremendously within the area, and is able to get suicidal individuals to appropriate hospitals within a timely fashion. However, they can also get "held up" in a given ED due to waiting to "hand over" the client.

Police and hospital are beginning to develop collaborative relationship with community mobile crisis services.

[Our local MCIT] works well to divert numerous persons from the ER - when they bring in a client, he/she usually needs admission.

The mobile crisis team in our area has helped bridge between the ED and police, and has been highly effective.

Since introduction of MCIT methodology, there has been a substantial improvement in understanding of police and hospitals' unique cultures and an overall easing of tensions. Hospital staff now view police as allies and colleagues.

The development of a joint mobile crisis team with police department was a major advance. The team, from my observations, improved the assessment process in the community, assisted with triage to the best resources and brought more humane care to the patients. Our overall relationship with the police was enhanced by this joint program.

We have relatively new mobile crisis teams now 24/7 and there is the beginning of a shift to better support to police pre-hospital and more diversion opportunities. The mobile teams have, or are working towards, protocols where the community assessment is shared at the hospital and can expedite the assessment at the ER. This may translate into prompter release of police and more coordinated care.

The Crisis Lines are now funded and in place and are a key element in suicide prevention and diversion from police/ER. They are the entry point for community mobile crisis and constitute a one-stop, one-number entry point for crisis services 24/7.

Police provide information to hospital

Transfer of info from police to ED staff.

Good information transfer (though not always formal).

ED MD seeks info from police.

Communication between police and our charge nurse in psychiatry assessment unit in the ED.

Crisis teams in ED

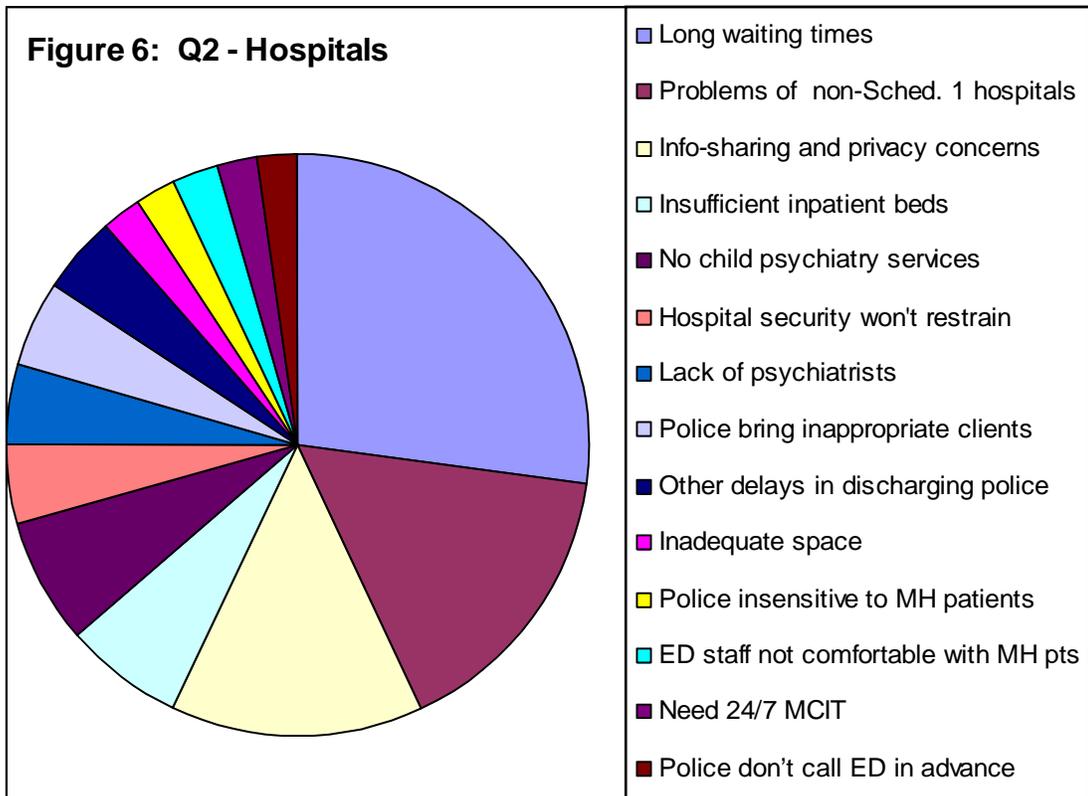
Crisis team can begin assessing the case prior to the ER physician having contact.

Early involvement of the psychiatry team in [ER] facilitates patient assessment and allows police to leave the ED sooner.

What works best is the relationship that crisis workers have with the emerg docs. Sometimes the docs don't acknowledge the crisis workers recommendations and allow the community supports to assist the consumer in the community so they are not hospitalized. There needs to be recognition of the crisis worker expertise.

3.4.2 Hospital Response to Q2: “What Problems Remain?” 44 Responses

Category of Response	# Responses	% of Total
Long waiting times	12	27.3
Problems of concern to non-Schedule 1 hospitals	7	15.9
Information-sharing and privacy concerns	6	13.6
Insufficient inpatient beds	3	6.8
No child psychiatry services	3	6.8
Security officers reluctant to restrain some patients	2	4.5
Lack of psychiatrists	2	4.5
Police bring inappropriate clients	2	4.5
Other delays in discharging police	2	4.5
Inadequate space	1	2.3
Some police insensitive to MH patients	1	2.3
ED staff not comfortable with MH pts	1	2.3
Need 24/7 MCIT	1	2.3
Police don't call ED in advance of bringing patient	1	2.3
	44	100



Long waiting times

ER physician has time limitations; mental health patients not considered priority status by ER physicians. Query stigma/discrimination re care given to mental health patients.

For this relationship to work it is important that ED physicians make an effort to assess patients and determine quickly whether the police can be excused to return to duty. If the physician assessment is delayed, then there is additional stress for the officers and their watch commanders. Not all ED physicians believe that it is appropriate to "fast track" such patients ahead of others who may have been waiting longer even if the other patients are not more seriously ill. In my opinion this is not a collegial or practical approach to the issue.

Limitation of general hospital system (i.e. too few beds, competing triage priorities, ambivalence of general medical staff, etc.) still impairs efficiencies of fast tracking referrals.

My experience... has been that when the police have a highly agitated suicidal client, the first course of action that they have asked for is restraints or threats to handcuff a person... the difficulty here is that often the ED doc can't get to the individual quickly enough due to high ED volumes, so a re-traumatizing situation occurs.

Police intimidation of nursing staff to try to have patient assessed sooner by a physician.

Police unwilling to arrest under MHA due to length of stay in ER.
Police drop clients/patients off at the front door, or bypass Triage.

Problems of concern to non-Schedule 1 hospitals

Stephen Arif MA MD CCFP FCFP, Chief of Staff at Atikokan General Hospital, sent this detailed response:

In rural Ontario, especially in Northern Ontario where distances are vast, we face unique challenges. The challenges created by distance are quite something. Atikokan is uniquely situated 200km west of Thunder Bay, which is our closest center of a Schedule 1 facility. The next closest centre is Kenora, which is 430km west of Atikokan, and there is no regular bus service or any schedule service between the two.

When our police department needs to take a psychiatric patient on a Form 1 from our facility to Thunder Bay Regional Hospital, it means a two hour drive and turnaround time in return, which ends up being at least five hours for them to take the patient to the Schedule 1 facility.... Taking a patient to Kenora is over a ten-hour turn around trip for the police crew. It is also very awkward for the patient to be in a police cruiser for 4 ½ hours. Unfortunately, too often, we do have to send the patient to the farther Schedule 1 facility because of a lack of beds at the closest Schedule 1 facility.

The police say it is a problem in transferring the patients even to the closest centre, Thunder Bay. If the patient needs to go to the washroom on the two-hour drive, it is a desolate highway without much in the way of facilities. On the longer 4 ½ drive, they would certainly need to stop somewhere for the patient to go to the washroom. As well, it is a long time for the patient to be stable in chemical restraints for the transport

Air ambulance is reluctant to take psychiatric patients for fear that the psychiatric patient may somehow act out and disrupt the aircraft, such as opening the aircraft door.... Thus, for safety reasons, most of our patients, despite the great distance, have to travel by police car.

...A policy of making sure that adequate resources are available within reasonable distance most of the time is extremely important in Northern Ontario where distances are great. Thus, some degree of bed excess in the referral Schedule 1 facilities is required, rather than running at over 100% capacity at all times.

Other responses:

There is no ER with an attached Schedule 1 hospital in [our area]. If a person is apprehended under the MHA, a Form 1 is completed at the ER (there is no psychiatrist at our hospital) and no bed is available, the police have been held up for hours or even days.

Our small rural hospital is not equipped to deal with prolonged supervision. [There is] no security on-site and no locked ward. Patients often stay at our facility many days. The police charge a lot of money to supervise such patients.

Transportation of patients to another Schedule 1 facility is now dependent on ambulance services. No policy exists for patients accompanied by police.

We (the hospital) have to pay for OPP to escort patients from our emerg to a Schedule 1 facility... reflects silo mentality to budgets (both are provincial, no commitment to smooth patient care).

[Police are] reluctant to accompany Form 1 patients in transfer (usually I [a physician] have).

There is no dedicated system to allow expeditious transfer of [suicidal adult or child patients]... that leaves the one nurse, one physician and police officer caring for individual until a transfer can be arranged (often hours).

Information-sharing and Privacy concerns

Police need to recognize and [respect] confidentiality law. [Sometimes they] ask for (or help themselves to) information in the ED.

Individuals, who are apprehended under the MHA, may in some communities be at risk of having this information documented on future police checks (i.e. for employment or volunteer positions).

Occasionally, problems due to PHIPA, police wanting info we cannot give.

Due to confidentiality differences between Police and the hospital, limited information can be shared between the Police and Crisis Workers. This is frustrating especially when dealing with frequent users with numerous presentations. Obviously better management is required and both service providers should be contributing to the establishment and maintenance of the patient's treatment plan.

Hospital Responses to Q2 "What problems remain?"

Police are not aware of, or do not comply, with privacy legislation.

Notification to police often requested by police (i.e. inform police when discharged) -- can we do that?

Insufficient inpatient beds

Our inpatient psychiatric ward is always near or at capacity, leading to admitted psychiatric patients remaining in the ER for longer periods of time.

Back up in ER due to 'no beds.'

No child psychiatry services

There is no child psychiatry service available for Form 1 admits. Criticalll does not help with these cases.

Poor acute child psychiatry services.

Problem with children aged 16 and 17. No place in smaller community will accept this age patient on a Form 1.

Each of the remaining categories had 2 or fewer responses:

Security officers reluctant to restrain some patients

My major challenge in caring for suicidal patients is the widespread belief among security staff that they cannot restrain or interfere with a patient trying to depart unless a Form 1 has been completed. We have obtained legal opinions and briefed our contractor on this issue, but the belief is so widespread and ingrained that it is very hard to dispel. The result is that until an MD has completed their assessment, we continue to have patients at risk of eloping despite a nurse having requested a constant watch. ...that is likely the greatest risk facing our patients in our ER's at this time.

Security not comfortable to accept custody/care/security of patients in a timely manner.

Lack of psychiatrists

Lack of psychiatrists; heavy demands for on-call psychiatrist.

Police bring inappropriate clients

Too many individuals brought in clearly not suffering from mental illness but simply bad behavior and know that if they mention suicide, [they] get a trip to the hospital ...[and a] late trip to jail.

Delivery of intoxicated patients to emergency room due to misinterpretation of Mental Health Act issues.

Delays in discharging police

Some police do not feel comfortable with the Crisis Worker's assessment and/or disposition recommendations and will opt to stay with the patient until the Physician sees the patient.

.... Police do not understand the types of risk assessments that we conduct nor do they necessarily see Crisis Worker's as "experts" as they would an ED Physician. The

problem here is that we assess all MHA patients first, and [then] make recommendations to the ED Physicians who almost always trust our recommendations and base their decision to admit or discharge on that. Further, police have stated that at times they are concerned about risk factors and who would be held accountable should a suicidal patient actually attempt or complete if discharged. Again I think so many of the difficulties that we face [are due to] poor communication.

Police are not able to speak directly with the ED Physician when they bring an individual to the ED until the Crisis Team intervenes. As our ED is very busy, consultation with an ED Physician can take hours, and in our department some physicians are reluctant to discharge police until the patient is under the care of the on-call psychiatrist and has a bed available.

Inadequate space

Inadequate areas in ER to adequately provide safe and/or respectful care.

Some police insensitive to MH patients

I have also had the experience of a suicidal client on the telephone when police arrive at their door. Again, when they're good, they're great, when they're not.... oh my.... the yelling, screaming, pounding, threatening that I get to listen to is frightening...and my interpretation is that much of it is based on fear on the part of both parties.

Clients repeatedly tell me horrendous stories about police telling them that if they were "serious" why didn't they...x, y, or z. If they have self-injured, there are similar stories that hinder the alliance, thus increasing the contentious relationship and mood and behaviour of the patient before they walk through the ED doors.

ER staff not comfortable with MH pts

ER staff also feel unprepared or unaccepting of mental health patients ...again, stigma of mental illness and feelings of incompetence, lack of skill.

Need 24/7 MCIT

Providing enough resources to make the Mobile Crisis Team operational 24 hours per day 7 days per week.

3.5 EMS Responses

3.5.1 Q1: “What is Working Well?”

Response by police department is working well. Most officers work with us in a team approach.

[Our] geographic area ...has developed a Mental Health Crisis Team with a signed agreement between the various police forces, the ambulance service, the hospitals and the crisis team. This is a very proactive approach and provided tremendous resource. It is good that all these partners get together to discuss a procedure for dealing with mental health issues.

3.5.2 Q2: “What Problems Remain?”

We have had particular problems in that the agreements are not always followed. The geographic area is restricted to three counties and the major treatment center for our area is ...outside of the geographic area. There are often "tailgate" discussions about whose mandate should be followed in the transportation of the ill patient for further treatment.

There are no issues with patients that are suicidal and have medical emergencies. The problems seem to be associated with patients that have issued suicidal threats but have not harmed themselves physically. The police tend to feel that once they in the hospital the patient becomes a medical emergency and tend to want ambulance transportation. I cannot speak for the local police departments but it appears that there are boundary issues about where they can and cannot travel without permission.

The ambulance service is often uneasy about these types of transports because the Patient Care Standards in this regard ask for police escorts. The ambulance service is often unable to procure this resource making the transportation, by definition, substandard. The hospital often does not see a need to provide an escort, so the paramedic is often stuck trying to negotiate with a patient that has been cooperative but now is becoming agitated for various reasons (confined to a vehicle, traffic flow issues, wait times in emergencies etc..). We have had instances where paramedics have had to abandon the vehicle while a patient has become violent beyond the physical strength of the attendant in the back. We have done nonviolent crisis intervention training above and beyond the minimum standards of the paramedic qualifications, but this is intended to educate the paramedic on escalation issues, not on restraint. In other words we are taking the riskiest approach in dealing with safety issues with these types of transports.

Police are sometimes reluctant to invoke the arrest powers under the MHA for patients we cannot take due to capacity. ERs sometimes see patients as a disruption to their department as opposed to sick.

3.6 Family & Advocate Responses

3.6.1 Q1: “What is Working Well?”

Hospitals

Hospital staff appear to have an increased [understanding] of suicide ideation and lethality.

Police

...appear to be responding in a positive and informed manner.
... respond quickly to calls.

Police-Hospital Interaction

I can relate an experience ... a few years ago... there was a problem with officers bringing those at risk to the emergency department and having to wait for hours before they were seen. This created increasing frustration for the officers (and those at risk) in addition to tying up two officers for hours. The police and hospital services met and agreed that those who police brought in would be triaged right away. Apart from increasing the effectiveness of services, officers were more likely to respond to those who were suicidal.

3.6.2 Q2: “What Problems Remain?” (7 Responses)

Caregivers receive little feedback from staff (3 responses)

Caregivers receive little feedback from staff.

If a person has had several attempts, family then expresses concern than nobody is communicating with them because of confidentiality issues (this does not include minors). When the patient is released into someone's hands, [physicians should] tell caregivers about meds and time to react. This is when "caregivers" are caring for the patient on discharge, i.e. will be discharged back into caregivers' hands.

