Tools for Developing Police-Hospital Transition Protocols in Ontario May 2019

A COMPLEMENTARY GUIDELINE TO SUPPORT THE IMPLEMENTATION OF *IMPROVING POLICE-HOSPITAL TRANSITIONS: A FRAMEWORK FOR ONTARIO*

Canadian Mental Health Association Ontario | Association canadienne pour la santé mentale Ontario
HSJCC Human Services & Justice Coordinating Committee
OHA Ontario Hospital Association
Ontario Association of Chiefs of Police OACP

Acknowledgements

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- Ministry of Health and Long-Term Care
- Ministry of the Solicitor General
- Provincial Human Services and Justice Coordinating Committee
- Canadian Mental Health Association (Ontario)

Legal Disclaimer

Police-Hospital Transition Task Force

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Overview

The following tools and resources have been developed as a complementary guideline to support the implementation of *Improving Police-Hospital Transitions: A Framework for Ontario*.

These tools and resources were developed based on existing promising practices in Ontario. Their use is not a mandatory requirement, rather they are designed to help police, hospitals and others comply with legal requirements (e.g. as found in Ontario's mental health, human rights, policing and privacy legislation) and best practices. These tools may be tailored to the specific needs of local communities (except for Tool 4: interRAI Brief Mental Health Screener which is a trademarked product).

The use of the term "hospital" throughout these documents refers to public hospitals under the *Public Hospitals Act*, and the term "Schedule 1 Psychiatric Facilities" refers to psychiatric hospitals which provide inpatient services and are designated under the *Mental Health Act*.

Tool 1: Stages of Transition for an Individual in Crisis

This diagram provides a general overview of an individual's pathway from the moment of the onset of a mental health or addictions-related crisis, to police officers arriving on the scene for support, to their arrival at the hospital, through to their release back into the community. This tool represents a simplified map of the pathway of an individual that has been apprehended under the *Mental Health Act*. Each person's pathway is very different, and some journeys will not be reflected here. This map is meant only as a general overview.

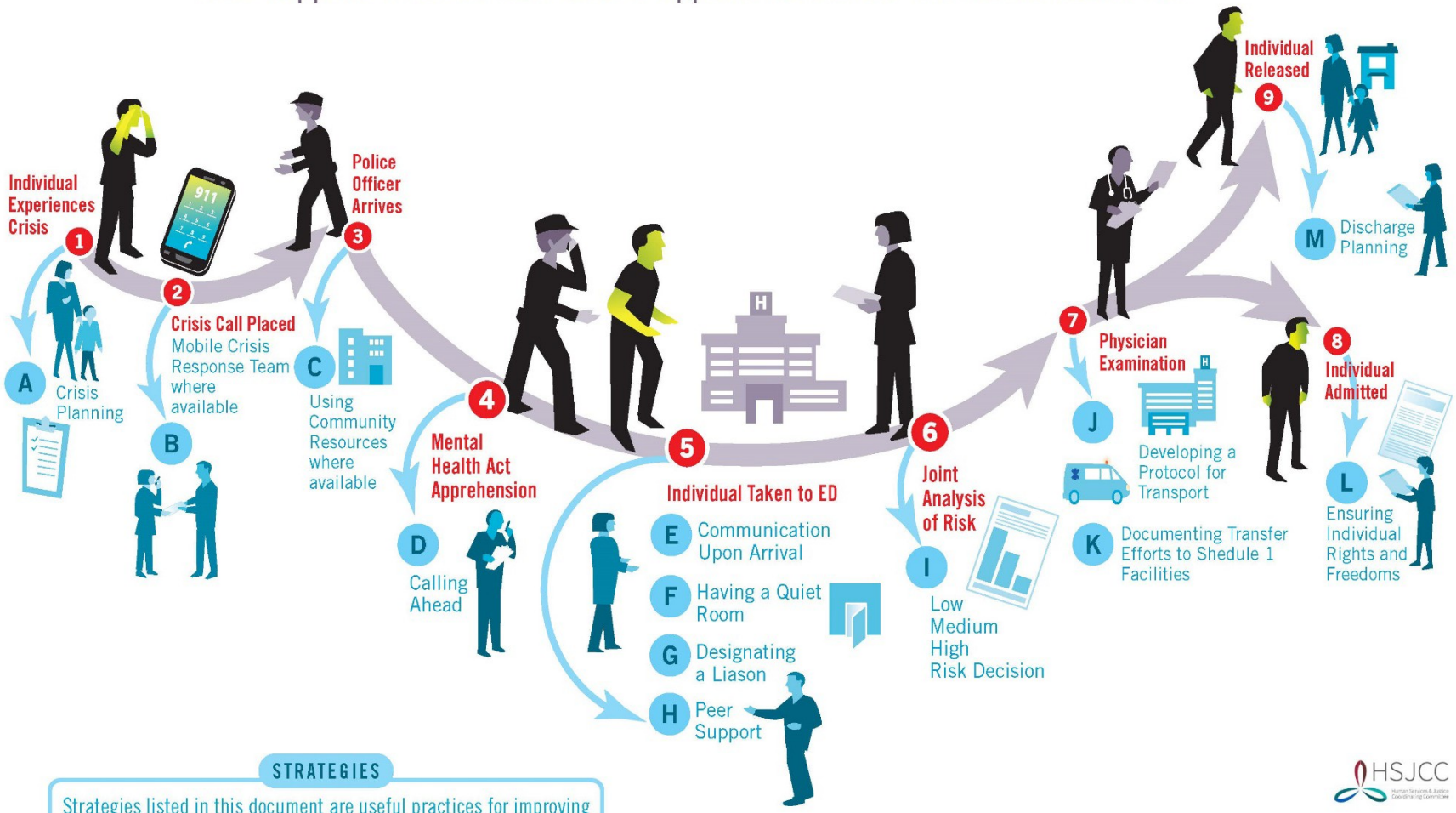
The Stages of a Police-Hospital Transition map can be used for two purposes:

- To inform users of the health care system about the general pathway to care that an individual may experience if they are apprehended under the *Mental Health Act* (map can be printed as a single page hand out for use with the general public with shortened descriptions of each step and strategies).

- To educate hospital staff, police officers and other community service providers involved with *Mental Health Act* apprehensions about the typical stages of transition for the individual experiencing a mental health or addictions-related crisis.

Stages of a Police-Hospital Transition

What happens when an individual is apprehended under the *Mental Health Act*



STRATEGIES

Strategies listed in this document are useful practices for improving client experiences and reducing police-hospital wait times.

HSJCC

Canadian Mental Health Association Ontario — Mental health for all

Association canadienne pour la santé mentale Ontario — La santé mentale pour tous

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For more information please visit **www.hsjcc.on.ca**

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1. Individual Experiences Crisis: When an individual is experiencing a mental health or addiction-related crisis, the person requires care and attention to address their physical and mental health needs while ensuring that they and others are kept safe in a difficult and often unfamiliar situation. A mental health or addictions-related crisis can include: a serious, immediate mental health or addictions problem, a situational crisis, psychosis, risk of self-harm or harm to others, emotional trauma, agitation or inability to sleep as a result, severe depression or anxiety, symptoms of moderate withdrawal and needing support, or suicidal thoughts.

There are many individuals that may be involved to provide support during a crisis situation, such as an individual's family and friends, crisis centres, dispatch staff, police officers, paramedics and emergency medical services, hospital staff, emergency nurses and doctors, community mental health and addictions organizations and peer support workers. In many communities, there are crisis services available that may be called before 911. ConnexOntario hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions-related concerns. For more information, visit:
www.connexontario.ca

2. Crisis Call is Placed: When someone is experiencing a mental health or addictions-related crisis, additional help for the person may be required and the individual or their family may not know where to go for help. In these cases, friends, family members, or the individual themselves may call a crisis line to seek assistance, such as ConnexOntario which operates a free, 24-hour crisis response line: 1-866-531-2600. If crisis lines are not available within a community, then 911 may be called for help.

3. Police Officer Arrives: When the police are called or they come into contact with an individual experiencing a crisis, they have a large role in determining the best course of action to help the individual and ensure public safety. If the police officer determines that the individual requires care for mental health or additions-related concerns, they may apprehend the individual under the *Mental Health Act*.

4. *Mental Health Act* Apprehension: Under the *Mental Health Act,* police officers have the responsibility to take individuals who may be at risk of harming themselves or others to an appropriate place for examination by a physician, often to a hospital emergency department. Upon making the apprehension, the police officer remains with the individual until transfer of custody to the hospital occurs. At this point, police officers can use a mental health and addictions screening form (such as the interRAI Brief Mental Health Screener) to document their observations of the individual apprehended under the *Mental Health Act*. The individual may also be subject to a safety search by a police officer at this time.

