POLICE INTERVENTION IN EMERGENCY PSYCHIATRIC CARE

A BLUEPRINT FOR CHANGE

British Columbia Schizophrenia Society

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POLICE INTERVENTION IN EMERGENCY PSYCHIATRIC CARE: A BLUEPRINT FOR CHANGE

EXECUTIVE SUMMARY

The purpose of this project was to examine factors influencing long wait times for police accompanying psychiatric patients in emergency wards in British Columbia hospitals, and to propose possible solutions to alleviate the problem.

To begin, it must be said that there is certainly hope to be found in some excellent police/mental health liaison programs that developed over the last few years through community initiatives. However, one of the major conclusions reached through our research and consultation is that systemic changes are required in the health care system and other systems that provide services for people with mental illness. Without such changes, it is unlikely that any specific recommendations for reducing police wait times can be wholly successful.

There is growing recognition and acknowledgement of our failure as a society to provide basic care for people with serious and persistent mental illness. Police are acutely aware of this fact, since they have the ultimate responsibility of attending when individuals and families find themselves in crisis situations in the community.

Most people consulted during this project noted that police duties to *serve and protect* people with mental illness have increased, contributing to resource shortages in other areas of police responsibility. Police data show that "street crime" offences and disorderly behaviour both represent a continual demand on police resources. There is a perceived lack of effective response to offences such as property theft and cars broken into, and there is an identified "capacity gap" for crime fighting and the prosecution of gang related crime in BC.

In addition to a chronic shortage of mental health and police resources, consultations with BC police, health care providers and justice workers consistently articulate the same theme – lack of coordination between systems that deal with the mentally ill.

In an attempt to overcome the numerous barriers caused by "stove pipe" budgets, overlapping jurisdictional authority, confidentiality concerns, plus a myriad of other challenges—clinicians and others have come together with the police to develop police/mental health liaison strategies within their own communities. In some areas, innovative approaches to helping people with mental illness and their families are becoming part of the fabric of the care system. It is evident that principles of contemporary community policing—prevention, community empowerment, partnership development and problem solving—fit well with the dedicated work of other agencies that support people with mental illness within the community.

But despite innovative efforts by some police and other professionals in our communities, there is dissatisfaction everywhere at the large number of seriously ill individuals who continue to fall through the cracks. While resource limitations are an obvious concern, the *lack of coordination and information sharing* between government ministries,

regional authorities, and community agencies is just as often identified as the culprit. Everyone is aware that, to some extent, results are typical of a system that is bifurcated with so many separate lines of accountability.

For many years, family and community advocacy groups have criticized "the mental health system" for its lack of resources and poor quality of care. Their complaints are finally now being echoed at the national and provincial levels of government, as well as by professional groups and policy, planning and administration officials.

When considering specific things that can help us move forward in BC, one encouraging fact is that British Columbia is fortunate in having good mental health legislation—although some professionals in the mental health field do not know the Mental Health Act well and therefore misinterpret it or underutilize it. The BC Mental Health Act for a type of conditional leave (*extended leave*) that should be helpful in dealing with the *revolving door* syndrome, whereby people with untreated mental illness continually rotate in and out of our health care and justice systems. In addition, the BC government provides concise guidelines that clarify the Freedom of Information and Protection of Privacy Act and specify how information may be shared for the purposes of continuity of care or if a person's health or safety is at risk. Again, many professionals working in mental health are unaware of these provisions. Knowledge of both these tools – the BC Mental Health Act *and* the guidelines for sharing personal health information – should be essential for all professionals involved in service delivery to the mentally ill.

A comprehensive provincial strategy is needed to (i) improve information-sharing between health, justice and social services; (ii) increase professional education and training; and (iii) standardize treatment guidelines and hospital discharge planning procedures for people with serious mental illness. Some key approaches suggested are:

- A high-level inter-ministry committee with representation from all ministries responsible for health care, social services, police and justice services to examine current provincial resource utilization for people with mental illness. A common observation in the literature and in consultation with professionals is that, ethics aside, not providing appropriate medical treatment, accommodation and rehabilitation for people who are ill to live with dignity in the community appears to be expensive when high use of hospital emergency, ambulance, police, and the courts are considered.

- Support for community police/mental health liaison programs, including resources for police/hospital protocol development, information management and evaluation. Promising community partnerships have been developed in British Columbia. However, many arrangements depend solely on courtesies extended by individual professionals to each other. Written protocols and ongoing evaluation models would not only help existing programs; they would foster similar program development throughout the province.

- Strategies for increasing awareness of BC's *Guide to the Mental Health Act*. Wider knowledge and distribution of this document would greatly improve communication not only between police and hospitals, but also at many levels of service delivery for people with mental illness in British Columbia.

- Support for Early Psychosis Intervention (EPI) programs. The age of onset for serious mental illness is usually mid teens to early twenties. The longer a mental illness is left untreated, the greater the risk that the young person's life will be permanently derailed. Research shows that a significant time period often separates the onset of psychotic symptoms and the initiation of appropriate treatment. The longer the illness goes untreated, the longer it takes for remission of symptoms, the lesser the degree of remission, and the greater the chance of early relapse. BC has led the way in developing a provincial initiative that has resulted in some excellent Early Psychosis programs – but some regions still lag woefully behind. To help prevent chronic mental illness from derailing young people's lives to point where police intervention is frequently required, BC must continue to create and sustain effective Early Psychosis Intervention programs that are inter-regional and can be accessed from anywhere in the province.

- Timely access to clinical care. Police are aware of the many people suffering from severe and persistent mental illness who live in a state of continuous psychosis, with no pattern of care or medical help. Untreated psychosis is associated with slower and less complete recovery, an inability to function in the community, increased risk of relapse, and substantial treatment resistance. Treatment is essential at the onset of chronic mental illness, so hospital or hospital-like care is particularly important for patients in the early phases of the illness. Access to hospital care is also important for individuals who are treatment-resistant, and for those who, from time to time in the course of their disease, need the extra care that only a hospital setting can provide.