I feel as if there is something terrible missing in the entire process of assessment and of follow-up care. I know that my daughter's illness was poorly explained to us... and had confusion of diagnosis with different psychiatrists saying she had [Borderline Personality Disorder] and others not saying so implicitly... We carried on... and we had periods when she seemed to be doing better, but at [the] end, we failed, the system failed. She died because we were not supported adequately, nor advised adequately of risk, nor did the various doctors we saw put her situation in careful context so that we could act on this appropriately.

...

I think it comes down to ER people and police understanding the tragedy... Perhaps many do, but before this happened to me, my perception of suicidal acts was reaction and upset more than compassion and trying to understand why? So often, suicidal people have great difficulty letting out the reality of their pain and hurt.

...

I believe that medical caregivers need better education and better standards of practice because now looking at the care my daughter received, I realize that it was largely incompetent, doctors who were ignorant, and also that the system as it is failed her as there was not a good sharing of medical records between her medical caregivers.

During these various incidents, we never ever received information about suicide risk or about the realities of her illness. The explanations were so often vague and

uncertain, and unhelpful. There was almost no accountability. The tragedy at [the] end is that my daughter lost her life and wounded those who loved her and still love her, mortally....

Ineffective assessment / management in ER (2 responses)

Police come out and "seem to get it," then patient [is] brought to hospital, then patient is spoken to by someone (maybe a doctor, maybe not) and released immediately.

Family is directed to ask for psychiatric assessment, and patient has means and desire to die by suicide. Patient says "I feel better" and is discharged, then suicides.

Emerg staff has to learn to listen to caregivers and police.

In [our region], responses are inconsistent and depend on who you get on-call at the emergency dept. A number of medical personnel have little experience/training in working with those at risk. While similar to many centers, there is a lack of psychiatrists, [and] a few associated with the hospital have acted inappropriately. Officers report frustration in long wait times, brief assessments and no service or follow up.

Youth Mental Health services unavailable (1 response)

Youth mental health services are vastly under-funded and unavailable in [our region]. For example, ... a boy of 16 who was suicidal, was admitted to [an] adult psychiatric ward because [there was no] youth unit in the region. This was not a good environment for him (drug addicts, alcoholics, psychotics, etc.). Follow-up services were also either nonexistent or poor.

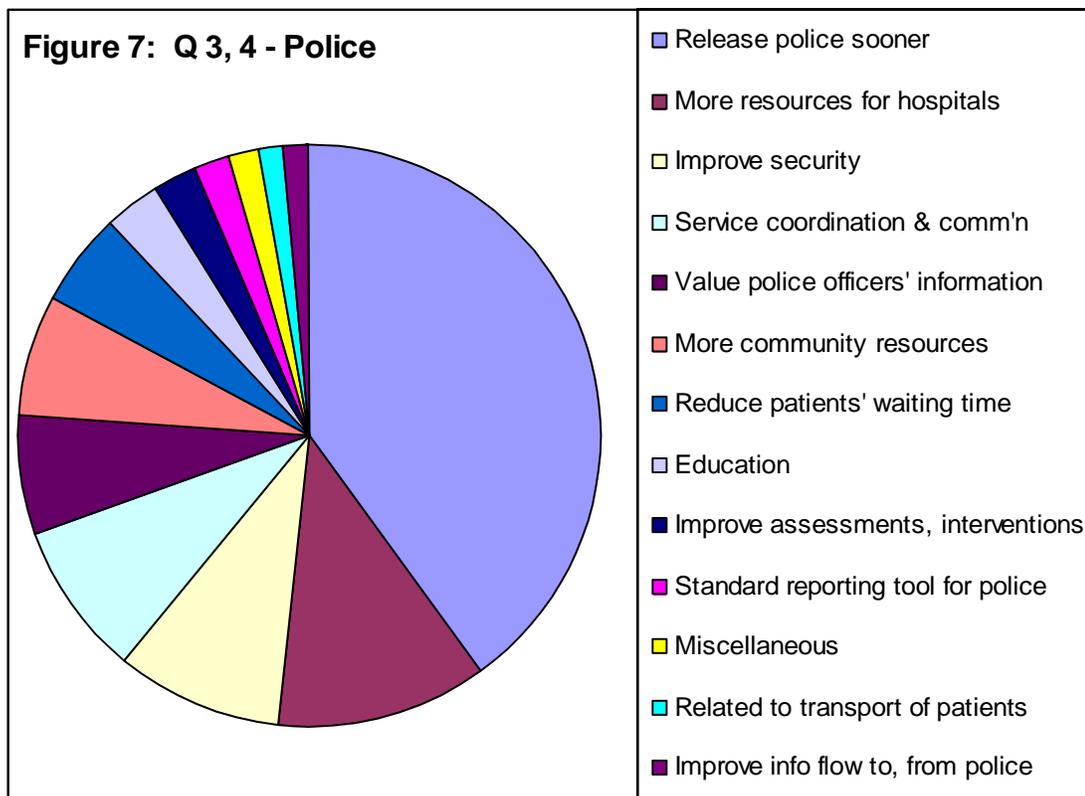
Follow-up inconsistent (1 response)

Follow-up arrangement depends on the hospital. For hospital with good in-house crisis team and sufficient beds, consumers will be much happier.

3.7 Suggestions for change (Questions 3 and 4)

3.7.1 Police Suggestions: 285 responses

Category of Response	# Responses	% of Total
Release police sooner	114	40.6
More resources for hospitals (staff, beds, money)	33	11.6
Improve security	26	9.1
Improve service coordination and communication	25	8.8
Value police officers' information	19	6.7
More Community Resources	19	6.7
Reduce patients' waiting time	15	5.3
Education	9	3.2
Improve assessments and interventions	7	2.5
Standard reporting tool for police	5	1.8
Miscellaneous	5	1.8
Related to transport of patients	4	1.4
Improve information flow to and from police	4	1.4
	285	100



Release police sooner

We have to stop taking these individuals through the front door of emerg to be triaged with everyone else. This generally results in significant wait times for police and the associated criminalization aspect of waiting while under police guard. If no criminal offence has been committed, the emergency medical system must be equipped and staffed to take control of this medical issue.

When the police arrest an individual under the Mental Health Act, they have to be able to articulate the reasons for the arrest. As long as this can be communicated to the [hospital staff], it should then become the accepting facility's responsibility to take over immediately. This should not take 4 to 5 hours to happen. If a police officer can determine a person is a threat to [himself/herself] or the public, then why can't a nurse?

Hospitals need Crisis nurses to see parties ASAP, and security personnel in order to free up officers ASAP.

Once information is relayed, the hospital... would take responsibility of the person....

Earlier acceptance by the hospital of nonviolent apprehended mentally ill individuals, and having trained security watch these people until assessment completed.

Police put on a priority list above those who are not critical. We receive no priority at this stage. 3 to 5 hour wait is the norm, not the exception. How would medical staff feel about being stopped for a violation and having to wait over an hour? All the time, this takes two of four or five officers off the road. This is ridiculous.

Make getting police officers back on the street a higher priority.

Set a standard time limit on the number of minutes police-accompanied individuals wait for an assessment in the emergency department (similar to the model followed in Vancouver), or allow police to leave the individual in the care of emergency staff, enabling the individual to get the appropriate care and the officer to focus on other policing issues.

It would be nice to get a call-ahead policy set up so people could be kept in the cells while they are waiting to see a doctor. Officers would call the hospital and book an appointment with the on-call doctor. Police would then be advised an appropriate time for the party to be brought to the Hospital with the goal of reducing wait time and mitigating risk to officers and the public.

Provincially-standardized practices made in conjunction with the Ontario Hospital Association that will streamline this process of admission.
Remove the requirement for police escort, once the [patient] is admitted to a local medical facility, medicated and is no longer an immediate threat to themselves or anyone else.

Police in most cases can be entrusted to determine if someone is suicidal. That person once determined should go directly to a facility for immediate intervention. In those cases where the officer is not sure if the danger is imminent he could consult with an admitting ER doctor at the local hospital.

Police Suggestions For Change (Q 3 and 4)

An expedited check-in process for police to bring “patients” straight into the emergency room instead of spending time to check them where violence could occur in a public place.

More resources for hospitals

(Note: of the 33 responses in this category, 24 suggested increase in ER staffing, and 7 suggested more MH beds)

More staff designated for mental health patients that are brought to the emergency room to assess & relieve police officers.

Increase the number of on-site nurses and doctors. This is not a new issue, and, unfortunately, it most likely will not be addressed due to government budget constraints.

The availability of Schedule 1 facility to local hospitals.

More beds at mental facilities are the real problem. Suicidal people should not be waiting 12-24 hrs and longer to get help.

Increase staffing and beds in the psychiatric wings of our hospitals. The jails are full of people who should, in my opinion, be cared for under mental health rather than a correctional system.

Hospitals need to have the people and resources to take in these people and look after them. Unfortunately the police do not have the time to sit for 4-5 hours. The doctors and nurses are already there. So lets give them the people and room to handle the mental health side. Too many times society, and the medical profession, ignore mental [health] issue opting for the quick fix.

Lack of dollars. Before providing same, services must realize that they have to come together as one in order to be fiscally responsible. Policing learned this lesson sometime ago. Look towards streamlining services.

Improve security

Security personnel

Have hospital personnel hired to receive patients. These guards, or whatever you want to call them, can be guards just like our guards are. On-call trained personnel. You don't need full time employees for this position. We have complained to hospitals before about the time to receive patients and it hasn't got any better.

Increase on-site security personnel to alleviate police remaining for extended periods of time.

There should be at least one full time, trained security professional on duty 24 hours a day to accept and deal with mental health inpatients.

The security staff could float or be shared by many different hospitals.

Eliminate the use of police as security for mental health patients in hospitals (hospitals to provide their own security).

Security in hospitals [is] a priority.

Everyone always says 'training'. An easy, catch-all remedy that is often over-worked and over-emphasized. Training is over-rated.

Security will also allow an officer to brief them, possibly leave a written account of what transpired, a contact number for a worthwhile chat on the phone, and the officer is then allowed to clear, and return to the street.

The suicidal party CAN WAIT in a secure room. Look after the kids, the elderly, the sick and injured. Take your time with the mental health patient. Read the intake form, contact the officer, get the story, and then make contact with the EDP.

Taking a step back, I find the tail is often wagging the dog.

If the hospital security fell under the local police force, could the officers go back into service immediately upon booking them in. I am thinking of the current system for court security/prisoner transport that is used in [city]. The staff there are sworn members that do the runs to/from court, and take the prisoners to/from cells at the courthouse, and provide security in the courtroom. They are under the supervision of a uniform Sgt. The benefits to both may make the cost worthwhile for the hospital (where it is practical for the hospital and local force to implement). Some large US cities have a sworn police on each floor (but they are huge hospitals). The most common theme I would guess you'd hear is time.

Develop service agreements with police to "employ" Special Constables as on site security who can take custody of patients transported to the hospital and also they are able to supplement hospital security departments.

Some hospitals have police working as "paid duty" as in the Windsor model, but their presence is restricted to dealing with rowdy emergency room patients.

There is too much inconsistency when comes to police being required to guard patients for extended amounts of time. Some hospitals pay for paid duty officers and some refuse so the officers must be called in on overtime.

All hospitals need to have the same protocol when they require police to act as security for a patient.

Safe Room

A safe room designated in the hospital for the police to guard a patient. At times rooms used for guarding are right in the emergency room (too many hazards accessible to the patient).

Hospitals should provide a secure room where parties can be held while they wait for assessment.

Police have authority when they are involved

Make it clear to hospitals that the security of the patient, when police are involved, are the responsibility of police. Medical physicians, nurses or other medical staff cannot order the removal or non-use of restraints for violent or potentially violent [patients].

Firearms

Clients with mental illness should not possess firearms. Clients should have to disclose if they have firearms if they become sick after their possession of firearms.

Transport

Once person is committed to a [mental health] facility it should be the ambulance's responsibility to transport that person, [who is now a medical patient], unless they are violent.

Service coordination and communication

One set of protocols with hospital, mental health community and. police services within county and city

Coordinated response from all services and understanding of needs and restrictions.

Standardizing policy across the Province.

Protocols between police and available services. However only one -- not more than that.

Meetings with hospital officials to brainstorm and gain support.

Better relationships and partnerships between hospitals and police.

A combined and agreed-upon provincial policy, displayed and understood by both sides, should be posted and used at all times. This would eliminate any misunderstandings that occur from day to day. Communications are essential in keeping the [mental health] process running smoothly.

Value police officers' information

When an officer arrests and brings in a suicidal person, the hospital should recognize this process, and bring the officer / investigation / witnesses to the table immediately. The first person the attending Doctor should speak with is the arresting officer. Get the story, get the pain and concern, get the truth, rather than walking by this foot-soldier, and do an uninformed and blind assessment.

Crisis team members must continue to weigh the police involvement and other occurrence background. Ask the police if there has been any other police involvement of similar nature. If the police officers are doing their job they should have that information.

Medical Staff must be willing to believe police officers when they are describing why the officer apprehended the individual in the first place. We have had a number of incidents where the officers have related an individual's attempts at a police-assisted suicide and the physicians have 'written' it off as not being serious.

For chronic suicide attempters, consider case conference WITH police prior to discharge.

Improve assessments and interventions

Involve the family.

Information on mental health needs to be provided to family members of the patient so that they can better understand what they may face in dealing with the patient. Health care providers need to collect information from family members during the admission process, so that they can understand possible risks i.e. firearms available. People do not generally

Police Suggestions For Change (Q 3 and 4)

understand the risk of suicide, to most it is unimaginable, therefore they do not automatically think of removing firearms from the home etc. Case Example: 50 yr. old female taken to local emerg by her husband because she has been demonstrating behaviour that was believed to be the result of mental illness (depression). Health care are told by female that husband is just trying to "lock her up in the hospital." Health care tell

husband that his wife does not wish to see him. There is very little communication with husband at all. Mother of female attends and subsequently the female is discharged and eventually returns home to husband and three children. She apparently left the hospital prior to seeing a medical doctor. Within a short period of days the husband again takes his wife to the hospital again because of her behaviour. Again, his wife indicates to health care workers that she does not wish to see her husband. She is provided medication for depression and released to her mother and returned home to her husband and children. At no time was any significant background information sought from the husband, in this case. [If this information had been sought,] the health care workers would have found that the female had made recent inquiries with her husband and her eldest son about accessing her husband's gun cabinet. A short time later, when her husband was at work and after she sent her children to school on the bus, she opened the cabinet and fatally shot herself. At that point in time the husband had not spoken to a health care worker or doctor. He knew that his wife had been prescribed anti-depressants and never admitted to hospital.

There should be some sort of limit as to how many times a suicidal individual can be released before they are admitted for some sort of treatment.

Have a 12-72 hour hold on clients to ensure no lies have been told. Clients being brought in for assessment and then released, a few days pass and the client is returned to be assessed. If the client was held for assessment in the first place time, [then] resources could be have been used in other areas of concern.

It tends to become tedious when you are constantly bringing back certain individuals who had been released earlier after being deemed "safe". If we have to bring back a patient a second time then the initial assessment was clearly incorrect. This issue may have more to do with the lack of beds (read: funding) than the lack of appropriate training for the hospital staff.

Risk assessment tools need to be utilized in the case of suicidal patients. Questions relating to availability of firearms, children, spouses need to be asked to assist in assessing risk to the patient and others.

ALL form 1 patients need to be assessed by a qualified psychiatrist before being released.

It is also inadequate and immoral to have a lesser trained health care professional make mental health assessments that can result in life and death implications when they are inaccurately made or worse; done under the guise of fiscal responsibility. Again, that means more psychiatrists and more beds are needed.

General practitioners are not necessarily qualified to assess suicidal patients.

More Community Resources

Mobile Crisis Intervention Teams (MCIT)

\$ for deployment of social/crisis worker available for 24 hr intervention and to assist police for possible pre-apprehension options.

In a perfect world, every hospital should have a MCIT consisting of a police officer and psychiatric nurse.

Funding to develop police/mental health teams in every community.

I believe that every community should have a specialized police/mental health team to respond in the community to mental health crisis. Preferably, a specially trained officer coupled with a psychiatric trained nurse.

Physician accessible to police by telephone

An emergency number for police only to consult with an attending doctor who could be given information on the occurrence and could consult with the officers at the scene.