5. Individual Taken to Emergency Department: An officer that has made an apprehension under the *Mental Health Act* is required to transport the individual to a psychiatric or health care facility. Often, the best option for immediate care for the individual is the hospital emergency department. When arriving at the hospital, as part of the intake process, the individual in crisis may be subject to a safety search.

6. Joint Analysis of Risk: After arriving at the hospital, the police officer(s) and hospital staff should jointly conduct an analysis of the level of risk the individual poses to themselves and others within the hospital. Depending on the outcome of this risk assessment, the police officers will either remain in the hospital or leave the individual in the care of the hospital. If the police officers are no longer required, the individual has the option of remaining in the hospital for an assessment by a physician to determine their mental health care needs, or the individual may leave.

7. Physician Examination: After an examination, the physician makes a decision about whether a Form 1 is required. If the individual is issued a Form 1, there is the authority to take the individual in custody to a psychiatric facility forthwith and detain the individual for up to 72 hours for psychiatric assessment. If a Form 1 is not issued, the individual can either stay voluntarily at the hospital for additional care, or they can leave. Following this assessment, the physician or a hospital staff person may ask the individual if the outcomes of this assessment can be communicated back to the police officer(s) that apprehended the individual under the *Mental Health Act*.

8. Individual Admitted: An individual can be voluntarily or involuntarily admitted to a psychiatric facility once they have been assessed by a physician. If a Form 1 is issued and an involuntary admission is made, the hospital then has the authority to hold custody of the individual for up to 72 hours. Persons assessed on a Form 1 have a right to know the outcomes of their assessment and potential detention, and to know of their right to counsel.

9. Individual Released: Leaving an acute care setting for individuals that have experienced a mental health or addictions-related crisis requires good quality discharge planning for a successful transition back into the community. Recovery from a crisis is experienced differently by everyone. For many, it is important that the proper community supports are put in place and connections or referrals to community programs are provided. To keep an individual well within their community, it is important for hospital staff to identify unique needs of individuals when released from the hospital.

A. Planning for a Crisis: Crisis Planning helps to ensure client-centred care and offers a way for individuals to establish a plan of action in preparation for periods of illness. Crisis plans provide time-tested strategies for de-escalating crisis situations, provides the tools for reducing triggers, and outlines specific treatments and medications that have either mitigated or aggravated such experiences in the past. Individuals maintain the ability to control the care they receive when they may be unable to effectively communicate. For more information about crisis planning, see the Provincial Human Services and Justice Coordinating Committee Information Guide: *Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario* (pg. 13-15) available at www.hsjcc.on.ca

B. Mobile Crisis Response Teams: Mobile crisis response services may involve health care professionals responding to a crisis or may involve a joint response between police services and health care organizations. The joint response teams typically include a police officer working alongside a mental health professional. Where available, these response teams may be dispatched to assist the individual in crisis and they generally arrive on the scene after the area has been made secure. The mobile crisis response team assesses the individual in crisis and refers them to the appropriate place in the community for care, whether it is a hospital or a community-based mental health and addictions service provider.

C. Using Community Resources: If a mental health apprehension is not made, police officers can connect individuals to community resources in their area. ConnexOntario can connect individuals in crisis (youth and adults), family and friends, and professionals with information on types of services/programs and estimated wait times for support within their community. The crisis response lines are staffed by Information and Referral Specialists that are trained in suicide intervention skills and most have worked within frontline mental health and/or addictions services. They engage in supportive listening with callers to help ensure that individuals requiring support are linked to the most appropriate services in their community. For more information, visit: www.connexontario.ca

D. Calling Ahead: When police officers are en route to the hospital, it is best that the police officers or the Police Service Communication Centre (dispatch) call ahead to inform the emergency department staff that a mental health apprehension has taken place and police officers will be arriving at their facility with the individual. This information allows emergency department staff some additional time to adequately prepare for the incoming individual.

E. Communication Upon Arrival: Establishing communication between the police officers and hospital staff upon arrival in the emergency department, and having the officers provide all relevant information to hospital staff, can expedite the process and can assist hospital staff in providing the best possible care to the person in crisis. Furthermore, establishing strong communication upon arrival can help determine the length of time that police officers will be required to remain at the hospital.

F. Having a Quiet Room: Having a quiet space for individuals experiencing a crisis can reduce the stigma associated with mental health and/or addictions conditions. The quiet space provides privacy for the individual and offers shelter from the watchful eyes of others waiting in the emergency room. A quiet space can also provide safety and security for the individual in crisis.

G. Designating a Liaison: A designated crisis coordinator in the emergency department can be an asset to hospital staff as well as police officers in terms of establishing clear communication. The designated crisis coordinator can also provide services and supports to the individual experiencing a mental health or addictions-related crisis, including conducting an initial mental health assessment, providing counselling services, and connecting the individual to appropriate mental health and addictions resources in the community.

H. Peer Support: Some hospitals have peer support workers available within their facility that can play a key role in supporting an individual in crisis. Having peer support available for individuals experiencing a mental health or addictions-related crisis can help the individual, family or other support people have conversations with a person that is familiar with their situation and can assist with planning for any potential future crisis situations that may arise.

I. Low/Medium/High Risk Decision: An individual experiencing a mental health or addictions-related crisis can be low, medium or high risk in harming themselves or others, or fleeing from the hospital. The police officers and hospital staff should engage in a conversation to collaboratively determine the risk level of the individual in crisis.

J. Developing a Protocol for Transport: Non-Schedule 1 Facilities with emergency departments should develop a protocol for transporting individuals who require a psychiatric assessment to Schedule 1 Psychiatric Facilities. It is best practice that the physician completing the Form 1 also provide a clinical assessment of how the individual can be safely transferred to the new facility. The determination of transfer method and rationale should be recorded by the physician. If paramedic services are needed for the transport of the individual between facilities, the Provincial Transfer Authorization Centre will need to be consulted during the development of the protocol.

K. Documenting Transfer Efforts to Schedule 1 Facility: The *Mental Health Act* states that the transfer of an individual to a Schedule 1 Psychiatric Facility for an assessment needs to be completed "forthwith" which is generally interpreted in case law as "as soon as reasonably possible." It is recommended that the hospital staff document the efforts made to transfer to the individual to the new facility, the care provided while waiting for the transfer, and the ongoing monitoring and assessment of the individual to ensure that the criteria for an individual to require a psychiatric assessment under Form 1 are still present.

L. Ensuring Individual Rights and Freedoms: The hospital and police officers responding to a crisis should take necessary steps to ensure that the individual's right and freedoms are protected at all times.

- To learn more about individual rights when a Form 1 has been issued, please see the Community Legal Education Ontario resource *Are you in hospital for a psychiatric assessment?* available at: http://www.cleo.on.ca/sites/default/files/book_pdfs/form1.pdf
- For individuals seeking additional information on their rights while in the care of an Ontario hospital for a mental health or addictions-related concern, contact the Psychiatric Patient Advocate Office at 1-800-578-2343
- To learn more about the legal authorities of hospitals to detain individuals that may be at risk to harming themselves or others, please see the Ontario Hospital Association *Practical Guide to Mental Health and the Law in Ontario* available at www.oha.com

M. Discharge Planning: Support from family, the community, and having access to the social determinants of health (for example: housing and food) are key to increasing wellness and preventing individuals from coming into contact with police or experiencing additional, unanticipated visits to the emergency department. It is recommended that discharge planning for individuals that have been frequently apprehended under the *Mental Health Act* be reviewed by hospital staff to identify any gaps or issues that need to be addressed to better connect individuals to community services while respecting the individual's right to treatment, choice and privacy.

Stages of Transition for an Individual in Crisis

The stages of transition for individuals that have experienced a mental health or addictions-related crisis and have been apprehended under the *Mental Health Act* are described below. The strategies listed below are based on promising practices that have been implemented in communities across Ontario. Please note that the strategies are intended to support the development and implementation of a successful police-hospital emergency department transition protocol and should be considered as recommendations only, and are not mandatory requirements. Some strategies require resources which may not be available in all communities.

1) Individual experiences a mental health or addictions-related crisis

When an individual is experiencing a mental health or addictions-related crisis, the person requires care and attention to address their physical and mental health needs while ensuring that the person and others are kept safe in a difficult and often unfamiliar situation. A crisis may require the assistance of professionals to help reduce risks and provide care for the individual and others, especially if the circumstance is new or unmanageable for the individual and those around them.

