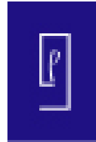
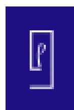


People At Risk Of Suicide Project:

Identifying Activities and Opportunities in General Hospital Psychiatric Services

Report on Phases 1 and 2

September 2008



FOREWORD

AGHPS is pleased to provide this report on Phases 1 and 2 of the People at Risk of Suicide Project. We believe that the information collated in this report can be helpful to clinicians, program leaders, community colleagues, systems planners, and funders in continually improving the design and delivery of services to people at risk of suicide.

Every day, physicians and staff in "Schedule 1" General Hospitals in Ontario assess and treat hundreds of people who are at risk to harm themselves. Patients, families, and communities look to our member hospitals to effectively intervene to minimize this suffering and prevent needless tragedy. We are often faced with acute, complex presentations which require expert judgment and thoughtful action. Due to the competence, compassion and commitment of hospital personnel, these situations are usually resolved without significant harm to the suicidal person or to others.

Given the importance and complexity of this work, our members want to continually improve their knowledge and skills in dealing effectively with these challenging situations.

AGHPS was fortunate to be able to partner with the Ministry of Health and Long Term Care in undertaking this Project to study, collate, and distribute current, evidence-based information on this topic. Project activities included literature reviews, surveys, stakeholder consultations, conferences, and detailed analyses of data and reports. The Association is deeply appreciative of the involvement of the researchers, presenters and seminar leaders, survey participants, and conference attendees whose knowledge, ideas, and experience contributed to the Project and the compilation of this report.

The Summary Report describes the Project's main activities and findings. Appendices contain the full papers and reports which were produced for the Project. The Summary has been written to highlight major points so that already busy readers could follow up in more detail on the ideas or suggestions in which they had most interest. Our goal was to make the Summary Report succinct, accurate, and sufficiently useable that it can be a starting

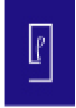
point for further study of the literature or consultation with identified colleagues and hospitals.

We believe that there are many good ideas that individual hospitals could explore and we encourage you to contact one another to get more information in areas of mutual interest.

AGHPS itself could not have undertaken this project without the support and financial assistance of the Ministry of Health and Long Term Care. We are deeply appreciative of the Ministry's support and for the ongoing work of our member facilities.

Sincerely

F. G. McNestry, M.D. FRCP(C)
President



About the Association of General Hospital Psychiatric Services (AGHPS)

The AGHPS is a voluntary association of the General Hospitals in Ontario which are mandated under the Mental Health Act of Ontario to provide specific psychiatric/mental health services, including the responsibility and authority to assess, and involuntarily admit and detain persons suffering from a mental disorder who pose a serious risk of harm to themselves and/or others. Hospitals with this mandate are known as Schedule 1 * Facilities.

AGHPS Mission

> To promote the continuing development of optimal psychiatric services in Ontario by enhancing the role and effectiveness of general hospital psychiatric services. The Association will increase the knowledge and skill of member hospitals. It will provide a coordinated and effective voice on issues relevant to the delivery of psychiatric services.
>
> The Association will endeavour to achieve these aims through mutual support among members and effective liaison with government, allied health care associations and other services and programs, both institutional and community based.

Currently, the majority of General Hospitals with "Schedule 1" designation are members. The Association is governed by a Board of Directors comprised of Chiefs of Psychiatry and Directors of Mental Health Programs throughout the province.

** Schedule 1 is a designation in the Regulations of the Mental Health Act of Ontario. Schedule 1 facilities are mandated to provide specific psychiatric services (inpatient, outpatient, partial hospitalization, emergency services, and education/consultation). Schedule 1 facilities are also authorized to involuntarily admit and detain patients who meet specific criteria.*

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APPENDICES

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Appendix B - Preventing Suicidal Behaviour in a General Hospital Service: A Review of the Literature". Dr. Paul S. Links and Dr. Brian Hoffman, March 2004

Appendix C - AGHPS Stakeholder survey results, February 2004

Appendix D - 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. Dr. David Gotlib, January 2007

Appendix E - Guidelines for the Development of Suicide Prevention Programs in Departments of Psychiatry in General Hospitals in Ontario. Dr. Brian Hoffman

Appendix F - Notes/presentations from conference March 2008

- Program Outline
- Preventing Recurrent Suicidal Behaviour in a General Hospital Psychiatric Service: Realistic Opportunities. Dr. Paul S. Links
- Suicide Vignettes: The good, the bad, and the ugly. Dr. Brian Hoffman
- Summary notes from the day

Appendix G - Highlights of Findings and Recommendations

BACKGROUND and OVERVIEW

Each year, thousands of "suicidal" persons are assessed and treated in Ontario's Schedule 1 Facilities. Their "suicidality" may range from fleeting thoughts of harming themselves to severe suicidal behaviours that may result in death. They range in age from young children to the elderly, and represent all segments of the population.

Regrettably, some of these people die. Although the numbers are low, each successful suicide ends one life and takes a significant toll on others – family members, friends, colleagues, health care providers, etc. Valued lives are lost to families, businesses, and communities.

As committed and caring professionals, providers of health and mental health services in Schedule 1 facilities are constantly looking for ways to reduce/minimize the number of completed suicides among their clientele. Out of this desire grew the focus for this project…. **That AGHPS provide leadership, and coordinate the development of suicide prevention services in general hospitals in Ontario, and suggest evidence-based priorities for programming and service delivery**.

This project could not have been undertaken without the financial support of the Ministry of Health and Long Term Care (MOHLTC). Several discussions with MOHLTC officials in 2002/03 resulted in a one-time Ministry grant to produce a paper based on the findings of a comprehensive literature review on this topic. This Phase 1 work was seen as a foundation on which future activities would be based.

Dr. Paul S. Links (Arthur Sommer Rotenberg, Chair in Suicide at the University of Toronto) collaborated with Dr. Brian Hoffman, Chief of Psychiatry at North York General Hospital, Toronto to produce **"Preventing Suicidal Behaviour in a General Hospital Psychiatric Service: A Review of the Literature"** dated March 1, 2004. A copy of this paper is attached as Appendix B. This paper was subsequently published in the July 2005 issue of the Canadian Journal of Psychiatry.

Recommendations from that paper resulted in a second grant from MOHLTC for Phase 2 of the Project. Components of Phase 2 were:

1. The Development of a “Provincial Fast Track Model” for Police Department personnel who accompany patients at risk for suicide to the General Hospital Emergency Department
2. Study of Coroner Reports
3. The development of a Framework for each Department of Psychiatry
4. Educational Programs

The focus in the following sections of this report is to provide information that will be helpful and useable by AGHPS members and their colleagues in their day- to- day work. It has been organized to allow these professionals to identify potential opportunities that they find relevant to their setting and to follow up in a more detailed manner by accessing literature and/or learning more about successful practices in other facilities.

Our primary goal is to assist Schedule 1 hospitals to turn what’s known from research and/or what’s working well in the field into action in their own settings. It is intended that the information and ideas in this Report will provide a stimulus and direction for further service development.

Content includes 1) brief summaries of the main findings of studies undertaken in each phase; 2) identified practices that are working well in identified settings and 3) practical suggestions/guidelines for service delivery.

Readers are encouraged to reference the full reports included in the Appendices of this report, and to consult with colleagues in settings where successful practices have been identified about any practices or ideas that seem worthy of further exploration.

PHASE 1: ACTIVITIES AND OUTCOMES

The People at Risk of Suicide project – Phase 1 – was conducted over the period 2002 to 2004. AGHPS Board of Directors, in conjunction with MOHLTC, developed *guiding principles* which were fundamental to the project design:

1. The findings and recommendations must be evidence based.
2. The preliminary findings must be "tested" by eliciting feedback before any conclusions/recommendations were finalized.
3. The recommendations must be useful to those professionals providing care to people at risk of suicide.
4. Stakeholders must include professionals from various disciplines and departments within hospitals throughout Ontario.
5. Issues and priorities must be determined by the professionals working in, or collaborating with, general hospitals.

Main activities of this phase were:

1. One-day conference to dialogue with a cross-selection of professionals (November 2002).
2. Review of literature, development of draft report
3. Feedback on draft Report
4. Stakeholder survey
5. Finalizing of report and meeting with MOHLTC

1. Highlights from One-Day Conference:

A one-day conference, held on November 30th 2002, featured presentations from the Office of the Coroner, the Ontario Provincial Police, a Chief of an Emergency Department in a Schedule I hospital and a Chief of Psychiatry in a Schedule I hospital. In the afternoon the participants, drawn from a wide cross-section of professionals working in psychiatry / mental health, were asked for their viewpoint and suggestions on the topics covered in the morning. The following is a brief summary of the outcome of the discussions:

When asked about communication, stigma and education there were 3 general conclusions / recommendations.

1. Develop principles to guide allotment and allocation of space in ER regarding mental health.

2. Develop expectations regarding teamwork with other professionals within the hospital (e.g.: ER staff, crisis) Include follow up.

3. Educate others, within our hospitals and in the community, about the role of Schedule I hospitals, including the Emergency Department.

Other issues and questions that were identified for additional follow up included:

1. Education and monitoring for our own professional development – can we do this in a more systematic manner?
2. Should we use an assessment tool?
3. How do we approach patient discharge?

It was recommended that AGHPS do further work and write guidelines on these issues.

2. Highlights from Literature Review:

AGHPS commissioned Dr. Paul S. Links to conduct a literature review and produce a working paper on this topic. In collaboration with Dr. Brian Hoffman, Dr. Links produced a report entitled **"Preventing Suicidal Behaviour in a General Hospital Service: A Review of the Literature"** dated March 1, 2004 (See Appendix B). The following are selected highlights.

73 papers were identified and reviewed, 24 of which contained articles relevant to this study. Findings were organized into the following 5 categories:

1. Screening Tools
2. Interventions for individuals with suicidal behaviour
3. Treatment of major psychiatric disorders
4. Reducing risk in discharged patients
5. Reducing access to means (e.g. guns, medications, etc.)

A. Screening Tools:

No research was identified on the issue of the development of screening tools for individuals at risk for suicide. Current evidence indicates that it is not possible to accurately predict suicide in the individual patient due to the low base rate of the behaviour. Therefore, Jacobs and colleagues stated "the goal of a suicide assessment

is not to predict suicide, but rather to place a person along a putative risk continuum, to appreciate the basis of suicidality and to allow for a more informed intervention".

Based on the lack of research regarding screening tools for predicting risk of suicide, clinical assessment is still considered as the gold standard (American Psychiatric Association, 2003). No measurement scale has been developed that can replace clinical assessment by a skilled clinician.

B. Interventions for Individuals with Suicidal Behaviour

- Evidence indicated that low dose flupenthixal may reduce recurrence in non-psychotic patients with two or more suicide attempts.
- Dialectical Behavioural Therapy (DBT) was found to be the most promising therapeutic approach in individuals with Borderline Personality Disorder.

A number of jurisdictions have already developed guidelines for the assessment and active engagement of patients presenting with suicidal behaviour. Guidelines are available through the Royal College of Psychiatry in the U.K. (www.mentalhealth.org/suicidepreventions); in Australia and New Zealand (www.ranzcp.org/puglicarea/cpg.asp); and the American Psychiatric Association (www.psych.org.psych_pract/treatg/pg/pg _suicidalbehaviors.pdf).

Issues for consideration in the development of guidelines include:

- Importance of staff training
- Educational resources are needed for families and families need to be actively engaged to ensure compliance with follow-up.
- Engagement plan should include permission to inform the family physician about the presentation for suicidal behaviour.

C. Treatment of major psychiatric disorders:

- Studies showed a 26% reduced risk of suicide with clozapine in schizophrenia or schizoaffective disorder.
- Lithium seems to have an effect on reducing suicidal behaviour in patients with bipolar affective disorder, and suicide that is observed after the first few years of treatment. The authors of several of these reports also found a high

risk for suicidal acts if Lithium was discontinued. This risk was highest during the first year of discontinuation.

D. Reducing Risk in Discharged Patients

- 24% of all suicides in U.K. had mental health service contact in the year before their death.
- Almost one third of the suicides of psychiatric inpatients occurred on the ward, and of these, 74% had been by hanging.
- Suicides tend to cluster in the first week following admission or around discharge, with 23% occurring within 3 months of discharge.
- Maintaining contact with ongoing services following discharge from hospital may be sufficient to reduce the risk of suicide.

E. Reducing Access to Means (e.g. guns, medications, etc.)

Evidence exists that the simple intervention of providing education (to individuals and families) should be incorporated into the care of all mental health patients.

4. Presentation and feedback on draft Links/Hoffman report

The draft report was presented to mental health personnel in selected hospitals. Questions, comments and suggestions led to helpful changes which were incorporated into the final document. The finalized paper was placed on the AGHPS website and was published in the Canadian Journal of Psychiatry in July 2005.

5. Implications for General Hospital Psychiatric Services of Above Findings:

Because clinical assessment remains the gold standard, clinical staff have to be trained and their training updated regularly about the assessment of suicide risk.

- Individuals with suicidal behaviour need to be adequately assessed and followed, and policy and guidelines should be in place to assist both emergency personnel and mental health staff
- Hospital personnel need to be educated about treatments that are known to be effective to reduce risk of suicide, e.g. clozapine for schizophrenia, and lithium in bipolar affective disorder.

- Patients with a history of suicidal behaviour should be assessed 24 to 48 hours before discharge.
- Guidelines should be developed to ensure that patients with suicide risk are assertively followed up after discharge and that limits are placed on prescription quantities.
- Reducing access to means should be incorporated as part of routine psychiatric care in general hospital psychiatric services.

4. Survey of Stakeholders in General Hospital Psychiatric Services

23 hospitals responded to the AGHPS survey (38% response rate). The survey asked for information about hospital specific practices in education regarding suicidal behaviour, suicide reviews, and interdisciplinary / interdepartmental collaborations. It also asked about the use of assessment tools, whether psychiatrists reassessed for suicide behaviour prior to discharge, and what would have the greatest impact in improving process and outcome.

There was striking similarity among stakeholders regarding their perceived needs, and their feedback on the role the AGHPS is positioned to take leadership on.

Professionals in general hospitals consistently articulated a need to:

1. Develop provincial guidelines for suicidal presentation for pre-assessment, assessment, treatment and follow up within mental health, emergency departments and on medical units.
2. Provide leadership in developing standards and identify best practices.
3. Investigate and provide guidelines on issues such as false positives, repeat suicide assessments, rapid follow up, documentation, care planning.
4. Develop provincial liaison initiative with police
5. In collaboration with the Coroner's office, undertake a review of suicide and recommendations from Coroner inquests, and provide this consolidated information to general hospitals.

PHASE 2: ACTIVITES AND OUTCOMES

After submission of the Phase 1 report and in further discussion with the MOHLTC, the AGHPS received one-time funding to extend the project to address some of the specific needs identified in Phase 1. Funding was received for follow up in four areas:

1. The development of a "Provincial Fast Track Model" for the Police Department personnel who accompany patients at risk for suicide to the General Hospital Emergency Department
2. Study of Coroner Reports
3. The development of a Framework for each Department of Psychiatry.
4. Educational Programs.

Main Activities and Findings

1. The Development of a "Provincial Fast Track Model" for the Police Department personnel who accompany patients at risk for suicide to the General Hospital Emergency Department

AGHPS commissioned David Gotlib, M.D., FRCPC, Medical Director, Emergency Psychiatry Team, St. Joseph's Health Centre, Toronto, Ontario to prepare a paper on this topic. A copy of the paper ***"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"*** is included as Appendix D.

Relevant information was obtained from 3 primary sources:

- Literature review
- Stakeholder survey of police, community mental health agencies, hospital services, and families
- Inquest reports

Findings and Conclusions

1.1 Literature Search

a) 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.
b) Suicidal behavior is essentially unpredictable. Clinical assessment of suicidal risk remains the standard of care.
c) Such an assessment requires diligence in obtaining collateral information
d) Police who bring a patient to the ER, though a logical source of collateral information, often perceive their input as unwelcome and undervalued

1.2 Stakeholder/Survey

The report devotes approximately 50 pages to responses to questions posed to the stakeholder groups:

Q1. What's working well?
Q2. What problems remain?
Q3. In what ways could current policies and practices be improved?
Q4. What new policies, practices, and resources are needed?

The charts and text below briefly summarize the findings (*Taken from pages 84 - 86 of the Report)*

Q1: "What is working well?"

Most Common Responses (by Stakeholder)

	Hospital	**Police**	**CMHA**
1st most frequent	Good relationship with police	Nothing	Police quick response and good judgment
2nd most frequent	MCIT	Confidence in MH assessments	Communication with police
3rd most frequent	Police provide information to hospital	Suitable facilities for MH pts	Info-sharing and f/u with police
4th 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.

Q2: "What problems remain?"

	Hospital	**Police**	**CMHA**
1st most frequent	Long wait times	Wait times too long	Ineffective assessment / management in ER
2nd most frequent	Problems of concern to non-Schedule 1 hospitals	Ineffective assessment / management in ER	Long wait times
3rd 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 *in*congruent: 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.

Q3 & 4: Suggestions for Change

	Hospital	Police	CMHA	Inquest recommendation
1st most frequent	Improve communication and coordination	Release police sooner	Improve cooperation between all	MH clinicians in ER
2nd most frequent	MH clinician to assess before ED MD	More resources for hospitals	Increased mental health expertise in ER	Improved communication between all
3rd most frequent	Educate police	Improve security	Education of all involved parties	More beds and streamlined access
4th 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.

Part 7 of Dr. Gotlib's Report contains 3 broad recommendations with sub-recommendations and elaborations for each. (*Taken from pages 90 to 93 of the Report)*

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 in the Report 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 -- 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).

Readers are encouraged to review this substantive report (Appendix D) for a detailed explanation and analysis of the various issues and recommendations. It is likely to trigger thoughts about actions that could be pursued.