- Mandated case management for people with severe and persistent mental illness would go a long way towards alleviating many of the difficulties faced by police. Ill people who are at risk for harms should be recognized and supported in treatment regimes for their own safety and for that of the general public.

- Chronic disease management strategies are needed for people with schizophrenia. The British Columbia Schizophrenia Society has asked that schizophrenia be added to the government's Chronic Disease Management list. Inclusion in the Chronic Disease Management program would help clear pathways to care and standardize treatment practices for this patient population, and improve population health outcomes and functional clinical outcomes.

THINGS WE CAN DO NOW

The *Blueprint for Change* report concludes by identifying three steps that can be taken immediately by police and regional health authorities to help reduce police wait times wait times with psychiatric patients in BC's hospital emergency rooms.

(1) Development of written protocols between individual police departments and the hospitals they attend while escorting psychiatric patients. Written protocols have proven to be extremely useful in several jurisdictions across Canada. This report's Appendix F offers a number of protocols developed between police and hospital emergency departments in Montreal, Winnipeg, Cornwall, and Vancouver, which might be adapted for use by communities in British Columbia.

(2) Ensure that hospital and community psychiatrists, nurses and all other professionals in British Columbia who work regularly with people with mental illness know of and have access to the BC *Guide to the Mental Health Act*. The *Guide to the Mental Health Act:*
- Clearly explains the meaning and use of the *Act*
- Offers advice specifically for police, doctors, other professionals and families
- Includes all pertinent legal forms, which may be copied for use
- Contains the BC government's *Freedom of Information and Protection of Privacy* (FOIPPA) *Fact Sheet,* which clarifies when—lacking patient consent— professionals can and should share information with other public bodies, family members and other caregivers for the purposes of continuity of care.

Despite government efforts to make this information widely known and easily available, consultation for the report revealed that there is still extensive misinterpretation of the *Mental Health Act,* and many misconceptions regarding "confidentiality". The BC *Guide to the Mental Health Act* contains important knowledge that should be transferred to where it is most needed in the health care regions. The *Guide* is available online at www.health.gov.bc.ca/mhd/mentalhealthact.html

(3) Evaluation of existing and new police/mental health liaison programs in British Columbia, with resources specifically allocated for this process. There is no doubt that police/mental health liaison programs will continue to grow as both police and regional health authorities advance the principles and practices of community mental health liaison services. Evaluation is critical to understanding outcomes, furthering our knowledge of how such programs are successful, and improving accountability. A generic *logic model* is highlighted in the *Blueprint for Change* report to help facilitate evaluation of police/mental health liaison programs. In addition, a concrete evaluation example of Victoria's police/mental health liaison program is provided. Both the logic model and the Victoria example of a successful evaluation from an already-existing BC program should prove useful templates for helping other communities design their own program evaluations.

Beginning with the above three steps and working together with the police, BC Regional Health Authorities can help alleviate some of the long wait times police experience in British Columbia's hospital psychiatric emergency departments.

At the same time, the larger communication and systems issues mentioned in this report must also be addressed in order to bring about meaningful change.

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RECOMMENDATIONS

This Report makes the following recommendations:

1. That the provincial government undertake the development of a high level inter-ministry committee to try to determine real costs of service delivery to people with mental illness and their families. Input from all ministries responsible for service delivery – most particularly health care, social services, and police and justice services – is required, although information from the Regional Health Authorities and the Ministry of Children and Family Development would also be critical to obtaining an accurate picture of current spending.

2. That Regional Health Authorities continue to encourage the development of community police/mental health liaisons in their regions, with an emphasis on:
    - Encouraging the development of written protocols for police and hospitals to establish agreed upon procedures and reasonable wait times with psychiatric patients in emergency departments. Where they exist, written protocols help reduce police wait times in hospital emergency departments by clarifying roles and responsibilities of police and hospital emergency staff.
    - Requesting that resources for evaluating police/mental health liaison initiatives be built in as a component of individual programs. Knowing whether program goals are being met and having access to data from evaluations can improve future planning for mental health service delivery by Regional Health Authorities.

3. That an educational initiative be undertaken to improve knowledge about British Columbia's *Guide to the Mental Health Act* among individuals who deliver mental health services to people with mental illness and their families. Targets should include the following professionals and university faculties that provide professional training:
    - Health care professionals in acute and community settings, with special focus on hospital emergency staff and community mental health workers
    - Social workers, particularly front-line Financial Aid Workers and professionals working with dysfunctional families
    - Justice and court officials at all levels of the legal system

4. That BC Regional Health Authorities continue to fund, encourage and monitor the development of **Early Psychosis Intervention (EPI)** programs. This will help prevent chronic mental illness from derailing young people's lives to the point where families and others are forced to resort to the police and the criminal justice system as a means of accessing treatment for the young person.

5. That the provincial government consider mandated assertive case management (ACT) for people with severe and persistent mental illness who have accompanying functional disabilities and who are intensive users of the health care and justice systems. Assertive case management was defined as a BC *Best Practice* because controlled research studies link this approach to positive client outcomes, a feature that is missing from other case management models. Consistent with research evidence, it is expected that ACT will decrease hospital

utilization, improve individuals' level of functioning and decrease caregiver burden.

6. That the provincial government through the Ministry of Health add schizophrenia to BC's Chronic Disease Management list. Schizophrenia is a chronic life long illness that usually starts between ages 15-24. Modern treatment is available, and it works. Inclusion in the Chronic Disease Management strategy will assist the medical profession by clarifying pathways to care and standardized treatment practices. It will also assist people with schizophrenia by helping them find the best tools to manage their illness so they can live with dignity in their communities. In addition, population health outcomes and functional clinical outcomes in British Columbia will be greatly improved.