A mental health or addictions-related crisis can include: a serious, immediate mental health or addictions problem, a situational crisis, psychosis, risk of self-harm or harm to others, emotional trauma, agitation or inability to sleep and, as a result, severe depression or anxiety, symptoms of moderate withdrawal and needing support, or suicidal thoughts.

There are many individuals that may be involved to provide support during a crisis situation, such as an individual's family and friends, crisis centre dispatch staff, police officers, paramedics and emergency medical services, hospital staff, emergency nurses and doctors, community mental health and addictions organizations and peer support workers.

In many communities, there are crisis services available for individuals experiencing a mental health or addictions-related crisis that may be called before 911. ConnexOntario

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hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions concerns.

STRATEGY A: Planning for a crisis

Individuals and families can develop a plan to prepare for a crisis situation. Crisis Planning helps to ensure client-centred care and offers a way for individuals to establish a plan of action in preparation for periods of illness. Crisis plans provide time-tested strategies for de-escalating crisis situations, provide the tools for reducing triggers, and outline specific treatments and medications that have either mitigated or aggravated such experiences in the past. Individuals maintain the ability to control the care they receive when they may be unable to effectively communicate.

For more information about crisis planning, see the Provincial Human Services and Justice Coordinating Committee Information Guide: *Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario* (pp.13-15). www.hsjcc.on.ca

2) Crisis call is placed

When someone is experiencing a mental health or addictions-related crisis, additional help for the person may be required and the individual or their family may not know where to go for help. In these cases, friends, family members, or the individual themselves may call a crisis line to seek assistance. If crisis lines are not available within a community, a 911 emergency call may be placed.

The role of the Police Service Communication Centre (dispatch) is important in the response to individuals in crisis when a 911 call is placed. Particularly in communities where there may be mobile crisis response teams that can be dispatched to a location to assist police officers in their response, these teams can potentially divert individuals away from emergency departments and the justice system, and offer care where the individual is located. Crisis bed programs in the community may also be available to support individuals in crisis.

ConnexOntario hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions concerns.

STRATEGY B: Utilizing mobile crisis response teams or other community mental health and addictions agencies for support, where available

Mobile crisis response services may involve health care professionals responding to a crisis or may involve a joint response between police services and health care organizations. The joint response teams typically include a police officer working alongside a mental health and addictions professional. Where available, these response teams may be dispatched to assist the individual in crisis and they generally arrive on the scene after the area has been made secure. The mobile crisis response team assesses the individual in crisis and refers them to the appropriate place in the community for care, whether it is a hospital or a community-based mental health and addictions service provider.

3) Police officer(s) arrive to assist the individual in crisis

When the police are called or they come into contact with an individual experiencing a mental health or addictions-related crisis, they have a large role in determining the best course of action to help the individual and ensure public safety. In some cases, there may be a criminal incident that has also occurred at the same time as the mental health or addictions-related crisis. In those situations, there may be times when a police officer has to decide whether it is appropriate to make a mental health apprehension or to lay a criminal charge. In appropriate circumstances, police officers should be encouraged to make all efforts to divert a person away from the criminal justice system. Police officers should give primary consideration to whether the *Mental Health Act* can appropriately address the factors of concern in any particular case.

Police officers can connect individuals to community resources at any point. For instance, where a criminal charge is not laid and a mental health apprehension is not made, a police officer may connect the individual to community resources in their area. ConnexOntario hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions concerns.

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ConnexOntario can connect individuals in crisis (youth and adults), family and friends, and professionals such as police officers with information on types of services/programs and estimated wait times for support within their community. The crisis response lines are staffed by Information and Referral Specialists that are trained in suicide intervention skills, most have worked within frontline mental health and/or addictions services, and engage in supportive listening with callers to help ensure that individuals requiring support are linked to appropriate services in their community.

STRATEGY C: Using community resources, where available

If a criminal charge is not laid and a mental health apprehension is not made, then police officers can connect the individual to community resources in their area. For more information about community resources contact ConnexOntario, which hosts an online listing of a community's mental health and addictions resources and operates a free, 24-hour crisis response line for mental health and addictions concerns: www.connexontario.ca

4) Apprehension under the *Mental Health Act*

Under the *Mental Health Act*, when the required circumstances are met, police officers have the authority to take individuals who may be at risk of harming themselves or others to an appropriate place for examination by a physician, often to a hospital emergency department. Upon making the apprehension, the police officer remains with the individual until transfer of custody to the hospital occurs.

At this time, police officers can use the interRAI Brief Mental Health Screener form to document their observations of the person apprehended under the *Mental Health Act*. See Tool 4: interRAI Brief Mental Health Screener for more information.

During this process, the individual may also be subject to a safety search by a police officer.

STRATEGY D: Calling ahead

When police officers are en route to the hospital, it is best that the police officer(s) or the Police Service Communication Centre (dispatch) call ahead to inform the emergency department staff that a mental health apprehension has taken place and the police officer(s) will be arriving at their facility with the individual. This information allows emergency department staff some additional time to adequately prepare for the incoming individual.

5) Individual taken to the hospital emergency department

When the police officer(s) arrive at the hospital emergency department with the individual experiencing a mental health or addictions-related crisis, a number of service dynamics can occur during this transition process resulting in issues that impact on police services, hospital staff and the individual in crisis. At this point, as part of the intake process of the hospital, the individual in crisis may be subject to a safety search.

Establishing a Police-Hospital Transition Protocol is recommended to support everyone involved in the transition. See Tool 3: Police-Hospital Transition Protocol for a general template that may be adapted as needed.

STRATEGY E: Communicating upon arrival

Establishing communication between the police officer(s) and hospital staff upon arrival in the emergency department, and having the officer(s) provide all relevant information to hospital staff, can expedite the process and can assist hospital staff to provide the most appropriate care to the individual in crisis. Furthermore, establishing strong communication upon arrival can help determine the length of time that police officers will be required to remain at the hospital.

STRATEGY F: Having a quiet room

Having a quiet space for individuals experiencing a crisis can reduce the stigma associated with mental health and/or addictions conditions. The quiet space provides privacy for the individual and offers shelter from the watchful eyes of others waiting in the emergency room. A quiet space can also provide safety and security for the individual in crisis.

STRATEGY G: Designating a liaison

A designated crisis coordinator in the emergency department can be an asset to hospital staff as well as police officers in terms of establishing clear communication. The designated crisis coordinator can also provide services and supports to the individual experiencing a mental health or addictions-related crisis, including conducting an initial mental health and addictions assessment, providing counselling services, and connecting the individual to appropriate mental health and addictions resources in the community.

STRATEGY H: Peer support

Some hospitals within Ontario have peer support workers available within their facility that can play a key role in supporting an individual in crisis. Having peer support available for individuals experiencing a mental health or addictions-related crisis can help the individual, family or other caregivers have conversations with peers that are familiar with their situation and can assist with planning for any potential future crisis situations that may arise.

6) Joint analysis of risk

After arriving at the hospital, the police officer(s) and hospital staff should jointly conduct an analysis of the level of risk the individual poses. The joint analysis of risk should be completed by a designated hospital staff person (not necessarily a physician) and the police officer.

The purpose of the joint analysis of risk is to determine whether the individual poses a risk in harming themselves or others at the hospital, and whether the individual poses a risk of fleeing from the hospital. In view of these particular risks, the designated hospital staff person and the police officer should determine whether the hospital is ready to take immediate custody of the individual such that the police officer(s) may leave the hospital premises.

This risk analysis is distinct from the assessment associated with the decision about whether to issue a Form 1. When required, the decision regarding issuing a Form 1 under the *Mental Health Act* rests solely with a physician.

At this point, a transfer of custody form can be used by hospital staff to document decisions pertaining to the joint analysis of risk conducted by the hospital staff and the police officer. See Tool 5: Transfer of Custody Form for a general template that may be adapted as needed.

Strategy I: Low, Medium, High Risk Decision

An individual experiencing a mental health or addictions-related crisis can be low, medium or high risk with respect to harming themselves or others, or fleeing from the hospital. The criteria for high, medium and low risk should be defined clearly and should appear on the transfer of custody form keeping in mind the overarching goals of the protocol, specifically, to improve and formalize the transition process.

If the individual is **low-risk**, the police officer(s) can transfer custody to the hospital staff immediately.

Medium-risk individuals may or may not require the police officer(s) to stay. To determine if the police officer(s) need to remain in the hospital, the hospital staff and police officer(s) should engage in a conversation to collaboratively determine the decision.

If the individual is **high-risk**, the police officer(s) must remain with the individual until the individual has been assessed by a physician for the purpose of determining whether to issue a Form 1.