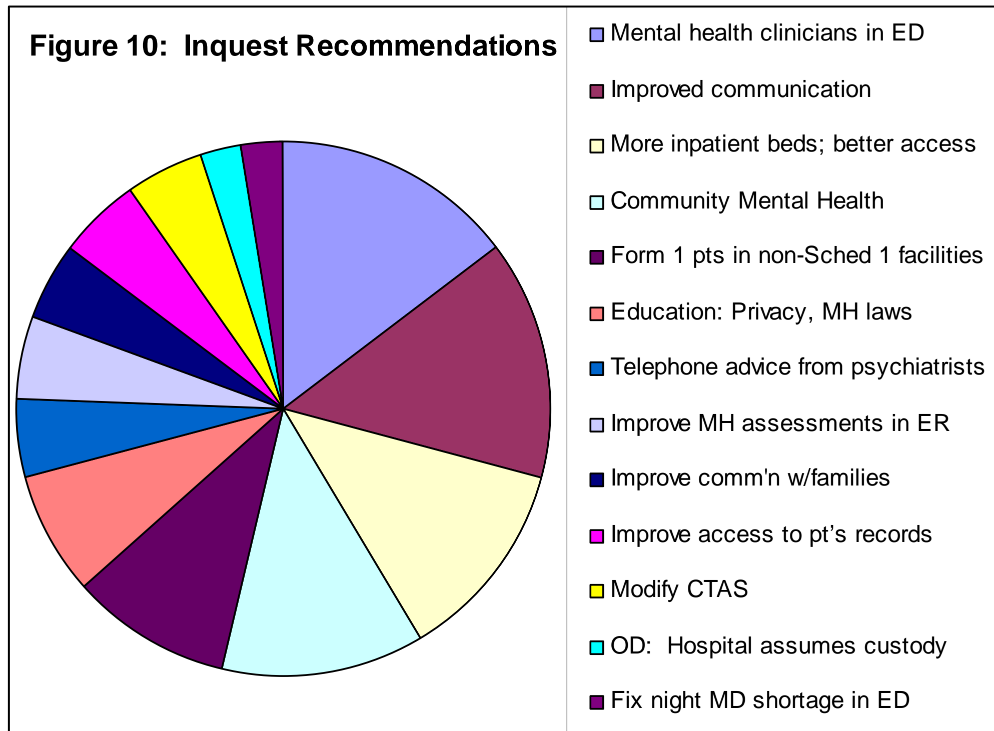
2. Study of Coroners' Reports

Coroners' reports and inquest recommendations for the period January 2006 to December 2007 were reviewed and the recommendations collated. Particular emphasis was placed on recommendations that related to the work of General Hospital Psychiatric Services, and those recommendations which occurred thematically across a number of inquests. Beyond any specific recommendations there are three underlying issues that were worth noting. The first is the ***importance of communication and reporting,*** and the second is ***access to means***. Finally, we are also aware that a ***number of incidents that involved suicide or attempts at suicide occurred while prisoners were incarcerated***. The role of general hospitals in those cases may be through the Emergency Department after the event. However, there may be value in sharing the findings of the AGHPS project experience with those working within the justice system. The lessons learned through this project might have application in preventing the risk of suicide in the prison system.

Dr. Gotlib studied the recommendations from 5 Ontario inquests in which police and/or emergency room involvement played a role in the case. The findings were categorized as follows:

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. *(Taken from page 75 of the Report)*

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



Details of the recommendations in each category are provided in pages 75 to 83 in his report. (See appendix D)

Building on the above, Dr. Brian Hoffman closely analyzed 8 cases and identified the following areas for attention by hospital personnel:

- Systematic risk assessment
- Clear policies (searches, levels of observation, previous records)
- On call and holiday coverage
- Education of family members

Approaching it from the perspective of a practicing psychiatrist, Dr. Hoffman identified practical actions that should be undertaken to provide effective responses to suicidal presentations. Dr. Hoffman's slide presentation is included in Appendix F

3. Development of a Framework for Each Department of Psychiatry

Dr. Brian Hoffman's paper (Appendix E) entitled **"Guidelines for the Development of Suicide Prevention Programs in Departments of Psychiatry in General Hospitals In Ontario**", provides a framework for a focus of more detailed policy and procedure development in individual hospitals, and a description of the roles that AHGPS can play in facilitating this development. Five specific recommendations are put forward.

3.1 Development of a Suicide Prevention Resource Centre

The AGHPS should develop the resources to maintain a database of literature and other sources of information relevant to the identification, assessment and treatment of persons who are vulnerable to suicidal behaviour. Resources would be identified that would be useful to interested persons including professional staff, employers, law and policy makers, teachers, and relatives. This information could include literature, research findings, videos and documentaries, assessment tools, resource catalogues and results of coroner's inquests.

3.2 Development of Education Programs

It is recommended that the AGHPS work with each Department of Psychiatry in its member hospitals and develop suicide prevention education programs in its catchment area. There would be a focus on the education of professionals, especially those that work in hospital settings. There should be a focus on secondary and tertiary prevention with individuals identified with serious mental illness. Secondary prevention refers to the identification and treatment of patients with suicidal tendencies and tertiary prevention refers to the treatment and rehabilitation of patients who have demonstrated actual suicidal behaviours.

3.3 Development of Early Identification Strategies

It is recommended that the AGHPS work with each Department of Psychiatry in its member hospitals and develop strategies and policies for the early identification of persons vulnerable to suicidal behaviour. These could include the development of emergency and inpatient assessment protocols for individuals presenting with

suicidal ideation or behaviour in ER, screening of high risk populations such as those with chronic medical illness or chronic substance abuse and those admitted after a medically serious suicide attempt.

3.4 Development of Early Intervention and Treatment Strategies

It is recommended that the AGHPS work with each Department of Psychiatry in its member hospitals to develop "best practice" guidelines, protocols and safety standards of intervention and treatment of patients at risk of suicide. Policies regarding the diagnosis and intervention of patients presenting with suicidal ideation or behaviour will include best practices regarding the assessment, management and treatment of co-morbid psychiatric and substance abuse disorders. Each program will support the development of safe inpatient environments.

3.5 Support for other initiatives

It is recommended that the AGHPS work with each Department of Psychiatry in its member hospitals to work and cooperate with other initiatives that will decrease the incidence of suicidal behaviour including advocacy for comprehensive community services changes to mental health or other laws, and research and education projects in academic centers.

As part of Phase 2 of this Project, AGHPS proposed that a Psychiatric Fellow be engaged to action these recommendations. However, this did not occur for 2 reasons: an interested Fellow could not be found; and the financial resources devoted to other components of the Project left insufficient funds to pursue this objective.

In recognition of the commonalities among Schedule 1 facilities, and feedback from the member survey conducted in Phase 1, the Association remains committed to assisting each member to develop relevant practices by providing consultation as

requested, and by linking facilities with others which have an effective practice in place.

Future AGHPS sponsored educational programs will also focus on the issues and challenges faced by our members on this topic.

4. Educational Programs

The main activities of the educational components of Phase 2 were:

1. March 2008 conference
2. Distribution of Summary Report
3. Posting materials on AGHPS website

4.1 March 2008 Conference Highlights

Objectives for the conference were

- to present summaries and updates of the papers by Drs. Links, Hoffman, and Gotlib
- to identify policies and/or practices that are currently being used by hospitals that effectively address an issue highlighted in the above papers
- to facilitate present and future networking among the participants.

Drs. Hoffman's and Gotlib's papers have been discussed previously in their report and will not be repeated here.

Dr. Links added an update to his earlier work noting that the assessment of suicide risk has refocused on the importance of "warning signs" that are specific to the individual with less emphasis on 'risk factors' which are based on demographics. Warning signs represent a constellation of indicators unique to each individual which, when taken together, can more likely help the clinician foretell the proximal risk of suicide. The ability to use warning signs increases as the clinician's knowledge of the individual deepens. It follows that, the less well known the patient is to the clinician, the less likely the clinician can determine warning signs that are unique to that individual. This increases the importance of obtaining collateral information from those who have a history with the patient.

In a review of some of the lessons from legal cases, Dr. Hoffman stressed the importance of hospitals collaborating to improve access to services. Schedule 1 facilities should have formalized agreements (such as a Memorandum of Understanding - MoU) to describe how inpatient beds will be accessed when there are no beds available in a particular Schedule 1 hospital. Similarly, MoU's should be established between Schedule 1 and non-Schedule 1 General Hospitals in the area.

Dr. Gotlib summarized one of the main findings in his stakeholder survey as follows: "Everybody thought that everybody should be talking to everybody else, but nobody does".

Interactive sessions amongst the participants focused on the questions, "What can you do to improve the management and assessment of suicidal patients a) in the Emergency Department, b) on the ward, c) after discharge?"

Among the successful practices identified by conference participants were:

<u>In the Emergency Department</u>

- Crisis worker model working well in many settings.
- University Health Network has monthly meetings with ER, Mental Health Services, and Community. The patient is seen as "our patient" and action plans are based on who is best able to treat at that time.
- Psychiatrist regularly attending nursing homes has reduced number of nursing home patients in emergency. (North York General)

<u>On the Ward</u>

- Monthly safety walk-about of ward, assessing specific items on a printed form.
- Alarm made for shower hose so that if it is detached, the alarm sounds.
- All staff carry a safety alarm to summon help quickly.

<u>After Discharge</u>

- Discharge patients a top priority for follow-up in outpatients. (Peterborough Regional Health Centre)
- Try not to discharge on a Friday.

- Participation in day hospital program prior to inpatient discharge to ease transition.

More details of the presentations and discussions are found in Appendix F.

4.2 Distribution of Summary Report

Copies of this report will be sent to:

- MOHLTC, Ontario
- All Schedule 1 facilities including tertiary care facilities.
- All LHINS
- Other organizations working with issues relating to mental health and specifically risk of suicide (e.g. Ontario Psychiatric Association. Coalition of Ontario Psychiatrists; CMHA; OHA, the Ontario Federation of Mental Health and Addiction Programs).

4.3 The Report will be posted on the AGHPS website.

CONCLUSIONS AND NEXT STEPS

The studies, surveys and discussions undertaken during Phases 1 and 2 of this Project have successfully enabled AGHPS to consolidate much valuable information. Some of this information confirmed what we already knew. Some provided new or enhanced insights. These include:

- Suicide is a major public health issue.
- Dealing with People at Risk of Suicide is a constant, integral component of the work of physicians, psychiatrists, and staff in Schedule 1 Hospitals.
- Considerable expertise exists in these facilities to provide effective services to these individuals.
- Personnel in these facilities have a deep commitment to providing effective assessment and treatment sources to these people.
- Individuals at risk of suicide do not exist in isolation. Professionals in Schedule 1 facilities engage with stakeholders in a wide range of settings during their work with this population.

- The tensions that occur between hospital personnel and other stakeholders (families, police, community agencies, etc.) need to be addressed systemically within each community to contribute to better outcomes.
- Individual hospitals have independently developed excellent protocols, guidelines, and/or practices to address specific aspects of working with this population.
- The “Good” or “Best” Practices developed by individual hospitals are not widely known by others in the field. At present, there is no formal system or mechanism for disseminating or sharing this information.

In short, there is useful information in the literature and there are good services and practices in individual hospitals. However, there is currently no established mechanism to transmit this information from one hospital to the next, and there are no common guidelines to address many of the complex challenges faced by professionals providing service to people at risk of suicide.

The work completed to date has confirmed the original premise that there is a role for AGHPS to provide leadership and coordinate the development of suicide prevention services in hospitals in Ontario and suggest evidence-based priorities for program and service delivery.

As with most projects, the work has identified opportunities for further study and action both by individual hospitals and by AGHPS.

Individual hospitals can use information in this report to evaluate their own practices, identify practices and programs that can be improved or developed, and implement practice changes.

As a provincial Association, the Board of AGHPS can set priorities, and take action in areas such as information collation and distribution, education, and guideline development. The Board will need to determine how to best use the existing resources (clinical expertise, knowledge, infrastructure, and funding) within the Organization, and what additional resources can be mustered to enable all Schedule 1 General Hospitals to work consistently and effectively with this population.

Appendices

Appendix A - Notes from the conference March 2002.

Appendix B - Preventing Suicidal Behaviour in a General Hospital Service: A Review of the Literature". Dr. Paul S. Links and Dr. Brian Hoffman, March 2002

Appendix C - AGHPS Stakeholder survey results, February 2004

Appendix D - 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. Dr. David Gotlib, January 2007

Appendix E - Guidelines for the Development of Suicide Prevention Programs in Departments of Psychiatry in General Hospitals in Ontario. Dr. Brian Hoffman

Appendix F - Notes/presentations from conference March 2008

- Program Outline
- Preventing Recurrent Suicidal Behaviour in a General Hospital Psychiatric Service: Realistic Opportunities. Dr. Paul S. Links
- Suicide Vignettes: The good, the bad, and the ugly. Dr. Brian Hoffman
- Summary notes from the day

Appendix G - Highlights of Findings and Recommendations

Appendix A
Initial Conference to Seek Direction from Stakeholders

A one-day conference was held at the initiation of Phase I of the Project to dialogue with a cross section of professionals. The goals of the one-day conference were:

1. To accurately identify the issues and challenges in providing services to persons who present to hospital emergency departments at risk of suicide.

2. To identify pragmatic strategies to respond effectively to these presentations.

3. To develop an action plan outlining how the AGHPS can be most helpful to its members in increasing their effectiveness when providing these services.

The format utilized to achieve these goals was comprised of presentation in the morning by:

- Dr. Paul Links, Arthur Sommer Rotenberg Chair in Suicide Studies and Professor of Psychiatry
- Dr. James McGorman, Medical Director, Emergency Services Peterborough Regional Health Centre
- Dr. Jim Cairns, Deputy Chief Coroner, Investigation, Province of Ontario
- Dr. David Hoath, Psychologist and Consultant to the Ontario Provincial Police

This was followed by an expert panel. The format for the afternoon was break out sessions. The participants were asked to:

- Identify common issues and opportunities to collaborate
- Identify practical suggestions/strategies for suicide prevention
- Determine baseline data required and identify the role of the AGHPS in facilitating implementation of identified strategies
- Identify next steps for the project

Thirty-three professionals participated in the conference

- 12 psychiatrists
- 2 Emergency physicians
- 5 nurses
- 7 Directors/managers
- 3 crisis team
- 4 Other (occupational therapist, psychogeriatric resource consultant, 2 executive directors of mental health associations)

The following is a summary of the issues identified by the conference participants, organized into categories:

A. Organizational Issues

1. Pre-Assessment Issues
    - ***Related to Police*** – liaison initiatives, education on mental health issues, Involvement with assessment, methods to "fast track" patients brought to Emergency to reduce waiting times for police officers
    - ***Related to the Public*** – education and awareness to enhance knowledge of risk factors and signs of suicide risk, shifting attitudes and addressing stigma associated with suicide

- ***Related to the Hospital*** – Education to support effective triage and enhance ability to recognize risk factors, as well as guidelines and processes to ensure adequate communication with mental health professionals regarding follow up.

2. Assessment Issues –
   - Information and education for differential diagnosis
   - Information and education for differential treatment
   - Tools to assist in risk assessment for professionals as well as patient/ significant others

3. Treatment Issues– in Emergency Department
   - Investigate options and practices such as
     - Holding beds
     - Crisis at home
     - Pool of beds
     - Crisis clinic
     - ACT teams

4. Follow-up Issues
   - Timeliness
   - Consistent follow up protocols
   - Appropriateness for families

B. Systemic Issues

1. Monitoring of coroners Inquests
2. Enhancing communication (Community / Police / Housing Corp / ER / Hospital / family)

C. Funding

Initiatives that would require funding include:

- Expectations of Care
- Standards for physical space related to safety (including emergency departments and intensive care units)
- Education
- Information sharing
- Risk assessment tool
- Stigma issues
- Liaison – monitor – fast track

D. Communication

Communication efforts to be collaborative with

- Emergency Rooms
- Coordinated access
- Community
- Other agencies
- Family physicians
- System integration

E. Education

Education efforts to include

- Staff – Family physicians – When to admit?
- Public
- Agencies
- Outreach Education to police

F. Liaison

Liaising efforts to include collaboration with:
Community health agencies

- Public health
- Crisis lines
- Suicide councils
- LTA
  UK

G. Areas where the AGHPS could / should take leadership

1. Develop provincial guidelines for suicidal Presentation for pre-assessment, assessment, treatment and follow up.

2. Develop principles to guide ER space for psychiatry.

3. Develop expectations for consult, liaison, RAIMH, wait times, collaboration with ER.

4. Assist in raising profile of Mental Health Services within hospital.

5. Provide leadership in developing standards and identify best practices.

6. Advocacy related to suicide issues within hospital.

7. Position (paper) on the issue of suicide.

8. Investigate and provide guidelines on issues such as false positives, repeat suicide assessments, rapid follow up, documentation, care planning.

9. Develop provincial liaison initiative with Police.

Appendix B

A Review of the Literature - March 1, 2004

Prepared for the Association of General Hospital Psychiatric Services by:

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Professor of Psychiatry

Department of Psychiatry

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Summary

The Ministry of Health recommended that the Association of General Hospital Psychiatric Services (AGHPS) provide *leadership* and *coordinate* the development of suicide prevention programs in general hospitals in Ontario. This review of the literature was completed to *suggest priorities for programming*. Our procedure was to update the review by Gunnell and Frankel (1994) that guided priorities for "Health of the Nation", the national suicide prevention strategy in the UK. A search was completed using the terms "suicide prevention and control" on all research limited to the English language and clinical trials done between 1994 to the present. 73 papers were identified and grouped by Secondary Care Setting Categories. The number of papers by category was:

- Screening tools for predicting risk of suicide – 0 articles
- Interventions for individuals with suicidal behaviour – 14
- Treatment of major psychiatric disorders – 6
- Discharge from hospital – 2
- Reducing access to means – 2

Each of the categories is reviewed and the implications for developing suicide prevention programs and policies for General Hospital Psychiatric Services are discussed.