POLICE INTERVENTION IN EMERGENCY PSYCHIATRIC CARE: A BLUEPRINT FOR CHANGE

A couple of years ago I found myself at a dinner at Rideau Hall in honour of recipients of the Order of Canada. I found myself seated next to a police officer who was in charge of the police precinct in a downtown area of Toronto where people were poor and crime was high.

"What", I asked the officer, "is the biggest challenge you face?"

I expected him to reply that his biggest problem were all those defense-oriented Charter rulings the Supreme Court of Canada kept handing down. But he surprised me.

"Our biggest problem," the officer answered, "is mental illness."

– Chief Justice, Supreme Court of Canada (2005) [1]

BACKGROUND

One of the most common difficulties encountered by police who intervene in psychiatric emergencies is the lack of available hospital emergency room space and long waiting times for intake procedures. It is critical that people in a psychiatric crisis receive timely medical assessment and treatment and that British Columbia police officers are not made to wait for unacceptable lengths of time ─ often hours ─ to release the person to the hospital's care.

Early in 2005, Vancouver Police Chief Jamie Graham reported that his officers were experiencing substantial hospital emergency room waits, with 7 or 8 hours being the norm. Acting RCMP Commander Gary Forbes reported that his officers in Surrey were facing waits of 10 to 12 hours, and Ward Clapham, Officer in Charge of the Richmond RCMP concurred that this was a significant problem.

Not only is such a situation unacceptable in terms of timely access to appropriate medical care, it is unnecessarily costly in terms of salaries and benefits to deploy police the officers to stay with the patient. Police resources are invaluable. Having the police remain for lengthy times with psychiatric patients in hospital emergency is just one example of where police resources currently allocated to dealing with the mentally ill might be better utilized in other areas. For instance, there is an identified "capacity gap" for crime fighting and the prosecution of gang related crime in BC.[2]

In March 2005, a comprehensive report to the Attorney General of British Columbia[3] on street crime identified people with mental illness as a major

concern within the justice system. Consultations by the Justice Task Force's Working Group with a wide variety of stakeholders confirmed:

- The justice system is not the appropriate place to deal with mentally ill offenders.
- There are high numbers of mentally disordered offenders in the criminal justice system.
- There are a significant number of mentally ill residents and many of them are not receiving needed support in the community.

The Justice Working Group concluded that
Fundamental changes are required to the culture of the criminal justice system, and to the way that health, social and justice system agencies interact. This approach has attracted support within the health and justice system for the kind of collaboration recommended and demonstrated by the Working Group itself.

Among the key recommendations to the BC Attorney General is that the Provincial Government should establish a Community Health and Justice Committee to oversee the cross-agency implementation of recommendations contained in the Working Group's report.

To ensure more timely access to medical assessment and treatment for all people with mental illness, a *comprehensive provincial strategy* needs to be developed and implemented in British Columbia that includes services delivered by Regional Health Authorities, acute care hospitals, social services, justice officials, and the police. Otherwise, our jails will continue to become the default mental health system for people who are in a psychiatric crisis and needing care and treatment. The development of such a strategy will result in procedures that would both ensure timely medical care and shorten the wait times at hospital emergency facilities for police.

Focusing on a province-wide basis and working mainly with provincial agencies, efforts in preparing this report for the Provincial Health Services Authority also dovetailed with a Canadian Mental Health Association (CMHA) BC Division community project using six site-specific models in BC to improve interactions between police and people with mental illness.[4] Vancouver, Delta, Richmond, Nanaimo, Cranbrook, and Williams Lake were chosen for the project. One of the major goals was to share these communities' learnings provincially, which has resulted in a set of helpful *Fact Sheets* to provide information on various aspects of community interaction between police and mental health consumers.[5]

The CMHA project clearly identified three major priorities:

- Hospital emergency wait times
- Lack of communication and information sharing protocols and systems
- Need for systematic continuing education on mental illness and crisis response

Possible remedies have been explored for this report through the existing research and literature on these topics and provincially with the BC Association of Chiefs of Police, individual police officers, hospital administrators, psychiatrists, psychiatric nurses, emergency mental health service professionals, and mental health patients and their families.

THE CURRENT DILEMMA : POLICE PERSPECTIVES

In British Columbia, as well as throughout Canada and elsewhere in North America, there is agreement amongst all concerned that with deinstitutionalization and the movement of people with severe mental illness into the community, the police have become frontline professionals who manage these individuals when they are in crisis.

In our society, the police have a duty to assume responsibility for persons with mental illness under two major principles of law:
(i) Their power and authority to protect the safety and welfare of the community
(ii) Their *parens patriae* obligations to protect individuals with disabilities.

Therefore, it is often the police who are in the role of gatekeeper in deciding whether a person with mental illness ends up in the mental health system or the criminal justice system. Unfortunately, criminalization can and does result if this role is not performed appropriately.[6,7]

Research consistently shows that people with mental illness are frequently the subject of police calls and use a substantial proportion of their resources.[8] Furthermore, there is a growing national awareness in Canada of the both the ethical issues and the economic burdens arising from this situation.[9, 10] (See Appendix A, p. 41)

At the community level, a community resource base approach has progressively evolved to try and help people with mental illness. Beginning with the premise that people with a mental illness can live full and complete lives in the community, the theory puts them at the centre of a care and support system that engages them in partnerships amongst themselves, their families, mental health service providers and other community services.[11] In fact, this community resource base approach fits well within the tenets of community policing, which are prevention, community empowerment, partnership development and problem solving.[12] Fundamentals of the contemporary model of policing reflect community involvement and teamwork – all indispensable to police working with people with mental illness.[13]

Because provincial and community mental health initiatives are compatible with community policing principles[14], some communities in British Columbia have developed police liaison programs to try and increase support for people with mental illness. Recent research on such programs states that 47% to 80% of police officers rate their mental health liaison programs as effective in meeting the needs of people in crisis, which is significantly higher than police departments without specialized programs.[15]

Community awareness of the value of police/mental health liaison programs has greatly increased in recent years. How this awareness translates into actual services and programs appears to vary across the province. A fundamental issue

is that while mental health services in British Columbia are primarily community based, for the most part they do not interact in a coordinated manner with hospital inpatient services. Other studies have noted that this lack of integration is one peril of community initiated program coordination, and that further work to overcome the schism between hospital and community care is imperative.[16]

As 'first responders' and gatekeepers of our mental health system, the police have been dubbed *Psychiatrists in Blue*.[17] However, as noted in 2004 by the Canadian Mental Health Association study[18]— police are being forced to play their role without the necessary resources or support to carry it out properly.