An individual's level of risk may fluctuate from low-to-high or high-to-low at any time during or after the transition of custody. If the individual's observable behaviour indicates that they present a noticeable increased risk of harm after the police officers have left, the hospital may call the police to return – police services should prioritize these return calls.

It is best practice that if there is any dispute on the decision of the joint analysis of risk, the police officer(s) should stay in the hospital at the request of the hospital staff. If disagreement is persistent and systematic, police services and the hospital may trigger their dispute resolution mechanism through their Police-Hospital Transition Protocol to address the ongoing issues.

7) Physician's Form 1 related examination

After an examination, the physician makes a decision about whether a Form 1 is required (whether the test in Section 15 of the *Mental Health Act* is met). If the individual is issued a Form 1, there is the authority to take the individual in custody to a psychiatric facility forthwith and detain the individual for up to 72 hours for psychiatric assessment. If a Form 1 is not issued, the individual can either stay voluntarily at the hospital for additional care, or they can leave.

Following this assessment, the physician or a hospital staff person may ask the individual if the outcomes of this assessment can be communicated back to the police officer(s) that apprehended the individual under the *Mental Health Act*. The individual's consent to share or not to share information with the police officers should be documented.

(7a) Transport to Schedule 1[1] Psychiatric Facility may be required

In some situations, the hospital where the person had been accompanied to by a police officer does not have the legal authority to detain a patient on an involuntary basis. Where this is the case, the person should be transported to a Schedule 1 Psychiatric Facility,[1] that provides in-patient services, under the *Mental Health Act* for further assessment and care.

A Form 1 is effective for seven days and provides authority to take the individual in custody to a psychiatric facility where they may be detained, restrained, observed and examined for no more than 72 hours.

STRATEGY J: Developing a protocol for transport

Non-Schedule 1 Facilities with emergency departments should develop a protocol for transporting individuals who require a psychiatric assessment at Schedule 1 Psychiatric Facilities. It is best practice that the physician completing the Form 1 may also provide a clinical assessment of how the individual can be safely transferred to the new facility. The determination of transfer method and rationale should be recorded by the physician. Should it be determined that paramedic services are needed for the transport of the individual between facilities, the Provincial Transfer Authorization Centre will need to be consulted when developing the protocol as this is the body responsible for coordinating and approving all transfers conducted by paramedic services in Ontario.

[1] A full list of designated Schedule 1 Psychiatric Facilities that provide in-patient psychiatric services in Ontario can be found here: http://www.health.gov.on.ca/en/common/system/services/psych/designated.aspx

Currently, within Ontario communities, the transport of the individual to a Schedule 1 Psychiatric Facility may be done by a family member, friend, paramedic services or other patient transport service, or police officer(s). It is recommended that hospitals, paramedic services, police services, and other appropriate transport entities ensure that a process has been established for transporting clients to Schedule 1 Psychiatric Facilities. This process can be embedded into the Police-Hospital Transition Protocol.

STRATEGY K: Documenting transfer efforts to Schedule 1 Psychiatric Facility

The *Mental Health Act* states that the transfer of an individual to a Schedule 1 Psychiatric Facility for an assessment needs to be completed "forthwith" which is generally interpreted in case law as "as soon as reasonably possible." It is recommended that the hospital staff document the efforts made to transfer the individual to the new facility, the care provided while waiting for the transfer, and the ongoing monitoring and assessment of the individual to ensure that the criteria for an individual to require a psychiatric assessment under Form 1 are still present.

8) Individual is admitted to hospital

An individual can be voluntarily or involuntarily admitted to a Schedule 1 Psychiatric Facility once they have been assessed by a physician. If a Form 1 is issued, the hospital then has the authority to hold custody of the individual for up to 72 hours.

It should be considered best practice for hospitals to inform individuals assessed on a Form 1 of their right to learn the reasons for their assessment and potential detention, and be informed of their right to counsel, upon admission at the psychiatric facility. Psychiatric facilities have certain obligations under the *Mental Health Act*, including obligations to advise individuals of their rights (usually through delivery of a Form 42).

STRATEGY L: Ensuring individual rights and freedoms

The following actions can be taken by hospital staff and police officers to ensure that an individual's rights and freedoms are protected in a crisis situation:

- ✓ As much as possible, it is recommended that hospital staff review internal processes to ensure that individuals apprehended under the *Mental Health Act* are quickly assessed, and that a decision for the hospital to assume custody is made as early as possible (and so in compliance with legislation). Hospitals can ensure that Canadian Triage Acuity Scale (CTAS) levels being assigned to individuals presenting with mental health or addictions-related crises are accurately reflecting acuity by internally reviewing CTAS guidelines and how they are being applied within the emergency department setting. Where all acuity is equal, the hospital can put a process in place that prioritizes individuals accompanied by police officers to be seen first in an effort to expedite the transition process for individuals in crisis.

- ✓ Provide supervised or monitored quiet rooms without locks.

- ✓ Train hospital staff on the limits of their detention, search and restraint powers, and alternative measures that may be used.

- ✓ Train hospital and security staff on the legal rights framework, de-escalation techniques, and human rights accommodations and privacy requirements, with an emphasis on appropriate and effective communication.

- ✓ Train hospital staff on how to assess and triage apprehended persons who are unable or unwilling to communicate.

- ✓ Identify clear procedures around the provision of Form 42 and the availability of peer support and advocacy services.

Additional resource for hospitals: To learn more about the legal authorities of hospitals to detain individuals that may be at risk of harming themselves or others, please see the Ontario Hospital Association *Practical Guide to Mental Health and the Law in Ontario* available at www.oha.com

9) Individual is released from hospital

Leaving an acute care setting for individuals that have experienced a mental health or addictions-related crisis requires good quality discharge planning for a successful transition back into the community. Recovery from a crisis is experienced differently by everyone. For many, it is important that the proper community supports are put in place and connections or referrals to community programs are provided. To keep an individual well once back in their community, it is important for hospital staff to work with the individual to identify their unique needs when released from the hospital.

STRATEGY M: Discharge planning

The "revolving door" can occur in the emergency department. Police officers may accompany an individual apprehended under the *Mental Health Act* to the emergency department; yet once the individual is examined by the physician, the individual may be released back into the community because they did not meet the criteria for involuntary admission to a psychiatric facility.

Support from family, the community, and having access to the social determinants of health (for example: housing and food) are key to increasing wellness and preventing individuals from coming into contact with police or experiencing additional, unanticipated visits to the emergency department.

It is recommended that discharge planning for individuals that have been frequently apprehended under the *Mental Health Act* be reviewed by hospital staff to identify any gaps or issues that need to be addressed to better connect individuals to community services while respecting the individual's right to treatment, choice and privacy.

Tool 2: Police-Hospital Committee Terms of Reference

This tool is a template for Ontario communities to use to assist with establishing a joint police-hospital committee to support the development of a police-hospital transition protocol. Communities can adapt and change this template to their local needs using available resources. The purpose of this Terms of Reference document is to clearly outline the role and scope of the Police-Hospital Committee, including the committee's objectives, membership, frequency of meetings and key contact information for matters relating to police-hospital transitions and the corresponding protocol.

Police-Hospital Committee Terms of Reference

(Insert date when Terms of Reference was created or revised)

Purpose of Police-Hospital Committee

The purpose of the committee is to bring together representatives from police services, hospitals, paramedic services and community mental health and addictions organizations in (*insert name of your city/town*) to develop and implement a police-hospital transition protocol that complies with legal requirements and best practices associated with Ontario's mental health, human rights, policing and privacy legislation.

To support the work of this committee, members are encouraged to use *Improving Police-Hospital Transitions: A Framework for Ontario.* The information, templates and tools in this framework will provide guidance to members of this committee to establish effective police-hospital transition protocols for individuals that have been apprehended by police officers under the *Mental Health Act* and subsequently accompanied to a hospital emergency department for assessment and care.

Objectives of Police-Hospital Committee

- To improve outcomes for people experiencing a mental health or addictions-related crisis that are accompanied to an emergency department by a police officer while respecting individual rights, including the right to privacy;
- To enhance collaboration and coordination between hospitals and police services in Ontario communities;
- To decrease police officer wait times to transfer custody of apprehended individual to hospital emergency department;
- To protect health care worker safety and security through system improvements
- To promote public safety
- To identify strategies and solutions to any issues that may arise during the implementation of the police-hospital transition protocol
- To develop strategies for ongoing monitoring and evaluation of the effectiveness of the police-hospital transition protocol
- To annually review the work of this police-hospital committee and update the terms of reference as necessary

Reporting Relationships

The *(insert name of your committee)* shall report to the Chief Executive Officer (CEO) of *(insert name of your hospital)*, and the Chief of Police of (*insert name of your police service)* or Ontario Provincial Police (OPP) Detachment Commander. Paramedic services and community mental health and addictions organizations are responsible for reporting to their own respective organizations' CEOs or their managers.