More than 4,000 individuals were victims of suicide in Canada in 1999 and this included 558 youth who died before the age of 24 (Statistics Canada, 2002). Given the magnitude of the loss from suicide, many nations have addressed the question - Can we prevent suicide? The first National Strategy to Prevent Suicide was initiated in Finland in 1986 and subsequently Norway, Sweden, New Zealand, Australia, U.K., the Netherlands, Estonia and France have all developed national prevention efforts. In 1999, David Satcher, the Surgeon General of the United States, initiated the "Call to Action" to prevent suicide and declared that suicide was a serious health problem (National Strategy for Suicide Prevention, 2001). The National Strategy for Suicide Prevention, the U.S. national strategy was published in 2001 and provided specific goals and objectives for the national suicide prevention initiative. In the document, the authors wrote "only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives" (National Strategy for Suicide Prevention, 2001). With the new impetus to develop suicide prevention initiatives, the Association of General Hospital Psychiatric Services (AGHPS) in Ontario, Canada was approached to provide leadership and coordination for the development of suicide prevention programs in general hospitals throughout Ontario. The purpose of this current review was to provide the evidence to suggest priorities for programming for suicide prevention in these general hospitals in Ontario.

Rationale for the Role of General Hospital Psychiatric Services

The AGHPS represents forty-eight out of sixty Schedule 1 Psychiatric facilities in Ontario. According to legislation, Schedule 1 facilities are required to provide essential psychiatric services including in-patient, out-patient, day-care, consultation and emergency psychiatric services. Given the mandate of the AGHPS, these services are well placed to have an essential role in suicide prevention. Firstly, more than 90 % of victims of suicides are known to have one or more psychiatric disorders at the time of their death so that psychiatric disorders may be considered a necessary; although, not a sufficient cause of suicide (Roy, 2001). Second, suicide attempters who present to hospital services are at a risk to die from suicide in the first year following the attempt - sixty-six times the annual risk in the general population (Hawton et al, 2003). Finally, evidence from a systematic review of the literature indicates that individuals in the general population that suicide, perhaps as many as 40 percent had been an in-patient within the year of their death (Pirkis and Burgess, 1998). All of this evidence indicates that people serviced within the general hospital psychiatric setting are at high risk for suicide because of their suicidal behaviour, not to mention individuals with chronic medical illness, substance abusing patients and the elderly. Therefore, general hospital psychiatric settings are appropriate targets for preventive initiatives.

Literature Review Process

To establish priorities for programming, the authors updated the review by Gunnell and Frankel (1994). The Gunnell and Frankel review provided priorities for "the Health of the Nation" preventive initiative in the U.K. Using their search terms "suicide prevention and control", the present review updated the search from 1994 to December, 2003. The search was limited using "English language" and "clinical trials" as restrictions. Based on this

methodology, seventy three papers were identified. For purposes of the review, the authors used the same categorization as the original Gunnell and Frankel paper. The articles were grouped based on their relevance to the following categories:

- Screening tools for predicting risk of suicide: 0 articles found
- Interventions for individuals with suicidal behaviour: 14 articles found
- Treatment of major psychiatric disorders: 6 articles found
- Discharge from hospital: 2 articles found
- Reducing access to means: 2 articles found

The results of the review will be presented under each of these categories. Key references that were judged to have adequate methodology and establish implications for service delivery were reviewed. The review will conclude with a discussion of the priorities and implications for developing a suicide prevention strategy within General Hospital Psychiatric Services.

Literature Review Results

Screening tools:

No research was identified on the issue of the development of screening tools for individuals at risk for suicide. Firstly, current evidence indicates that it is not possible to accurately predict suicide in the individual patient due to the low base rate of the behaviour. Therefore, Jacobs and colleagues stated "the goal of a suicide assessment is not to predict suicide, but rather to place a person along a putative risk continuum, to appreciate the basis of suicidality, and to allow for a more informed intervention" (Jacobs et al, 1999, page 4). Although there has been much research on risk factors for suicide, Rudd (2003) suggested attention should turn to "warning signs" for suicide. He suggested unlike risk factors which identify ongoing or chronic risk for suicide, warning signs suggested a person is at imminent or acute risk. Warning signs would apply to the individual rather than to a group and would likely be a constellation or collection of signs indicating the proximal risk for suicide. The value of these signs would be that they would demand a specific intervention as they would foretell the proximal risk of suicide.

Based on the lack of research regarding screening tolls for predicting risk of suicide, clinical assessment is still considered as the gold standard (American Psychiatric Association, 2003). No measurement scale has been developed that can replace a clinical assessment by a skilled clinician. General hospital psychiatric services have to ensure that staff are trained in the clinical assessment of suicide risk and that their training is regularly updated.

Interventions for individuals with suicidal behaviour:

Hawton and colleagues completed a meta analysis of treatments following deliberate self-harm as part of the Cochrane collaboration (2000). This review identified 24 randomized control trials dealing with individuals following suicidal behaviour. This study included all age groups and were grouped based on expert consensus ratings by the common therapeutic strategies that were employed as the intervention. Hawton et al (2000) identified that problem solving strategies versus standard aftercare showed significant

improvement in depression, hopelessness and improvement in problem solving skills but did not demonstrate a significant reduction in the recurrence of suicidal behaviour (odds ratio = 0.70, 95%, confidence interval (CI) 0.45, 1.11, non-significant). Outreach intensive interventions versus standard care following a suicide attempt also did not demonstrate a significant effect on the rate of recurrence (odds ratio = 0.84, 95%, CI 0.62, 1.15, non-significant). "Emergency cards" with phone numbers to call in an emergency or methods to improve access to care versus standard aftercare again did not demonstrate a significant effect on the recurrence of suicidal behaviour (odds ratio = 1.01, 95%, CI 0.72, 1.42, non-significant). One study suggested that easing the access to emergency services actually increased the repetition of suicidal behaviour in those with highly recurrent suicidal behaviour. Anti-depressant medication versus placebo targeted at reducing the risk of repetitive suicidal behaviour was not found to significantly reduce the risk of recurrence (odds ratio = 0.83, 95%, CI 0.47, 1.48, non-significant). However, one study of non-psychotic patients with two or more suicide attempts suggested that Flupenthixol, a neuroleptic medication, versus placebo did reduce the risk of recurrence (odd ratio = 0.09, 95%, CI 0.02, 0.50, significant). The potential of low dose neuroleptics to prevent recurrence of suicidal behaviour was further tested by Battaglia et al (1999) who compared low dose Fluphenazine (12.5 mgs) versus ultra low dose Fluphenazine (1.5 mgs) per month in individuals with multiple attempts presenting to emergency psychiatric services. Using a randomized control design, the authors found that both arms of the study produced marked reductions in self-harm behaviours during the period of the trial and there was no evidence that the low dose was more effective than the ultra low dose (the placebo equivalent). On the psychotherapy front, Hawton et al (2000) found the most promising therapeutic approach was dialectical behaviour therapy versus standard care which was judged to have a significant effect on the reduction of suicidal behaviours in individuals with borderline personality disorder (odds ratio = 0.24, 95 %, CI 0.06, 0.93). These findings have been replicated at least six times in clinical trials with the dialectical behavioural therapy demonstrating effectiveness in reducing suicidal ideation, suicidal behaviour, impulsivity, self-harm behaviours and relapses of substance abuse (Links et al, 2003). Harrington and colleagues (2001) have also studied a similar therapy approach in adolescents aged 12 to 16 years of age. They compared their developmental group therapy to routine care and found that those exposed to the group therapy were less likely to be repeaters (odds ratio 6.3). Similar to Linehan's findings, effects were demonstrated in those who had multiple attempts and the effects were more dramatic for behaviours rather than symptom status.

Interventions have also been developed that improve treatment adherence following presentation to an emergency room. Rotheram-Borus et al (1996; 1999) evaluated a program to enhance treatment adherence in adolescent suicide attempters presenting to an inner city emergency room service. The program involves three components: staff workshops to affect staff expectations and behaviours with adolescent suicide attempters; video tape presentations for families regarding the risks to the adolescent and the value of follow up and out-patient therapy; and brief family treatment assessment in the emergency service. The research compared a consecutive series of female adolescent attempters presenting before and after the establishment of this specialized program. Attempters receiving the program were significantly more likely to return for out-patient treatment (95.4 % versus 82.7 %, $p = 0.018$). Overall the program was successful at having adolescents attend 3.8 more therapy sessions on average than those exposed to the standard condition.

Based on these findings, the following recommendations for interventions for individuals with suicidal behaviors are proposed. First, more collaborative research is needed to know what are the most effective interventions for individuals with presentations related to suicide attempts. A number of jurisdictions have already developed guidelines for the assessment and active engagement of patients presenting with suicidal behaviour. Guidelines are available through the Royal College of Psychiatry in the U.K (www.mentalhealth.org/suicideprevention) and in Australia and New Zealand (www.ranzcp.org/publicarea/cpg.asp) and the American Psychiatric Association (www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf). Our literature review provides the evidence for the importance of staff training so that they are aware of the risks to people with recurrent suicidal behaviour and the need for intervention. These educational resources are also needed for families and families need to be actively engaged to ensure compliance with follow-up. The engagement plan should also include seeking permission to inform the family physicians about the presentation for suicidal behaviour.

The review supports that programs should be developed for individuals with recurrent suicidal behaviour. With the infusion new resources, dialectical behavior therapy or other problem solving approaches warrant development as potentially efficacious interventions for individuals with multiple attempts. The evidence points to the fact that the number of attempts may be an important parameter or moderator in the determination of effective interventions. Therefore it is possible that individuals with a single attempt require less intense and different follow-up intervention versus those with a history of multiple attempts.

Treatment of major psychiatric disorders:

Providing adequate interventions for major psychiatric disorders is felt to have an important role in suicide prevention but this broader topic is beyond the focus of this review. However, two areas of research published in the last ten years, have demonstrated that specific treatments will prevent the risk of suicidal behavior or suicide in major psychiatric disorders. The first evidence relates to the use of clozapine in individuals with schizophrenia at risk for suicide and the second area involves lithium maintenance therapy in bipolar affective disorder.

Meltzer and colleagues (2003) completed a highly unique study focused on patients with schizophrenia or schizoaffective disorder judged to be at high risk for suicide. They selected patients between the ages of 18 to 65 years who had a history of high risk for suicidal behaviour and compared clozapine versus olanzapine in these 980 patients. The results suggested that there was a 26% reduced risk for suicide attempts or hospitalizations to prevent suicide in the clozapine versus the olanzapine treated patients. Directly studying suicidal behaviour as the outcome and demonstrating a clear effectiveness of clozapine over the comparison treatment makes this a ground breaking study. The mechanism by which clozapine prevents suicide is unclear. It did not seem to be related to efficacy with treatment resistant individuals as most of these patients were not judged to be treatment resistant. Clozapine may have an intrinsic anti-depressant property or a specific effect on suicidality that is somewhat distinct from its' effects on psychosis and depressive symptoms. Suffice to say, clozapine should be considered as indicated in individuals with schizophrenia who are judged to be at high risk for suicide.

Lithium when used for maintenance therapy has been purported to have an anti-suicidal property in patients with bipolar affective disorder. This evidence comes from several sources. Kleindienst and Griel (2000) observed in a randomized control trial comparing prophylaxis treatment with lithium versus carbamazapine in patients with bipolar and schizoaffective disorders that there was no reported suicide attempts or suicides in the lithium arm versus 1 suicide and 5 attempts in the carbamazapine arm. Using a pre-post design, Tondo et al (1998) demonstrated that the risk of suicide before the lithium exposure was 6.5 times higher than following lithium treatment for bipolar affective disorder. Tondo and Baldessarini (2000) have since reviewed a number of prospective studies and all of them found benefits for lithium in preventing suicidal behaviour with a seven fold difference in suicidal behaviour before versus after exposure. Recently, using a retrospective cohort study design with data from two large managed care organizations, Goodwin and colleagues (2003) compared the risk of suicide attempts and suicides during lithium versus divalproex treatment in 20,638 healthcare plan members who were diagnosed with bipolar affective disorder and filled at least one prescription for the above medication. The individuals were aged 14 or older and were enrolled in the health plan that provided the data for the study. The authors found that the risk of suicide was 2.7 times higher during divalproex therapy versus lithium therapy, again supporting an anti-suicidal effect of lithium exposure. In summary, lithium seems to have an effect on reducing suicidal behaviour and suicide that is observed after the first few years of treatment. The risk is not eliminated completely; however, this risk reduction has not been demonstrated for other mood stabilizers. The authors of several of these reports also found a high risk for suicidal acts if lithium was discontinued and this risk was highest during the first year of discontinuation.

The implications of this research suggest that there exist specific treatments for major psychiatric disorders that have the potential to reduce the risk of suicide. It is important that psychiatric personnel working in general hospital settings be educated about the indications for clozapine in individuals with schizophrenia at risk for suicide and for lithium maintenance therapy in patients with bipolar affective disorder at risk for suicide. Adequate and effective treatment for psychiatric disorders, in general must be provided; although, this topic is beyond the realm of the present discussion. Bertolote et al (2003) suggested that the impact of effective treatment for major psychiatric disorders, had the potential to save 165, 000 lives in the year 2000 throughout the world.

Reducing risk in discharged patients:

The literature reviewed provided evidence for the high risk in patients discharged from hospital and also revealed a report of a possible intervention strategy for discharged patients. Robinson and colleagues (2002) published an abstract based on The National Clinical Survey which is a survey of all suicides of individuals with mental health service contact in the year before their death in the U.K. Of all the suicides, 5,099 suicides (24 % of all reported suicides) had contact with Mental Health Services and data was available on 4,859 of these suicides. Based on this sample, 754 individuals had been psychiatric in-patients at the time of their death. Almost one-third of the suicides of psychiatric in-patients had occurred on the psychiatric ward and of these deaths, 74% had been by hanging. In addition, the suicides tended to cluster in the first week or around discharge

with 23 % of the suicides occurring within 3 months of discharge. Of the suicides that occurred in the community, 1,133 (28 % of the total) had lost contact with their follow-up services and no action was taken to contact these individuals in 20 % of the suicides. In keeping with other research, this study provides evidence that the period around and the months following discharge are a high risk time for suicide.

Motto and Bostrom (2001) examined the usefulness of long-term contact with persons at risk for suicide following discharge from hospital. They used a sample of persons hospitalized for a depressive or suicidal state and focused on 843 (28% of all admitted patients) individuals who refused ongoing care. The researchers randomized the intervention of letter contact four times a year versus no contact to the individuals refusing care. The authors have published on five and fifteen year follow-up on the sample looking at suicide as the outcome. A survival analysis showed a significantly lower suicide rate in the contact group ($p = 0.04$) versus the comparison group for the first two years of follow-up after discharge. Over longer periods of follow-up, the differences were no longer significant. However the authors argued that the simple intervention showed the importance of "connectiveness" following discharge from hospital and that similar interventions may be sufficient to reduce the risk of suicide after discharge.

This research leads to some recommendations for services for reducing risk in patients recently discharged. First, this is one of the highest risk groups established yet little intervention research has been carried out and more studies are urgently needed. However, the National Suicide Prevention Strategy in England (Department of Health 2002) provided some very practical guidelines based on the evidence from the National Clinical Survey. They suggested that all in-patient wards be regularly reviewed for safety; particularly, looking for possible ligature points that would put persons at risk. These data highlight the requirement for documentation of a patient's risk for suicidal behaviour at each major transition in the level of care provided. Specifically, every patient with a history of suicidal behaviour requires a risk assessment 24-48 hours prior to discharge to ensure that the acute risk of suicide has been mitigated. In addition, their strategy recommends that follow-up within seven days of discharge be in place for everyone with severe mental illness or a history of self-harm in the previous three months who is being released from an in-patient service. Patients with a history of self-harm in the last few months are also recommended to receive no more than two weeks of medication at discharge from hospital. The guidelines recommend the development of individual care plans to specify actions that should be taken if a patient is non-compliant or fails to attend follow-up appointments. Assertive outreach to prevent loss of contact, particularly with vulnerable or high-risk patients are incorporated within the individual care plans.

Reducing access to means:

Two studies were relevant regarding the issue of professionals educating individuals and families about the need to reduce access to means. Kruesi et al (1999) looked at the value of patient education in the emergency room by examining prospectively a sample to determine if parental receipt of education to limit access to means of suicide led to actual action. They followed 103 adults whose children were given a mental health assessment in an emergency service and examined whether, following this injury prevention education, action was taken to prevent access to means. The authors found a significant association

between the educational input and action taken to limit access to means (odds ratio = 3.6, 95 %, CI 1.1, 12.1). Based on their evidence, adults were at least likely to take modest actions such as locking up firearms rather than totaling disposing of the firearms.

Brent et al (2000) evaluated their recommendations to remove firearms during a clinical trial of adolescents being treated for depression. The parents of 106 adolescents were asked about the presence of firearms in the home as an initial part of their assessment. If the parents answered in the affirmative, they were given education about the need to remove the firearms to prevent access to means. Of those with guns at intake into the study, 26.9 % reported removing the gun by the end of the clinical trial. However of those without guns at intake, and therefore not receiving education, 17.1% of the parents actually acquired firearms over the two year follow-up during the course of the clinical trial. The authors concluded that compliance was limited with this psychoeducational intervention; although, the intervention did reduce access to means. The authors cautioned for the need to warn all families about removing access to means of firearms because of the evidence that families went on to acquire firearms and the need to develop more effective interventions for families that would have a greater impact.

The implications of this research suggest that reducing access to means needs further study so that more effective interventions can be developed. However, evidence exists that the simple intervention of providing education about limiting access to means should be incorporated into the care of all mental health patients.

Implications

This review suggests that several priorities for action can be developed for General Hospital Psychiatric Services. Many of these actions can be undertaken currently; although, others would require the infusion of new resources. The implications for action will be discussed under the following headings:

- Screening tools predicting risk of suicide

Certainly further research is needed to develop appropriate screening tools or perhaps indicators of warning signs for those at immediate risk for suicide. Our review indicates as has been reiterated by the American Psychiatric Association (2003) practice guidelines that clinical assessment remains the gold standard in terms of suicide risk assessment. Clinical staff within a general hospital psychiatric service have to be trained and their training updated regularly about the assessment of suicide risk. This training would be equivalent to the updating that regularly occurs regarding cardiac resuscitation.