A 25-year member of the Vancouver Police Department, currently commander of District One, which comprises most of the downtown core of Vancouver, asks:

> *Shouldn't all people who suffer from mental disorders receive appropriate and timely treatment and services so they don't end up in situations that place them in contact with the justice system? Shouldn't we have systems in place that effectively deal with people who are continually involved in a cycle of crime due to mental disorders and addictions? Perhaps these seem like unattainable goals, but I believe they must be the goals to strive for. People who have an illness must receive the treatment they need, so they can live healthy and productive lives.*[19]

A true story highlighted by the above-cited BC Justice Review reveals the sad history of "Danny", a person with mental illness who revolves in and out of the justice system. In many instances, psychiatrists' assessments and the fact that the person had been a patient at Riverview Hospital in 2000 were unknown by the court. (See Appendix C, p. 45). Psychiatrists are an important professional group with excellent training, skills and influence, and they provide essential services in a variety of community contexts, but they are often left out of the picture. It is vital that they become more integrated in partnerships with other caregivers and professionals. Partnerships and committees that include ties with psychiatry would lead to better patient outcomes, and would also greatly assist the ongoing development of community police/mental health liaison programs.

PSYCHIATRY PERSPECTIVES

The Canadian Psychiatric Association (CPA) has stated that access to psychiatrists and to psychiatric services is a significant problem throughout the country, and a recent CPA policy paper identifies three general levels of urgency for access. [20] Urgency levels – *Emergent, Urgent*, and *Scheduled* – were chosen to equate to the categories described in the Canadian Medical Association's 2005 report, "It's About Time!"[21]

In the CPA policy paper, levels of pain and disability experienced by patients with psychiatric illnesses are categorized as equivalent to the pain and disability levels described by surgical colleagues. The *Emergent* category, for example, traditionally implies danger to life, limb or organ within a very short time frame, and the response to this level of urgency for patients in need of psychiatric care is best facilitated by hospital-based evaluation and urgent referral. Psychiatric patients with acute psychosis/agitation are also categorized as *Emergent* (Level II) in the Canadian Emergency Department Triage and Acuity Scale.[22] (See Appendix D, p.49)

Canadian psychiatrists acknowledge that achieving systemic benchmarks of care will be a challenge, and that inventive ways of service delivery have to be developed, including telepsychiatry and other innovative community initiatives. This is particularly important given a mental health care structure that is bifurcated with too many separate lines of accountability.

It is notable that in areas of BC where psychiatrists have been proactive in community partnerships, their interest has been vital to establishing protocols for dealing with various issues.[23,24] Their participation is clearly essential in helping solve two of the major problems that plague police throughout the province: (i) overly long waits in emergency wards; and (ii) finding that patients they transported and admitted to hospital have been too rapidly discharged and within a short period of time are back on the street, engendering similar calls for police assistance.

SHIFTING PATIENT POPULATIONS: A MEDICAL OVERVIEW

In 1999, a prominent BC medical journal article threw a spotlight on the increasing numbers of British Columbians with mental illness who are referred for forensic assessment and treatment.[25] The author, a forensic psychiatrist, pointed out that most if not all patients who are retained in the forensic system would, in the past, have resided in long-term hospitals such as Riverview for ongoing care and asylum.

Deinstitutionalization, changing social values, and uncertainty about hospital committal criteria are all factors that have contributed to the increasing numbers of people with serious mental illness who find themselves in the criminal justice system. Commenting on the BC Mental Health Act, the McCorkell decision, the adversarial nature of the legal system, review panels, budget issues, and Bill C-30, the 1999 article presented mounting evidence that people with serious mental illness are simply being moved from one institution to another. Also stressed was the fact that British Columbia's *Mental Health Act* is one of the best in Canada, with the broadest, least restrictive language and regulations — but that it is not being applied consistently by BC hospitals and clinicians.

Many clinicians mistakenly believe they may face civil litigation if they certify a person under procedures described in British Columbia's *Mental Health Act*. This not the case.[26] The Act itself protects them against this, as do most Mental Health Acts. Psychiatrists and mental health professionals have been under pressure for many years by civil liberties groups to change their treatment of mental illness. Sometimes this results in using overly narrow and inappropriate "dangerousness" criteria when deciding whether patients meet standards for committal to hospital.

Even when physicians do use correct standards as set out in McCorkell v. Riverview (in which the Appeal Court of British Columbia defined the word "protection" in broad terms as protection from harms), hospital Review Panels often apply narrower "dangerous" criteria when deciding whether the person should be discharged. This causes some physicians to second-guess Review Panel decisions, and to not certify patients who are very ill but likely to be released by a Review Panel because they are "not dangerous."

Unprotected mental health budgets have also resulted in fewer available beds for treating people with acute and chronic mental illness. Psychiatric units are under constant pressure to discharge patients quickly. When beds are not available, physicians often fail to admit ill patients. This occurs despite advice from the BC College of Physicians and Surgeons that shortage of beds is not a valid reason for refusing admission.