Mental Health liaison officer in every community

Every community needs to have an officer assigned to be a Mental Health Liaison.

Change the Provincial Standards for policing to include this.

Safe beds

Proper "safe beds" that are designated as Crisis Beds to provide appropriate lodging for this specialized clientele.

Community safe bed(s) in staffed secure type locations with supports for pre apprehension diversion.

We need some sort of facility like a group home that is equipped to deal with people in a suicidal state. Our options are Form 1 or lay charges, there is no in-between due to our geographical location.

Other comments

[Advertise and promote] more resources of community agencies that could help without having to take them in....

Better followup.

The amalgamation of mental health services under one roof. There seems to be a desire to get things done, however dysfunctional services are creating roadblocks.

Availability of further psychiatric services to hospitals.

The patients need better resources. A lot of the same people are brought in for attempt suicide and the feedback from them is that there is no one helping them so therefore they call police and it becomes a vicious cycle.

Resources should also be dedicated to follow up under the guise of tracking and recording the horror stories. i.e. each and ever MHA arrest deserves a follow up. Home visit, home

Police Suggestions For Change (Q 3 and 4)

interview, friends, family and co-workers should be interviewed or at least contacted. Questions to ask: How do you feel the system helped your loved one with their problems? Are they better? Are they 'fixed'? Do you feel they will again attempt suicide, or again be admitted to a hospital for mental health issues? Do they understand they can refuse to take their meds? How do you feel about that? What would you say to a sitting High Court Judge (i.e. Supreme Court, Provincial Court of Appeal, etc.) that supports the right to refuse the taking of meds? Would you like one of these learned persons to walk in your shoes for a month?

Have discharge plans for all "clients" with dedicated referral and follow-up.

Reduce patient's waiting time

Have a Crisis Team on 24/7.

Having social workers on standby at E.R.s greatly assists officers who attend the hospital with an EDP.... [social worker can] act as a 'go-between' for the Police when dealing with hospital staff. The social worker may also be able to supply additional support by means of arranging alternatives to detention, or to provide some type of follow-up or home visits.

Giving mental health assessments a higher priority. It is in the hospital's best interest not to have other patients subject to the potential problems associated with an individual with a mental illness and with the comfort level of seeing armed police officers present for extended periods of time.

The first doctor to see the patient could be from the psychiatric hospital instead of the busy emerg doctor.

Create a protocol that requires doctors to make suicidal persons a priority unless there is an urgent trauma or matter to deal with....

Patients should be seen within a half-hour by a doctor.

Put into practice the ideal that police contact the hospital while transporting the patient so that someone is prepared to examine the patient on arrival and arrangements to locate an available bed are already ongoing.

Streamline the process when dealing with suicidal patients.

Is there really a need for psych to confirm the patient acceptable to the facility even after a medical doctor has formed him/her????? I would think that after the medical doctor forms the patient, then we as police transport the patient to the facility, that we should be able to deliver to psych facility and have psych do their process after our departure....

Education

Hospital staff should be made to know that we cannot leave until the patient is assessed. While they may know this, it seems they often forget and I've had ER personnel ask me why I'm still hanging around. If they realize we MUST wait until a hospital takes custody of a patient maybe they will make a more conscientious effort to see patients sooner so that we can get back on the road.

Less policy and more practice. Training/awareness days together.

Police Suggestions For Change (Q 3 and 4)

Increase the knowledge of available resources and services on the part of both police services and emergency departments.

Inter-agency training that outlines each other's obligations under the various Provincial Statutes.

Policies currently in place are not being followed.

Develop a training program around dealing effectively with issues such as suicidal ideation, mental illness, concurrent disorders, de-stigmatization and sensitivity for police and emergency staff to be offered through the Ontario Police College, medical and nursing schools, and in the workplace.

Education and training for officers and medical staff to understand the problems facing both the law enforcement members and the medical staff. With understanding we can then develop more effective resolutions.

Ongoing info sessions for front line officers and frontline emerg staff

Require ongoing, on-the-job education regarding community resources, mental health issues, triage procedures, requirements for Forms 1, 2 and 3, police response, use of restraints and so on for frontline emergency department and policing staff.

Standardized reporting tool for police

Use of a mental health template by front-line officers. The template would be a simplified version of an emergency psychiatric assessment and would follow the same order of questioning and observations that a psychiatrist would use in making their assessment.

Create standardized reports/templates that Officers can fill out upon arrival at the hospital to check-off observed symptoms, record patient statements. Possibly similar to a Mental Health Triage Scale that the officer can provide to the hospital to assist in rating urgency.

Related to transport

[Transport mental health patients] by ambulance with police presence, since the person is under medical care when being transported by police.

More training should be considered for those that have to travel ... long distances or consider having medical personnel accompany the escort.

In general our detachments and the local hospitals have a good working partnership. One detachment had an issue about MHA clients needing to go to a hospital 2.5 hours way. An agreement was worked on in which Ministry of Health now pays for police, via paid duty, to transport the subject to hospital. This agreement has reduced police costs and improved officer availability in this community.

Miscellaneous

When loved ones die a resource to monitor next of kin to assist with the loss. Maybe a follow-up call to next of kin or family. Notify family of key signs of suicidal thoughts. Male tried to drive his car head on with others on the 401hwy and then got out and stepped

Police Suggestions For Change (Q 3 and 4)

in front of a transport truck. His wife died of cancer two months prior, the obituary made reference to his soulmate died. This should show signs that they were very close and family should be monitoring his actions.

Parking facilities at local hospital available and assigned specifically for police.

Schedule 1 facilities as the primary gateway to mental health crisis intervention is wrong.

The police cannot be the gatekeepers to this system. Healthcare needs to step up and take possession of this healthcare issue. The police are able to assist in the very limited dangerous situations. We are being relied upon to staff understaffed hospitals.

Develop an elopee registry with photographs to facility missing persons investigations.

Improve information flow to and from police

Communication policies must be changed at the hospitals to include input from police and to allow some communication to flow back to the police.

In order for the process to work effectively, police and hospital staff need to have better and open communication. For both sides, complete patient confidentiality might not be in the best interest of the patient or community.

There is good communication with [hospital] staff, however this privacy issue is causing delay for us to help [patients] or their families.

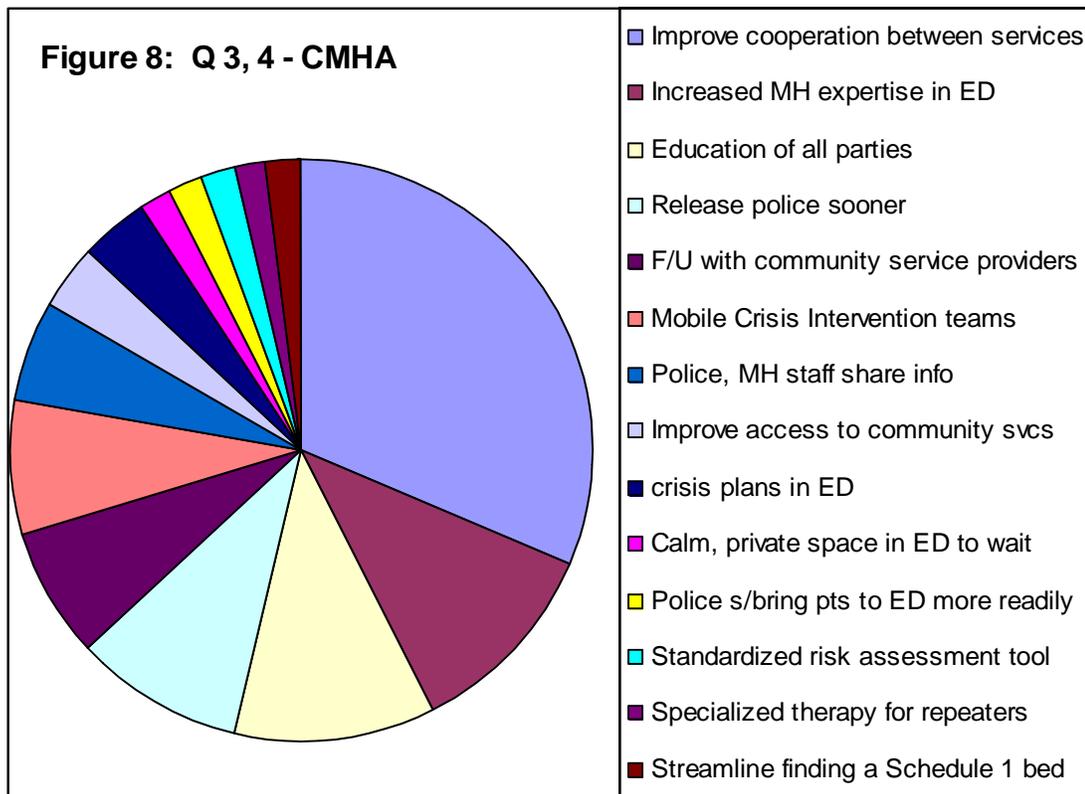
Understanding the need for police to have the most recent information to assist the victim and/or family in the recovery of these victims. Need for a more cohesive working relationship when sharing information.

Information sharing, including police representative in the patient's circle of care so that a diversion option may be found prior to apprehensions.

Just more communication and consistency when requesting information to aid in investigations in relation to those who need or help. We [police] are always on scene [first].

3.7.2. CMHA Suggestions for Change: 54 responses

Category of Response	# Responses	% of Total
Improve cooperation between community mental health programs, police and hospitals	17	31.5
Increased mental health expertise in ED	6	11.1
Education of all involved parties	6	11.1
Release police sooner	5	9.3
Follow-up with community service providers	4	7.4
Mobile Crisis Intervention Teams	4	7.4
Police, mental health staff to share information	3	5.5
Improve access to community services	2	3.7
Crisis plans in ED	2	3.7
Calm, private space in ED to wait	1	1.9
Police should bring patients to ED more readily	1	1.9
Standardized risk assessment tool	1	1.9
Specialized therapy for repeaters	1	1.9
Streamline finding a Schedule 1 bed	1	1.9
	54	100.2 (> 100 due to rounding)



Improve cooperation between community mental health programs, police and hospitals

Collaboration between all three services.
Streamlined access to services.
Police/mental health liaison workers, possibly connected with court outreach programs.

Create service agreements delineating roles, responsibilities and expectations. This acknowledges the need to partner, work better together and evaluate the effectiveness, outcomes and progress (or lack thereof). Based on this, determine what needs to change.

Community partnerships that are funded and supported locally.

Communication with community service providers i.e. crisis mandate between two services.

Services have their own internal policies and practices. There are no policies between services.

This issue must be looked at with a broader number of partners than just the hospital and the ER. Community services, the community at large and education systems must also be considered. Suicide is an issue that must be considered from a more global lens.

Example: A representative from the police services is involved in the local human services and justice coordinating committee. The relationship building from this involvement is outstanding. The police representative can be contacted when there are issues of concern regarding clients or the manner in which police have dealt with a particular situation. The police representative is often able to access information to clarify the situation, make modifications in the process, or utilize the situation as a learning opportunity.

Increased mental health expertise in ER

Access to psychiatric expertise: Physicians are responsible to make the decision about holding the individual for further assessment, yet they may not have the expertise, knowledge or time to make an appropriate decision. Access to expertise is essential.

There needs to be an expectation for the docs to use crisis workers.

Routine use of the mental health worker being called to the emergency and use of crisis line workers in off-hours.

More staffing. More psychiatrists/doctors. A mental health nurse in the triage would be beneficial. Increased resources for mobile crisis teams when the demand for the service is demonstrated.

Release police sooner

Reduce waiting times and improve privacy by ensuring timely triage and quicker shift of responsibility of individual to hospital from police.

Education of all involved parties

Police need to respect that doctors are assessing for immediate danger to self or assessing for behavior issues (in which case they discharge). Hospital staff needs to respect that it is important to view suicide as an important issue (just like any other emergency) and respect that the police can't spend hours in emerg.

Overall the police provide a high quality service to the mentally ill person. The additional training in recent years is paying off. Therefore, this training should be maintained and perhaps increased since a very high proportion of calls involve mental illness.

Attend educational sessions on mental health, suicide, Brian's law and more have specific officers trained to respond on each shift.

Mutual education and shared training. e.g. it would be beneficial for community agencies to receive a presentation from the ... police forces in regards to intervention with mentally ill or suicidal individuals. It would also be beneficial to have mental health consumers and survivors of suicide attend this presentation.

The police in particular could benefit from in-service training by and in conjunction with mental health service providers specialized "sensitivity" training for nurses and doctors working in emergency.

More education for Suicide Awareness and intervention skills training.

More training of police officers regarding the suicidal individual. Officers should be able to take individuals to hospital for assessment if a MH worker has indicated that the individual has just threatened suicide. Recently officers spoke briefly to such a client and decided that he was not a serious threat; that individual was not taken to hospital and committed suicide later the same day.

Follow-up with community service providers

Community organizations need to be aware of processes in place, and should be included in the process immediately if the person is not admitted.

Ensure police follow-up with service providers following apprehension.

Mobile Crisis Intervention Teams

Need to look at creative strategies to engage with people who are identified at risk. We engage in proactive outreach with the Police. Mobile and Police go out together on calls, when the risk has been identified and engagement with the person at risk is a challenge. Need increase resources to make this a more consistent practice.

Creation of mobile crisis team -- response team on-call comprising of officers and crisis personnel trained specifically for situational response.

Each of the remaining categories had 3 or fewer responses:

Share information

Allow sharing of information between police and mental health staff.

Improve access to community services

Access issues need to be addressed. Access to rapid response treatment services need to be based in the community, with easy access for police and mobile crisis teams. Current access is determined after the process is initiated in the hospital.

Protocol for referring individuals from hospital ER to community for follow up. ...Family members who have waited in ER were not even aware or advised of the Crisis Centre or any community agencies...persons not admitted or given any further assistance to find supports. Effective community partnerships are needed.

Calm, private space in ER to wait

Improve confidentiality by having a more private place to wait for services. Physical set-up environment is not conducive to a calming effect.

Crisis plans (care plans) in ED

Although crisis plans are submitted to the Emergency Department, I am not certain they are accessed regularly. [Crisis plans] could be very helpful.

Police should bring patients to ER more readily

As a matter of protocol, police could "err on the side of caution" and take clients to emergency without "assuming" they are just being difficult.

Standardized risk assessment tool

Standardized risk assessment tool which could be implemented by police/community support worker. This would potentially allow police to leave once individual is supported in the hospital waiting room by the community worker.

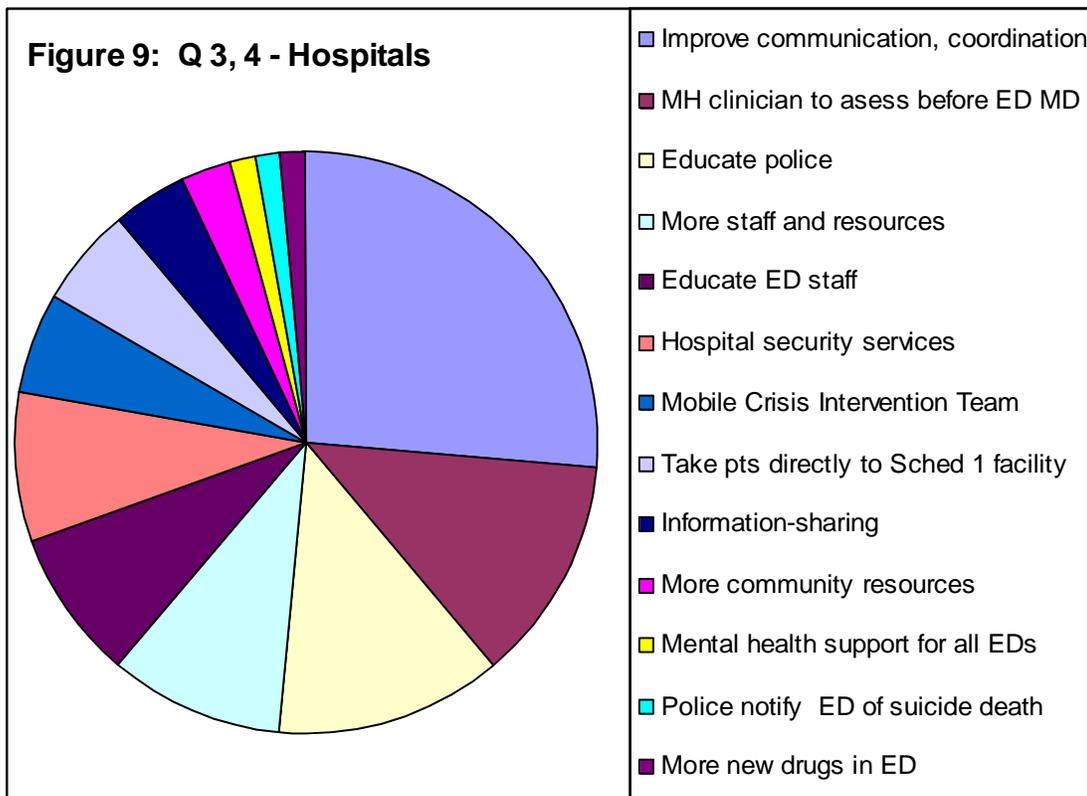
Specialized therapy for repeaters

Specialized therapy for individuals who self mutilate, a case example, a person who will cut themselves ... deeply... is admitted and discharged (repeatedly) with no access to therapy in the community. They continue to mutilate, the risk increasing each time.