- Interventions for individuals with suicidal behavior

This high risk group needs to be adequately assessed and followed and policy and guidelines should be in place to assist both emergency personnel and mental health staff to provide adequate assessment and follow-up. If new resources are available, intensive programming should be developed for those with recurrent suicidal behaviour as evidence indicates that

effective interventions are possible. These interventions involve dialectical behaviour therapy or problem solving therapies.

- Treatment of major psychiatric disorders

Effective interventions for psychiatric disorders should reduce the risk of suicide as psychiatric disorders are almost universally found in victims of suicide. In addition professionals within general hospital psychiatric services need to be educated about treatments that are known to be effective to reduce the risk of suicide. Currently two examples stand out; clozapine for use with individuals with schizophrenia at high risk for suicide and lithium as maintenance therapy for patient's with bipolar affective disorder at risk for suicide.

- Discharge from hospital

Patients discharged from hospital form one of the highest risk groups for suicide yet few interventions have been studied or put in place to reduce this risk. Patients with a history of suicidal behaviour should be assessed 24-48 hours before discharge to determine and document that the acute risk of suicide has been mitigated. New resources need to be acquired to develop and test interventions for post discharge risk prevention. In the meantime guidelines can be developed to ensure that patients with suicide risk are assertively followed up after discharge and that limits are placed on prescription quantities in high risk patients.

- Reducing access to means

There is evidence that education about reducing access to means should be incorporated as a part of routine psychiatric care in all patients seen in general hospital psychiatric services. Resources will be needed to develop research that will improve the impact of these educational interventions.

The review of evidence to date suggests that enough is known for general hospital psychiatric services to move ahead on preventative initiatives. At this point in time, Friedrich Engels reminds us that, "an ounce of action is worth a ton of theory".

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Appendix C

Stakeholder Survey Results
2004

Distributed to 60 hospitals
Total Number of Hospital Respondents: 23(38%)

Background Information

Number of Psychiatrists on Staff:

Number of Psychiatrists	Full Time	Part Time
1-5	4	11
6-10	2	1
11-15	3	1
16-20	2	0

Unsure	1
Use visiting/consulting psychiatrist	6

Comments

- A clinic runs on a bi-weekly basis.
- One psychiatrist visits the community every 2 months from U of Ottawa. Also offering a tele-psychiatry service in between the psychiatrist visit.
- 3 family physicians provide specific outpatient services. 1 family physician participating in on-call roster.
- Consulting psychiatrist 2 X per month from North East Mental Health Centre.
- Visiting psychiatry 4X /year (8 days?)

Number of inpatient mental health beds:

# of Beds	# of Respondents
0	8
1-50	10
51-100	
101-500	3

Comments

- Number of beds will go down as of Dec. 2003.
- Patients admitted to medical & surgical wards. Psychiatric consult provided to patient if requested by physician. Out-patient service provided by the Community staff from St. Joseph's Health Centre in London 5 days/week
- Medical beds used for acute psych as needed (Average 3).

Survey Questions

I. Education

1a) In your hospital, do you lead / participate in ongoing education regarding suicidal behaviour?

	# of respondents
Yes	11
No	9
No answer	1

1b) If yes, please indicate typical participants

	# of respondents
Mental health program professionals	11
Emergency Department professionals	6
Family physicians	6
Police	2
Community professionals (please specify)	3
Other (please specify)	

Comments

- This survey does not really apply. I am a psychiatrist in community private practice working ever other week with a community mental health team in Cornwall.
- When educational opportunities are available, i.e. North Network guest speakers in communities, these are rare, however theses would be the key players.
- Nursing staff
- Social Worker

1c) If you answered No to question 1a, in your hospital, would you have the support / cooperation of the hospital to conduct inter department (beyond psychiatry), multidisciplinary education regarding suicidal behaviour?

	# of respondents
Yes	11
No	
N/A	10

1d) If you answered No to question 1a, in your hospital, do you have the *resources* to conduct inter department (beyond psychiatry), multidisciplinary education regarding suicidal behaviour?

	# of respondents
Yes	4
No	8
N/A	10

II. Suicide Reviews

2a) Do you conduct multidisciplinary "suicide reviews" in your department?

	# of respondents
Yes	8
No	12
N/A	1

Comments

- Not sure what is meant by suicide reviews.
- No. But patient was suicidal in 23 ____ whilst an in patient.

3a) Do you conduct inter department, multidisciplinary "suicide reviews" for patients in other non-psychiatric departments of the hospital?

	# of respondents
Yes	3
No	16
N/A	2

Comments

- Done in the overall review of medical unit.
- Doesn't apply

3b) If you answered No to question 3a, do you have the *mandate* to conduct inter department, multidisciplinary "suicide reviews" in your hospital?

	# of respondents
Yes	3
No	12
N/A	6

3c) If you answered No to question 3a, do you have the *resources* to conduct inter department, multidisciplinary "suicide reviews" in your hospital?

	# of respondents
Yes	8
No	7
N/A	6

Comments

- No psychiatrist on site at all times.

3d) If you answered No to question 3a, what would you need to initiate "suicide reviews" involving the patients in other non-psychiatric departments? (Please be as specific as possible).

- Suicides. We are a small hospital no suicide outside mental health unit.
- Would need a psychiatrist/psychiatric department
- Agreement
- Would review any in hospital death.
- No patient has been suicided in 23 years whilst an in-patient.
- In my situation, I would like to have more psychiatrists working. Suicide assessment reviews are a "luxury" we cannot afford in isolated or remote schedule 1's.
- Time
- Increased psychiatrist involvement. Education on suicide & mental health. Materials/templates.
- Request from others to conduct the review.
- Co-operation with expectation from other MDs. Resources for data collection. Review reporting.
- Would need at least to work more than one day a week at the community mental health centre in Cornwall and at the Winchester District Memorial Hospital.
- Time: willingness of staff to participate in the review.
- Interest of other departments. Cases of suicide in other departments.
- Mandate and information on suicides.
- Interest/manpower

4a) In your hospital, with regard to *education* relating to assessment and treatment of suicide / suicidal behaviour, what one thing, if initiated, would have the greatest impact for your staff in assisting them in dealing with reducing / treating suicide / suicidal behaviour?

- More frequent suicide ground rounds.
- Attendance at conferences.
- Adequate education at present.
- Protocols for treatment of types of suicide behaviour.
- Adequate beds at schedule 1 facilities for transfer or psychiatric patients especially adolescents. Education needed on how to access the beds we have.
- Have an intake education program led by chair in suicide studies. Works well!
- Some type of suicide assessment tool.
- Core mandatory program on suicide prevention for staff.
- Better access to out patient high level consulting resources. Better day programs.
- Divestment of acute services to a General Hospital.
- Have given numerous CMEs. Usually include suicide assessment and treatment.
- Assessing risk and differentiating between self-mutilation, risk taking behaviours and suicidal
- Having the access to discuss their findings and concerns to a psychiatrist. Having the knowledge to appreciate the difference between acute and chronic recurrent suicidal behaviour and some expertise and comfort level in pursuing behavioural interventions.
- More crisis staff to do the education.
- Expert speakers, hands on sessions with work shops on suicide.

- Workshop with practical approach to suicide prevention on the inpatient unit. Information about Best Practices/screening tools for emergency & outpatients.
- Ongoing open suicide reviews. We do this but could do more. Improved assessment skills. Family education.
- Yearly training & revision of assessment process in suicidal situation. Public education or forum.
- Suicide reviews (teaching anchored in clinical events.
- Education of staff at emergency service in the hospital and community support – believers in the community.
- Assessment tool presentation semi-annually.

4b) What would you need to implement that initiative? (Please be as specific as possible).

- A core policy.
- Funding.
- Set priority
- Interest of the department-SW likely to be the people most responsible to do this.
- Awareness of such a tool existing, being user friendly and reliable.
- Certainty re; the ability to reopen without the risk of litigation.
- Time, money, resources – expert speakers.
- Staff and time.
- Time, money, educational materials.
- Expert education from clinicians with the expertise in suicide assessment & prevention. There should be a province wide education in any format feasible to deliver education to the frontline healthcare workers. We do not have local resources.
- Government to supply adequate crisis beds so that farmed patients could get their assessment – need to then be taught how to access the source.
- Scheduling on a semi-annual basis

III. Assessment

5a) Do you currently have suicide risk assessment tools in your hospital?

	# of respondents
Yes	10
No	10
Unsure	1

- No. but it can be obtained easily from St. Joseph's Health Center London if needed.

5b) If yes, what tools and how well do they work?

- By what measure?
- SAOs scales
- Nursing. They contribute something to the assessment.
- SW -- --- --- tool that --- SI question
- Routine scripted assessments. Especially in emergency. Was developed in house.
- Living Works – Resources
- Sigecaps Sadpersons – work well used by crisis services emerg inpatients.

- Centre Alliance – risk assessment. Crisis Intervention – risk assessment.
- Psychosocial assessment by social work - works well, but done by one person.
- CMHC does do crisis assessment – now have a tool for adolescent but usually have no way to respond.
- The clinical interview and properly trained & supported staff are the best tools available.

6a) In the past 2 years have you undertaken a formal / comprehensive assessment of the physical facility to minimize the potential for suicide?

	# of respondents
Yes	7
No	13
N/A	1

6b) If you answered Yes to question 6a, please describe findings and outcome.

- Meet Standards.
- Changing shower hooks and individual panic alarms
- We're preparing to open schedule 1 facility and currently implementing the state of art knowledge/technology to accomplish safe facility.
- Review of structure, staffing of emergency dept. Physical changes. MO responsibility from ER to psychiatry redefined.
- More than 2 years ago, outside consultant assessed facility and made a series of recommendations, which were implemented.
- Sliding doors on unit.
- We know we don't have a safe facility and that we're sitting on a time bomb with respect to holding patient on form 1 awaiting schedule 1 placement. Esp. adolescents.
- Building a new wing - maintain 2nd floor-no higher – nursing station well placed.

6c) If you answered No to question 6a, please indicate whether you believe this would be beneficial.

	# of respondents
Yes	7
No	6
N/A	8

- No, but one done in psychiatry 3 years ago.
- Yes, in terms of documenting the safety.

7) Would it be beneficial to have a standardized tool to guide the assessment of the physical facility?

	# of respondents
Yes	16
No	2
N/A	2
Unsure	1

- Do not know. Not in their hospital. One floor above ground.

8a) In your hospital, with regard to *assessment* of suicide / suicidal behaviour, what one thing, if initiated, would have the greatest impact for your staff in assisting them to conduct the most accurate assessment?

- We have a core program
- Continued education - multidisciplinary
- Educational activities.
- Education & practical resources
- assessment tool
- Education/evaluation/feedback. 3-4X/y
- Education
- Teaching and supervision of clinical assessments.
- More staff
- Tool that compares with Best Practice.
- Tools, templates to properly assess patients @ risk. Link/liaison with a psychiatric facility specifically psychiatrist for psych nurses.
- Having the appropriate clinical knowledge, the confidence in the staff personal skills and the ability to communicate suicide concern to the in-charge clinician.
- Have to assess risk.
- Adequate training for nurses
- Standardized tool
- Having a secure area to hold & do assessment – all emerge rooms full of dangerous things for patients & interviewer
- Regular CME
- Because of availability of beds ANY suicidal patient is admitted.

8b) What would you need to implement that initiative? (Please be as specific as possible).

- Monies.
- Priority.
- Tools.
- Tools
- Time for staff to attend.
- Time and money
- Time, human resources and money allocated to this venture.
- We do this. Again resources – increase clinical trainers.
- Staff, training, time, money
- Frontline staff needs to have time, knowledge, motivation and interest in assessing psychiatric patients and suicide in particular. Not many particularly busy ERPs are willing to dedicate effort and energy to this process. It is far easier to fill a form 1 and admit the patient.
- A person/employee mandated to fulfill this task.
- Staff well educated generally. Can always use more education.
- Make psychiatry a mandatory part of nurse training.
- Adequate staff
- Designate lockable interview room with glass viewing area.

IV. Treatment and Follow up

9a) Are you generally able to access an inpatient bed to admit a suicidal patient?

	# of respondents
Yes	15
No	4
sometimes	2

9b) If you answered No to question 9a, please elaborate.

- Yes, but...delays in admission. Too few beds in Hamilton region.
- Almost never with children or adolescents as far as appropriate placement but are put on medical ward.
- Sometimes none available.
- Depends on bed situation in London
- Most frequently there are no schedule 1 beds available when needed – no choice but to try to treat person in acute care setting.
- All efforts are made to send the patient to a schedule 1 facility on a form 14. However, patients are admitted until they can be sent to a psychiatric Facility or until the crisis is over.
- If a patient has been admitted I will see them in the hospital during the day. If a patient in the clinic would be deemed suicidal, I would refer him/her to the Cornwall Hospital.
- We are not a schedule 1

10a) Is continuous observation for patients with suicidal behaviour readily accessible in your hospital?

	# of respondents
Yes	13
No	7
Y & N	1

10b) If you answered No to question 10a, please elaborate.

- No staff to do this – using families and residents
- Lack of staff and money.
- Resource problem often unable to provide 1 on 1 also physical space not allowing
- An extra visit or filter could be arranged for pending transfer to a schedule 1 facility.
- Not enough staff – budget constraints to keep staff on care to one when it is not the mandate of the hospital to offer such treatment.
- It is a general hospital, and the nursing staff are not trained in the psychiatric field. They don't feel comfortable to deal with this.
- Available but used in critical cases because of cost

11a) Does a psychiatrist reassess the suicidal patient before discharge?

	# of respondents
Yes	14
No	3
N/A	1

Usually – Not always.
We can consult with a psychiatrist over the phone if available.
If I happen to be there. By and large, the patient will have been transferred to a schedule 1
If needed and requested.

11b) If you answered Yes to question 11a, please indicate the most typical reassessment time frame:

	# of respondents
Within 24 hours before discharge -	11
Within 36 hours before discharge	3
Within 48 hours of discharge	4

12a) Do you have a specific discharge policy / protocol for suicidal patients?

	# of respondents
Yes	1
No	19
Unsure	1

12b) If you answered Yes to question 12a, please describe.

- Protocols exist with community lectures and O.P.P.

13a) Are you able to undertake early follow up (within 7 days) of discharged suicidal patients?

	# of respondents
Yes	11
No	10

13b) Please elaborate.

- Yes, but with ongoing difficulty. By bringing back to unit or emerg service. This is not satisfactory or ideal clinically.
- In most cases
- Yes & no – family doctors, mental health workers can assess but currently no 7 day access to psychiatrist.
- Most GPs have longer waiting times. Sometimes CMHC social workers & psychologists or nurses follow up is available. Homewood outreach person is excellent with those discharged from these which is our only referral agency for Wellington.
- Urgent clinic.
- Would be different as everyone very busy but each Dr. could access own patient.
- There is a waiting list that is always longer than 7 days.
- Person is referred to local mental health services
- There is only one psychiatrist for 100,000 population. Follow up is arranged with own GP or with mental health professional.
- Patients would be referred to the Mental Health Program Alliance Centre and/or Crisis Intervention Program for follow-up. Both programs are within the hospital.
- Appointment with Psychiatrist
- Patient/client is soon either at Turning Point or at home.

- The case load is very heavy for all the staff in the clinic. But we do see the patient as soon as possible if needed.
- Urgent clinic – crisis clinic – out patient f/u 4
- If asked for but not routine.

14a) Do you have a mechanism to ensure that the discharge plan is carried out?

	# of respondents
Yes	7
No	11
N/A	6

14b) If you answered Yes to question 14a, please describe.

- Urgent clinic
- The patient/client is followed in the community by an employee of turning point.
- Care plans are established between patient and mental health worker. These plans are kept on the patients health record to be referred to as needed.
- I have 2 competent social workers who are capable and willing to do the task.
- Ongoing communication with mental health agency.
- We usually follow our own patient, especially high risk suicide.

15a) Are the Mental Health Act provisions regarding 'risk to self' sufficient for clinical practice?

	# of respondents
Yes	14
No	3
N/A	3
Unsure	

15b) If you answered No to question 15a, please explain.

- It often is nebulous as to what degree of risk impulsivity always a problem
- They are too broad. There are many people who are at chronic risk and hospital admission is unhelpful.
- Form 2 needs to be simplified.
- We follow the Public Hospital Act as a General Hospital.

16a) Do you currently receive coroner reports?

	# of respondents
Yes	8
No	12

16b) If you answered Yes to question 16a, do you have a formalized process for reviewing coroner recommendations?

	# of respondents
Yes	5
No	5
N/A	10

16c) If you answered Yes to question 16b, please describe the process.

- Via clinical divisions and by Director of Quality.
- Mortality rounds / Department Meeting
- Through the suicide review committee and through senior admin group. / risk management committee.
- A consent is signed to authorize this report, however if not signed we do not get a copy nor do we have access.

17a) When a suicide happens, is there a process in your hospital to review / debrief?

	# of respondents
Yes	13
No	5
N/A	1

No - I don't know of any case of suicide in the hospital
Informal critical incident stress debriefing.
Has not happened – out patients have occasionally suicided.

17b) If you answered Yes to question 17a, please describe.

- A debriefing to help staff cope with it and a mortality services chaired by the psychiatrist in charge of the clinical division.
- If in hospital suicide – Dr. and Nurses would meet over case to discuss it.
- Led by head of in-patient services.
- On psychiatry only.
- Critical incident review, usually senior nurse, administrator, physician.
- We have a debriefing for staff at instigation of doctors or hospital professional staff.
- Through standing post vention review group.
- Mortality rounds / team meeting / debriefing team
- Debriefing performed with clinical team and supervisor.
- Emotional debriefing
- Procedural review
- Hospital employee assistance program facilitation.
- A debrief session takes place with nurse and physicians involved to discuss.
- Nurse Manager & psychiatrist. Any other necessary staff.
- Immediate review lead by treating psychiatrist

17c) If you answered No to question 17a, please indicate whether you believe this would be beneficial.