Budget pressures and shorter hospital stays often mean that doctors do not have the opportunity to observe patients long enough to see whether treatment is effective. For example, patients can take 6-24 months to respond to a trial of a medication such as clozapine. But if the initial response is unclear, there may be pressure to discontinue the medication at six months, before it has time to work, depriving the patient of a chance for better mental health.

Communities “at their wits' end” between difficult-to-manage patients and a lack of resources fall back on the legal solution. Families, social workers, police, and general practitioners, frustrated at the inability of the mental health system to help people with mental illness, seek help from the criminal justice system. Family members desperately trying to find medical help for a relative who is severely ill report that they have been advised by hospital staff or mental health workers to have the ill person charged and arrested so they can receive proper medical treatment.

Once in the criminal justice system, treatment for mentally disordered offenders is usually of adequate length, involves intensive aftercare, and the rate of relapse is low considering that the patient population is very ill. But treatment in a forensic setting is extremely costly:

> *Many case studies clearly illustrate how psychiatric patients are disappearing from our hospitals and clinics into our prisons. What should be very obvious is that this route is not cheap, does not preserve anyone's rights, is potentially harmful to innocent bystanders, and does not provide a long-term solution.*
>
> *Acute psychosis is often accompanied by disorganized and aggressive behaviour, and it is incumbent upon the medical profession to resist any definition of mental illness that fails to account for this fact. Adequate resources to treat people with mental illness and better education for physicians about the correct use of the BC Mental Health Act are essential to help alleviate the current situation and prevent it from deteriorating further*. [27]

JUSTICE PERSPECTIVES

Police are not physicians, and even if they sense that "something is not quite right" with an individual who has committed an offence, it is not their job to diagnose underlying mental illness.

Undiagnosed mental illness is very frequently masked by the more obvious symptoms of drug and alcohol abuse and chronic "bad" behaviour symptoms. During public consultations, one corrections official estimated that there has been an 80% increase of people with serious mental illness over the last 10 years in our prison population.[28] 60% of people with serious mental illness in prison initially arrived without a diagnosis, but rather with a "history" of substance abuse, petty crimes and violence that was masking their illness.[29]

Thus, it is only by coming to the attention of the courts and eventually being sentenced to jail that some people suffering from severe mental illness get the medical treatment and other resources they need to recover and manage their illness. Once in jail, they finally receive proper assessment, diagnosis, medical treatment, and comprehensive case management. However, the difficulty in accessing community support services upon release is an enormous concern for corrections officials; there is next to nothing available in the community for this population. In addition to their mental illness, patients are now doubly stigmatized by the fact that they have been in prison.

The mentally ill have become one of the major priorities of the corrections system. As one corrections worker put it, "I used to think that the lack of services in the community for our people was because they were stigmatized from having been in prison. But when I see what little is out there [in the community] for anyone with serious mental illness, I understand things differently. No wonder they keep coming back."[30]

Canada's Bill C-30 established Review Boards to oversee the treatment and supervision of accused persons found "not criminally responsible because of mental disorder" (NCRMD). This has resulted in more people with mental illness being processed through the courts if they cannot or will not get help from the medical system. In fact, families and others are regularly encouraged to press charges, hoping that the offender will at least obtain medical treatment within the forensic system.[31]

An important recent Vancouver community Justice Report to the BC Attorney General[32] states that mental illness is often a contributing factor to street crime, and homelessness contributes to visible disorder in the system. In the Vancouver area alone, there are over 11,000 mental health patients and over 9,000 intravenous drug users. Between 35-40 offenders with mental illness symptoms appear in the Vancouver Provincial Court each day. Existing health and justice systems are poorly coordinated and often ineffective.

Specifically, the Justice Report found:

- A disconnect between the community and the criminal justice system
- Insufficient avenues for the community to participate in the criminal justice system
- A lack of "triage" mechanisms to help assess the complex problems that often affect the people who commit street crime offences and disorderly conduct
- A lack of court responses designed specifically for chronic offenders who repeatedly commit relatively minor offences
- A lack of alternatives to traditional court-imposed sanctions that would allow more referrals before and during the court process to mental health, detox, drug treatment and housing resources
- A lack of integration between enforcement and rehabilitation approaches, between health and justice information systems, and a lack of knowledge about relevant health and social resources.

Current court processes involving mentally disordered accused can be lengthy and complex — and expensive. In some circumstances, a case will be adjourned to permit assessment and treatment. For example, the person may have stopped taking medication prescribed by a psychiatrist for a mental disorder before committing an offence. When brought to trial, the person is found unfit and sent for treatment. Once the accused's condition is stabilized, court proceedings continue and may conclude with a finding of NCRMD as a result of the individual being off his or her medication at the time of the offence. In other circumstances, the accused person may be found not fit to stand trial initially, but later found fit, tried and convicted.[33]

The acting director of Ontario's Psychiatric Patient Advocacy Office, criticizing the national trend towards criminalization of people with mental illness, agrees that the trend towards correctional "solutions" to mental health problems must be reversed. Calling for better access to appropriate care and treatment and more education for both mental health and criminal justice professionals, the author proposes an independent advocacy and rights protection program for inmates.[34]

What still must be dealt with is the very thorny issue – often ignored in the literature – of the large number of mentally ill who, by the very nature of their illness, are unable to recognize their need for treatment.[35] As British Columbia rightly acknowledges in legislation, and as BC physicians have pointed out[36], medication is the cornerstone of treatment for serious mental illness, without which all other community support efforts will fail. This a particular challenge for the justice system, since Canada's Bill C-30 also stipulates that persons incarcerated as not criminally responsible on account of a mental disorder (NCRMD) who are successfully treated and subsequently discharged cannot be mandated to take medication. In 1999, the Supreme Court of Canada ruled in R. versus Winko that detention is only warranted if the accused presents a significant threat to the public that is criminal in nature. In cases where evidence is not sufficient to establish a significant threat to the safety of the public, an absolute discharge must be issued. Two possible solutions to this dilemma in Canada are the use of community treatment orders and court diversion programs.