Responsibilities of Members

All members are responsible for attending Police-Hospital Committee meetings on a regular basis and working to achieve committee objectives noted above. The responsibilities outlined below indicate specific responsibilities of committee members.

Police Chief/OPP Detachment Commander and Hospital CEO will:

- Be the executive sponsors of the protocol

Police Designate with decision-making authority and Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.) will:

- Provide guidance to staff on the successful implementation of the protocol and resolve any disputes that may arise between the organizations
- Ensure all frontline staff complete the necessary training needed to implement the police-hospital transition protocol
- Provide guidance to frontline staff throughout the implementation phase
- Ensure the ongoing monitoring and evaluation of the police-hospital transition protocol
- Manage relationships and resolve issues between representatives of police service(s), hospital and other members

Frontline police officers and hospital emergency department and privacy office staff will:

- Deliver on the expectations associated with the written agreement between the hospital and police service(s)
- Participate in all necessary training related to the police-hospital transition protocol
- Work with other frontline police and hospital staff to implement the protocol
- Communicate progress and report any issues to their respective superiors

Other Service Provider Roles and Responsibilities:

- Deliver on the expectations associated with the protocol
- *(Insert additional details)*

Police-Hospital Committee Membership

Hospital representatives

Police representatives (can include multiple municipal police services and the OPP)

Paramedic Service representatives

Community Mental Health and Addictions Organization(s) representative(s)

Individual(s) with lived experience of police-hospital transitions

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Police-Hospital Committee Meetings

Meetings will be held at least annually at *(insert name of meeting location)*.

Meetings will be chaired by the Police Designate with decision-making authority and Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.).

Secretarial support for this Committee for minute-taking and other activities will be provided by (*insert name of organization*).

Contact Information

For information about the Police-Hospital Committee, contact:

Hospital representative:
Title:
Telephone Number:
Email:

Police representative:
Title:
Telephone Number:
Email:

Tool 3: Police-Hospital Transition Protocol Template

This tool is a template for Ontario communities to use to assist with the development of a police-hospital transition protocol. Communities can adapt and change this template to their local needs using available resources. The purpose of this tool is to determine the processes involved with police-hospital transitions when an individual has been apprehended under the *Mental Health Act*.

Police-Hospital Transition Protocol

(insert names/logos of partner organizations)

1. Introduction

This protocol is designed to enhance collaboration between hospitals and police services with the purpose of improving outcomes for individuals that have been apprehended by police officers under the *Mental Health Act* and subsequently accompanied to a hospital emergency department for assessment and care.

The intent of this protocol is to 1) Improve outcomes for individuals apprehended by police under the *Mental Health Act*, while respecting individual rights, including the right to privacy; 2) Improve transitions between police officers and hospital workers; and 3) Improve coordination and collaboration among partners involved in the transition.

The protocol may be extended to include partnerships with other stakeholders in the community, such as paramedic services, community-based mental health and addictions agencies, peer and family support organizations, child and youth mental health and addictions agencies and others.

2. Purpose

This protocol was developed in collaboration with key stakeholders who are the first responders to individuals experiencing a mental health or addictions-related crisis. This document reflects the commitment of all participants to provide an effective and integrated response to such crisis situations in (*insert name of your town/city*).

The purpose of this agreement is to:

- To improve outcomes for people experiencing a mental health or addictions-related crisis that are accompanied to an emergency department by a police officer while respecting individual rights, including the right to privacy;
- To enhance collaboration and coordination between hospitals and police services in Ontario communities;
- To decrease police officer wait times to transfer custody of apprehended individual to hospital emergency department;
- To protect health care worker safety and security through system improvements; and
- To promote public safety.

This agreement outlines:

- The roles of the signatories in responding to the individual that has been apprehended by police officers under the *Mental Health Act*; and
- The respective responsibilities of each signatory to ensure seamless transition between frontline police officers and hospital staff.

3. Key Definitions

Mental Health: is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity.[2]

Mental Illnesses: mental illnesses are health problems that affect the way we think about ourselves, relate to others, and interact with the world around us. They affect our thoughts, feelings, and behaviours. Mental illnesses can disrupt a person's life or create challenges, but with the right supports, a person can get back on a path to recovery and wellness. It is important to understand that there are many different types of mental illnesses that affect people in different ways.[3]

Addiction: The term addiction is generally applied to patterns of heavy use of psychoactive drugs that are taken primarily for their effects on consciousness, mood and perception. In general, addiction has been replaced by the more specifically defined term substance (or drug) dependence. However, "addiction" continues to be used widely and is generally thought of as compulsive use leading to physical symptoms of withdrawal when use is discontinued. For that reason, it is often equated with physical dependence.[4]

Form 1: This is the Application for Psychiatric Assessment and can be used to bring someone to a psychiatric facility for an assessment that lasts up to 72 hours (three days). To order a Form 1, a physician must have personally examined the person within the previous seven days and have reason to believe that the person meets certain criteria under the *Mental Health Act*. During the assessment, other mental health professionals (e.g., nurses, psychologists and social workers) may meet with the person and their family members, friends or caregivers to get additional information.[5]

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[2] Public Health Agency of Canada's definition of mental health, taken from: http://www.phac-aspc.gc.ca/mh-sm/mhp-psm/index-eng.php

[3] Canadian Mental Health Association's definition of a mental illness, taken from: https://www.cmha.ca/mental_health/mental-illness/

[4] Canadian Centre for Substance Abuse's definition of addiction, taken from: http://www.ccsa.ca/Resource%20Library/ccsa-011811-2010.pdf

[5] Centre for Addiction and Mental Health's definition of Form 1, taken from:
http://www.camh.ca/en/hospital/visiting_camh/rights_and_policies/Pages/challenges_choices_appclegalform.aspx

Hospital and Schedule 1 Psychiatric Facility: Hospital refers to public hospitals under the *Public Hospitals Act*, and Schedule 1 Psychiatric Facility refers to psychiatric hospitals which provide inpatient services and are designated under the *Mental Health Act*. Schedule 1 Psychiatric Facilities have the legal authority to detain involuntary patients under the *Mental Health Act*, and they provide inpatient mental health programs, including acute and short-term care and treatment, to individuals experiencing mental health and addictions related issues.[6]

4. This protocol is between:

(List all organizations involved with the protocol)

Hospital

Police Service (can include multiple municipal police services and the OPP)

Paramedic Services

Community Mental Health and Addictions Organization(s)

(List any other partners)

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5. Team Response

As soon as a *Mental Health Act* apprehension has been made and the police officer(s) take the individual experiencing a mental health or addictions-related crisis to the hospital emergency department, the following procedure will be followed:

5.1) The police officer(s)/Police Service Communications Centre will advise the hospital emergency department of the estimated time of arrival and that an individual experiencing a mental health or addictions-related crisis will be brought in for assessment.

[6] A full list of designated Schedule 1 Psychiatric Facilities that provide in-patient psychiatric services in Ontario can be found here: http://www.health.gov.on.ca/en/common/system/services/psych/designated.aspx

5.2) The police officer(s)/Police Service Communications Centre will share the following information with the emergency department:

- Estimated time of arrival; and
- Whether the individual is being transported in a police vehicle or by ambulance.

5.3) The responding police officer(s) will complete the interRAI Brief Mental Health Screener *(see Appendix for sample form)*. A copy of the completed Form may be provided to *(insert appropriate emergency department staff position)*.

5.4) If the individual experiencing a mental health or addictions-related crisis is being transported by police and their state as observed is such that routine triage may not be appropriate or safe, the transporting officer(s) will use the ambulance entrance of the hospital emergency department.

5.5) When an individual experiencing a mental health or addictions-related crisis is brought to the hospital emergency department pursuant to the *Mental Health Act*, the triage assessment will be completed by *(insert appropriate emergency department staff position)*.

6. Joint Analysis of Risk

After arriving at the hospital, the police officer(s) and hospital staff should jointly conduct an analysis of the level of risk the individual poses. The joint analysis of risk should be completed by a designated hospital staff person (not necessarily a physician) and the police officer.

The purpose of the joint analysis of risk is to determine whether the individual poses a risk in harming themselves or others at the hospital, and whether the individual poses a risk of fleeing from the hospital. In view of these particular risks, the designated hospital staff person and the police officer should determine whether the hospital is ready to take immediate custody of the individual such that the police officer(s) may leave the hospital premises.