	# of respondents
Yes	5
No	
N/A	13

Possibly – we have had 1 in patient suicide.

18) Is the "on call" psychiatrist available to family physicians / Emergency Room staff?

	# of respondents
Yes	16
No	4

Via our nurses who work in ER
Via phone
No on call psychiatrists
No psychiatrists
A call can be placed to North Bay Psychiatrist on call.

19a) In your hospital, with regard to *treatment and follow up* relating to suicidal behaviour, what one thing, if initiated, would have the greatest impact on reducing / treating suicidal behaviour?

- Quick access to outpatient services. Now they are provided by another agency clinic.
- Access to well trained staff.
- Extremely frequent follow up to ensure treatment compliance MAY help but not as much as the ability to predict behaviour including impulsivity.
- Expanded urgent clinic
- Good clinical assessment - timely follow-up
- Good community support and close supervision by staff in the community.
- Funding and more staff
- Quicker access to follow up with Rx. Need more acute
- A standard consistent approach to treatment of personality disorders
- A care map for patients progressing through the process from start until finish/wellness.
- Staff
- Money for treatment/education
- The availability of the ability to monitor compliance with discharge plan and to access resources ie; crisis line
- Access to schedule 1 bed for high risk suicidal person.
- More psychiatrists.

19b) What would you need to implement that initiative? (Please be as specific as possible).

- Prioritize the type of care by the clinic. (They try to do this.)
- Increase in funds
- Money
- Any patient deemed to be at risk is referred as a priority to the community mental health team
- Money
- More staff/ money/ space
- Working group to develop Best Practice
- Experts on Care mapping & suicide
- Templates
- Resources allocated to this venture – perhaps using our mental health centre and hospital discharge planner, in a greater capacity.
- Staff and money
- Case management
- Crisis response teams
- More empathy physicians

- More psychiatric beds.
- I feel assessment & appropriate treatment of suicidal behaviour is basic psychiatric care & should be incorporated into every psychiatric inpatient treatment program.
- Better recruiting.

Appendix D - 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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Submitted to
Association of General Hospital Psychiatric Services

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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:

<u>1. Literature Search</u>

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.

<u>2. Stakeholder Survey</u>

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.

<u>3. Inquests Reports</u>

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 that 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 deffused 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 <u>for the first time</u> 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.

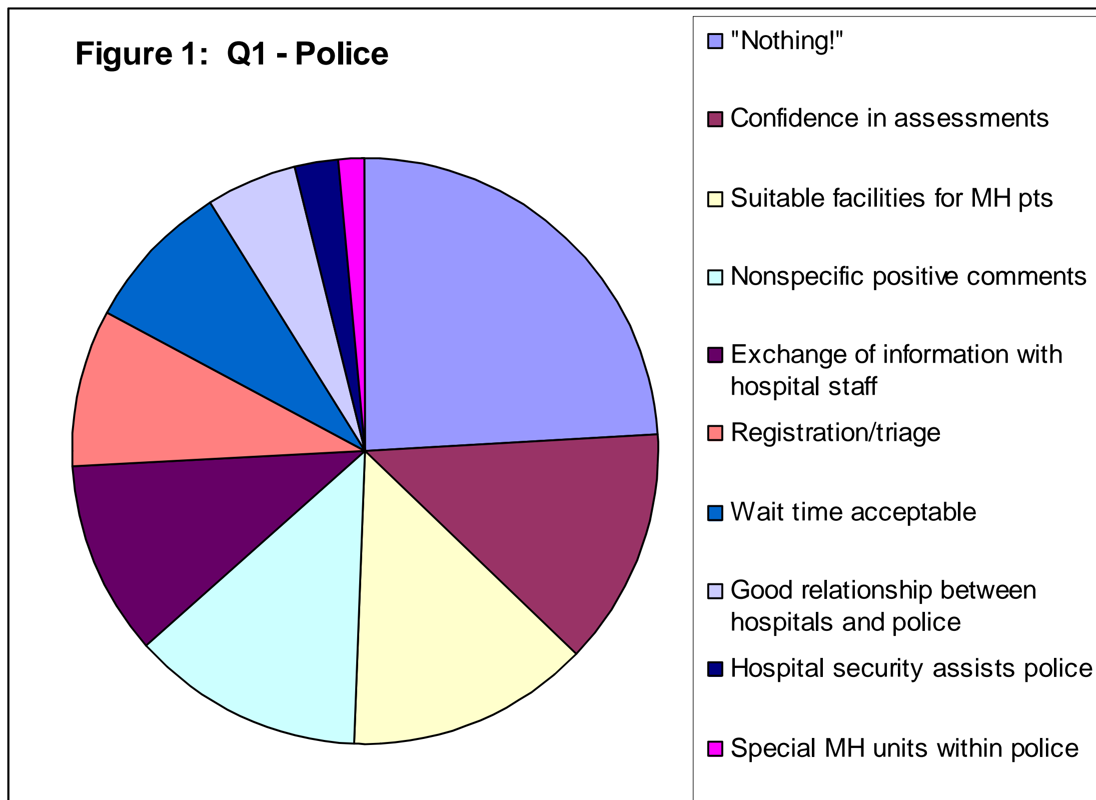
Abbreviations:

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

Category of Response	***# Responses***	***% of Total***
"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 %



Police Responses to Q1 "What is working well?"

"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.

<u>SOME</u> 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.

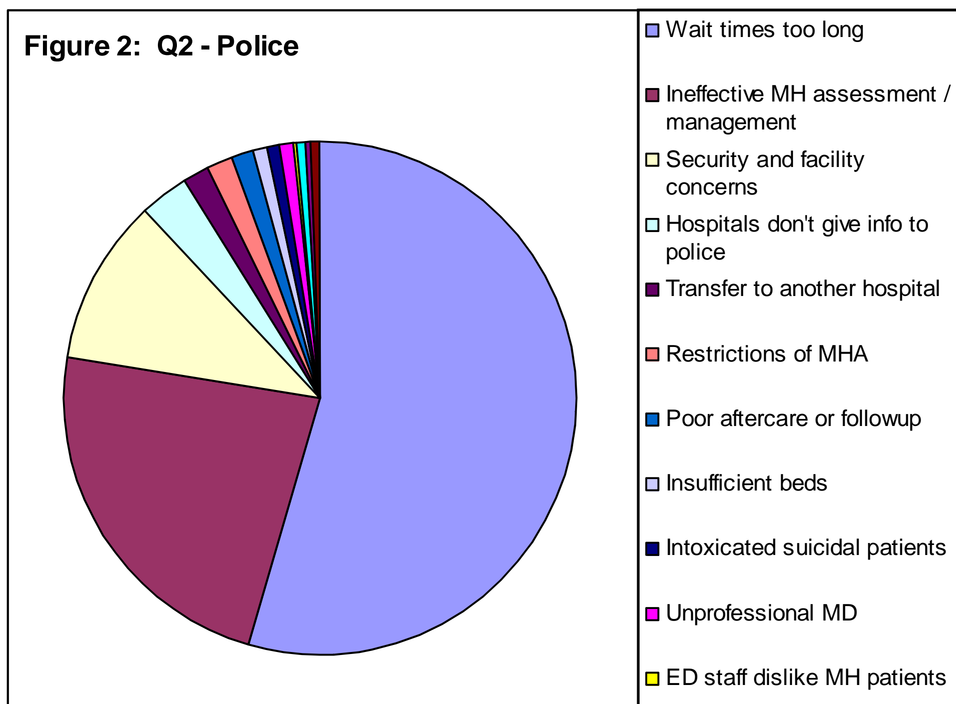
Although there is no written protocol, there is a clear understanding between hospital management and detachment supervisors as to what course of action is to be taken in cases involving mental health patients.

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 pysch…..
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.

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…

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.

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.

<u>Hospitals don't give info to police</u>

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.

<u>Transfer to another hospital</u>

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.

Police Responses to Q2 "What problems remain?"

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 there 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

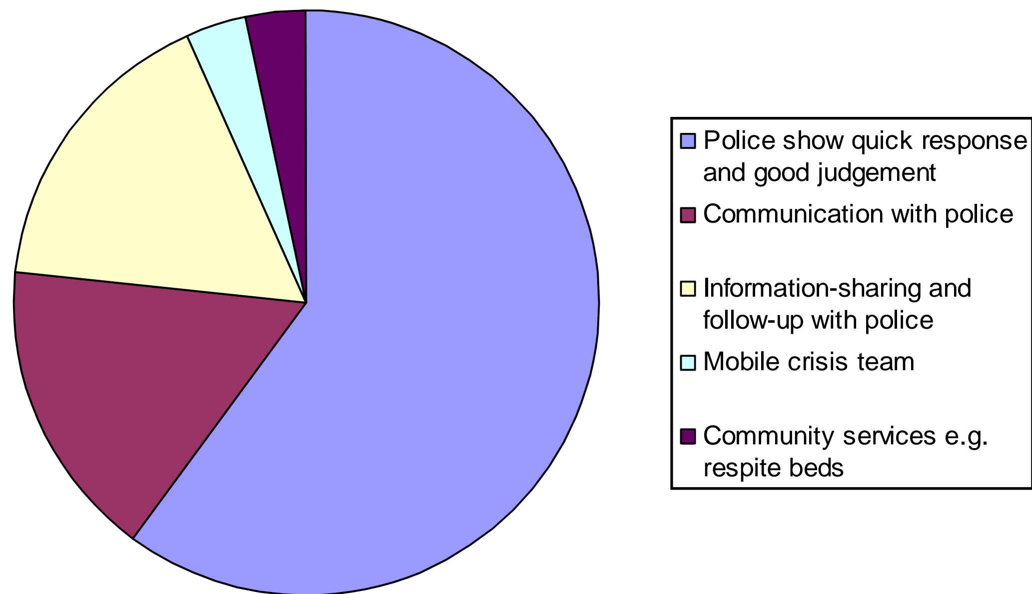
3.3.1 Q1: “What is Working Well?” 30 Responses

"...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.

Figure 3: Q1 - CMHA



CMHA Responses to Q1 "What is working well?"

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.

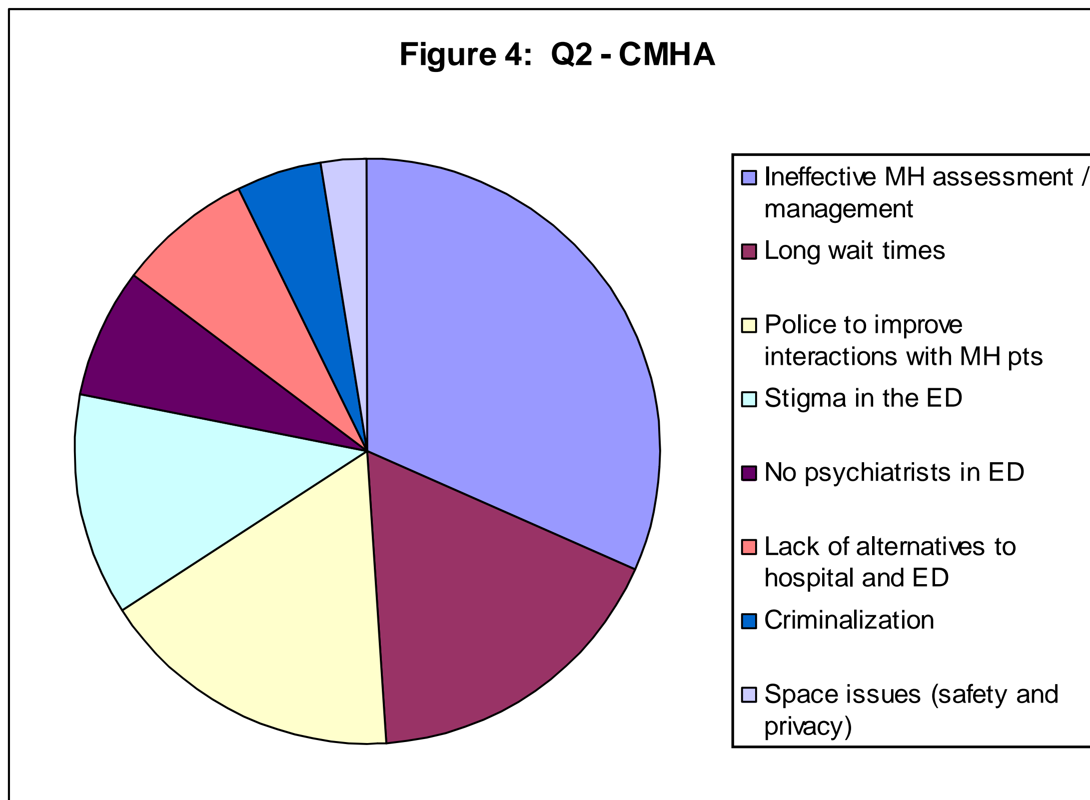
Mobile Crisis Team

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.

<u>Lack of alternatives to hospital and ER</u>

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.

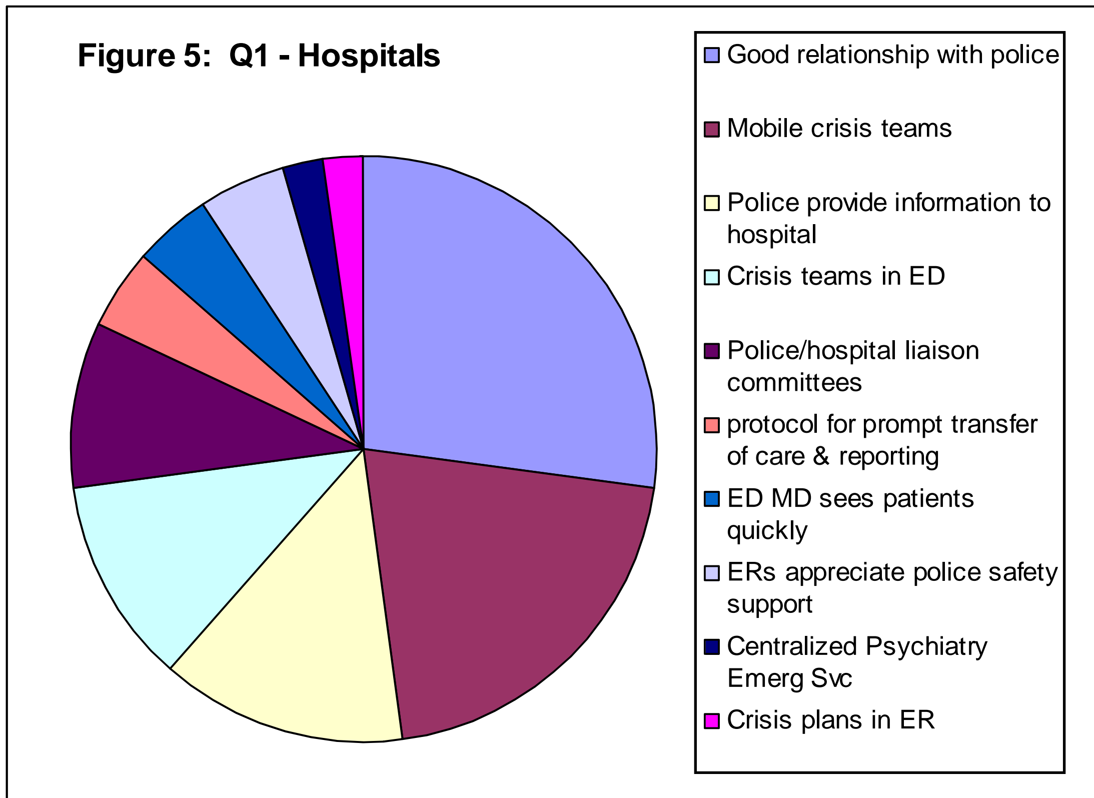
Lack of access to community based treatment services that act as an alternative to hospital. These services are often at capacity, closed for referral, and in this community are accessed after an ER assessment (which means a lengthy wait).

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 %



Hospital Responses to Q1 “What is working well?”

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

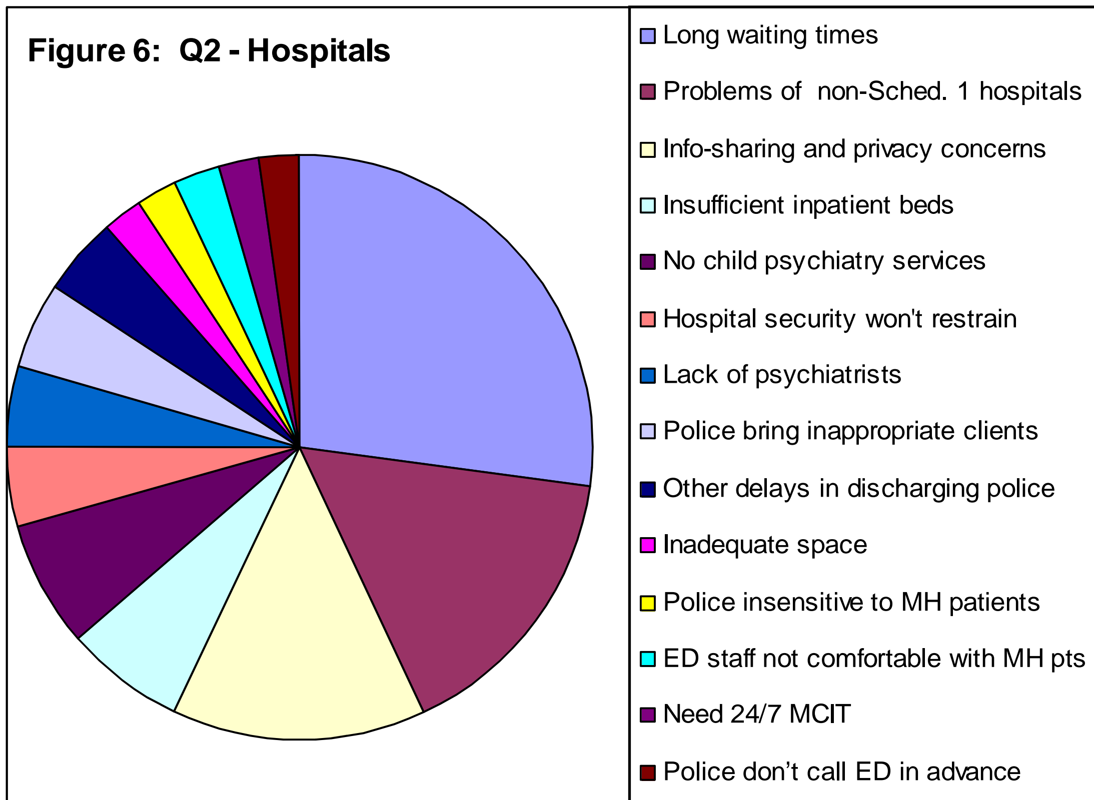
Crisis team can begin assessing the case prior to the ER physician having contact.