If the Schedule 1 facility cannot accommodate the admission *they* find another bed.

3.7.3 Hospital Suggestions for Change: 72 responses

Category of Response	# Responses	% of Total
Improve communication and coordination	19	26.4
Mental Health clinician to assess before ED MD	9	12.5
Educate police	9	12.5
More staff and resources	7	9.7
Educate ED staff	6	8.3
Hospital security services	6	8.3
Mobile Crisis Intervention Team	4	5.6
Transport patients directly to Schedule 1 facility	4	5.6
Information-sharing	3	4.1
More community resources	2	2.8
Mental health support for all EDs	1	1.4
Police notify psychiatry emergency service of suicide death	1	1.4
More new drugs in ED	1	1.4
	72	100



Improved communication and coordination between police and ED

All services need to be coordinated to ensure mental crises are dealt with in the community where possible, and mental health emergencies only go to police and ERs.

I feel that we should have a committee in each hospital that is made up of ED head, Crisis Coordinator, Police administration and front line constables, crisis workers, crisis mobile worker and Charge Nurse. So much manpower is involved here between the Police, Crisis and the ED and there are too many inconsistencies. Often information stays at the management level and it is the front line staff who need to be familiar with protocols, policies and procedures.

Better coordination for all groups involved with concurrent disorders.

Local police/hospital teams with adequate funding to staff to allow working groups to meet.

More resources for joint programs, more evaluation of these programs, and better policies to facilitate communication in emergency situations.

Collaborative initiatives/resources/planning.

Better communication between police, emerg and psych staff informally in the ED and formally at the police department and ED with meetings, presentations, etc.

Improved communications -- not just when problems occur.

Hospital ER and police services need to be coordinated and partnered with community crisis services. There are different models for different contexts.

Bigger issue that our [local] systems/government/communities [can solve. We] need to advocate for a National Strategy for Suicide Prevention.

Develop policy for patients being brought to ER under Mental Health Act (? police have policy but hospital does not). Communication/report on arrival for direction.

Mutually agreed on algorithm to facilitate patient assessment, police discharge and patient disposition.

Everyone needs training as each of these sectors (police, hospitals community services) has a different 'culture,' mandate and legal framework.

Joint education for ER physicians, ER staff, hospital crisis team, police, and community mobile crisis service.

Early notification of doctor on call in mental health services that police are bringing individual to ER so that any history available can be accessed, i.e. doctor's notes, therapists notes, old charts in advance.

Standardization of practices across general hospital system.

Mental Health clinician to assess before ED MD

Dedicated experienced mental health workers in the ED to receive these patients.... and let the police go.

Where a physician assistant or other psychiatric paramedical worker is available to see such a patient, it would be helpful for them to perform a preliminary risk assessment (rather than the more customary exhaustive and time-consuming assessment) then report to the ED attending what the patient's risk status is and whether the police should be authorized to leave.

Mental health staff available in the ED when the patient is brought in to immediately begin de-escalation / assessment as opposed to having to wait for "medical clearance"...before skilled de-escalation can occur...

Perhaps arriving police to hand off patients to crisis worker (as opposed to waiting for physician).

ER triage has been identified as holding up the process. [Police], when they call Crisis directly, wait for less time.

Fast-track of MCIT patients directly to psychiatric emergency service system with concurrent rather than sequential medical clearance.

Fast-tracking of mental health patients to psychiatric emergency service beds.

Educate police

Increased training in mental health issues for police.

Education of police re Mental Health Act. Guidelines for police re observation and attention of intoxicated/abusive patients with non-mental health act issues.

Education of police officers as to what should be of concern and when we need to see patients.

Sensitivity and tolerance.

There should be some clear exceptions under MHA apprehensions. Often police present to the ED with individuals under the MHA that do not require admission (psychiatric or medical) that the Crisis team can manage. Further, if police bring an individual to the ED not under the Act, some hospital staff believe police are required to stay with the patient until they are cleared by the ED Physician. At the same time, some police feel that they are required to do this as well. Again this demonstrates a flawed communication system, as it is apparent that there exists confusion amongst both the Police and the Hospital.

Develop a multi-governmental approach for consistent training of police re mental health issues.

Written documentation/assessment form for transfer of care (e.g., tick-off list).

Common risk assessment language, e.g., Applied Suicide Intervention Skills Training.

Consistent, uniform approach by police to transfer responsibilities of Form 1 patients.

More staff and resources

More available psychiatrists and child psychiatrists.

More resources for adolescents at risk.

Adequate/enhanced resources (physical space/staffing/support).

On-site crisis team; 24/7 social worker.

Capital and operational \$\$ to operate more ACU secure beds.

Hospital/corporate support of the increased issue of suicide [and] the demands upon our ER and Psychiatric services... Assessment is done by clinicians/people not machines. We spend \$\$\$ on new laboratory and diagnostic technology, but fail to invest in our clinicians and programs.

Greater hospital bed capacity and flow would allow fewer admits in the ED and facilitate all patients being assessed sooner. Having the triage and/or charge nurse frequently communicating with the police about wait times, expected assessment and disposition would improve the current situation.

Educate ED staff

[Educate] ED staff and police regarding suicidal clients, and ways to help de-escalate the situation. [For example], what gaffer statements are likely to make the situation worse and how to avoid those...e.g.

“What did you do this for? You’re so pretty.”

“You’ll never get a husband if you keep doing this.”

“What, you again?”

We could all use more training on how to work with dual diagnosis patients from intoxicated to fully cooperative stage.

A high number of suicidal clients will likely have experienced trauma in their lives. Currently, many are re-traumatized in their interactions with the police and subsequently in the ED with transfer from handcuffs to restraints as [according to perception of police and ED] “a matter of course”... We need to figure out how to manage suicidal clients in the ED differently. [Patients] will also be highly attuned to attitudes and non-verbal responses of providers. It appears a number of ED staff are not trained to deal with mental health patients, nor do they want to deal with mental health patients. Similarly I have heard police officers talk about “hating” having to respond to EDP calls. Neither of these unconscious/conscious responses is going to get beyond the highly attuned, hypersensitive suicidal patient who will respond/react one way or another.

Staff who ... “hate” some of the stigmatized diagnoses ... [and patients] who come in for suicide attempts or suicidal behaviour.

Understanding that restraints are a last resort, not a first...even if the ED is busy.... a lot of clients can be de-escalated with words... and time.

The “unwritten” or written rules (I’m not sure which is what) about how long it “should” take to see a patient in the ED before they are resourced out...a solid de-escalation is likely going to take more than 15-20 minutes.

Hospital security services

Added security staff who can take over one-on-one supervision and release police.

Better security services for maintaining patient in ER.

24-hour security presence in ER.

When police are, very occasionally, needed for one-to-one on our unit, they feel they are only there for when patient acts out and they need to intervene. We feel they could contribute greatly to the care and safety and security of patient, and try to prevent escalation, by providing one-to-one "eyes-on" care. Officers have refused to "watch" patient one-to-one, which leaves me asking the true value of them if they are only emergency management and will not assist in observation or intervention.

Clarification of the role of non-physicians, e.g., emergency nurses, mobile or ED- based crisis nurses, to direct hospital security officers to prevent a patient from leaving if the nurse believes the patient to be high risk (i.e. pending an MD assessment and form 1 completed). If RNs can, in fact, direct security officers in this way, we could assume care of the patient and relieve the officers more quickly.

Transport patients directly to Schedule 1 facility

If the patient is deemed suicidal by the police, it would be preferable that they be directly brought to a Schedule 1 facility for assessment and treatment, instead of our local [non-Schedule 1] hospital.

Each small community hospital should have a Schedule 1 psychiatric facility to arrange transfer of both adult and pediatric patients.

Would be helpful if police could transport patients on Form 1 to our regional mental health centre. Right now they are not allowed to do this. Patients [who] need ambulance transport often wait for hours.

In non-medical emergencies it would be more efficient use of resources and police time if patients under MHA are taken directly to [a Schedule 1] facility if the patient's immediate health issues are not a concern.

Information-sharing

Need solid direction and policy on "informing police if patient is discharged" that balances patient's rights, staff's comfort in informing police, and community safety.

Must have procedures for information-sharing, [not just] at the ER but at all crisis/emergency service junctures.

We need better policies around the sharing of information; particularly when someone is an acute risk for suicide.

More community resources

We need to ensure that community resources are adequate to prevent crisis and divert from emergency services.

Access to psychiatric consultation and assessment in the community is critical to diverting from ERs and police. If the only way a GP or mental health worker can get psychiatric assessment is to go through the ER or hospital we will not reach our goals of de-criminalizing mental health and ensuring appropriate use of ERs and hospital beds.

Mental health support for all EDs

Hospitals without psychiatry resources at the ER need access to psychiatry consult by phone or other ways. Other mental health workers need to support them, e.g., mobile workers or psychiatry hospital outreach workers to do assessments in small ERs.

Notify Psychiatry Emergency Service [PES] of suicide deaths

It would be very helpful if police notified specialized PES of persons who died by suicide for QA purposes. Some sort of formalized system would help a PES to review our care of the person, especially if patient was recently discharged from hospital.

3.7.4 EMS Suggestions for Change: 8 responses

Education

On a more provincial note, I think the educational standards in dealing with mentally ill patients at the paramedic level is insufficient and should be addressed.

Education on mental illness so patients more likely seen as medically ill instead of criminally.

Training with police department regarding [their powers under Mental Health Act].

Clarify roles and responsibilities between police and EMS

I think the police colleges and the paramedic colleges need to discuss a systemic approach to these patients as both services are required to be involved. Under the current mental health legislation, paramedics can assess a patient as a threat to themselves or others, but must involve the police when the patient is uncooperative and will not go the hospital. Practical items need to be worked out, such as, what happens if the paramedic assessment is not agreed with when the police arrive? How do the police deal with vehicle movements if their officer is in the ambulance? How long do the police have to stay posted at the hospital until they can be released to the community? These are practical concerns that make it difficult to get the patient what is needed.

Give EMS powers under MHA?

I would like to see EMS have some power under the MHA for patients without capacity, or patients that are suicidal.

Escorts have authority to restrain/sedate

In order to assist with the health and safety concerns of the ambulance service, I would like escorts with the authority to sedate/restrain patients be mandatory, not dependent on hospital resources at the time.

When is ambulance needed for Form 1 pts?

I would like a clear definition of when an ambulance is not required for transportation of a Form 1 patient (and Form 2, on occasion).

I would like emergency physicians/hospitals to be educated on the system approach of the patient not just "get them out of the emergency".

3.7.5 Family & Advocate Suggestions for Change: 11 responses

Training (4 responses)

Review training and ensure that all medical personnel connected with emergency departments have appropriate training in risk assessment and intervention.

If the police, paramedics, firefighters, EMTs, etc. were required to take Applied Suicide Intervention Skills Training or similar training, their level of understanding would be greatly increased as well as compassion and tolerance. This couldn't help but also improve the relationship with others trained to deal with suicidal clients. Front-line emergency response workers NEED to know, among other things, that depression is a disease and to recognize the behaviour as how the disease presents itself.

...make the course a compulsory continuing education course.... if CPR is one of the many required skills to be updated and practiced in order to be prepared for lifesaving intervention, then "CPR for the psyche" is just as important for the same reason - it is a life saving skill and needs to be regularly updated and practiced.

...I see Suicide Intervention Training as the beginning with occasional presentations by specific survivors of suicide such as myself who can relate to them as an emergency responder, but who can reach into their hearts to help them feel the true pain that people with mental illness suffer, and stir that sense of compassion and desire to care, back to the surface again.

Involve caregivers (3 responses)

The whole family should be involved in the healing process. Families need to understand suicide prevention, to be able to watch for danger signals, to know where to go for help, and when to approach the health care system. Family members need to be able to understand their own feelings and fears, and need to know what to say and what to do for their suicidal relative. Suicide affects the whole family. A family systems approach should be implemented, to assess the family from a holistic point of view.

Disclosure of practical information to caregivers should be addressed. Too often, patients are released to the care of someone who has little idea of medication available, support, etc. Confidentiality should be scrutinized. Flexibility in releasing information is important if caregivers are to be effective.

Have some good information brochures for patients and family members.
Show compassion and concern more than frustration -- it is easy to be frustrated when someone is risking their own life when others are dying from illness.

Standards of care (1 response)

Develop response algorithms, and adopt standards of care for risk assessment with documentation to ensure that they have been followed.

Reduce wait times (1 response)

[Long waiting times] may be grudgingly tolerated for illness or a broken bone, but are hardly justifiable if someone is in distress and at risk. Poor service likely means that those at risk will view emergency services as not helpful, decreasing the chance that they will consider using them if they should become at risk again.

Youth Mental Health needs (1 response)

Youngsters should not be hospitalized with adults. Their needs are different. Specialized

units, perhaps freestanding ones, should be set up to meet the needs of suicidal individuals. Need highly specialized teams to assess their needs, treatment, follow-up protocols, etc.

More community services (1 response)

Earlier risk assessments and interventions in the community could help reduce inappropriate referrals.

Part 4: Existing Agreements between Hospitals and Police

Section 33 of Mental Health Act: Duty to remain and retain custody.

“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.

I found four agreements between Ontario hospitals, police departments and other services intended to reduce police waiting times and otherwise facilitate cooperation between services. I also describe a protocol from Winnipeg which takes a different approach to the Ontario agreements, and I also mention one Ontario hospital with a standard of care addressing timely release of police.

By way of explanation, there are three types of security personnel referred to in the following documents:

- *Commissionaire*: A uniformed attendant with no responsibility for restraint or physical intervention
- *Security officer /Protection Services Officer (PSO)*: Expectations of PSOs differ between sites. Some sites use PSOs for restraint of patients as needed; other sites do not allow their PSOs to restrain patients.
- *Special Constables*: A peace officer with powers to enforce specific federal and provincial legislation. Employers must be authorized by the province to employ special constables.

Two additional points:

- “EDP” (“emotionally disturbed person”) refers to an individual apprehended by police under the Mental Health Act.
- Typically two police officers are required to safeguard an EDP until the hospital assumes custody.

4.1. Windsor Hotel-Dieu Grace Hospitals

This agreement, titled "*Fast Tracking Persons With Mental Illness Under Police Accompaniment To Windsor Hotel - Dieu Grace Hospitals Emergency Departments*," states "every effort will be made to giving priority to the transfer of custody," but does not include a maximum waiting time.

The agreement requires police to call ahead to the ER. On their arrival, a designated staff member (from 0900-2100, a psychiatric assessment nurse; from 2100-0900, crisis centre staff) takes pertinent information from police and assesses the patient. Police remain with the patient until the hospital accepts custody.

More recently, crisis centre staff has been doing assessments for "walk-ins", thus freeing up the psychiatric assessment nurse to attend to patients brought by police.

Experience

No quantitative information is available to evaluate the effectiveness of this plan (private correspondence, 2006).