Community Treatment Orders

Some provinces have Community Treatment Orders (CTOs) to help provincial mental health systems provide the benefits of medical treatment and other supports to people with serious mental illness. CTOs allow a patient to enjoy the freedom of living in the community and to consent in advance to any treatment or detention that might be necessary should their condition deteriorate. A mentally disordered person's return to treatment through a Community Treatment Order may take several forms. It is often invoked when a member of the community recognizes that the patient is in need of further mental health treatment. While re-entry usually involves doctors, family members and general social contacts, in some cases the patient may come into contact with the police and be returned directly to their treatment program. CTOs are also used in other jurisdictions to avoid hospitalizing young "first break" early psychosis patients.[37]

British Columbia has no provisions for Community Treatment Orders, but it is a subject that should be revisited. The BC Mental Act provides for conditional leave ("extended leave") by a hospital director, and the leave provisions usually include an agreement to take medication. However, it is generally thought that the person must actually be in a hospital in order to be put on extended leave. While a correctional facility may offer the same care as a hospital, its origin and purpose are different under the law. In key interviews with professionals, there was interest in investigating whether BC's Forensic Psychiatric Hospital, as a "designated psychiatric facility" under the Mental Health Act, would be legally able to use extended leave provisions of the Act. The fact that the BC Act also says "in or *through*" a designated psychiatric facility also raises the possibility that it might be possible to make provisions for community treatment under the Act. These are legal questions that are beyond the scope of the current discussion, but that should be further explored.

Diversion from the Criminal Justice System

In some provinces, mentally disordered persons charged with minor offences may be sent directly to a treatment program rather than go through full court procedures. Diversion also serves to provide the correctional system with relief from treatment, safety and control issues mentally disordered persons may present while incarcerated. Diversion might occur upon contact with police, initial incarceration, or upon arrival in court. In Ontario, for example, the accused can be referred to a caseworker at an initial hearing in provincial court. Diversion is generally only available to those accused who are willing to participate in a treatment program, or who are covered by a community treatment order in those provinces where they are available.[38]

Two decades ago, as enthusiasm for diversion was at its peak in North America and elsewhere, early reviews of the research and evaluation literature routinely lamented the paucity of controlled research in the area. A typical lament is voiced by Mullen (1975): "Regrettably, enthusiasm for diversion has grown with surprisingly little validated support from the evaluation literature. Thus, [a review of the evaluation literature on diversion] is largely a commentary on the unknown."[39]

Despite the intervening years, the above statement is as true today as it was when originally written. There are still only a handful of rigourous, comprehensive evaluations in the field of adult (or even juvenile) diversion that address the key questions of interest to policy-makers and program specialists.
- Government of Canada Review of Diversion Programs for Adults [40]

Although Joan Nufeld, author of the above review of Canadian court diversion programs, found no rigourous evaluations of programs for diverting the mentally ill from pretrial detention and later justice processing, she is clear that there is no question about the importance of diverting mentally ill people from the justice system. As Nufeld points out, the justice system is ill-equipped to deal effectively with this population, including the problems of treatment, safety, and control that they present in the correctional population. Their diversion into settings where their needs can be better met and the risks they present to themselves and others minimized is therefore considered generally desirable by police, jail administrators and other justice officials.

As already noted, since deinstitutionalization began, people with mental illness have been increasingly shifted from the health care system to the criminal justice system. Estimates of the percentages of seriously mentally disordered persons currently in jails and prisons range from 15 to 40%, highly disproportionate to the occurrence of mental illness in the population at large.[41]

Early identification of mental disorders of arrested persons and appropriate action are critical to an integrated response to these situations. Moreover, as calculated in Nufeld's review, the further mentally ill offenders penetrate the justice system, the more likely it is that there will actually be an attempt to shore up and provide more treatment and more teeth to existing community-based responses. Indeed, this appears to be happening – albeit in a patchwork fashion. Community partnerships between police and health care professionals are an important part of this emerging picture.

CONCERNS OF HEALTH CARE PROFESSIONALS

Studies have consistently demonstrated that violent and aggressive behaviour is a major concern among healthcare sector workers. In addition to the physical injuries sustained by individual health care professionals, violence can cause mental stress, loss of job satisfaction, and job retention issues. A 2003 comprehensive literature review of this topic for the Occupational Health and Safety Agency for Healthcare (OHSAH) in BC provides a definition of violence, its effects, and some potential prevention and mitigation strategies with a focus on the acute care healthcare sector.[42] However, it is likely that violent and aggressive behaviour towards healthcare workers in acute care and community settings is a much bigger problem than the statistics reveal.

Violent incidents are a persistent problem in healthcare, and they are underreported for a number of reasons. For example, one study at Langley Memorial Hospital in BC found that more than 55% of staff reported only some or none of their exposure to workplace violence. Other studies cited in the literature found that most verbal abuse in hospital emergency rooms was not reported and, in one notable case, 29% of nurses had not even reported their last physical assault. In addition to the different types of violence mentioned, there are a number of other reasons why violence is apparently underreported:

- No injury is sustained, and the incident is not believed to be serious
- Time constraints
- It is accepted as part of the job, and to report it would be admitting performance failure
- Disruptive and assaultive behaviour is expected
- There is no action after an incident is reported
- Fear of retaliation.

A variety of causative factors are identified in the literature as contributing to and increasing the incidence of violent and aggressive behaviour in acute care environments—including substance abuse/mental health issues, and early discharge of patients with acute and chronic mental illnesses without adequate outpatient treatment and services.[43]

As the OHSAH study emphasizes, no matter what the reason for under-reporting, the true extent of the problem is not obvious, thus making it difficult to tackle. It does, however, make it easier to understand why under-resourced community mental health staff with heavy case loads and virtually no security may refuse to see difficult clients and "close" their files, or why nursing staff report feeling "safer" when a psychiatric patient waiting in the emergency department is accompanied by a trained police officer.