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. Criticall 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.

Hospital Responses to Q2 "What problems remain?"

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 theses 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?"

<u>Hospitals</u>

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

<u>Police</u>

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

<u>Police-Hospital Interaction</u>

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)

<u>Caregivers receive little feedback from staff (3 responses)</u>

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.

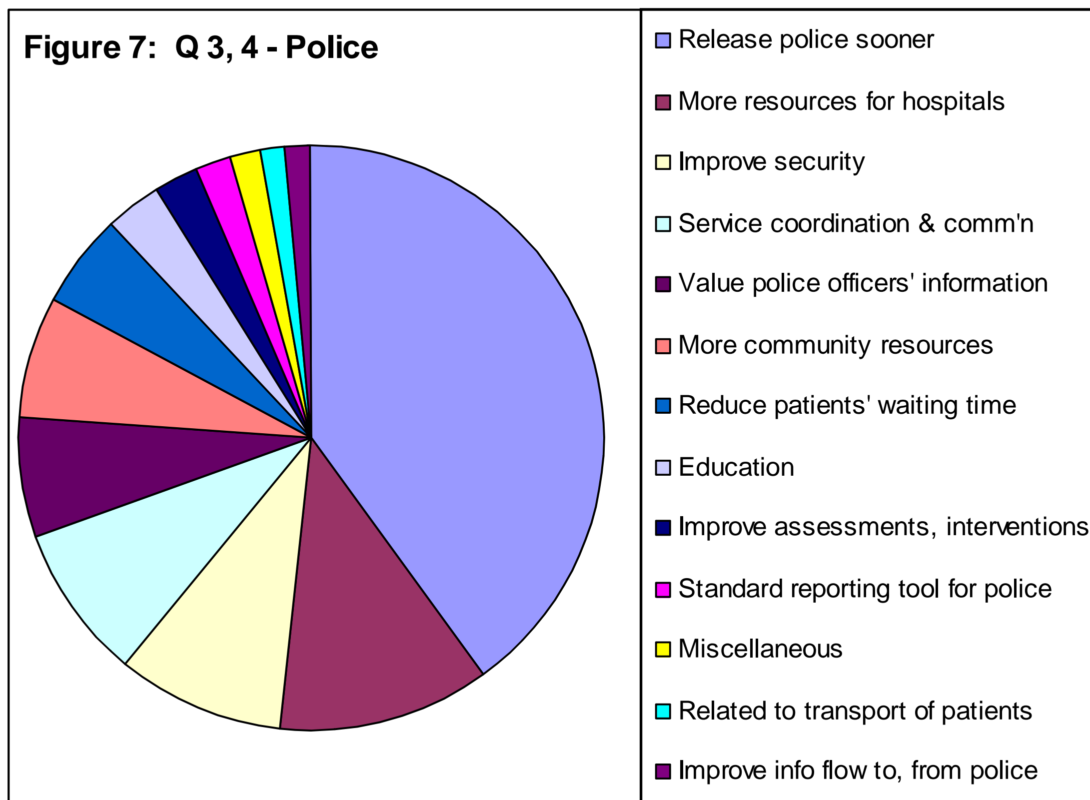
Follow-up inconsistent (1 response)

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.

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 heath 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

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 <u>qualified psychiatrist</u> 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

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.

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

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 form 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.

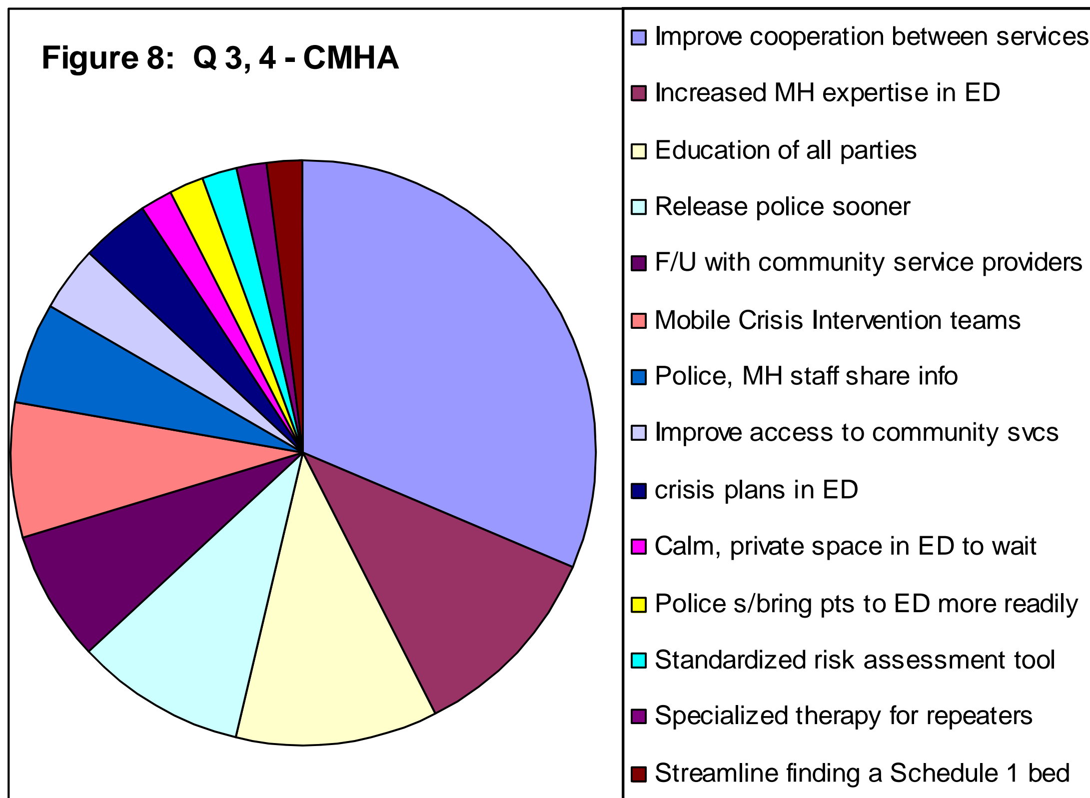
Understanding the need for police to have the most recent information to assist the victim and/or family in the recovery of these victims. Need for a more cohesive working relationship when sharing information.

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.

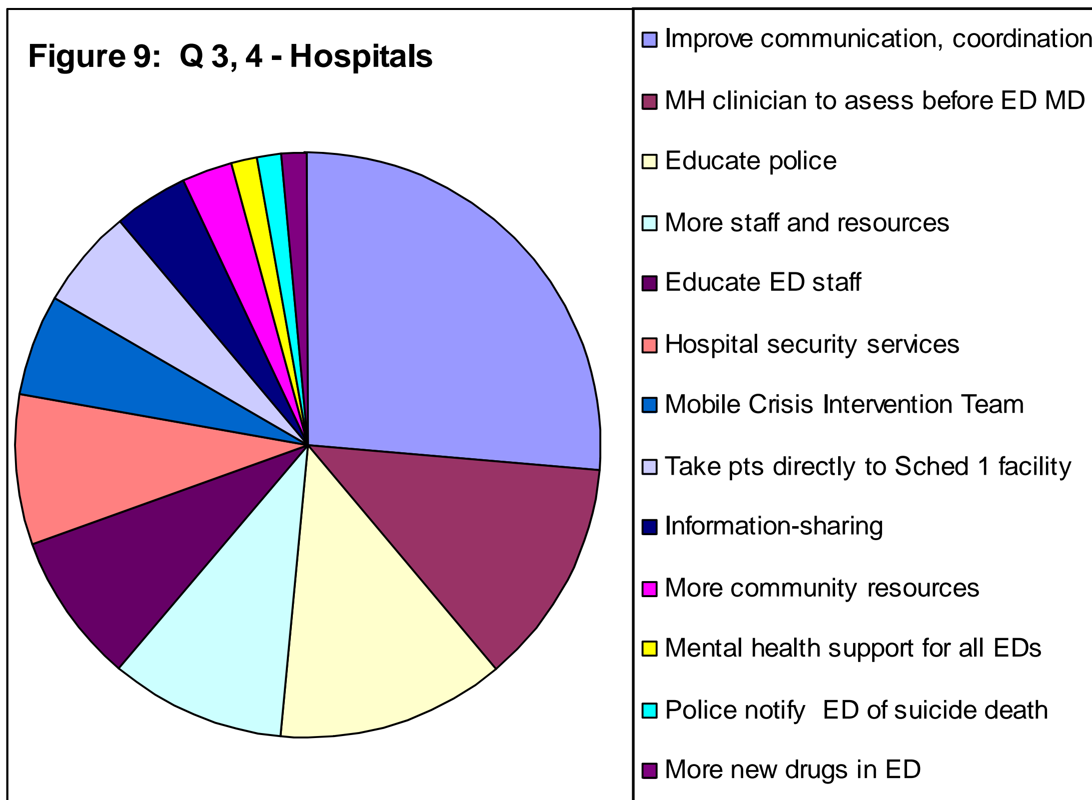
Specialized therapy for repeaters

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 <u>last</u> 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

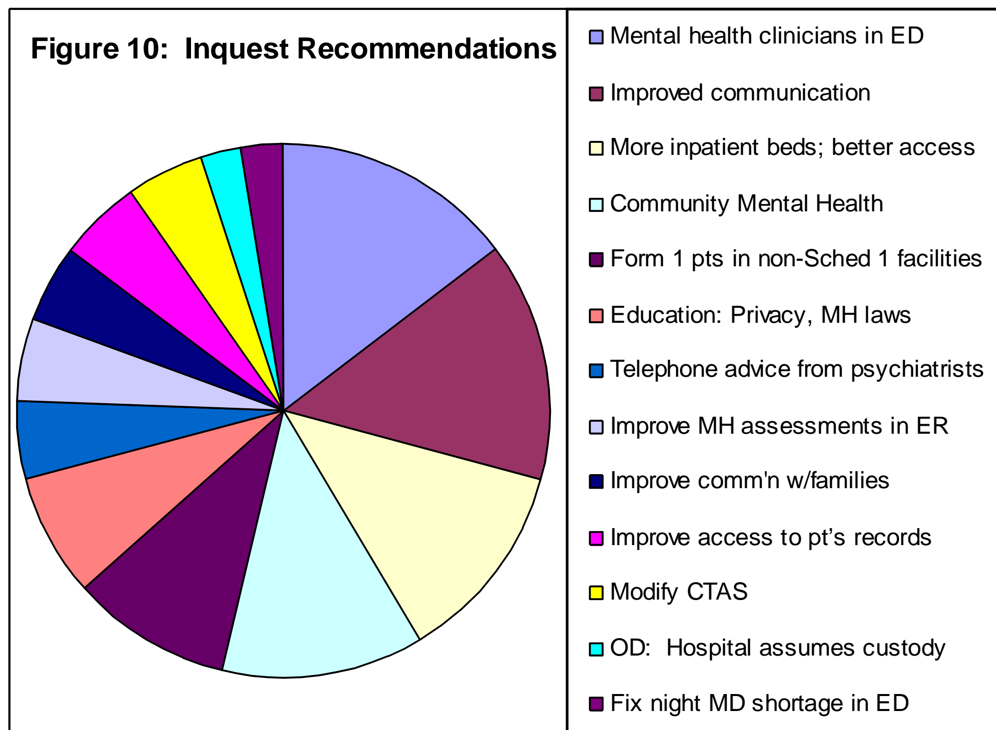


Figure 10: Inquest Recommendations

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.*

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.*

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*

> *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.*

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.

... 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*

> *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]

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
1st most frequent	Good relationship with police	Nothing	Police quick response and good judgment
2nd most frequent	MCIT	Confidence in MH assessments	Communication with police
3rd most frequent	Police provide information to hospital	Suitable facilities for MH pts	Info-sharing and f/u with police
4th 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
1st most frequent	Long wait times	Wait times too long	Ineffective assessment / management in ER
2nd most frequent	Problems of concern to non-Schedule 1 hospitals	Ineffective assessment / management in ER	Long wait times
3rd 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 *in*congruent: 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
1st most frequent	Improve communication and coordination	Release police sooner	Improve cooperation between all	MH clinicians in ER
2nd most frequent	MH clinician to assess before ED MD	More resources for hospitals	Increased mental health expertise in ER	Improved communication between all
3rd most frequent	Educate police	Improve security	Education of all involved parties	More beds and streamlined access
4th 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 adequate 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.

Part 9: References

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Appendix E - GUIDELINES FOR THE DEVELOPMENT OF

SUICIDE PREVENTION PROGRAMS

IN DEPARTMENTS OF PSYCHIATRY IN GENERAL HOSPITALS IN ONTARIO

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Appendix E - GUIDELINES FOR THE DEVELOPMENT OF SUICIDE PREVENTION PROGRAMS IN DEPARTMENTS OF PSYCHIATRY IN GENERAL HOSPITALS IN ONTARIO

Executive Summary of Recommendations

It is recommended that the Association of General Hospital Psychiatric Services (AGHPS) provide leadership and coordinate the development of suicide prevention programs in general hospitals in Ontario. The AGHPS should develop a resource base and work with its member hospitals to develop suicide prevention programs in Schedule 1 facilities that would have the following components:

1. **Development of a Suicide Prevention Resource Centre**

The AGHPS should develop the resources to maintain a data base of literature and other sources of information relevant to the identification, assessment and treatment of persons who are vulnerable to suicidal behavior. Resources would be identified that would be useful to interested persons including professional staff, employers, law and policy makers, teachers, and relatives. This information could include literature, research findings, videos and documentaries, assessment tools, resource catalogues and results of coroner's inquests.

2. **Development of Education Programs**

It is recommended that the AGHPS work with each Department of Psychiatry in its member hospitals and develop suicide prevention education programs in its catchment area. There would be a focus on the education of professionals, especially those that work in hospital settings. There should be a focus on secondary and tertiary prevention with individuals identified with serious mental illness. Secondary prevention refers to the identification and treatment of patients with suicidal tendencies and tertiary prevention refers to the treatment and rehabilitation of patients who have demonstrated actual suicidal behaviors.

2(a) **Education Programs for Professional Non-Psychiatric Staff**. There is a need for continuing education programs for professional staff working in the community or in hospital who may come in contact with persons at risk of suicidal behavior (in the community this would include police officers, case managers, probation officers, staff of community agencies, family doctors; in hospital, emergency room staff, security, medical and non-medical staff on other wards would be included)

2(b) **Education Programs for Psychiatric and Mental Health Staff**. Psychiatric staff, including psychiatrists, physicians, nurses, social workers, must receive continuing professional education related to prevention of suicide that is of the highest level whether they work on the in-patient unit, ambulatory care programs or outreach programs.

2(c) **Public Education** may not be the highest priority or need in a general hospital compared to the education of hospital staff but may occur from time to time such as during Mental Illness Awareness Week.

3. **Development of Early Identification Strategies**

It is recommended that the AGHPS work with each Department of Psychiatry in its member hospitals and develop strategies and policies for the early identification of persons vulnerable to suicidal behavior. These could include the development of emergency and inpatient assessment protocols for individuals presenting with suicidal ideation or behavior in ER, screening of high risk populations such as those with chronic medical illness or chronic substance abuse and those admitted after a medically serious suicide attempt.

4. **Development of Early Intervention and Treatment Strategies**

It is recommended that the AGHPS work with each Department of Psychiatry in its member hospitals to develop “best practice” guidelines, protocols and safety standards of intervention and treatment of patients at risk of suicide. Policies regarding the diagnosis and intervention of patients presenting with suicidal ideation or behavior will include best practices regarding the assessment, management and treatment of co-morbid psychiatric and substance abuse disorders. Each program will support the development of safe inpatient environments.

5. **Development of Longer-term Treatment and Follow up Strategies for Suicidal Patients**

It is recommended that the AGHPS work with each Department of Psychiatry in its member hospitals and develop guidelines and programs for persons who remain vulnerable to suicidal behavior. Each program will develop specific policies on follow-up after discharge from a psychiatric inpatient service and maintenance of follow-up for individuals with severe and persistent mental illness or those judged to be at risk for suicidal behaviour. The AGHPS should develop policies for reviewing suicides of patients and provide guidelines for the interventions with family and staff following a patient's suicide.

5. **Support for other initiatives**

It is recommended that the AGHPS work with each Department of Psychiatry in its member hospitals to work and cooperate with other initiatives that will decrease the incidence of suicidal behaviour including advocacy for comprehensive community services, changes to mental health or other laws, and research and education projects in academic centres.

Rationale

The Association of General Hospital Psychiatric Services represents approximately 48 of the 60 Schedule 1 psychiatric facilities in the province. Since 1982, the AGHPS has actively represented and advocated for mental health professionals within General Hospital/Schedule 1 facilities. In it's activities, the Association seeks to reflect the concerns and views of its members and to ensure that general hospital psychiatry is represented in policy and service planning.