4.2. Cornwall Emergency Mental Health Response Protocol

Signatories to the Cornwall protocol include the Cornwall Community Hospital (CCH) Emergency Services, CCH Psychiatry Services (including a Schedule 1 inpatient unit), and the local Mental Health Crisis Team. The crisis team, based in the same building as the CCH ER, serves the ER, provides assistance in the community to police and ambulance, and provides next-day assessment to clients seen by police/ambulance/emergency room when the crisis team is not available. Crisis team also provides short-term follow-up.

Security in the CCH ER

Commissionaire staff only; there is a non-secure observation room in the ER.

The Protocol

The protocol requires the police to remain with the patient in the ER "for a period of up to one hour unless other medical emergencies in the ER make this time frame unrealistic." The ER Physician is **to consider a potential involuntary admission a medical emergency** (only medical trauma situations have a higher priority), and is expected to see the patient as soon as possible, but no more than 1 hour after the patient's arrival.

Details of assessment process

Police contact crisis team to determine if the situation can be dealt with outside of ER. If patient needs to be taken to hospital, police inform ER in advance.

On arrival, if the patient does not require immediate medical stabilization, the Crisis Team does a brief initial assessment, and then the triage nurse, crisis team and police determine immediate safety needs. This information is communicated to the ER physician on his arrival. The crisis team then proceeds with their assessment, usually before the ER physician sees the patient.

The hospital accepts custody -- and police may leave -- when

- (a) the ED doctor and police agree there is no safety risk, or
- (b) if a safety risk is present, when the police bring the patient to the CCH psychiatric unit, or
- (c) If patient requires admission but there are no beds at CCH, police transfer the patient to another Schedule 1 facility.

If the patient requires admission, the ED physician, or the crisis team acting on the ED physician's behalf, contacts the on-call psychiatrist by telephone. The psychiatrist can give a telephone admission order (and will see the patient the next morning).

Experience with this agreement

Since implementing protocol, the waiting time for police has been significantly reduced. **The average waiting time for police is below an hour, and 64% of visits are under an hour.** Of note, for most of the patients, the ED physician accepts custody after he/she sees the patient and agrees with police there is no safety risk. Only a small percentage of MH apprehensions result in admission (Private correspondence, 2006).

A committee consisting of representatives of Police, ER, Inpatient Psychiatry and Crisis Team meets regularly to review wait times.

4.3. Lanark, Leeds and Grenville Mental Health Crisis Response Protocols

This protocol is similar to the Cornwall protocol discussed above.

Signatories include

- OPP, Police services of Brockville and surrounding communities
- Ambulance services
- Brockville Psychiatric Hospital [BPH] / Royal Ottawa Health Care Group Elmgrove Service -- a Schedule 1 facility with no general medical services serving the three hospitals below.
 - The BPH Crisis Team is key to this arrangement. A crisis worker from BPH is stationed in the BGH ER 8 hrs/day, Monday to Friday.
- Brockville General Hospital [BGH] -- across town from BPH; has no inpatient psychiatric services
- Kemptville District Hospital (30 minute drive from BPH)
- Perth/Smiths Falls Community Hospital (90 minute drive from BPH)

Security in the ER

BGH has in-house security personnel but none are stationed in the ER. Security staff are *not* expected to restrain patients. The ER does not have a secure room for Form 1 patients.

The Protocol

"Police will remain with patients transported to the ER for evaluation under 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 will be made at the point that a decision regarding admission or discharge is made. Police will remain in the ER if specifically requested to assist with an agitated, aggressive or volatile patient."

Details of assessment process

(a) BGH: When crisis worker on-site

The crisis worker does the triage assessment, in part to determine if police can be released. If the crisis worker determines police are no longer needed for safety, and the patient is unlikely to be placed on a Form 1, then police can leave. Otherwise, police stay.

The crisis worker then proceeds with the complete mental health assessment, then consults with a BPH psychiatrist by telephone. If the patient is to be admitted to BPH, police must wait until medical clearance is obtained and then transport the patient to BPH. If the patient is to be discharged, the Crisis Team provides follow-up the next day.

(b) When crisis worker not on-site (BGH); for Kemptville and Perth/Smith Falls hospitals

BPH provides a **crisis line manned by a nurse on an inpatient psychiatry unit.** The ER physician discusses the case with the crisis nurse, who in turn may then consult with the psychiatrist on-call, and together offer the ER physician recommendations. If the ER physician

wishes to admit the patient to BPH, the patient is placed on a Form 1, medically cleared, and police then transport the patient *directly* to a bed at BPH. The crisis worker follows up on discharged patients the next working day.

Experience

For non-Form 1 patients, when the crisis worker is onsite, police wait time is minimized. When the crisis worker is not available, or when the patient requires admission, police retain custody of the patient. On the night shift in Brockville there are only three officers. If a patient is being held in the ER, two officers must stay with the patient, and only one officer is available to the community.

4.4. The Scarborough Hospital (Toronto)

The Scarborough Hospital (TSH), a general hospital and Schedule 1 facility, has a 24/7 onsite crisis worker, and security personnel available to safeguard and manage aggressive patients in their emergency department (but there is no security officer *assigned* to the ED). The ED does not have a locked area.

Enroute to the hospital, police call ahead to the hospital's **crisis team** (not the triage nurse). When Police arrive, the crisis worker begins an assessment, including obtaining necessary information from the police. If the patient clearly needs admission, the crisis worker facilitates the ER physician completing a Form 1, and then hospital security can take over for police (security cannot restrain unless a Form 1 is complete). The Form 1 can be completed even before medical clearance is completed. If a Form 1 is deemed not necessary, i.e. there are no safety issues or concerns re restraint, the crisis worker (or, if crisis worker is not available, the RN, or more rarely the ED physician) and police jointly decide when police may leave. A form for transfer of custody must be completed.

Key features of this arrangement:

1. Police call the on-site crisis team *themselves*.
2. Crisis can begin assessing the case prior to the ER physician having contact.

TSH maintains close relations and consistent communication with the Community Relations officers of police divisions in their area. Police forward cases that involve lengthy (> 90 minutes) waits in ER to their TSH contact and these cases are studied to further improve the system.

4.5. St. Joseph's Health Centre (Toronto)

St. Joseph's Health Centre (SJHC) in Toronto has no formal protocol with the police regarding transfer of custody. Rather, the standard in the SJHC ER is to release police officers **within 30 minutes of arrival**. Within that time, an ER physician will have briefly assessed the patient and determined whether the patient requires a Form 1 (in which case security has authorization to detain the patient) or will stay on a voluntary basis. Crisis workers are based in the ER 24/7, and do brief screening interviews with patients newly arrived to the ER to assist the ER MD, but this screen is not required for the ER physician's initial assessment.

In addition to a departmental commitment to the community and local police officers, the ER has certain characteristics which permit this level of service:

- A locked Crisis Area contiguous to, but physically separate from, the main ER. The Crisis Area has capacity for 12 patients, and includes three single rooms which can be used as seclusion rooms.
- A PSO is stationed in the Crisis Area 24/7. Additional officers from elsewhere on campus can be summoned when needed.
- Services of crisis workers are available 24 hours a day.

- Collaborative relationship between crisis workers, RNs and ER physicians.

Experience

Though no statistics are kept on police wait times for MHA apprehensions, medical and nursing staff informally (and independently) estimate an average wait time of about 30 minutes, with the longest wait times rarely longer than an hour. Toronto police tend to see the SJHC ER as a site from which they can expect to be released quickly.

4.6. Winnipeg Health Sciences Centre

Under an agreement between Winnipeg Health Sciences Centre (HSC) and the Winnipeg Police Department, once police have brought an EDP to the ER, provided information to the triage nurse, and "potential for violence is under control", a special constable (SC) employed by the hospital will take custody of the patient, so that the police may leave. **Release of the police does not require either medical clearance or psychiatric assessment.**

(Note: All in-house security at HSC are Special Constables, a fact that predates this agreement).

This agreement requires the police take the individual to the "most appropriate hospital", defined as:

- a) If apprehending the patient under the Manitoba equivalent of a Form 1 or Form 2, the specific hospital named on the form, or
- b) Hospital where the person's psychiatrist attends, or
- c) If no prior psychiatric history, hospital where the person's family physician attends (or where they have previously received medical care), or
- d) Hospital nearest the person's residence.

Experience

No SC is assigned to the ER, so when police come, an SC must be pulled from another task to relieve the police. When no SC on duty is available, one must be called in, at double-time pay. No additional funds were made available to implement this agreement. Thus, while this arrangement is quite favourable to the police, it is burdensome and expensive for the security department (Personal correspondence, 2006).

4.7 Summary

These agreements represent a commitment on the part of the hospitals to reduce police wait time. ER practice changes involve

- (1) Higher prioritizing of mental health cases by the ER physician, and
- (2) Mental Health clinicians available to do initial, then comprehensive, crisis assessments. (All of the facilities in this section have mental health clinicians involved in the assessment of patients, either onsite or available by telephone.)

When there are no safety issues this works well. When there is a safety issue (and the patient is on a Form 1), then police must stay until assessment and disposition (e.g. admission) is completed, **unless**

- (3) hospital security staff can assume responsibility for safeguarding the patient.

Police wait times in the ER will be minimized if *both* mental health expertise and security resources (staff and physical plant) are available (as in the St. Joseph's model).

Part 5: Inquest Reports

Requests for inquest reports involving suicides were made to all provincial coroners. There were only five cases in Ontario in which police and/or hospital ER involvement played a role in the case. No such cases were identified in responses from Alberta, Saskatchewan, Quebec, Prince Edward Island, Newfoundland and Labrador, Yukon or Northwest Territories. No response was received from British Columbia or Nova Scotia. New Brunswick had a coroner's review of suicide cases already available but the findings were not considered germane to this paper.

In this section I will present first a summary of the Ontario cases, then a summary of the recommendations from all five cases (in the same format as the survey results from Part 3).

5.1 Summary of Inquest Cases

While these reports are in the public record, I have removed identifying information in the descriptions which follow.

5.1.1 Inquest #1: BT (2002)

BT, who had a history of depression and substance abuse, and one previous psychiatric admission for 3 months at psychiatric hospital A, was assessed by her GP psychotherapist as being at risk of suicide. She was placed on a Form 1 and went to the Emergency Department of her local hospital (Hospital Q, not a Schedule 1 facility). Her doctor advised the hospital that she would require transfer to psychiatric hospital A when a bed became available. The day she arrived at the ED, hospital A was over census and had 8 other Form 1 patients requiring assessment. She was kept in a room in Hospital Q to await transfer.

BT, a heavy smoker, became more agitated if she could not smoke. The doctor in Hospital Q reluctantly agreed to give her smoking privileges outside, knowing that while she could not always be accompanied outside for her smoke breaks, there were not enough staff to watch her or deal with her if she had increasing emotional outbursts.

BT was treated with medications, but received no counselling or psychotherapy. Though on a Form 1, she was essentially voluntarily staying in the ED because she wanted to be reassessed by a psychiatrist at psychiatric hospital A with whom she had a previous therapeutic relationship.

On the 3rd day of waiting, BT "experienced pseudoseizures and began doing some self harm gestures to herself namely scratching herself on the forearms with some sort of blunt instrument." An attempt was made to transfer her to another Schedule 1 facility, Hospital Z. As BT's current location was outside the primary catchment area for Hospital Z, Hospital Z required the psychiatrist from psychiatric hospital A to first assess BT to confirm she was appropriate for a Form 1. That psychiatrist was unable to perform the assessment because of his heavy workload and the transfer did not happen.

BT was placed on a Form 3.

On the 5th day of waiting, BT left the unit, telling the nurses she was going out for a smoke. She did not return. She was found the following day, deceased. The cause of death was determined to be suicide due to drug overdose. Her bloodstream contained high levels of medications she had been prescribed in the past, but she was not receiving during her stay in Hospital Q.

5.1.2 Inquest #2: RC, JT, and EM (2002)

(All three deaths occurred in the same Schedule 1 hospital, Hospital R)

RC

RC was a 31-year-old man at the time of his death, who was too disabled to work since being diagnosed with schizophrenia in 1993. He suffered from a delusion, unresponsive to medication, that he had killed a number of people while driving.

RC lived with a relative who noticed one day that he had marks on his wrists. The relative became concerned RC was a risk to himself. She was unable to reach his psychiatrist, and watched him closely. Eventually she sought out a nurse from an outreach program who visited with the family. The nurse felt RC was a danger to himself but did not send RC to hospital "in part because the [outreach] program is designed to be an alternative to hospital admission and in part because the family did not want [RC] admitted to [Hospital R] due to unhappy previous experience." RC's antipsychotic medication was increased, and family members were to watch him over the weekend until RC could be assessed by the outreach program's consulting psychiatrist 3 days later.

Two days later, while in the home of another relative, RC stabbed himself in the abdomen. He was taken to hospital by ambulance, underwent a laparotomy. He told a nurse on the surgical floor that it was the pain caused by his delusion that triggered his suicide attempt. A few days after the laparotomy, he was transferred a few days later to the psychiatric ward at Hospital R where he remained until his death by suicide. "His psychiatrist and nurses saw improvement in [RC's] mental state with a reduction in his risk of suicide...However ... the occupational therapist at ... an outpatient treatment program to which he had been referred found him too unstable for the outpatient program and communicated this view to the primary nurse and to the team by recording a note in the record." About five weeks after admission, and one day before he was to be discharged in the care of his sister, he was found dead, hanging by the belt of his track pants in the closet of his room.

JT

JT, 20 years old, was taken to Hospital R by friends after disclosing he had taken an overdose of Tylenol and that he wanted to die. After waiting for an undisclosed duration, JT left the waiting room (his friends followed) and went to the top of the nearby hospital parking garage. A police constable in the vicinity attempted to calm JT but finally felt he had to grab him or he would go over the edge. JT was escorted to the emergency by police and immediately locked in a secure room with supervision by a security guard. After he was cleared medically (high levels of acetaminophen were not found in his bloodstream), he was transferred to the psychiatric ward of Hospital R on a Form 1.

JT was an inpatient on this ward until his death 8 days later, cared for by a multidisciplinary team including the psychiatrist and primary nurse who had cared for him on a previous admission. He was given medication. He was under close supervision during the early part of his stay but reacted very angrily to restrictions to his privileges, so he was allowed more freedom including the privilege of wearing his street clothes. His psychiatrist was concerned that he was still suicidal and wrote an order that he should be made an involuntary patient if he decided to leave the hospital, however, his privileges on the ward were not otherwise restricted because his previous suicide attempts had always been associated with abuse of drugs and alcohol, items he did not have access to on the ward.

On the evening of his death, he told a fellow patient that he had to kill himself and he was very distressed. The patient told a nurse about this conversation. The nurse found JT having a private conversation with his assigned nurse and she asked the nurse if he knew what was going on. The assigned nurse said he knew so the other nurse went about her duties. She did not record the incident in the record or speak to the assigned nurse after he left JT.

At the end of the conversation between the assigned nurse and JT, JT entered into a verbal contract with the nurse to report suicidal thoughts and plans to the staff instead of acting on them. After that conversation, JT called a family member, and then his girlfriend (who had ended their relationship) to say he was sorry and he loved her. JT was found early the following morning in the bathtub of his bathroom, was submerged in water, a plastic bag tied tightly around his neck with a shoelace. He could not be resuscitated.

EM

EM was a 32-year-old man with a history of drug and alcohol addiction. One evening his wife left him in charge of their infant son while she went out. When she returned she discovered EM had been drinking while alone with the baby and she was angry with him. EM went to the basement. In response to some noise from the basement his wife went down and stopped EM from using a noose which he had made. He came upstairs with her and in her presence apparently took a large number of clonazepam tablets. EM's wife got the baby dressed and took EM to the emergency department of Hospital R. She did not go inside with him because she had the baby with her and she knew that he had records of previous hospital admissions for depression and suicide at the hospital.

EM was seen by the triage nurse in the ER. He was not very forthcoming with information other than the fact that he had taken an overdose. The triage nurse called security to be with her while she interviewed EM. After her assessment she told EM to wait in the waiting room. EM left the waiting area and was observed to be spitting on police cars in the parking area. The police were called. Hospital security was also present because a security guard was concerned that a patient was leaving without being seen. After a time, the security guard and a police officer convinced EM to go back to the ER waiting area. The crisis nurse was called to calm him down.