Some police officers dealing with lengthy waits in emergency also identified this as a factor in increased wait times, noting that the privatization of hospital security has added to the problem. "When security guards were part of the team in emergency, they received training and worked in concert with other emerg staff. Everyone there felt they were part of the team. Now it seems like the average age of security guards has gone up by at least 20 years. They're not seen as part of the team, and they don't necessarily look like they'd be reliable in a crisis." [44] As a result of contracting out practices, some police observe that the average age of security personnel appears to have increased considerably, providing "lots of geriatric employment."

Staff in hospital emergency departments have certainly voiced this concern. In 2003, emergency room nurses publicly questioned a Vancouver hospital's decision to begin contracting out health-care security services, fearing it would jeopardize people's lives.[45] One nurse stated that she was threatened physically about once every shift, and credited security staff employed at the time directly by the hospital for their ability to deal effectively with patients. "It's the most violent place I've ever worked," said another nurse, "but I've never felt so safe." There is a perception by some nursing staff that their situation was better (i.e., safer) when the hospital staff "worked together as a team." The use of private

security firms has increased safety concerns in emergency departments, and some hospital staff mention this practice as one of the reasons—along with the downsizing of Riverview and lack of community services—why the police play an increasing role in dealing with people with psychiatric disorders.

Sometimes police officers present to the emergency department with individuals who do not require psychiatric or medical admission, and that the hospital staff believe community mental health services should be managing. If the police bring someone to emergency under the Act, some hospital staff believe the police are required to stay with the patient until they are cleared by the emergency department physician. Some police believe this as well, while others don't.

BC Ambulance Services can also stay with patients in hospital, so some professionals believe it is not always necessary for police to wait. If there is a means of triaging for risk of violence, they say, there is no reason for police to wait unless the patient is apprehended under a warrant and/or there is a risk for violence. If it's a simple certification and the person is not violent, some professionals also believe that transporting paramedics should probably stay with their patient rather than having police take over. In practice, sometimes they do, but sometimes they don't, e.g., "We're leaving now because the police are here." In this instance, it is not clear to what extent police are considered in BC Ambulance policy decision-making.

Some BC hospitals have devised "special arrangements" so that police are not required to wait. For example, Surrey Memorial has 'secure rooms', and written hospital policy now states that patients can only be put in a secure room on authority from a physician. This means that when police arrive with a patient, a psychiatric liaison nurse contacts a physician for approval to use the secure room. Written policy is based on legal opinion and took approximately one year to implement. The new policy has been helpful in reducing police wait times, as long as the secure rooms are not all full. Police hand over a psychiatric assessment form and make a note on their file that the patient was turned over to hospital authority.

In Victoria, fire and security personnel were previously provided with 'special constable' designation. They worked directly for the hospital. Once the triage nurse had done an assessment and the patient was settled in a room, security personnel could take custody of patients apprehended under the Mental Health Act in their capacity as peace officers. This arrangement worked well for a while, but did not last. An incident occurred where a patient hanged himself, suffered subsequent brain damage, and the family sued the hospital, doctors, and the police. Victoria no longer has special constables, but there is now a separate psychiatric emergency facility adjacent to the regular ER at Royal Jubilee Hospital, which has helped. Police still have to go through a regular ER triage nurse to be checked for other medical concerns, but patients can then be taken next door for physician assessment.

In Prince George, an extra secure room ('soft room') was added to emergency but it is not being used. Nurses will not care for patients in the room, claiming extra nursing staff is required for patient observation. Nor will security take responsibility for standing by the door, possibly because of previous legal suit.

Police accompanying psychiatric patients feel that they are considered "low on priority scale because patients aren't visibly injured."

In a concerted attempt to help police reduce emergency wait times in Williams Lake, doctors got together informally with RCMP officers and gave them their pager numbers so they could receive a "heads up", enabling the police to bypass the emergency triage nurse.

There is concern that such a variety of interpretations regarding appropriate procedures indicates flawed communication systems within and between agencies. Also, it is apparent that there is confusion regarding provincial regulations amongst both the police and the hospitals.

HOSPITAL FISCAL CONCERNS

With the closure of many psychiatric hospitals and the move to manage mental illness in the community (despite lack of community infrastructure and shortages of psychiatric health professionals), the need to provide ED crisis management services and arrange follow-up for day programs and other community psychiatric programs has risen dramatically.

The Case for National Standards for Hospital Emergency[46]

As hospital emergency is increasingly identified as an entry point to mental health services, escalating budget pressures lead administrators to seek cost-cutting measures such as replacing unionized staff with private service contracts. A recent survey by McMaster University investigators of Ontario's emergency psychiatric services[47] provides other useful insights. The survey's introduction states that increasing pressures to reduce the length of hospital stays have put emergency psychiatric services in Canada in a state of "crisis."

In the hope of facilitating the flow of psychiatric patients through a general hospital's emergency department, experienced psychiatric nurses in Sudbury, Ontario were asked to participate in a pilot project for the general hospital.[48] One emergency psychiatric nurse's experience is documented in a paper reflecting on the experience of her role being transformed into that of a gatekeeper. The notion of "gatekeeper" as a metaphor in this instance highlights *keeping psychiatric patients out* of an already strained emergency system. As a means to balance fiscal demands with patient care, the emergency psychiatric nurse inadvertently served to obscure entry for patients with mental illness who were seeking emergency services.

It is widely known that many hospital emergency facilities throughout British Columbia are frequently in a state of crisis. Emergency room doctors and health care workers feeling "under siege" are speaking out publicly about hospital bed shortages. Further discussion of the numerous factors contributing to this situation and possible solutions are beyond the scope of this paper.