Schedule 1 facilities are required to provide essential psychiatric services including in-patient, out-patient, day care and emergency services as well as consultative and educational services to local agencies.[1] Schedule 1 psychiatric facilities in general hospitals have the mandate to provide emergency psychiatric

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1 Regulation 741, amended to O. Reg.112/98, Mental Health Act.

assessment and care of persons at risk of suicide in each community. Persons at risk of suicidal behavior are often taken to the Emergency Department of a local general hospital which is open 24 hours a day, seven days a week. Suicidal persons who want treatment will often come to Schedule 1 facility because of the psychiatric and mental health expertise that exists in such facilities. Only Schedule 1 facilities have the authority and resources to admit persons at risk of suicidal behavior involuntarily under the Mental Health Act of Ontario. Patients who are perceived to be at risk by the police or Justices of the Peace to meet criteria for a Form 2 must also be taken to a Schedule 1 facility for a psychiatric examination.

In 1998, there were 3,699 Canadians who were reported to have died as a result of suicide; the actual number is likely much higher as many are unreported because of religious or insurance repercussions and social stigma.[2] Suicides represent approximately 2% of all deaths. Suicide is one of the most common causes of death especially among young adults; suicide accounts for 24% of all deaths among 15-24 year olds and 16% 25-44 year olds. Suicide rates among the aboriginal population in Canada are 3-6 times the rate of the national average depending on the community. The vast majority of suicides are associated with mental illnesses that are treatable. Most suicides are preceded by periods of depression, behavioral disorganization, substance abuse or other form of mental disorder that would likely have been temporary or treatable if suicide had not occurred. Many signs of impending suicide are ignored by persons at risk or by family members, colleagues, health care providers such as family physicians and other members in the community.

General Hospitals have a mandate to address the health needs of the population they serve through education, health promotion and public health initiatives. The staff in Departments of Psychiatry in general hospitals are in an ideal position to develop strategies to decrease the incidence of suicidal behaviour and successful suicides. Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives.[3]

The staff in the psychiatric department of a general hospital has the mandate and resources for early identification, intervention and treatment of mental disorders because emergency rooms are open 24 hours a day and are accessible to both public and professionals when a crisis occurs.

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[2] Health Canada: Chapter 7: Suicidal behavior. in A Report on Mental Illnesses in Canada, Ottawa, 2002.

[3] National Strategy for Suicide Prevention. U.S. Department of Heath and Human Services, 2001.

Although, some suicides may appear to be "rational", for example, a patient facing a chronic and severe debilitating or terminal illness, suicide is never inevitable; the vast majority of patients who are actively suicidal are ambivalent and will change their minds with time or as circumstances and supports change. The negative impact of suicide on the family, friends, colleagues, community and health professionals is immense and there is a need for many different kinds of post-suicide interventions to decrease subsequent morbidity and mortality.

It must be acknowledged that not all suicides are preventable, and that suicide is always an option or possibility for some persons. However, the AGHPS is in an excellent position to assist and enable professional staff in hospitals to adopt "Best Practices" during the assessment, treatment and follow-up of persons who are vulnerable to suicidal behavior. There is a need to disseminate clinically relevant information about the differential diagnosis and treatment effectiveness of suicidal behavior. For example it is important for clinicians to differentiate diagnostic groupings and the effectiveness of treatment options for the subtypes of Major Depressive Disorder, various forms of acute and chronic psychosis, substance abusers, the chronic self-mutilating behavior of the Borderline Personality, and the medically ill patient who feels demoralized and helpless.

Detailed Discussion of Recommendations

1. Development of a Suicide Prevention Resource Centre

At present, there is no central resource or repository of information on clinical aspects of suicidal identification and treatment strategies especially information that is relevant to patients that could be seen and or treated in a general hospital setting. For example, there is no one professional body or group that is focused on the recommendations of coroners' inquests of suicides or encouraged the development and dissemination of identification and treatment guidelines applicable to this population. The AGHPS could have a leadership position in distilling information and recommendations relevant to hospital based psychiatric services.

2. Development of Education Programs

There are many reasons why the topic of suicide is "taboo" in our society. Although the act of suicide was decriminalized in Canada thirty years ago, there remain religious, family, psychological and social

reasons why the topic is not talked about. Some of the reasons include the stigma of mental illness, feelings of shame and embarrassment and an irrational fear that talking about suicide will increase its incidence.

As a provincial resource, AGHPS can encourage and assist its member hospitals to develop education programs on the topic of suicide prevention focused on professional groups in its catchment area.. The AGHPS through its membership of Chiefs of Psychiatry and Clinical Directors is in an excellent position to collect, develop and disseminate information, recommendations and potential protocols to psychiatric and mental health services across the province.

2(a) Education Programs for Professional Non-Psychiatric Staff

The staff of the Departments of Psychiatry in general hospitals are in an excellent position to educate targeted professional groups in the hospital and in the community in their catchment areas. The general hospital often has the most qualified professionals who are in a position to provide current and relevant information to other professionals. Targeted professionals could include ER staff, family physicians, other professional staff in the hospital, as well as police officers, justices of the peace, probation officers, case managers, staff of community mental health agencies, and staff in group homes.

Staff in the hospital and emergency room physicians have special needs to be informed about the assessment of the suicidal patient and the resources that are available within or outside the hospital. Some departments may develop protocols for “fast-tracking” patients who are suicidal. Protocols should be established to ensure that relevant informants and sources of information including family members and prior charts are accessed as soon as possible and the information is made available to the relevant psychiatric staff in a timely manner. Education and the development of ongoing relationships with nursing and medical staff in other parts of the hospital where suicidal patients are often admitted will help to ensure that suicidal patients are treated safely and with dignity and referred for timely psychiatric treatment and management when indicated.

2(b) Education Programs for Psychiatric and Mental Health Staff

All staff in the Department of Psychiatry should have advanced knowledge related to the assessment, management and treatment of suicidal patients. There should also be clear lines of responsibility and accountability when a staff member has concerns about a patient's safety. Communication between professionals and between programs as the patient moves from out-patient to in-patient status, to partial hospitalization and then to out-patient again must be emphasized. Staff should also develop an understanding of the needs of the chronic suicidal patient and develop strategies of management and treatment in and out of the hospital that do not take undue risk with patient safety.

The AGHPS can assist psychiatric and mental health staff to regularly update their knowledge of the Mental health Act including up-to-date information on findings of Review Boards and court decisions related to rights advise or interpretations of the criteria for Involuntary Hospitalization, findings of incapacity to consent to treatment or patterns of the use of Community Treatment Orders across the province, for example

2(c) Public Education Program

The AGHPS should assist psychiatric departments in the general hospitals to develop periodic public education programs to educate the public about the incidence, nature and prevention strategies related to suicide. This may include encouragement to work cooperatively with other groups such as academic health science centres or the Canadian Mental Health Association to put on selected programs, for example during Mental Illness Awareness Week or to respond to a community crisis such as 9/11 or the community response to a violent crime.

Public Education serves many purposes including decreasing the stigmatization of mental illness and suicidal behaviour, increasing knowledge of resources that are available, increasing public and family support for the suicidal patient and increasing the partnership between the public and the hospital on an important public health issue.

3. Development of Early Identification Strategies

The AGHPS can assist the staff in Departments of Psychiatry to develop programs to educate the public and targeted professional groups to identify depression and antecedents of suicidal behaviour. Unfortunately, family members of a suicidal patient are often "surprised" by a suicide despite the

presence of obvious warning signs. Many suicidal patients have recently seen a family doctor or psychiatrist. The warning signs of impending suicidal behaviour may vary for different populations including the aboriginal population, prisoners in custody, the chronic psychiatric patient, the substance abuser, the medically ill patient and the patient in psychiatric treatment.

Departments of Psychiatry have highly trained staff and resources (Psychiatric Crisis Team or Clinic) to accommodate the patient who may have suicidal tendencies.

Justices of the Peace should be educated regarding serious mental illnesses and suicidal behaviour so that they can understand the criteria for a Form 2. Family physicians and emergency room physicians should be educated regarding the criteria for an Application for Psychiatric Assessment (Form 1).

Resources should be allocated so that family members can express their concerns when they have concerns about their relatives who may have suicidal tendencies and services should be available to help the family develop a range of options and interventions.

4. Development of Early Intervention and Treatment Strategies

The staff in the Department of Psychiatry should have the mandate and resources to intervene quickly and effectively when a person has been identified as having suicidal tendencies. A psychiatric crisis nurse or other staff member should be available on short notice to the emergency room staff. Crisis clinics for urgent mental health consultations and follow up may help to decrease the load on emergency departments. Staff at the hospital including security and mental health professionals should take over the supervision and care of the patient who has been identified as being potentially suicidal in the emergency room as quickly as possible and allow the police and the staff of the emergency department or other community partners to go back to their primary duties. There should be a resource in the hospital that would help family members identify suicidal patients and access appropriate crisis, legal or health services.

Psychiatric staff should develop early identification and treatment guidelines/protocols for suicidal patients and update these on a continuing basis as new information, resources and treatments become available. Management and treatment of the suicidal patient must often begin in the Emergency Room. All psychiatric staff should understand the importance of beginning biological and psycho-social treatments in the emergency room while ensuring the safety of the patient. Early intervention also involves decreasing the patient’s access to the means of suicide including potential access to lethal means after

the patient leaves hospital. The staff of the Departments of Psychiatry in general hospitals are in an excellent position to help some patients with recurrent or chronic suicidal ideation to limit self-destructive behaviour and to maintain their functioning in the community (e.g. removing medications, street drugs or potential items of self harm behaviours while providing access to therapeutic programs)

Protocols and guidelines should be established regarding searching patients, limiting visitors and involving relatives and significant others in the assessment and care of the patient who is potentially suicidal. Staff should develop a proactive attitude toward the management and treatment of the patient that accommodates his/her civil and legal right to legal representation and appeals to the Consent and Capacity Board regarding the requirement for involuntary hospitalization or a determination of an incapacity to consent to treatment. Psychiatric staff should understand the different legal and clinical ramifications of involuntary hospitalization and finding of incapacity to consent to treatment. There is often a need to inform family members of the potential risk of suicidal behaviour as well as involving them and others in providing support to the patient during and after hospitalization.

Once a patient has been identified as having suicidal tendencies, the staff must understand their obligation to continuously monitor and document their assessment of the patient's suicidal risk. Some units may develop suicide assessment tools or treatment protocols; however, it is recognized that these should be continually reviewed and updated with the changes in literature

and knowledge, the availability of newer treatments and greater accessibility to effective community resources.

Staff in the Departments of Psychiatry should be skilled not only in managing the psychiatric behaviour of a suicidal patient, but also in treating any underlying psychiatric, behavioural or substance abuse problem that exists.

Patients with recurrent suicidal behavior provide special challenges to the skills, knowledge and attitudes of psychiatric staff in Schedule 1 facilities. Although some newer psychological treatments hold promise for some patients, for example Dialectic Therapy for patients with Borderline Personalities, competing principles often cause staff and vulnerable persons to accept a “degree of risk” depending on fluctuating emotional states, wishes to avoid creating dependency, the lack or availability of community, family resources and effective treatments, to name a few factors. The AGHPS can assist psychiatric and mental health staff in each hospital to make informed decisions about diagnosis, management and treatment based on the best practices of assessment and treatment.

5. Development of Longer-term Treatment and Follow up Strategies for Suicidal Patients

Since suicidal ideation and behaviour are usually acute and temporary phenomena, treatment in hospital makes up a small portion of the necessary treatment plan to be continued in the community over a longer period of time. In-patient staff should recognize the need to work with outside therapists and programs that will facilitate the patient living in the community with a decreased risk of suicide. Models of shared care with family physicians or referral to community agencies and use of Community Treatment Orders and Assertive Community Treatment (ACT) teams may be critical to the successful management and treatment of the suicidal patient.

Although staff of a psychiatric unit may be subject to a number of fiscal or clinical pressures to discharge psychiatric in-patients, psychiatric staff should recognize that the management and treatment of the suicidal patient should be individualized and clinical decisions made that are in the patient’s best interests.

Formal linkages with community partners will help to mobilize resources for vulnerable persons while ensuring that mental health staff and hospitalization is available when needed during a future crisis. The AGHPS can facilitate the development of these linkages and development of appropriate contract prototypes.

6. Support for Other Services

Although hospital-based services for the suicidal patient make up a small proportion of the total services required, hospital staff should advocate for increased community services and increased resources for research and education concerning this population. General hospital psychiatric services are an important resource that can contribute to increased knowledge regarding the incidence of suicidal behaviour and successful suicide in various populations as well as identify improvements in service or treatment that could be very helpful. The need for computerized

networks or “smart cards” that identify patients who could be at risk and their service providers so that treatment and provider continuity is maintained wherever possible.

Conclusions

The AGHPS should become a resource or clearing house of information for professional organizations, hospital staff and members of the community on the topic of suicide prevention.

The AGHPS should play a central role and assist the Departments of Psychiatry of general hospital in Ontario to develop a multi-faceted, multi-disciplinary and comprehensive program for the prevention of suicide and the early identification and treatment of vulnerable persons. Its work in this area will complement the work of other groups including the professional colleges, research facilities, the coroner’s office, the National Network for Mental Health, and the Canadian Mental Health Association, to name a few. Each psychiatric service in a general hospital should then be assessed on whether they have adopted “Best Practices” in each of the areas described above.

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Appendix F
Notes from March 2008 Conference

The conference held in March 2008 had two primary objectives. The first was to disseminate the information learned throughout the People at Risk of Suicide Project. The second was to engage professionals from across the province in a conversation about the realities of suicide prevention in actual general hospital / Schedule I settings. We wanted to hear about the innovations as well as the gaps to begin to act as a clearinghouse for the information shared with us.

Faculty for the conference:

- Dr. David Gotlib, Medical Director, Emergency Psychiatric Team, St. Joseph's Health Centre, Toronto
- Dr. Brian Hoffman, Medical Director, Mental Health & Justice Program and Acting Vice President, North York General Hospital
- Dr. David Koczerginski, Chief of Psychiatry, William Osler Health Centre
- Dr. Paul Links, Arthur Sommer Rotenberg Chair in Suicide Studies, University of Toronto
- Dr. Gerry McNestry, Chief of Psychiatry, Peterborough Regional Health Centre, and President, AGHPS
- Mr. Bruce Whitney, Past Director Mental Health, Peterborough Regional Health Centre

Participants:

The conference was attended by 37 interdisciplinary professionals from 12 regions across Ontario: Ariss, Barrie, Chatham, Etobicoke, Guelph, Kitchener, London, Midland, Peterborough, Richmond Hill, Toronto, Whitby.

Program Outline

Conference Programme

8:30 – 9:15	Registration Continental breakfast	
9:15 – 9:30	Opening Remarks	Dr. Gerry McNestry
9:30 – 9:40	Overview of the day	Dr. David Koczerginski
9:40 – 10:00	Clinical updates from the Literature	Dr. Paul Links
10:00 – 10:10	Q&A	
10:10 – 10:30	Suicide Vignettes – The Good, the Bad and the Ugly	Dr. Brian Hoffman
10:30 – 10:40	Q&A	
10:40 – 11:00	Refreshment Break	
11:00 – 11:20	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	Dr. David Gotlib
11:20 – 11:30	Q&A	
11:30 – 11:50	System Improvements to Manage, Decrease and Treat Suicidal Behaviours	Dr. Brian Hoffman
11:50 – 12:00	Q&A	
12:00 – 12:30	What can you do to improve the management and assessment of suicidal patients presenting to the Emergency Department Gaps and innovations	Interactive Session Leaders – Dr. Gotlib / Dr. Koczerginski
12:30 – 1:15	Lunch	
1:15 – 1:45	What can you do to improve the management and assessment of suicidal patients on the Ward Gaps and innovations	Interactive Session Leaders - Dr. Gerry McNestry/ Mr. Bruce Whitney
1:45 – 2:15	What can you do to improve the management and assessment of suicidal patients after discharge Gaps and innovations	Interactive Session Leaders - Dr. Brian Hoffman/ Dr. Paul Links
2:15 – 3:00	Putting it Together – the summary report	Gerry McNestry / Bruce Whitney
3:00	Wrap Up	Gerry McNestry

The following is a brief summary of the presentations

Dr. Paul Links
An Update to the Literature Review

Dr. Links spoke on 5 updates to the initial literature review

1. *Screening Tools as a Predictor of Risk:*
There is recent attention to warning signs as opposed to risk factors as specific indicators of risk, and then applying warning signs to clinical practice. While this is just emerging it is the beginning of a concept and may have a future role.