Over two hours after EM had been assessed by triage, he was taken to a bed in a large treatment room with 14 beds and a nurses' station. All of the beds were full. EM did not wish to change into hospital gown and he was reluctant to talk but did tell the nurse that he had attempted to hang himself that evening in addition to taking the overdose of clonazepam. The nurse left the curtains to his bed open and went to call his wife for information. EM's wife told the nurse of the events of the evening. The nurse felt EM was a moderate risk for suicide and checked that the doctor had EM's chart.

He was the next to be seen when a patient in the treatment room suffered a grand mal seizure. At some point, EM closed the curtains around his bed. About 45 minutes after he was brought to the treatment room, his nurse was going on break when she walked past his curtained enclosure. Something caught her eye and she entered to find a fully clothed EM with his head in a noose made from a hospital gown suspended from an IV pole. Resuscitation was unsuccessful.

5.1.3 Inquest #3: KC (2004)

KC, a 21 year-old female with a long history of mental health problems (including a learning disability, communication difficulties, impulsivity, bulimia and depression). Her first psychiatric admission was at age 18 (in 2000) for 4 weeks, after taking an overdose of medications. She was followed as an outpatient by a psychiatrist, but continued to have problems with impulsivity, delusions, hallucinations, overuse of alcohol, and noncompliance with treatment. In May 2003 she presented to Hospital S with symptoms of depression, delusions and paranoia, and was admitted on a Form 1 with admitting diagnosis "personality disorder with psychotic episodes." She was discharged 8 days later, with arrangements for twice weekly home visits by a mental health nurse and a community social worker.

About three weeks later, she dramatically deteriorated, "trashed" the house, and "went to bed with a kitchen knife in her possession because of paranoid ideation." The social worker, on an emergency home visit, spent over two hours negotiating with KC to go to hospital. "The social

worker volunteered to remain longer to assist [KC's mother] with getting her daughter to the hospital. [Mother] felt that she could manage on her own, so the social worker left." However, just as they were to depart for the hospital, mother "perceived that her daughter was concealing a knife on her lower leg in her sock." When confronted, she locked herself in a basement bathroom. Police were dispatched to the residence, and attempted to negotiate with her but she refused to leave the bathroom. Eventually they forced their way into the bathroom. She suddenly collapsed as police were transporting her out of the house, at which time they discovered a "kitchen steak knife penetrating her left upper chest." The wound, which had penetrated the pericardial sac and the left ventricle, was fatal and she died on the scene.

5.1.4 Inquest #4: CC (2005)

CC was 44 years old at the time of her death. She had two admissions to a Schedule 1 facility, in 1995 and 2002. Her driver's license had been suspended following one of those admissions. A diagnosis of bipolar disorder had been "suggested but not confirmed." She was seeing her family physician regularly. He was treating her for chronic back pain with alternating prescriptions of narcotics.

In the days prior to her death she was observed by her family physician, by friends and others in the community to be acting in a bizarre or confused fashion. Neither her family physician nor an officer she encountered felt they had grounds to certify or apprehend her under the MHA.

She was eventually apprehended on Feb 7 under the MHA and was taken to Hospital T (a Schedule 2 facility). The chart indicated CC "was on numerous medications and had been running in front of cars that night." The inquest reports

"the emergency room physician spoke to [CC] without the officers present. ... he testified he spent approximately 6 minutes with her...by his account [CC] related what had happened that evening and had explanations for her actions that he felt were plausible.... She denied being suicidal or having any psychiatric illness or admissions. A search of previous admissions to [another hospital] revealed only visits to the radiology department. Requests for information from other sources (e.g. next of kin, family physician) were not made. He left [CC] to go to speak to the police and advised them that he did not find her behaviour to be bizarre. He advised that he couldn't discuss the particulars of the conversation he had with her, and that he would bring her to them to discuss the matter."

"...The officers testified they told the emergency room physician that they still had concerns about [CC]. They both testified that her demeanour had changed from what they had witnessed earlier. ... The doctor responded that he had no grounds to keep CC and the police were to take her back to the motel [where she had been staying]."

The following morning, CC drove her rented car southbound on the northbound lanes of a local highway, and collided with another vehicle. CC, and the five occupants of the other vehicle, died instantly.

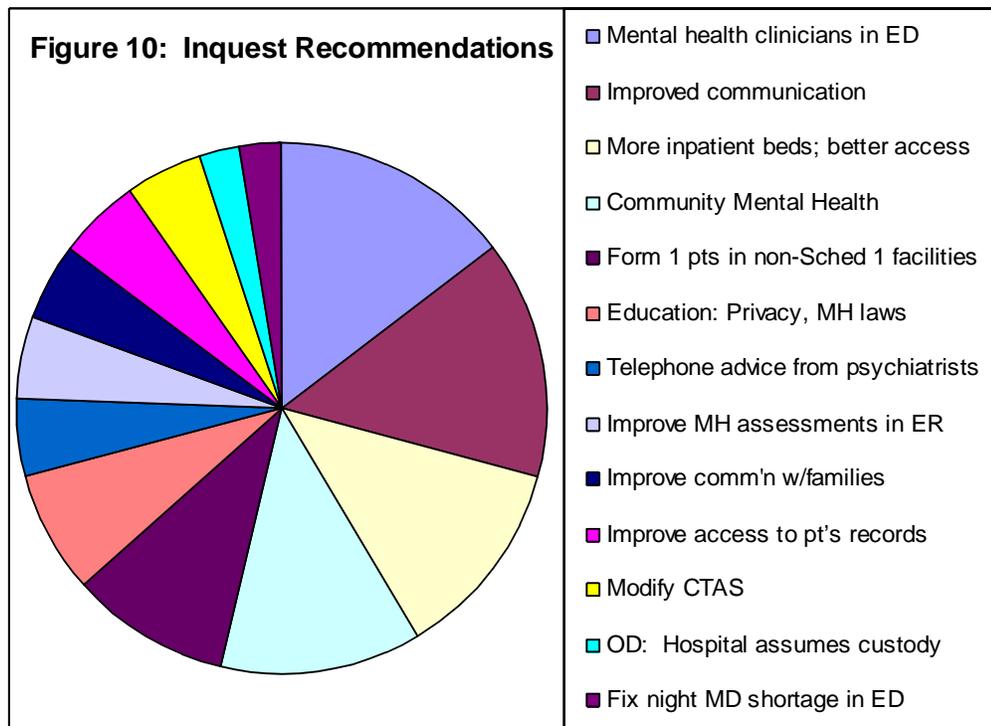
5.1.5 Inquest #5: BJ (2005)

BJ was a gentleman who was admitted under the Mental Health Act, taken to Hospital D, found to have significant medical issues due to an overdose of Methanol, and transferred to Hospital E for dialysis and acute medical management. He was medically cleared and while awaiting transfer to a Schedule 1 hospital broke through a window plummeting three floors to the ground. Medical resuscitation and surgery took place both in at Hospital E and Hospital F where he was later transferred but in spite of this he died.

5.2 Inquest Recommendations

The individual recommendations from each of the five Ontario inquests were collated and grouped in a similar manner to the stakeholder survey results. Summary results are shown in table below.

Category of Response	# Responses	% of Total
Mental health clinicians in ED	6	14.6
Improved communication between police, hospital ED and mental health services	6	14.6
More inpatient beds; streamline access	5	12.2
Community MH resources: Increased awareness and funding	5	12.2
Address problem of detaining Form 1 patients in non-Schedule 1 facilities	4	9.8
Education on privacy and MH laws	3	7.3
Telephone advice from psychiatrists	2	4.9
Improve mental health assessments in ED	2	4.9
Improve communication with families	2	4.9
Improve access to patient's records	2	4.9
Modify CTAS	2	4.9
Hospital assumes custody when patient presents with overdose	1	2.4
Address night MD shortage in ED	1	2.4
	41	100



Inquest Recommendations
(Coroners' Comments indented and italicized)

Here is the text of the recommendations, with Coroners' Comments indented and italicized:

“We the Jury recommend”

Mental health clinicians in ERs

...establishing the presence of a Community Mental Health Worker in all emergency rooms to facilitate more access and utilization by police and emergency room physicians. [CC]

...the Canadian Association of Emergency Room Physicians recognize the need for support crisis mental health teams within hospitals to assist the Emergency Room physician in collecting information and evaluating a patient's mental health. [CC]

The jury heard evidence about the availability of crisis mental health workers in the community and to the hospital emergency room. Crisis mental health workers could be of great assistance to emergency room physicians in assessing the status and gathering information about patients who present in crisis or for Form 1 assessments..

...[to Hospital Q] Take all steps and make every effort to get a crisis worker hired immediately. [BT]

Evidence was heard that a crisis worker had left the employment of Hospital Q the week before BT's admission. BT received no counseling while in the emergency department and the jury felt that if a crisis worker had been there, BT may not have become increasingly suicidal.

...the Ontario Government urge Colleges and Universities to address the urgent need for the training of more Mental Health Practitioners.

The inquest court was presented with information with regards to the shortage of Mental Health practitioners throughout the province and particularly in rural and remote areas.

... increased funding in relation to the issue of Mental Health Care in general with a view towards increasing the number of psychiatrists available to service rural and/or remote areas. [CC]

The jury heard evidence that there is a scarcity of psychiatrists not only locally but also provincially.

...[To The Ministry of Health, OMA, Hospitals] There is a staffing crisis in relation to psychiatrists who practice within Schedule 1 facilities and Community Hospitals throughout the province. Resources and incentives must be found to recruit and retain these doctors. [BT]

Evidence was heard that it is very difficult to attract and retain psychiatrists to work in the Hospital setting. It is much more attractive financially and life-style wise for psychiatrists to do solely office practice. ...The evidence indicated that this shortage was a province-wide problem and was at a crisis stage.

Inquest Recommendations
(Coroners' Comments indented and italicized)

Improved communication between police, hospital ER and mental health services

...frequent informal discussions be established between [community mental health], police, emergency room personnel and doctors to provide updated information on mental health issues. [CC]

Witnesses testified that there was little contact between police, local Community Mental Health and physicians. More contact may facilitate the awareness of options available when dealing with individuals with mental health issues and particularly those in crisis.

...the Ministry of Health and Long Term Care (MoHLTC) should develop a protocol for police, community mental health practitioners and emergency physicians to use when liaising with one another. [CC]

Evidence was heard by the jury, that the roles of persons involved in providing service to persons with mental health issues were not always clear. Guidance from the MoHLTC would facilitate improvements in awareness and the effective provision of services.

... Public Hospitals Act should be amended to require every hospital providing emergency services establishment of appropriate protocols and programs to facilitate the relationship between all emergency response teams. (Police, Paramedics, Emergency Room Personnel, and Community Mental Health). [CC]

The jury heard evidence that an important factor in timely implementation of any change was effecting a 'regulation' amendment as opposed to changing the legislation.

... the [local] detachment of the OPP should liaise with the [local] Community Mental Health services to improve awareness and establish contacts for front line officers. This recommendation also should apply to all policing services across Ontario in regards to Mental Health Services in their jurisdiction. [CC]

The officers who had direct contact with CC, testified they were not aware of the availability of the Community Mental Health Services.

...the communication process between the front line workers of community care agencies, such as visiting nurses and or social workers, and the patient's psychiatrist and family physician be reviewed with a view to increase the flow of information between these parties especially in the period immediately after discharge. In particular, we the jury, recommend that a copy of any notes taken by the visiting nurse and/or social worker be forwarded to the attending psychiatrist and family physician on a per visit basis. [KC]

...a forum be provided whereby hospitals meet to discuss best practices. [RC/JT/EM]

The jury heard about the practices of a tertiary care psychiatric facility. They also heard that health care professionals attend conferences to learn about recommended ways of managing patients so I think they have made this recommendation for hospitals as well as individuals.

Inquest Recommendations
(Coroners' Comments indented and italicized)

More inpatient beds, and streamline access to same

...[To The Ministry of Health and District Health Council] Allocate to [local county] a total of 72 acute care Schedule 1 psychiatric beds to bring the area up to the Ministry's benchmark allocation. Funding must also be provided to physically accommodate the new beds, and to provide an interim solution until permanent locations can be found in the hospitals....These beds should be distributed across three sites as recommended by the District Health Council. [BT]

Evidence was heard that The Ministry of Health and the District Health Council for [local] County had already acknowledged a lack of psychiatric beds in Schedule 1 facilities in the region at the time of BT's death. Because of a number of reasons, some regarding disagreement over allocation of beds, and lack of actual physical space to accommodate these beds, this recommendation had not been acted on as of the date of the inquest. Evidence was presented that the lack of psychiatric beds in the Region was a major reason for BT's prolonged stay at Hospital Q.

...[To The Ministry of Health and The Ontario Hospital Association] Direct all Schedule 1 facilities that they must accept Form 1 patients regardless of their geographic location in Ontario. Hospitals are not designated to service limited catchment areas and should not impose extra steps or limits on "out of catchment" patients. [BT]

Evidence was heard that Hospital Z differentiated between psychiatric patient referrals within and outside of their catchment area. The extra step of having a Hospital Q patient assessed within their catchment area by a psychiatrist, before transfer to another psychiatric facility was seen as unduly repetitive and detrimental to patient care. There was evidence that setting significant barriers to different subsets of patients may contradict the Canada Health Act.

...develop a central bed registry for Schedule 1 beds within [County] to streamline patient access and transfer to those beds [BT]

... recommend a long-term study be conducted to determine whether this constantly growing region needs a psychiatric hospital. [RC/JT/EM]

...develop a province-wide registry of available Schedule I beds managed by Criticall to streamline access to beds beyond [County]. Expand the Criticall System to include acute psychiatric beds. [BT]

It was felt inefficient to expect nursing staff or doctors to spend their time phoning around to find a Schedule 1 psychiatric bed. The [Hospital Q] locum physician did not know that there might be beds available at facilities other than Hospital A. It seemed appropriate to expand the present Criticall system, which helps physicians find beds for trauma or critically ill patients, to include a registry and structure for psychiatric beds. Of course, concomitant funding must be forthcoming to support this expansion.

Inquest Recommendations
(Coroners' Comments indented and italicized)

Increased awareness of, and funding for, community mental health (CMH) resources

... increased awareness, funding and staffing for outpatient programs like [local Outreach Services] and [local Day Treatment Program]. [RC/JT/EM]

The jury heard evidence that the patient load of these programs has steadily increased since their inception but the staff and funding has not kept pace with the increased demand.

...funding increase and resources be made available to Community Mental Health service programs to allow for increased proactive involvement both within the community at large and local hospitals. [CC]

The jury heard that the CMH services are grossly under-funded.

... CMH brochures and posters be updated and placed in a prominent place in all emergency rooms, police stations, and doctor's offices. [CC]

The availability of a community health worker in emergency rooms would increase the opportunities for referral and improve understanding of the roles of mental health workers.

... more provincially-funded group homes as well as transitional facilities from hospital care to home care be established in this region for patients suffering from mental illness. [RC/JT/EM]

The jury heard evidence that RC's family felt they had to take him back to their home regardless of the stresses involved because there was no available transitional facility that would provide a sufficient level of care for him.

...Create, support and fund "safe houses" for psychiatric patients who do not require formal hospitalization. Also, fund community care access centers to assist psychiatric outpatients. [BT]

Evidence was presented that many psychiatric patients require foremost "a home, a job, and a friend." Many do not require formal hospitalization, and in fact there is a stigma to in-hospital psychiatric admission. As well, if psychiatric patients had a place to go following hospitalization, more beds would be available for those mental health patients who are in greater need. Much evidence was presented that psychiatric patients need to be treated in their own communities, on an outpatient basis whenever possible.

Address problem of detaining Form 1 patients in non-Schedule 1 facilities

...Non Schedule 1 facilities must provide security staff to support Form 1 detainees. [BT]

Since Form 1 detainees presently are illegally held in non-schedule 1 facilities unless it is for forthwith transport to a psychiatric hospital, it was felt appropriate that security personnel be available 24 hours per day, 7 days per week to accompany these patients. Evidence was presented that these patients cannot legally or morally be kept in locked rooms in an emergency department or ward and the best solution is to have security observe these patients. If these patients try to leave, then hospital personal will at least

Inquest Recommendations
(Coroners' Comments indented and italicized)

be immediately notified about what is happening and then decide on the best course of action. It was not felt that nursing staff were able to perform or should have to perform this duty on top of their other duties.