This risk analysis is distinct from the assessment associated with the decision as to whether to issue a Form 1. When required, the decision regarding issuing a Form 1 under the *Mental Health Act* rests solely with a physician. Following the assessment to determine if a Form 1 will be issued, the physician may ask the individual if the outcomes of this assessment can be communicated back to the police officer(s) that apprehended the individual under the *Mental Health Act*. The individual's consent to share or not to share information with the police officers should be documented.

The police officer shall remain with the individual until the transfer of custody responsibility is complete. The transfer of custody is considered complete when the responsible hospital staff member and police officer have reviewed the Transfer of Custody Form and both have signed off in the designated areas *(see Appendix for sample form)*.

(In the following section, the criteria for high risk, medium risk and low risk should be defined clearly and should appear on the transfer of custody form keeping in mind the overarching goals of the protocol, specifically, to improve and formalize the transition process.)

An individual experiencing a mental health or addictions-related crisis can be low, medium or high risk:

- If the individual is **low-risk**, the police officer(s) can transfer custody to the hospital staff immediately (*add additional information as appropriate*).

- **Medium-risk** individuals may or may not require the police officer(s) to stay. To determine if the police officer(s) need to remain in the hospital, the hospital staff person and police officer(s) should engage in a conversation to collaboratively determine the decision (*add additional information as appropriate*).

- If the individual is **high-risk**, the police officer(s) must remain with the individual until the individual has been assessed by a physician for the purpose of determining whether to issue a Form 1 (*add additional information as appropriate*).

An individual's level of risk may fluctuate from low-to-high or high-to-low at any time during or after the transition of custody. If the individual's observable behaviour indicates that they present a noticeable increased risk of harm after the police officers have left, the hospital may call the police to return – police services should prioritize these return calls.

It is best practice that if there is any dispute on the decision of the joint analysis of risk, the police officer(s) should stay in the hospital at the request of the hospital staff. If disagreement is persistent and systematic, police services and the hospital may trigger their dispute resolution mechanism through their Police-Hospital Transition Protocol to address the ongoing issues.

7. Dispute Resolution

In the event of a dispute between the hospital and the police service concerning any matter arising under this protocol, the Police Designate with decision-making authority and the Head of the Emergency Department (i.e. the most senior person responsible for the Emergency Department, such as a Chief of the Department, Vice President, Program Director, etc.), shall meet, by telephone, or in person, to engage in conversation to resolve the dispute.

In the event that any matter referred to the representatives set out above remains unresolved after a period of 20 business days from its referral, then resolution will fall to the Police Chief/OPP Detachment Commander and the Hospital CEO.

8. Forms to Complete

- interRAI Brief Mental Health Screener for use by frontline police officers to document observations regarding the individual apprehended under the *Mental Health Act* *(see Appendix for sample form)*.

- A Transfer of Custody Form for use by hospital staff to document decisions pertaining to a joint analysis of risk conducted by the hospital staff and the police officer. The joint analysis of risk can be completed by a designated hospital staff person (not necessarily a physician) and the police officer. However, when required, the decision regarding issuing a Form 1 under the *Mental Health Act* rests solely with a physician *(see Appendix for sample form)*.

9. Depending on the needs and resources available in your community, insert the following:

Connecting Individual to Supports in the Community

(If community based agencies are involved with the police-hospital transition protocol, then include the instructions for connecting the individual to supports in the community here, including those related to respect for the individual's right to treatment, choice and privacy).

10. Information sharing associated with a *Mental Health Act* apprehension

Information sharing between police and hospital personnel concerning an individual apprehended under the *Mental Health Act* will typically involve both the individual's personal information and their personal health information. For example, a police officer's observations about the individual will be the individual's personal information. When the hospital collects and uses information for the purpose of providing health care to the individual, the information is the individual's personal health information.

In sharing information, police, hospital and other emergency service partners must be cognizant of their privacy-related obligations under relevant statutes such as the *Freedom of Information and Protection of Privacy Act*, *Health Care Consent Act*, *Mental Health Act*, *Municipal Freedom of Information and Protection of Privacy Act* and *Personal Health Information and Protection Act*. This means that the disclosing organization must have the authority to disclose and the recipient organization must have the authority to collect and use the personal information and/or personal health information at issue.

In this context, it is noteworthy that hospital staff must generally comply with the limiting principles set out in Section 30 of the *Personal Health Information and Protection Act*. Section 30 generally requires that no personal health information be collected, used or disclosed if other information will serve the purpose and that no more personal health information be collected, used or disclosed than is reasonably necessary to meet the purpose. Similar limiting principles also apply to the collection, use and disclosure of personal information by police under *Municipal Freedom of Information and Protection of Privacy Act*.

10.1) Disclosures and collections related to apprehension and transport

Under the *Mental Health Act*, police officers have the authority to take individuals who may be at risk of harming themselves or others to an appropriate place for examination by a physician, often to a hospital emergency department. In the course of apprehending an individual under Section 17 of the *Mental Health Act,* police officers may collect relevant information about an individual's demeanor, behavior and circumstances, and use that information to safely apprehend and transport that individual to hospital.

While in transit, police officers may call ahead to inform the emergency department staff that a mental health apprehension has taken place and police officers will be arriving at their facility with the individual. In addition, upon arrival in the emergency department, police officers may disclose further personal information to hospital staff where that information is reasonably likely to be relevant to the hospital's safe assessment, treatment, detention and release of the individual, including information describing the officers' observations about the individual's demeanor, behavior and circumstances.

As health information custodians, hospitals can only collect, use and disclose personal health information in accordance with the rules set out in the *Personal Health Information Protection Act* including the limiting principles set out in section 30.

Reasonable care should be taken by both police officers and hospital staff to ensure that information sharing be restricted to information that is as accurate, complete and up-to-date as possible.

10.2) Disclosures and collections related to transfer of custody

Upon making the apprehension, police remain with the individual until transfer of custody to the hospital occurs. The *Mental Health Act* regulations require that: a decision about the transfer of custody be made as soon as is reasonably possible; the hospital decision maker consult with the police officer(s); and hospital staff promptly inform the police of the decision.

Under this protocol, the transfer of custody generally occurs under one of the following two circumstances:

1. Custody of an individual may pass from police to the hospital where the responsible hospital staff member and police officer have reviewed the Transfer of Custody Form; agreed that the hospital is ready to take immediate custody of the individual; and signed the designated areas of the Transfer of Custody Form.

   In informing the police of this transfer decision, the hospital should restrict its disclosure of personal health information to the police to the information on the Transfer of Custody Form.

2. Where the responsible hospital staff member and police officer have determined that the police officer should remain at the hospital until a physician has decided whether to issue a Form 1, custody of an individual may pass from police to the hospital after the physician has made the Form 1 decision.

   Following an initial examination, hospital staff can inform the police officers of their decision to issue or not issue a Form 1 for the individual if the police officer has remained in the hospital. But if this assessment has occurred after the police officers have passed custody to the hospital and left the hospital premises, the hospital staff may ask the individual if they consent to sharing this information (whether the individual is admitted or not).

   If the police ask the hospital to disclose whether the individual is ultimately detained under a Form 1, the hospital may inform the police officer as to whether or not a Form 1 was issued with the express consent of the individual.

As a general rule, the hospital should only ask the individual to consent to this disclosure of their personal health information after the Form 1 decision has been made. Moreover, in order to ensure that the consent is knowledgeable and freely given, the individual must be informed of the specific personal health information that will be disclosed to the police (i.e. that a Form 1 has been issued or that no Form 1 has been issued), the specific purpose(s) for the disclosure, and the individual has the right to give or withhold consent to the hospital's disclosure of this personal health information. In addition, the individual should be informed that this disclosure of personal health information could lead to further mental health-related disclosures by the police (e.g. about the issuance of a Form 1 to other police services through the Canadian Police Information Centre).

In addition, the individual must be capable of consenting to any disclosure of their personal health information, which includes information regarding the issuance of a Form 1. The test for consent to the collection, use and disclosure of personal health information is set out in s. 21 of the *Personal Health Information Protection Act* (PHIPA).

10.3) Other disclosures and collections

An individual's level of risk may fluctuate during or after the transition of custody phase. If an individual's observable behavior indicates that they present a noticeably increased risk of harm after the officers have left (e.g. to another person or to themselves), the hospital may call the police and ask them to return to the hospital or assist in the re-location of the individual.

Authority for such a disclosure is found in Section 40(1) of the *Personal Health Information and Protection Act* which permits a hospital to disclose personal health information if the hospital believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. "Significant risk of serious bodily harm" includes a significant risk of both serious physical as well as serious psychological harm. Like all collection, use and disclosure provisions of the *Personal Health Information and Protection Act*, Section 40(1) is subject to the limiting principles in Section 30.