2. *Interventions for Individuals with Recurrent Suicidal Behaviour:*
5 different psychotherapeutic interventions have proven efficacy for BPD (DBT, TFP, SFT, MBT, Supportive). BPD with suicidal behaviours as a target may be best treated with DBT. Dr. Links reviewed some of the general principles for psychotherapy. These are

* Promote confidence and understanding
* Provide stable framework
* Validation plus control of destructive behaviour
* Connections between actions and feelings
* Differentiate nonlethal from true suicide intention
* Consultation or supervision

3. *Treatment for Major Psychiatric Disorders:*
Dr. Links reviewed the SSRI story noting some of the following:

- Decline in adolescent suicide rate has been attributed to increased use of antidepressants
- Reviewed the issues related to the use of SSRI starting with the US FDA advisory in 2003
- Many unresolved issues
- Need for studies in children and adolescents
- Non-reporting negative results
- Evaluating harm
- Risk of suicide much more related to inadequate treatment of depression
- Antidepressant – emergent suicidality exists rarely as rare event
- More common in adolescents
- Occurs early, no clear predictors of who is at risk; often with acute agitation
- Growing evidence for fluoxetine
- Combined therapy greatest improvement
- CBT specific benefit for suicidal ideation
- Notify parens and patients of risk
- Careful monitoring – especially early
- Guidleines for follow up

4. Discharge from Hospital
Dr. Links reviewed the standardized mortaility rates one month following discharge and noted 3 main categories of variables as predictors of suicide post-discharge; found in more than one study.
1. Suicidal History
2. Demographics and Psychopathological Factors

3. Care Variables

Other findings concluded

- Importance of immediate post-discharge period
- Inpatient services – Patients with history of suicidal behaviour need reassessment 24-48 hours before discharge
- Outpatient services – Follow up within 7 days of patients with recent suicidal behaviour or severe and persistent mental illness

5*. Reducing Access to Means*
Restricting access to means can lead to prevention of suicide

Overall Conclusions

- Hospital Psychiatric Services must have a leadership role in suicide prevention
- Need for new research and methods of translation of this new knowledge to psychiatric service providers
- Importance of advocating including with the Mental Health Commission of Canada

Suicide Vignettes: The Good, the Bad and the Ugly
Brian F. Hoffman, MD, FRCPC
(interim) Vice President of Medical Affairs
North York General Hospital

Dr. Hoffman reviewed eight cases of suicide from his experience.
His conclusions related to:
•Purposes of a schedule 1 facility
•Haphazard risk assessments (v.systematic)
-Previous records
-Documentation of risk assessment
•Clear policies re suicidal risk – searches, level of observations, previous records
•On-call, Holidays and Coverage
•Education of family members
Risk assessments > no harm contracts

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
Dr. David Gotlib

Dr. Gotlib noted that his study included the following:
•Literature Search
There is very little in the literature that addresses the interval from when the police present in Emergency until the time of admission.
• Stakeholder Survey

• Existing Agreements between Hospitals & Police

• Review of Inquest Reports

• Analysis & Recommendations

After reviewing each segment of the study in detail the recommendations were:
1. Crisis Service for every ER and partnership with a Schedule 1 facility

2. Hospital/Police/ER Liaison

3. More Treatment Resources (not just beds!)

4. Clarify confidentiality rules & procedures re Police, (& families/caregivers)

Suicide Prevention Strategies in a General Hospital
Suicide: a permanent solution to a temporary problem
Dr. Brian Hoffman

Parliament has given extra-ordinary powers to physicians and Schedule 1 hospitals to intervene
Strategies have been divided in to the following categories:
Pre-assessment

–Fast track for police
–Police contact form
–Psychiatric crisis team for ER
–Upgrading suicide assessment skills like CPR
–Crisis clinic for GPs
–Timely response in C/L consults
–Reciprocal contracts with community partners

Assessment protocols

–Risk assessments – all sources of information
-Intervention for individuals with recurrent suicidal behavior
–Safety on ward

Treatment of SMI: Scz, BAD, BPD

Discharge from hospital

–Algorithm for previous suicidal behavior
-Reducing access to means
-Post suicide reviews
–Coroners inquests
–Psychological autopsies
–Other wards
-Liaison with other clinical academic agencies
–CPA for public education
–Universities
–Canadian centre for suicide prevention

Summary of Notes from Interactive Session

People not identified in the serious mental illness (SMI) population, but who are at risk of suicide, require supports that are not necessarily built into the current mental health system. The general hospitals are often the first contact for these people and strategies to address the need of this population require development. The Project reflects preliminary work to develop strategies to address the needs of this group including methods of supporting consumers through primary care givers such as family physicians, nurse practitioners and emergency department staff and physicians.
The presentations included lessons that could be learned from actual experiences in Ontario. For example, Dr. Hoffman drew from his review of coroner inquests and his own medico-legal experience to present a summary of cases. He drew our attention to what we can learn from these tragedies – on a single case basis as well as through the identification of common "themes" and trends. Dr. Gotlib's study looks pragmatically at real experience and recommendations to improve management of the system. Decrease and treat suicidal behaviors in General Hospital / Schedule I settings.

The following are comments, gaps and innovations identified by the participants –

I. What can you do to improve the management and assessment of suicidal patients presenting to the Emergency Department – Gaps and Innovations

Dr. Koczerginski remarked that he had recently done an informal poll of Emergency practices and found great diversity in triaging practices. About half indicated that the patient sees the Emergency physician first while the other half see a crisis worker first. A show of hands from participants demonstrated a similar ratio.

The following are comments, gaps and innovations identified by the participants –

Triage

Gap
Some participants noted that their Emergency Rooms categorize mental health patients into category 4 or 5 (5 being least acute) which leads to prolonged wait times etc. Other participants commented that their ER patients were typically categorized with a higher score (above 4) – the approach to a consistent method of triage for mental health patients presenting to Emergency Departments is highlighted as an issue requiring follow up.
The group also noted, however, that no process replaces the need for strong working relationships. Must go past the process itself to build constructive relationships – collaboration with all professionals e.g. primary nurse

Gap
The crisis worker model can work well but crucial that crisis worker has clear lines of authority and communication – there must be a clear understanding of who to report to and accountability for decision-making. Otherwise the ambiguity can exacerbate inherent underlying tensions. The ER's focus is a decision to either admit or discharge – priority decision. Mental health patients may not fit well into that set of

priorities and as a result mental health visits are often not well received in Emergency Departments. With clear beginning and end for Crisis worker role they will not be placed under pressure from all sides resulting in negotiating with everyone.

Innovation
In London, the roles are evolving. All mental health patients go to one Emergency Department. That ER has mental health coverage in the Emergency Department 24/7. The team will go out to the waiting room even before triage – ID for fast track. Also have a crisis worker from community in ER.
It was noted that there was an article published out of London in 1996 that described how the ER had created a triage checklist model. 9 questions – if answer yes to 4 or more referred to ER doctor. This suggests that the issue has been looking for a solution for a long time.

Innovation
Community and University Health Network have developed methods of engagement with ER. Monthly meetings – "work the model together". "Our patient" = who is best able to treat at the time. Not so much who sees the patient but links with rational decisions around triage and decreasing wait times.

Appropriate use of ER
Gap
In at least one region it was noted that supporting agencies are closed in the evening, shifting the responsibility to the Emergency Department.

Gap
It was noted was that the hospitals and Emergency Departments tell people what not to do – e.g. don't bring x patient to Emergency. However, they are not provided with a viable alternative. Mobile crisis team was described as a way to manage this.

Gap
Medical clearance is a major issue – can miss the medical issues if labeled exclusively as mental health patient.
On the issue of medical clearance there was a comment that over 90% of medical issues will be picked up by a proper history and physical. The problem arises if / when a patient is predefined as a mental health patient and therefore do not receive adequate history and physical.

One site reported that waiting for medical clearance didn't work. Moved to model that required a medical assessment to ensure stable to transfer. Most people can identify their own health problems. Another commented that it is a shame that only a physician can do a Form 1 when there are other skilled health professionals who could potentially make the determination.

Some agreement that medical stability is a better term that medical clearance, which implies things that are beyond the scope of the assessment.

Gap
An issue was identified that resonated with many of the participants – receiving patients (Form 1) from nursing homes. Crisis teams are inundated with these cases

and the patients require physical care ++. The nursing homes then do not want to take the patient back into their care.

Innovation
One site explained that they identified 2 nursing homes that were sending patients as described above to ER. Now they send a psychiatrist to the nursing homes on a regular basis. As a result, the nursing homes plan for that and they almost never receive patients in ER. They commented that problems with nursing home patients presenting to the Emergency Department will never be solved in the Emergency Department.

Internal Processes

Innovation
With regards to staffing in the ER for mental health patients – at one site there is a separate locked area for mental health in the ER. They recruit and train nurses to rotate through that area. While this has been somewhat successful there are not enough nurses interested and therefore although they are nominally the "mental health" nurse in fact the ER nurse prefers other ER related work.

Innovation
One site has developed a "Form 1 page" - a reminder to check certain things

Gap
There was a discussion re interpretation of obligations. Emergency Departments have different interpretations as do different police departments on the obligation of police to stay with the patient. For example – police obligated to stay until accepted by the mental health facility. Police forces define this differently (as do ER departments) – some require decision to admit or discharge; others require decision on Form 1. There is a need to have a common definition and interpretation for issues such as these

II. What can you do to improve the management and assessment of suicidal patients on the ward? – Gaps and Innovations

Dealing with the Physical Plant

Innovation
One hospital described situation of single hospital but two sites. It was decided that because of the physical facility high risk patients would be safer in one site – sometimes the physical facility will drive decisions.

Innovation
One participant described heir inpatient unit – had been a medical ward – not built with the same issues related to risk in mind. On a regular basis do formal walk through and safety checks. They have implemented a number of "gadgets" – upgrades to minimize risk to high risk patients.
E.g. One hospital had an alarm made for the shower hose.

Innovation
In one hospital every staff member on the mental health unit owns a safety alarm.

Innovation
Size of units mentioned – older, medical unit with 40 beds – too large and noisy. Chaotic and difficult to keep track of everything / everyone. Have assigned a security guard with hourly checks. Also developed a form indicating what to look for when doing a security check. At least two other hospitals in attendance had a similar form. One hospital also described a safety committee with regular meetings. Other measures included a log to record environmental issues and surveillance cameras.

Comment
Changes to a smoke free environment have led to more patients outside and therefore a higher level of assessment needed.

Comment
The participants noted that this is an area where we may be able to pull together what individual hospitals have developed – rather than each hospital creating a unique form. This could be a role for the next phase of the Project.

Comment
Attendees asked whether the Royal College could give CME credit for auditing charts using specific questions.

Comment
There was some discussion regarding the RAI – MH.
Has a low threshold – will trigger for anything. Described as distinctly unhelpful. Value of the assessment tool questionable.

Comment
Assessments – mental health professionals are at a premium. (psychiatrists, psych RNs etc) – becoming more and more complicated to adequately train staff with shortages, transfers etc. – education is becoming more difficult

Comment
There is generally a good feeling of multidisciplinary collaboration and "whole team" discussion
The question was asked – is there a focus on suicide? Respondents said that it depends on physical environment. Secure unit segments this population of higher risk and therefore deal with it the most
One hospital noted that they had a dramatic, unexpected side effect of introducing a secure unit. The improved physical environment resulted in a saving of 75- 90 thousand dollars on constant care relative to before the unit was opened in 2000.

Discussion on the issue of suicidal risk assessment prior to discharge
One hospital commented that they assume everyone is unsafe to discharge as the first part of the care plan and have a multidisciplinary plan.
Another noted that they have protocols around discharge – everyone being discharged receives a form indicating what to do and whom to call if something goes wring
Comment that we do a lot that we do not document

Is discharge and rapid follow up a major issue?
It is becoming a bigger issue – especially when families are refusing to take patients home upon discharge. Patients often need more that a psychiatry appointment. Need different kinds of care – not possible to do this.

Can de discharged and in a waiting list for your own day hospital. ***Innovation -*** One hospital had negotiated that the inpatient spends some time in the day hospital before discharge and then is taken right away – seamless transition.
One observation was made that given the statistics around suicide post discharge it may be better to avoid the Friday discharge in favour of discharge earlier in the week when more resources are available
What do we do to manage leaving against medical advice (AMA)? – balancing the right to leave with worry re the outcome of the decision.

What can you do to improve the management and assessment of suicidal patients after discharge? – Gaps and innovations

Innovation
One hospital reported that they try to make discharge from hospital a top priority for referral to outpatient services. Post discharge group led by 2 clinical staff every Monday – Friday. Any patient can attend – walk in

Gap
Given the evidence there needs to be funding support for follow up after discharge. We are lacking a common system to share and learn from our own experiences with suicides. This could be an area that the AGHPS could advocate for.

Comment
Recruitment issue – potentially violent and potentially suicidal – are 2 factors that act as deterrents for staff recruitment

Innovation
At times when everything is full and the ER is waiting for placements, the Chief of Psychiatry and Director of Mental Health review the entire program using a form that identifies diagnosis, treatment etc. It appears that just the process of doing this causes discharges.

Questions and Answers
The following are participant questions and the answers from the presenters.

Question: There are 2 types of patients (intoxicated / suicidal) presenting to ER – one group goes to Psychiatry and the other goes to a Medical unit. It seems that the group going to a medical unit are treated differently to those going to Psychiatry unit. Did you look at these differences?

Answer: Recognize the issue – did not define 2 groups for the purposes of the Project. There is more evidence on patients who are admitted into Psychiatry units. The medical service also sees high risk groups. The immediate crisis is resolved but not always access to Psychiatry. If we continue to categorize patients with suicidal risk in ER as categories 4 – 5 we are sending the wrong message – we need others to recognize the true risk.

Question: It appears that there is increasing pressure to decide on outpatient psychotherapy for short treatment as a result of resource allocation (i.e. decisions

driven by resources rather than clinical rationale). What does the literature say about this?

Answer: The literature is evolving and changing. There is some evidence related to psychotherapy as an adjunct for some patients. There may be more research coming on this – an unfolding story

Question: Can you comment on suicide risk rating scales?
Answer: Our message is that no tool exists that has adequate psychometric evidence to allow endorsement. There is an analogy to CPR. The professionals need the skill and the ongoing training to maintain competence – this is the case for assessment for suicide assessments.. while this may not be an easy or preferred answer it is an important battle to fight

Question: Can you comment on the issue of reassessment after discharge – some specific thoughts?
Answer: Reassess for ideation, plan etc and document your findings before discharge. Be sure to communicate with the family – what to do and who to call if concerned.

Question: Are the issues of those presenting with suicidal risk the same in the ER, community and inpatient unit?
Answer: Many of the issues are the same. One consistent theme is the stories about how difficult it is to take up your life again. We hope that our research will provide more insight into this.

Question: If there is chronic suicide ideation in a person before discharge, are you required to get a second opinion?
Answer: It is not required if you are comfortable with your knowledge of that person but seeking a second opinion is a good way to manage the risk.

Question: In clinical practice is the RAI-MH providing any useful information on the issue of suicide?
Answer: Too early to have an opinion on that. We are not seeing anything yet

Comment:
On the issue of reducing access to means: We do a good job educating about guns but not as good at educating about medications in the house. We must be vigilant in this and also in prescribing small numbers of medications at a time

Question: In the ER – When intoxicating and verbalizing suicidal plans – should we "Form" at that time or wait until not intoxicated and reassess
Answer: Try to assess at both points and refer to psychiatry PRN

Appendix G
Highlights of Findings and Recommendations

We have appended several full reports for clinicians and policy makers wishing to focus on a specific areas of interest and / or concern. We have also provided a Summary Report that describes the Project's main activities and findings. In keeping with our objective to make this report user friendly for busy professionals, we are including Appendix G which highlights in a bullet format some key findings and a list of recommendations. This is not a comprehensive summary of all the information obtained from the Project. It captures some of the highlights and again we encourage the reader to access the broader report for full details.

Key Findings from the Literature - Clinical treatment

- Based on the lack of research regarding screening tools for predicting risk of suicide, clinical assessment is still considered as the gold standard (American Psychiatric Association, 2003). No measurement scale has been developed that can replace clinical assessment by a skilled clinician.
- Evidence indicates that low dose flupenthixal may reduce recurrence in non-psychotic patients with two or more suicide attempts.
- Dialectical Behavioural Therapy (DBT) was found to be the most promising therapeutic approach in individuals with Borderline Personality Disorder.
- Studies showed a 26% reduced risk of suicide with clozapine in schizophrenia or schizoaffective disorder.
- Lithium seems to have an effect on reducing suicidal behaviour in patients with bipolar affective disorder, and suicide that is observed after the first few years of treatment. The authors of several reports also found a high risk for suicidal acts if Lithium was discontinued. This risk was highest during the first year of discontinuation.
- The assessment of suicide risk has refocused on the importance of "warning signs" that are specific to the individual with less emphasis on 'risk factors' which are based on demographics.

Key Findings from the Literature - Patient management

- 24% of all suicides in U.K. had mental health service contact in the year before their death.
- Almost one third of the suicides of psychiatric inpatients occurred on the ward, and of these, 74% had been by hanging.

- Suicides tend to cluster in the first week following admission or around discharge, with 23% occurring within 3 months of discharge.
- Maintaining contact with ongoing services following discharge from hospital may be sufficient to reduce the risk of suicide.
- Evidence exists that the simple intervention of providing education (to individuals and families) should be incorporated into the care of all mental health patients.
- Patients with a history of suicidal behaviour should be assessed 24 to 48 hours before discharge.

Recommendations from the Experts

- Develop principles to guide allotment and allocation of space in ER regarding mental health.
- Develop and encourage provincial and regional liaison initiatives with police
- Develop expectations regarding teamwork with other professionals within the hospital (e.g.: ER staff, crisis) Include follow up.
- Clarify confidentiality rules
- Establish engagement plans that include permission to inform the family physician about the presentation for suicidal behaviour.
- Develop provincial guidelines for suicidal presentation for pre-assessment, assessment, treatment and follow up within mental health, emergency departments and on medical units.
- Develop policy and guidelines to assist both emergency personnel and mental health staff on how we approach patient discharge
- Ensure that *all* hospital Emergency Departments 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
- Develop formalized agreements in Schedule 1 facilities (such as a Memorandum of Understanding - MoU) to describe how inpatient beds will be accessed when there are no beds available in a particular Schedule 1 hospital. Similarly, establish MoU's between Schedule 1 and non-Schedule 1 General Hospitals in the area.
- Develop an ER Mental Health Implementation & Liaison Committee in every hospital
- Educate others, within our hospitals and in the community, about the role of Schedule I hospitals, including the Emergency Department.

- Educate hospital personnel about treatments that are known to be effective to reduce risk of suicide, e.g. clozapine for schizophrenia, and lithium in bipolar affective disorder.

- Investigate and provide guidelines on issues such as false positives, repeat suicide assessments, rapid follow up, documentation, care planning.

- Incorporate reducing access to means as part of routine psychiatric care in general hospital psychiatric services.

- Actively engage and educate families to ensure compliance with follow-up.

- Develop guidelines to ensure that patients with suicide risk are assertively followed up after discharge and that limits are placed on prescription quantities.

- Design a more systematic approach to education and monitoring for our own (Schedule I) professional development

- Develop the following specifically for Schedule I Hospitals
    - A Suicide Prevention Resource Centre with interactive electronic methods for sharing information
    - Education Programs
    - Early Identification Strategies
    - Early Intervention and Treatment Strategies