...create a multi-disciplinary task force to study and develop guidelines or protocols to be implemented province-wide which set out appropriate standards for the search, ... surveillance and holding of persons on a Form 1 in a non-Schedule 1 facility. Such standards should ensure the safety of the person detained as well as the public, while also maintaining the clinical best interest of, and minimal intrusion into, the privacy of the person detained. [BT]

There was much conflicting evidence about what was necessary in order to ensure the safety of Form 1 detainees. These standards must be balanced with the patient's rights. Given the legal, medical and social issues involved, the jury felt that a broad-based task force could address these issues most appropriately.

...create a multi-disciplinary task force ... to develop guidelines for non-Schedule 1 hospitals to use when those hospitals are housing Form 1 patients who are awaiting transfer to Schedule 1 facilities.... The task force should consider the various medical, psychiatric and security concerns involved in housing Form 1 patients in venues not specifically designated, designed or constructed for housing such patients.... The task force should consider recommending amendments to the Mental Health Act to recognize that non-Schedule 1 facilities are in fact called upon to house Form 1 patients who are awaiting transfer to Schedule 1 facilities. [BJ]

...the jury heard evidence from witnesses that the Ministry of Community Safety and Correctional Services has expertise both in the techniques and training of people for safely guarding people who are actually dangerous to themselves or to others and that this expertise would be very beneficial in guarding the safety of patients who are awaiting transfer to a Schedule 1 hospital for psychiatric evaluation.

...This situation is common and is not covered in the Mental Health Act. Thus they felt there was an urgent need to amend the Mental Health Act in order to protect patients' safety and dignity. Because this situation is common and ongoing in the province they felt this matter had to be addressed as soon as possible.

...the Ministry amend the Mental Health Act to allow non-Schedule 1 facilities to detain people on a Form 1 pending the first available Schedule 1 bed. Amend Section 15(5) (a) of the Mental Health Act to delete the word "forthwith" and replace with the words "as soon as practicable". [BT]

The evidence has shown that non-schedule 1 hospitals are routinely required to hold "Form 1" clients while waiting for Schedule 1 beds to open up. While necessary for the well-being of the patient, such detention is a violation of the Mental Health Act. Within the current healthcare system resource levels, compliance with the Mental Health Act is virtually impossible.

Evidence was presented that as the Mental Health Act is presently worded, non-Schedule 1 facilities have no right to detain Form 1 patients in their environs, unless the detainee will be transported forthwith to a psychiatric facility for psychiatric assessment. Therefore Hospital Q had no legal authority to detain BT on a Form 1 while awaiting admission to Hospital A. They had no legal right to prevent her from going out for a smoke break and in fact would have faced legal liability if they had tried to stop her.

Inquest Recommendations
(Coroners' Comments indented and italicized)

The jury also heard evidence that Hospital Q still had a moral obligation to keep her even though the Hospital, Doctors and Nurses could face legal recrimination if Barbara contested her detention in the Emergency Dept. As well, because there is no legal authority to keep BT in a non-Schedule 1 facility, BT therefore had no explicit rights protections under the Mental Health Act.

The jury felt that if the word "forthwith" was changed to as "soon as practicable," then there would be legal authority for non-Schedule 1 Hospitals to keep Form 1 detainees, while awaiting the next available psychiatric bed. Evidence was also presented that this was also the only way to ensure that these detainees would have specific patient rights, given the reality that psychiatric patients are held for varying periods of time in non-Schedule 1 Emergency Departments because there are no psychiatric beds available.

Education on Personal Health Information Protection Act (PHIPA) and Mental Health law

...additional education to physicians on ...PHIPA, and, that the ministry considers developing and implementing a protocol or system where former medical records can be more easily retrieved, possibly with a central information system. [CC]

The jury heard that privacy issues and the appropriate legislative authority for or prohibition from sharing/disclosing medical information is not well understood. The potential benefit of a central data source to retrieve information is identified in this recommendation.

... Physicians working in emergency rooms and Family Physicians receive training on the Mental Health Law, Consent Law and the relevant provisions of PHIPA. [CC]

... all parties involved [i.e. Ministry of Health, College of Physicians and Surgeons of Ontario, Ontario College of Nurses, Medical Schools, Nursing Schools and Ontario Provincial Police] receive increased and regular training regarding the treatment and care of patients with mental illness, and the provisions and requirements of the Mental Health Act. [BT]

Evidence was presented that physicians and nurses directly involved in this case, and in general, do not understand important facets of the Mental Health Act. This adversely affects patient care. For instance, evidence was presented that Hospital Z required a psychiatric assessment on a patient put on a Form 1 outside their catchment area, because in part they feel that many physicians are using this form improperly and don't want to use up valuable bed space for a patient that really isn't formable.

One or two recommendations fell under the following topics:

Telephone advice from psychiatrists

...development of a 1-800 type telephone number accessible 24/7 for doctors to receive assistance about relevant legal issues, psychiatric assessment issues, and having senior clinicians available for their use. [CC]

The jury heard from Mr. Bay, that telephone support for clinicians was an effective, practical and possible way to improve understanding and obtain advice when dealing with complex legal and psychiatric issues.

Inquest Recommendations
(Coroners' Comments indented and italicized)

... the implementation of a "shared care" model of care for psychiatric patients. [BT]

...evidence was presented that because of the shortage of psychiatrists, and the fact most mental health care is handled by primary care family physicians, or other professionals, a shared care model for these patients needs to be promoted by this task force. If Family Physicians had timely access to phone advice from psychiatrists, for instance, many patients could be managed appropriately in the family medicine setting and avoid the aura of crisis to access formal psychiatric care.

Improved mental health assessments in ER

A uniform protocol should be developed for Form 1 assessments to be used in emergency rooms across the province. The protocol should take into account the requirements of section 15 of the Mental Health Act and best clinical practices. The protocol should ensure that all relevant information is gathered and the roles of police and physicians are clearly understood. [CC]

Emergency room physicians and/or physicians in a position of assessing individuals pursuant to a Form 1 under the Mental Health Act be provided additional training for mental status examinations that would include a guideline or written checklist with the topic areas to be covered including accessing collateral information and questioning of the patient. [CC]

Mr. Michael Bay, an expert in Mental Health Law, testified at the inquest and advised the jury of the current difficulties in understanding and interpreting the legislation and the roles of doctors and police in Form 1 assessments. Of particular importance is the recognition that for physicians, in performing a Form 1 Assessment, the patient-doctor relationship is modified.

Improve communication with families

Effective communication with family be given high priority. It is important that health care professionals and families recognize their mutual alliance in the care for inpatients with a mental illness. There is a need for productive communication and cooperation between families of the patients and hospital staff. Significant communication with family be documented.

Recommendations to help facilitate this process include the following:

- a) A member of the staff who is knowledgeable about the patient be accessible to visitors during all visiting hours.
- b) Regular meetings with key family members be scheduled throughout the stay for the mutual exchange of information.
- c) Communication with family members at critical times including admission, when condition of patient significantly changes and planning discharge.
- d) Develop a leave of absence form for patients on pass to facilitate communication between the health care team and the patient's approved person (i.e. emergency numbers, contacts, medication instructions, behaviour concerns, etc.) This form is to be returned to the nurse in charge and included in the patient's chart.
- e) There should be dialogue with family after a visit or pass to discuss any significant issues that arose with the patient during that time. [RC/JT/EM]

Testimony from members of the RC and JT families revealed that family members felt that information from them about the suicidal intentions of their family member was not wanted by the staff but the staff testified that they did think that family information about

Inquest Recommendations
(Coroners' Comments indented and italicized)

suicidal patients was important. It was apparent from the testimony that documentation of family information about the patient would ensure that the primary nurse and psychiatrist received the information. This is most important in circumstances where a patient reveals suicidal thoughts and plans to family members and not to staff.

Improve access to patient's records

... establishing a data bank accessible to, and only to, physicians who are determining whether or not the presenting patient has been to a Schedule 1 facility when making a Form 1 assessment. [CC]

The availability of information regarding past mental health was an important issue in this inquest. The jury also recognized the unique and private nature of mental illness by suggesting that such information be available only to physicians conducting a Form 1 assessment. In this case, CC denied any previous psychiatric illness. Information to the contrary may have affected the decision of the emergency room physician.

...establishment of a patient history database for hospital use. This will help hospital staff to quickly access basic patient history from previous admissions and will become part of the patient's current chart. [RC/JT/EM]

The jury heard evidence that the past history of a patient with mental illness can be very helpful when they are being assessed in the emergency department or the crisis clinic. They also heard that getting old charts takes some time so past history can't be used in the triage of the patient.

Modify CTAS

... the Canadian Triage Acuity Scale (CTAS) be modified for those attending for psychiatric assessment and that the linking of the present financial relationship to this scale be reconsidered. [CC]

The jury heard evidence from an expert in Emergency Medicine, Dr. A. Lauwers, that funding determinations in some emergency rooms and for some emergency physicians is linked to the triage scores of the patients seen. Dr. Lauwers testified that patients with mental health issues are given a low score (i.e. not as emergent) however, the time required to appropriately assess their status may be greater than those patients who require immediate treatment.

... education and regular review of the Guidelines for the Canadian Emergency Department Triage & Acuity Scale. [RC/JT/EM]

The triage nurse testified that EM should be classified as level 3 (urgent) under these guidelines. Overdoses are level 2 and suicidal ideas are level 4. The Guidelines recommend classifying patients up the scale if the delay before they are seen becomes concerning.

Hospital assumes custody when patient presents with an overdose

... Legislation be changed so that when a suspected overdose is presented at emergency, that person becomes the responsibility of the hospital. [RC/JT/EM]

Inquest Recommendations
(Coroners' Comments indented and italicized)

The jury heard that EM left the ER waiting room after he was triaged and had admitted to taking an overdose of clonazepam. The security guard testified that the nurse said that since EM was not on a Form 1, if he wanted to leave he could - he was not the responsibility of the hospital.

Address ER physician staffing at night

...To ensure the proper balance between safety and timely intervention of psychiatric patients who present themselves at ER.... we recommend that staffing ratios of emergency physicians working nights be reviewed to ensure that there is not a physician shortage. [RC/JT/EM]

EM was in the emergency department for over three and a half hours prior to his suicide. He hanged himself before he was seen by a doctor.

Part 6: Discussion

6.0 A Note to the Reader

I suggest before you complete your review of this document you return to Part 3 (“Survey of Stakeholders”) and read that section carefully. Here again is the introductory note from that section:

... I encourage the reader to study the verbatim responses as well as the summary information. Respondents were encouraged to provide details of their views and experiences, and their responses convey a sense of immediacy and thoughtfulness that is inevitably lost in tabulations.

6.1 Analysis of Survey Results and Inquest Recommendations

6.1.1 Q1: “What is working well?”

Most Common Responses (by Stakeholder)

	Hospital	Police	CMHA
1 st most frequent	Good relationship with police	Nothing	Police quick response and good judgment
2 nd most frequent	MCIT	Confidence in MH assessments	Communication with police
3 rd most frequent	Police provide information to hospital	Suitable facilities for MH pts	Info-sharing and f/u with police
4 th most frequent		Generally positive comments	
(1st + 2nd + 3rd) as % of all responses	61 %	24 % (1st response only) 39 % (2nd + 3rd + 4th)	93%

The most striking disparity in perceptions is the different ways police and hospitals view their overall working relationship in the context being discussed. Overall, whereas Hospitals see a good working relationship, almost one quarter of the responses from police consisted of a caustic “Nothing!” And whereas Hospitals’ #2 response is police providing information to hospitals, Police’s #2 ranked answer to Q2 (ineffective assessment) includes the perception that information from the police is not sought out or, if offered, not given serious consideration.

It is also interesting to note that the top 3 CMHA responses all refer to interactions with police -- none with hospital ER services.

6.1.2 Q2: “What problems remain?”

	Hospital	Police	CMHA
1 st most frequent	Long wait times	Wait times too long	Ineffective assessment / management in ER
2 nd most frequent	Problems of concern to non-Schedule 1 hospitals	Ineffective assessment / management in ER	Long wait times
3 rd most frequent	Info sharing, privacy	Security and facility concerns	Police need to improve their interactions with MH patients
(1st + 2nd + 3rd) as % of all responses	60 %	88 %	66 %

Answers to this question reveal an area where perceptions are strikingly congruent: All three stakeholder groups agree that long police wait times are a significant problem.

Answers to this question also reveal an area where perceptions are strikingly *incongruent*: Police and CMHA identify lack of confidence in assessment and management of the suicidal patient as either the #1 (CMHA) or #2 (police) problem. (It was the #2 response from the Family & Advocate group, too). Some of the most passionate survey response, particularly by police, concern this issue. Yet this issue is not even identified in the hospital responses. Two hospital responses identify “lack of psychiatrists” as a problem, but my impression is that this reflects a desire for more expertise rather than a perception that existing hospital clinical interventions are ineffective.

The 2nd most common response among hospitals cite problems of particular concern to non-Schedule 1 hospitals. Hospital responses specifically citing waiting times are included in the “long wait times” count. However, the reader should be aware that extremely long waiting times for police to be released from the hospital are practically inevitable when non-Schedule 1 hospitals assess and house Form 1 patients.

6.1.3 Q3 & 4: Suggestions for Change

	Hospital	Police	CMHA	Inquest recommendation
1 st most frequent	Improve communication and coordination	Release police sooner	Improve cooperation between all	MH clinicians in ER
2 nd most frequent	MH clinician to assess before ED MD	More resources for hospitals	Increased mental health expertise in ER	Improved communication between all
3 rd most frequent	Educate police	Improve security	Education of all involved parties	More beds and streamlined access
4 th most frequent	More staff and resources	Improve communication, coordination	Release police sooner	More community MH resources
(1st + 2nd + 3rd) as % of all responses	61 %	70 %	63 %	53.6 %

The top four suggestions of each group are strikingly congruent: All stakeholders plus the inquests identify improving communication and coordination between stakeholders as an essential need. And three of the four groups identify placing MH expertise in the ER as an essential improvement. The #2 police suggestion, “more resources”, presumably subsumes this specific clinical improvement into a more general call for more resources, whereas the inquest recommendations more specifically call for both MH clinician in the ER **and** more inpatients beds (as well as community-based MH resources).

Interestingly, “education” appears in two of the “top 4 suggestion” lists above, but whereas the CMHA calls for education of *all stakeholders*, the hospital suggestions are focused on educating police – regarding the Mental Health Act and appropriate use of hospital ER. The police group also recommends education (# 8 in frequency of responses) but the specific responses tend to include more calls for education of police and hospital staff for mutual understanding of rules.

“Improve security” occurs only once the table above, as police recommendation #4. This is not surprising given their mandate of ensuring public safety.

6.1.4 What the Survey and Inquest recommendations tell us

- (1) All stakeholders perceive police waiting times in the ER as excessive.
- (2) Police, CMHA and family report being disconnected from the ED assessment process, in that
 - they are often not sought out to provide information about the patient,
 - they perceive their information is not given sufficient weight when it is offered (or given),
 - and they are often excluded from the disposition process.

These groups are angered by this disconnection, because they are responsible for the welfare and safety of the patient upon discharge from the ER. Hospital stakeholders did not identify this at all as an issue.

- (3) Police and CMHA often lack confidence in the quality of the mental health assessment in the ER, and in the ER’s interventions following that assessment. Specifically, respondents tended to perceive:

- ER assessments tend to underestimate the patient's risk of suicide,
- and are biased towards discharging the patient from the ER (vs admitting to a Schedule 1 facility, if only for further observation and assessment).
- The insufficient supply of inpatient beds is a powerful influence on this bias.
- Minimizing the value of collateral information in the mental health assessment is a reflection of this bias.
- There are Insufficient outpatient mental health resources to adequately compensate for this problem.

(4) Some non-Schedule 1 hospitals are *critically* under-resourced with respect to mental health patients in their ERs. They depend heavily on police for supervision of Form 1 patients, and they face considerable logistical and procedural challenges in transferring a Form 1 patient to a Schedule 1 facility. The situation is sometimes so bad that non-Schedule 1 hospitals are sometimes forced to contravene the law (by detaining the patient, essentially illegally, under the Mental Health Act) in the service of safeguarding the patient.