It is understood and agreed that the parties in this protocol shall hold all information, materials and client information gained through participation in this agreement in confidence in accordance with each organization's policies.

11. Joint Training

Training will be an important component of our ability to better serve the individual experiencing a mental health or addictions-related crisis. Our partners are committed to assisting each other in their training needs. Training will be constantly modified to enhance our ability to serve the individual experiencing a mental health of addictions-related crisis.
(Insert training details)

12. Contact Information

For more information about this protocol, contact:

Hospital representative:
Title:
Telephone Number:
Email:

Police representative:
Title:
Telephone Number:
Email:

13. Signatories

(Signatures from all organizations involved with the protocol)

Hospital

_____

Police Service (can include multiple municipal police services and the OPP)

_____

Paramedic Services

_____

Community Mental Health and Addictions Organization(s)

_____

(List other partners here)

Tool 4: interRAI Brief Mental Health Screener

The interRAI Brief Mental Health Screener provides police officers with a tool to assist in identifying persons experiencing a mental health or addictions-related crisis. This tool enables police officers to record their observations about the individual in crisis and articulate their observations to appropriate health care professionals. The use of the interRAI Brief Mental Health Screener is recommended for police services across Ontario.

About the interRAI Brief Mental Health Screener

The interRAI Brief Mental Health Screener (BMHS) provides police officers with a tool to assist in identifying persons experiencing a mental health or addictions-related crisis. It enables police officers to record their observations about the individual in crisis and articulate their observations to appropriate health care professionals. The purpose of BMHS is to develop an effective way of documenting the observations made by the police officers at the time of the crisis/incident so as to better inform and support decision-making by staff in the emergency department. The ultimate goal underlying the development and use of the BMHS is to ensure that people experiencing a mental health or addictions-related crisis who come into contact with police officers receive prompt access to appropriate health care services, reducing the risk of criminalization.

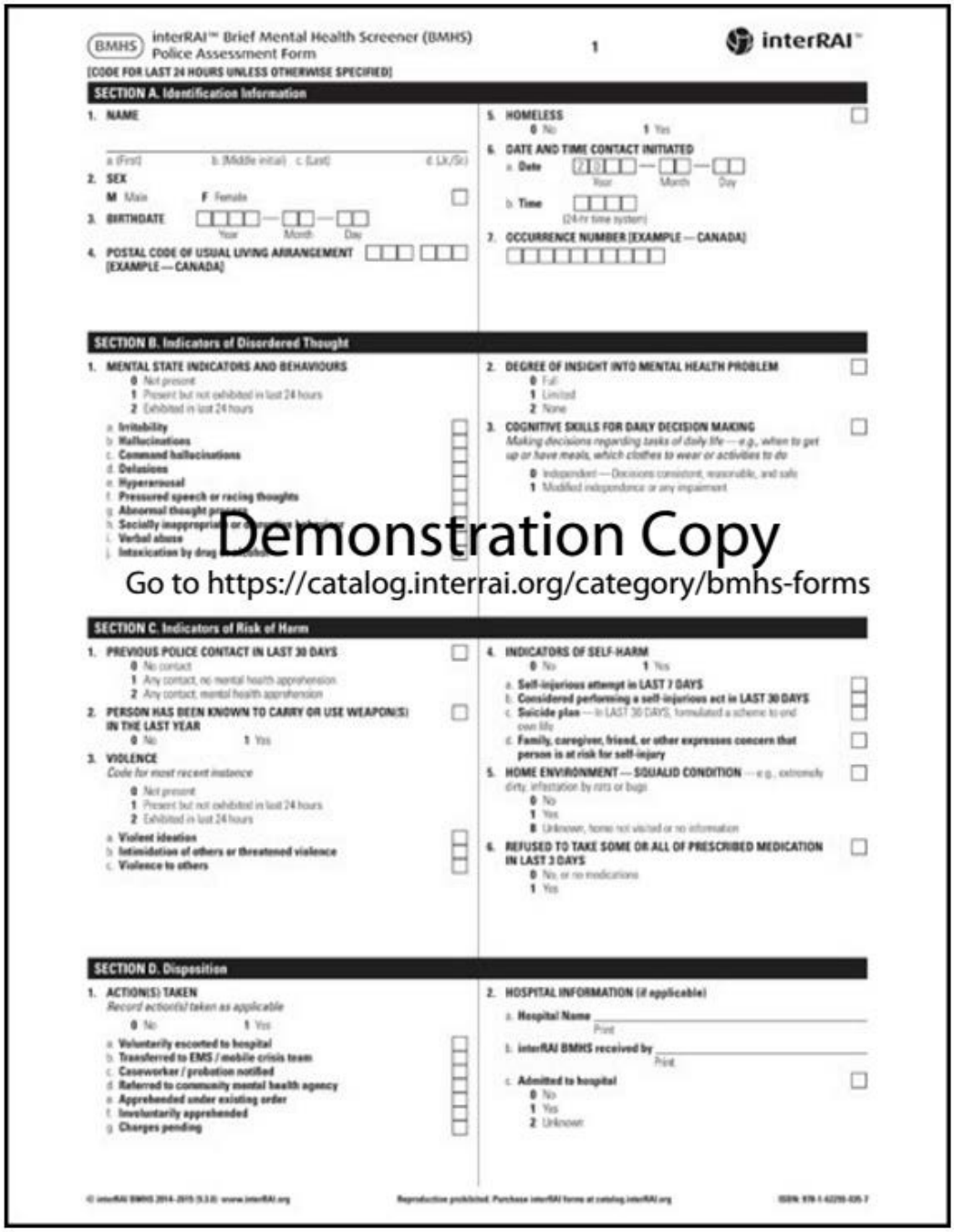
Core items on the BMHS were extracted from a sample of 40,000 cases in the Ontario Mental Health Reporting System database for the Resident Assessment Instrument for Mental Health (RAI-MH) version 2.0, which is the psychiatric assessment tool used with all patients admitted to psychiatric hospital beds in the province of Ontario. Additional items were identified through collaboration with police officers, hospital staff, and mental health and addictions professionals. A pilot study was conducted over an eight-month period with the participation of two police services, four general hospitals and one psychiatric facility in southern Ontario. The effectiveness of the BMHS was demonstrated by testing the association between police officers' ratings on the form and clinicians' assessments conducted in the emergency department of the general hospitals.

There are two major benefits to using the BMHS. First, when police officers learn to use the BMHS, they are receiving enhanced evidence-informed training on the key indicators of mental health and addictions conditions. Second, because the core items on the BMHS mirror that of the RAI-MH tool, police officers are using a form that is not only based on health system data but also written in health system language. Using common language acts as a bridge between the two sectors, thus laying the foundation for a more collaborative approach between hospitals, police services and community mental health and addictions service providers.

The BMHS does not replace a police officer's authority under the *Mental Health Act*. Police officers complete the BMHS for all persons presenting with a mental health or addictions-related crisis regardless of the officer's intended course of action (i.e. release, referral, diversion, *Mental Health Act* apprehension, arrest for criminal offence, etc.). A copy of the BMHS is provided to emergency department staff or to community mental health and addictions service providers, as the BMHS may be used by emergency department staff to assist in their assessment, and community mental health and addictions service providers may use the form to determine whether follow-up care is necessary with the individual.

interRAI Brief Mental Health Screener Demonstration Copy

Copies of this form are available at minimal cost. For more information, visit:
https://catalog.interrai.org/category/bmhs-forms



BMHS interRAI™ Brief Mental Health Screener (BMHS) Police Assessment Form 1 interRAI™

[CODE FOR LAST 24 HOURS UNLESS OTHERWISE SPECIFIED]

SECTION A. Identification Information

1. NAME
   a. (First) b. (Middle initial) c. (Last) d. (Jr./Sr.)
2. SEX
   M Male F Female
3. BIRTHDATE Year Month Day
4. POSTAL CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE — CANADA]
5. HOMELESS
   0 No 1 Yes
6. DATE AND TIME CONTACT INITIATED
   a. Date Year Month Day
   b. Time (24-hr time system)
7. OCCURRENCE NUMBER [EXAMPLE — CANADA]