(5) *Essential* solutions identified by all respondents, and identified in inquest recommendations, include

- Mental health expertise available in the ER;
- Physical plant and staffing suitable to permit dignified safeguarding of patients at risk to themselves (and, in transferring this responsibility to the hospital, police will be able to leave the hospital sooner);
- More Schedule 1 beds and more outpatient mental health services, ensuring these services are easily accessible when needed

(6) Police, hospital EDs, and community mental health providers must work together at all levels, from care of the individual, to consistent policies and mutual understanding of roles, to system coordination.

6.2 The Limiting Factor

Addressing the concerns identified in this paper will require improvements in three domains:

- 1) **Cooperation** among amongst police, hospital, community care providers.
- 2) **Mental Health Expertise** (crisis workers and psychiatrists) where they are needed, at the time they are needed – primarily in the ER and in ER diversion programs.
- 3) **Resources:** For secure ER areas (requiring structural modifications of ER areas, and security personnel), inpatient and secure assessment beds, and transportation of patients to those beds.

Sufficient funding is the limiting factor here. Without funding for needed resources, there is frankly little chance for substantive change in the situation:

- *Cooperation without funding for resources is insufficient.* Section 4 on “Existing Agreements between Hospitals and Police” demonstrates that agreements and protocols are of limited value if the resources to carry out responsibilities are absent. Regardless of a hospital's intention to release police quickly, if a patient is a safety risk then either the hospital provides security personnel, or the police stay until a bed is found. Hospitals without security personnel available for this duty cannot release the officers, thus downloading the cost of security to the police and depriving the community of policing resources. “Security” in this context is a medically necessary service.
- *Expertise without funding for resources is insufficient.* Mental health expertise can be made more widely available through recruitment, training, technology (e.g. telepsychiatry) and collaboration (e.g. Brockville providing telephone access to their psychiatrists and psychiatric RNs for non-Schedule 1 ERs). However, clinical assessment without a safe

setting, or without prospect of treatment when needed, is of little help to the patient in need.

6.3 The Cost of *Not* Funding Improvements

(1) Deaths from suicide

According to data from the National Trauma Registry, on average three people die of suicide and self-inflicted injuries every day in Ontario, i.e. there are over 1000 deaths per year in Ontario due to suicide. Yet a completed suicide is a rare event compared to the incidence of attempted suicides and ER presentations for suicidal ideation. Thus, when a physician discharges a "suicidal" patient from the ER, the odds are strongly in favour of that patient not completing a suicide. The small number of catastrophic outcomes in any one community, and the variable temporal proximity to an ER visit, present considerable obstacles, in a climate of fiscal "benchmarking," to hiring more staff (security and mental health) and upgrading the physical plant of ERs (let alone adding more inpatient beds to the mental health system).

(2) Money is wasted elsewhere; police service suffers

Money that is not spent by one part of the health care system is not always money saved – often it simply adds costs to the system downstream, or shifts it to another service. In a hospital ER with no security staff, the cost of keeping the patient secure is downloaded to the police. Yet police are not adequately staffed to provide this service without compromising their own responsibilities. To say that the police find this unacceptable is putting it mildly. And patients who are released from the ER without a satisfactory treatment plan in place may present to another hospital, or be brought back on another occasion by police or family.

(3) Hospitals are forced into illegal activities

The situation is worst in ERs of non-schedule 1 facilities, which can be compelled for safety reasons to detain a suicidal patient on a Form 1, but are unable to transfer them "forthwith" (meaning "immediately; without delay") to a Schedule 1 facility. If a Schedule 1 bed cannot be found by the expiry of the Form 1, the hospital is placed in the untenable position of having to continue to detain the patient but having no legal mechanism to do so, as a Form 3 (the legal basis for detention) is not applicable in a non-Schedule 1 facility.

(4) Increased Stigmatization of Mental Illness

Years of public education to destigmatize mental illness and to increase early detection of mental health problems (including suicidal risk) are starting to show results. The public, and police forces (who are often in the "first responder" role), are increasingly well-informed about mental illness, and often come to EDs seeking mental health treatment. Yet this report indicates the subjective experience of patients, families and the police are often quite negative. Police often feel they are perceived as nuisances in an ED, and their observations and concerns are not valued. Patients, encouraged to seek help and a place of safety if they feel at risk of suicide, are often made to wait for prolonged periods, and may feel that the ED staff sees them as an inconvenience, an annoyance, or not "really" sick. Families often feel shut out of the entire process.

Ironically, the likely end result of all this is an *increase* in stigmatization both of mental illness and of use of the mental health care system, and an increase in hopelessness and demoralization of those suffering, and those trying to help. Efforts to raise public awareness of mental illness, and suicide risk, are subverted by the very system which people are being encouraged to use.

(5) The Effect on Health Care Professionals

Health care professionals strive to improve their knowledge and skill base as part of their

professional responsibility. In a setting where essential treatment resources are scarce, clinicians accommodate to doing what they can with what is available. Simply put, if inpatient assessment of a suicidal patient is unavailable, or accessing inpatient care presents considerable logistic and cost obstacles, clinicians will tend to “set the bar higher” and provide this more intensive intervention to a smaller subgroup of patients. Over time, this may influence clinicians’ practice patterns, and the “higher bar” becomes the de facto standard of practice for that community. Thus it may become more difficult to identify some subgroups of patients at risk who also need more intensive treatment resources.

The existing practice guidelines for assessment and treatment of the suicidal patient are of very limited practical value in situations of limited treatment resources. The guidelines provide little direction to clinicians when an assessment indicates a need for a level of intervention which is unavailable.

Finally, despite the often negative perceptions reported in this paper, the reader is reminded that front-line clinicians -- ER physicians and nurses and social workers, mental health crisis workers and psychiatric nurses and psychiatrists – are dedicated to caring for their patients and adhering to the law. They must answer to themselves, to the law, and to their licensing bodies, for their care and their patients’ outcome. When medically necessary resources are unavailable or inadequate, clinicians will become frustrated and demoralized, more so as mental health legislation is changed to make it *easier* for people to be brought to hospital (i.e. “Brian’s Law” Mental Health Act revisions in 2000).

Demoralization, in this context, refers to “the various degrees of helplessness, hopelessness, confusion, and subjective incompetence that people feel when sensing that they are failing their own or others’ expectations for coping with life’s adversities. Rather than coping, they struggle to survive” (Griffith and Gaby, 2005).

If hopelessness and helplessness are characteristic of the psychological pain (“psychache”) of the suicidal individual, then a system which fosters similar feelings in those trying to help must surely require some improvement.

Part 7: Recommendations

"This is a systems problem that is bigger than any individual police service and any individual ER. Going head to head with the hospital is a no-win proposition. You have to define the problem as a common problem, not as a problem for you. Saying 'you guys in the ER are driving us nuts,' no matter how nicely, is not likely to be as effective as trying to make the hospital realize that, like them, the police are responsible for the health and safety of a specific community. And like the hospital system, police often find themselves overwhelmed with demands for service. So a 'what can we do to help you' approach often works well." [Anonymous, www.pmhcl.ca]

7.1 Recommendation #1: Crisis Service for every ER

***All* hospital Emergency Departments should have either a Mental Health Crisis Service (MHCS), or a partnership, with a hospital which has an ED-based MHCS, which permits the immediate transfer of a patient to that facility as soon as the patient is medically stabilized.**

Standards for MHCS services should be set by the MOHLTC, and an implementation team developed to assist sites in designing a solution suitable to that ER's and community's existing resources and needs.

Minimum standards for a MHCS include

- a. a crisis worker available 24 hours a day, and
- b. a partner Schedule 1 facility which will
 - i. provide a psychiatrist for consultation (at least from 8 am - midnight), and
 - ii. receive patients requiring inpatient assessment, and
 - iii. assist in locating a Schedule 1 bed elsewhere, when the partner facility is unable to accept the patient.
- c. Adequate secure facilities for patients at risk, and
- d. Security officers dedicated to the secure area in the ED.

The Ministry should also set standards for *maximum* police waiting time until a hospital accepts custody of a patient apprehended under the Mental Health Act. (In the absence of such standards, any hospital which implements changes to minimize police waiting time risks being overburdened by increased police apprehensions diverted from other hospitals in the area, thus effectively rewarding those hospitals with less inclination to cooperate with the police).

Each hospital should develop an **ER Mental Health Implementation & Liaison Committee**.

The committee has three mandates:

- a. **Implementation:** If no MHCS exists, to coordinate implementation of services to meet the minimum standards, or, if an MHCS exists, to ensure the service meets those standards;
- b. **Liaison:** To serve as an ongoing liaison committee for ER mental health services, in order to resolve service coordination issues and problem-solve around specific issues as they are identified.
- c. **Education:** review and address educational needs of local police and ED staff regarding the Mental Health Act, and each other's roles in dealing with individuals apprehended under the Act.

Each committee should include representatives from

- a. the hospital's emergency department

- b. the hospital's psychiatry department (where applicable)
- c. the partner Schedule 1 facility (where applicable)
- d. police department
- e. local community mental health services

7.1.1 Features of MHCS Operation

The following describes necessary operating features of a MHCS.

A) Minimize police waiting time

Each ED needs to make a commitment to minimize police waiting times. This can be accomplished by

- a. assigning a high priority to MHA apprehensions and
- b. creating a system for rapid initial assessment of the patient and debriefing of the apprehending officers. The reader is referred to Section 4 above for examples (Scarborough Hospital and St. Joseph's Health Centre in particular).
- c. providing secure facilities, and security personnel, in the ED.

B) Mental Health and Emergency Medicine assessments as parallel processes

A Mental Health assessment should begin as soon as *the patient's mental status permits*, and does not need to wait for "medical clearance" unless there is a specific clinical reason.

C) Clinical Practice Standards

A comprehensive discussion of clinical practice standards in suicide risk assessment is addressed in existing practice guidelines, and a detailed review of same is beyond the scope of this paper. Two features of clinical assessment were highlighted in the survey and inquest recommendations, and thus deserve emphasis here.

First, discharge of a patient apprehended under the MHA based on a *single* mental status examination should be the *exception* rather than the rule -- particularly when the findings are significantly different from what would be expected based on the police report. Note the brief initial assessment recommended in part (A) above can also serve as a first data point for this purpose.

Second, collateral **information should be seen as vitally important for a thorough assessment.** Good-faith efforts must be made to obtain information from family, cohabitants, sites of earlier hospitalization or ER psychiatry assessment, and outpatient treatment providers. With respect to due consideration of police observations, clinicians should be reminded of Section 7 of MHA (*italics added*): "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.*"

D) Develop ER treatment plans for patients who need them

For mental health patients who are frequently seen in an ED, or who frequent multiple EDs in a community, or for patients whose behavior or clinical problems are particularly challenging, case conferences involving hospital, community care providers, and police representatives, case conferences -- carried out at a time other than during the patient's ED visit -- can permit the development of a specialized treatment plan ("care plan") and bring coherence to the helping efforts of all involved. These care plans can also be developed by MHCTs without a formal case conference, but with contributions and approval from those involved in the patient's care.

Care plans will be kept on file in the hospital emergency department. A mechanism needs to be established to quickly identify patients with an active care plan. Care plans need to be reviewed regularly to ensure they are current and accurate.

7.2 Recommendation #2: More Treatment Resources

"There will never be enough beds."

[Anonymous psychiatrist, overheard at a meeting]

The need for more inpatient psychiatric beds is a dominant theme in the survey and in the inquest recommendations. Yet, as the aphorism above suggests, demands for more inpatient beds, however well-founded in data and supported by inquest recommendations, represent the most expensive solution to the problem, particularly in a climate of chronic fiscal restraint and emphasis on *alternatives* to hospitalization.

Thus the second key recommendation of this report is for more "Treatment Resources," which includes

- a. Schedule 1 inpatient beds
- b. Community mental health services
- c. Mobile Crisis Intervention Teams (MCIT)
- d. "Safe beds" and alternatives to traditional ER mental health assessment
- e. Security in MHCT-equipped EDs.

Specific measures should include:

- A. Regarding Schedule 1 beds:
 - I. Increase the number of Schedule 1 beds by region based on existing studies, e.g. Mental Health Implementation Task Force reports.
 - II. Develop a system to make Schedule 1 beds across the province easily accessible as needed, *regardless of catchment area*, if the originating hospital's Schedule 1 beds are unavailable.
 - III. A system for secure transportation from a non-Schedule 1 hospital ED to a Schedule 1 facility should be developed *and funded by the Ministry*. This system should not default to the local police without an explicit agreement between the relevant police department and hospital. Such an agreement must ensure (1) policing resources for the community are not diminished by use of police for transport, and (2) police are compensated financially for the true cost of their services.
- B. Community-by-community review of existing, and needed, outpatient mental health resources. Increase services, and community awareness of same, as indicated by this review.
 - I. Mobile crisis teams were cited by many stakeholders as being of great value. The cost-effectiveness and overall suitability of developing a MCIT should be part of this review.
 - II. Though enumerating specific improvements is beyond the scope of this paper, the reader is referred to section 5.2 on Inquest Recommendations for some specific suggestions.
- C. The true cost of providing necessary services should be identified. The practice of downloading onto the local police the responsibility and cost of secure supervision (e.g. in a non-Schedule 1 hospital, while waiting for a Schedule 1 bed) and secure transportation (e.g. to a Schedule 1 facility) should be seen as an extremely costly (to the province, the police force, and community policing needs, if not to the hospital) stop-gap measure to be

replaced by other solutions which take responsibility for the true cost of necessary services.

- D. The zeal to divert from hospital emergency departments should be tempered with the reality that (1) it will be impossible to demonstrate the effectiveness of such measures in terms of reduced rate of completed suicide, and (2) diversion strategies shift the responsibility for assessment of risk to family members, friends, police, community mental health, shelter staff, and others in the community, so that the *true cost* of implementing diversion strategies must include additional community mental health support to the diversion service.
- E. Secure facilities and security personnel should be identified as *medically necessary resources* in the care of the patient at risk of suicide.

7.3 Recommendation #3: Clarify Confidentiality Rules

7.3.1 The Role of Police in the “Circle of Care”

With respect to confidentiality vs. information-sharing with police, regarding patients apprehended under the Mental Health Act, existing privacy legislation needs to be brought up-to-date to clarify the status of police apprehending an individual under the Mental Health Act. An argument can be made that those officers are within the patient’s “circle of care” as defined by current privacy legislation, in that the individual was

- a. apprehended under Mental Health legislation,
- b. psychiatric literature recognizes police as “front-line mental health workers” (see Part 2, above),
- c. once the patient returns to the community, those same officers or their colleagues, are likely to be first contact if there is another episode.

Current interpretation of privacy legislation, and current clinical practice, essentially prohibits information to flow back from the hospital ED team to the police officers, without the express consent of the patient. This fosters in police a sense of frustration and futility, for example when officers repeatedly apprehend and bring to hospital the same individual, yet are excluded from any kind of information flow or crisis planning.

7.3.2 Family, Caregivers and Confidentiality

Similar conflicts about sharing of information were noted by family members participating in the survey, and by some of the inquest recommendations. As the focus of this paper is on police/hospital interactions, I will not deal with this issue in depth, except to say that there continues to be “a need for productive communication and cooperation between families of the patients and hospital staff” (RC/JT/EM inquest recommendation).

Part 8: Conclusion

Many of the observations and recommendations described in this document are not new. A review of the Mental Health Implementation Task Force's final regional reports reveals calls for

- 24/ 7 mental health workers in all Schedule I emergency departments with access to a psychiatrist, and access for non-Schedule I hospitals to such workers at their district Schedule I hospitals (Southeast, Northeast);
- Protocols to reduce police wait times in hospital (Northeast);
- Coordination among Schedule 1 hospitals (Central East Whitby, Central East Penetanguishene);
- Designated area in the ED for patients with mental health issues (Northeast);
- Increased mental health beds (Central East Whitby, Central East Penetanguishene);
- "Immediate and sustained investment in mental health service and support capacity" (Toronto Peel).

A complete review of the Task Force's recommendations is beyond the scope of this paper, which focuses on one step in the continuum of care. However, I believe the concerns and recommendations in this document are consistent with those of the Mental Health Implementation Task Force, and as such represent a consistent direction for improvement of the mental health system in Ontario.

As this report comes at a time of transition in governance of health care to the LHIN system, I hope this document will receive serious consideration in planning and implementing improvements in the mental health system, and the recommendations herein will be made a high priority by the LHINs.

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