SECTION B. Indicators of Disordered Thought

1. MENTAL STATE INDICATORS AND BEHAVIOURS
   0 Not present
   1 Present but not exhibited in last 24 hours
   2 Exhibited in last 24 hours
   a. Irritability
   b. Hallucinations
   c. Command hallucinations
   d. Delusions
   e. Hyperarousal
   f. Pressured speech or racing thoughts
   g. Abnormal thought process
   h. Socially inappropriate or disinhibited behaviour
   i. Verbal abuse
   j. Intoxication by drug or alcohol
2. DEGREE OF INSIGHT INTO MENTAL HEALTH PROBLEM
   0 Full
   1 Limited
   2 None
3. COGNITIVE SKILLS FOR DAILY DECISION MAKING
   Making decisions regarding tasks of daily life — e.g., when to get up or have meals, which clothes to wear or activities to do
   0 Independent — Decisions consistent, reasonable, and safe
   1 Modified independence or any impairment

SECTION C. Indicators of Risk of Harm

1. PREVIOUS POLICE CONTACT IN LAST 30 DAYS
   0 No contact
   1 Any contact, no mental health apprehension
   2 Any contact, mental health apprehension
2. PERSON HAS BEEN KNOWN TO CARRY OR USE WEAPON(S) IN THE LAST YEAR
   0 No 1 Yes
3. VIOLENCE
   Code for most recent instance
   0 Not present
   1 Present but not exhibited in last 24 hours
   2 Exhibited in last 24 hours
   a. Violent ideation
   b. Intimidation of others or threatened violence
   c. Violence to others
4. INDICATORS OF SELF-HARM
   0 No 1 Yes
   a. Self-injurious attempt in LAST 7 DAYS
   b. Considered performing a self-injurious act in LAST 30 DAYS
   c. Suicide plan — in LAST 30 DAYS, formulated a scheme to end own life
   d. Family, caregiver, friend, or other expresses concern that person is at risk for self-injury
5. HOME ENVIRONMENT — SQUALID CONDITION — e.g., extremely dirty, infestation by rats or bugs
   0 No
   1 Yes
   8 Unknown, home not visited or no information
6. REFUSED TO TAKE SOME OR ALL OF PRESCRIBED MEDICATION IN LAST 3 DAYS
   0 No, or no medications
   1 Yes

SECTION D. Disposition

1. ACTION(S) TAKEN
   Record action(s) taken as applicable
   0 No 1 Yes
   a. Voluntarily escorted to hospital
   b. Transferred to EMS / mobile crisis team
   c. Caseworker / probation notified
   d. Referred to community mental health agency
   e. Apprehended under existing order
   f. Involuntarily apprehended
   g. Charges pending
2. HOSPITAL INFORMATION (*if applicable*)
   a. Hospital Name (Print)
   b. interRAI BMHS received by (Print)
   c. Admitted to hospital
      0 No
      1 Yes
      2 Unknown

Accessing the interRAI BMHS

To use the BMHS, a police service must sign a User Agreement with interRAI and agree to purchase BMHS manuals for training purposes (manuals are available online at a minimal cost: https://catalog.interrai.org/category/bmhs-manuals). There are various ways that police officers can convey the information on the BMHS to health care professionals, from hand delivery to electronic transmission. To determine which method is most appropriate for your police service and to obtain a copy of the BMHS User Agreement please contact:

Dr. Ron Hoffman
School of Criminology and Criminal Justice
Nipissing University, 100 College Drive, Box 5002
North Bay, Ontario, P1B 8L7
Tel: (705) 474-3450 ext. 4565
Email: ronhoffman@nipissingu.ca

Development of the interRAI BMHS

There were several stages to the development of the interRAI BMHS including a focused literature review, an analysis of the RAI-MH database, the creation of a research team and advisory committee.[7] Input was also solicited from interRAI researchers and in particular the interRAI Network of Mental Health (iNMH) which was established in 2005 to support research and implementation of the interRAI mental health instruments. The iNMH is comprised of about 30 researchers and clinicians from nine countries (Canada, United States, Finland, Iceland, Netherlands, Australia, Brazil, Chile, Peru, Russia) with a broad range of expertise in mental health services.

About interRAI

interRAI is an international collaborative network of researchers in over thirty countries committed to improving the quality of life of vulnerable persons through a seamless comprehensive assessment system. As a not-for-profit consortium, interRAI strives to promote evidence-informed clinical practice and policy decision making through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings. For more information about interRAI, visit: www.interrai.org

[7] For more information about the interRAI BMHS, see: Hoffman, R. et al. (2016). The use of a brief mental health screener to enhance the ability of police officers to identify persons with serious mental disorders. *International Journal of Law and Psychiatry*, 47, 28-35. Retrieved from http://www.sciencedirect.com/science/article/pii/S0160252716300449

Tool 5: Transfer of Custody From

This tool is a template for Ontario communities to use to assist with the development of a police-hospital transition protocol. Communities can adapt and change this template to their local needs using available resources.

This form is used to document the joint analysis of risk conducted by the police officer(s) and hospital staff. The purpose of the joint analysis of risk is to determine whether the individual poses a risk with respect to harming themselves or others, and whether the individual poses a risk of fleeing from the hospital. The outcome of this analysis is to determine if the police officer(s) can transfer custody of the individual to the hospital staff or remain in the hospital. The joint analysis of risk should be completed by a designated hospital staff person (not necessarily a physician) and the police officer(s).

Transfer of Custody Form

This form is used to document the joint analysis of risk conducted by the police officer(s) and hospital staff. The purpose of the joint analysis of risk is to determine whether the individual poses a risk with respect to harming themselves or others at the hospital, and whether the individual poses a risk of fleeing from the hospital. The outcome of this analysis is to determine if the police officer(s) can transfer custody of the individual to the hospital staff or remain in the hospital. The joint analysis of risk should be completed by a designated hospital staff person (not necessarily a physician) and the police officer(s).

Personal Information

Name	
Address	
Telephone	
Date of Birth	

interRAI Brief Mental Health Screener Completed by Officer(s):

☐ No ☐ Yes ☐ BMHS form attached

Behaviour(s) Observed:

Disposition

Disposition of the individual. Descriptors are guidelines only.

High Risk ☐	Many verbal and physical indicators are demonstrated in the past 30-minutes. Individual is not cooperative. Has a history of violence or of absconding from institutions. Recent substance abuse. If the individual is **high-risk**, the police officer(s) must remain with the individual until the individual has been assessed by a physician for the purpose of determining whether to issue a Form 1.
Medium Risk ☐	Some verbal and physical indicators are demonstrated in the past 30-minutes. Individual is cooperative some of the time. May have a history of violence or absconding from institutions. May have had recent substance abuse. **Medium-risk** individuals may or may not require the police officer(s) to stay. To determine if the police officer(s) need to remain in the hospital, the hospital staff and police officer(s) should engage in a conversation to collaboratively determine the decision.
Low Risk ☐	Individual is docile and cooperative during the past 30-minutes. No history of violence or absconding from institutions. No recent substance abuse. If the individual is **low-risk**, the police officer(s) can transfer custody to the hospital staff immediately.

Action

Did the Police Officer leave the individual at the hospital?

Yes ☐	Time Officer left:
No ☐	Officer remained for the following reasons:

Additional Comments or Observations:

The signatures below indicate agreement with the behaviour(s) observed and the disposition checked:

Hospital Staff:		Time:
Police Officer:	Badge Number:	Time:

Police Officer returned to the facility:	Time:
Reason:	

Additional Resources

Hoffman, R. et al. (2016). The use of a brief mental health screener to enhance the ability of police officers to identify persons with serious mental disorders. *International Journal of Law and Psychiatry*, 47, 28-35. http://www.sciencedirect.com/science/article/pii/S0160252716300449

Ontario Hospital Association. (2012). *Practical Guide to Mental Health and Law in Ontario*. http://www.oha.com/CURRENTISSUES/KEYINITIATIVES/MENTALHEALTH/Pages/MentalHealthandtheLaw.aspx

Provincial Human Services and Justice Coordinating Committee. (2013). *Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario.* http://www.hsjcc.on.ca/Provincial/Planning%20and%20Priorities/Strategies%20for%20Implementing%20Effective%20Police-Emergency%20Department%20Protocols%20in%20Ontario.pdf

Public Services Health & Safety Association. (2013). *Completing the Violence/Aggression Assessment Checklist (VAAC) for Emergency Departments (ED) or Emergency Medical Services (EMS).* https://www.pshsa.ca/wp-content/uploads/2013/02/VAACEtoo_-instruction.pdf.pdf

Relevant Legislation can be accessed at: https://www.ontario.ca/laws

- *Freedom of Information and Protection of Privacy Act, 1990*
- *Mental Health Act, 1990*
- *Municipal Freedom of Information and Protection of Privacy Act, 1990*
- *Personal Health Information Protection Act, 2004*

Canadian Mental Health Association
Ontario

Association canadienne pour la santé mentale
Ontario