However, police who present at emergency with psychiatric patients are well aware of the difficulties in hospital emergency rooms, and genuinely sympathetic to the plight of all concerned. For the most part, they recognize that they are involved in a systems problem that is bigger than any individual police service and any individual hospital emergency room:

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…

When there's a delay, look around you. If the waiting room is full and all the Doctors are covered in blood, then there's a good chance that the physically healthy emotionally disturbed person in the custody of trained and fully equipped Officers is not going to be seen in a hurry. But remember, we work in a profession where it could very well be you that's being brought in.[49]

CONFIDENTIALITY CONCERNS

Confidentiality issues sometimes arise between police and hospital, resulting in a limited sharing of information. This was described during consultations as particularly frustrating, especially when dealing with "frequent fliers" – patients who have numerous presentations. In consultation workshops, teleconferences and key interviews, there has been consensus that better management is required and that all service providers should be contributing to the establishment and maintenance of the patient's treatment plan.

Although the British Columbia government provides a good Fact Sheet that clarifies issues regarding releasing personal health information to third parties, many health care providers and other professionals do not appear to be aware of it. The Freedom of Information and Protection of Privacy Act (FOIPPA) clearly allows health care providers employed by a public body (e.g., hospitals and publicly funded clinics) to disclose clients' personal information to third parties under certain circumstances.[50] The FOIPPA Fact Sheet provides guidelines for releasing clients' information to third parties such as family or friends of the client or health care providers. It specifically states that public bodies may release necessary personal information to third parties without the consent of the client where disclosure is required for continuity of care or for compelling reasons if someone's health or safety is at risk. Wider knowledge and distribution of this document would greatly improve communication not only between police and hospitals, but also at many levels of service delivery for people with mental illness in British Columbia.

POLICE/MENTAL HEALTH LIAISON PROGRAMS

BC's regional and community mental health service delivery approach and the new community policing values clearly dovetail, a fact that has given rise to the evolution of community liaison programs between police and mental health professionals. Most modern police officials see responding to mental health emergencies as an appropriate role for police officers. However, many police agencies feel that their methods of dealing with people with mental illness are inadequate.[51] This, coupled with national recommendations in the Kirby Report[52] for improved linkages between mental health and justice sectors, means more police and mental health authorities want to establish and strengthen partnerships that provide integrated police/mental health liaison services.

A comprehensive survey[53] of urban American communities differentiates between three types of police/mental health liaison initiatives: (i) police-based specialized police response; (ii) police-based specialized mental health response; and (iii) mental health-based specialized mental health response.

Crisis intervention models that have evolved include police, mental health workers, consumers and family members. They have proven to be successful in helping people with mental illness gain access to treatment. A recent US study examined police dispatch logs before and after implementation of a crisis intervention team program in Akron, Ohio.[54] The authors looked at data for a six-year period beginning in May 1998 and ending in April 2004. Their purpose was to determine the number of mental health crisis calls to police (10,004) and to assess the effect of specialized training on officers' response to incidents involving "emotionally disturbed persons in crisis." Results showed that police with crisis intervention training were more likely than non-trained officers to transport a person for treatment to psychiatric emergency services, and that transport was more likely to be on a voluntary basis after the program was initiated.

Canadian police/mental health liaison experts[55] describe several models that have been used that may be utilized alone or in combination:

- Comprehensive advanced response model: All police officers receive training related to working with individuals with mental illness. Thus there are no singular experts but all members have an increased level of knowledge and understanding and are expected to be able to handle most situations
- Mental health professionals co-response model: Mental health professionals with whom the police have a working agreement respond to a police call upon request, generally after police have responded and assessed – although some agencies co-respond immediately (e.g., Montreal)
- Mobile crisis team co-response model: Police and mental health workers are co-employed, sometimes by having mental health workers employed by police services and sometimes by having police

officers seconded to community mental health agencies. In Canada, the example of Vancouver's *Car 87* has been replicated in other Canadian centres including Surrey, Victoria, Hamilton, and Ottawa.[56]

- Crisis Intervention Team (CIT) model: Widely-cited in the literature as "the Memphis Model". Specially trained officers respond to problematic situations. The officers are assigned to other duties, such as traffic patrol, from which they may be pulled as needed. Involves people with mental illness, their families and local mental health professionals in the design and delivery of at least 40 hours of specialized training that includes spending time with people with mental illness and their families.[57]
- Telephone consultation model: Probably most effective in remote and rural areas where mental health resources are not readily available. Police have a toll free number to a mental health unit or hospital psychiatry floor which is staffed 24/7 and whom they may call whenever there is an incident to get advice and direction (e.g., some remote areas of British Columbia)
- The "cross your fingers" method: *"Mental health staff and police officers simply rely on the system to work and hope someone will be around/agreeable when a problem comes up. It works amazing well at times and in some places! (lots of places!!*)"[58]

In British Columbia, community-based mobile crisis response services are one of the five core components of a crisis/emergency response network cited in BC's 1998 Provincial *Best Practices*. It is anticipated that the growth of integrated partnerships between police services and mental health and addictions services in BC will continue to promote diversion from acute hospital resources and enhance linkage to community service providers.

Where police/mental health liaisons do exist, there is wide agreement that they are having a positive impact on helping people with mental illness and averting hospital emergency department presentations. However, there is also agreement that police wait times in emergency to see a physician are still too long in many jurisdictions, even taking into account the fact that many emergency departments are very busy and they are at Level 3 status quite often.

Whichever type of police/mental health liaison program BC communities have developed or may contemplate creating, nowadays they will inevitably be challenged with evaluating its effectiveness. Given increasing concerns about accountability for how public funds are spent and the expectation that funding is used to support evidence-based best practices, this is a particularly important point. Unfortunately, there is as yet little evaluation and research on the effectiveness of such programs.

The two major solutions that appear to universally help reduce police wait times in hospital emergency are:

(i)The development of police/mental health liaison services, especially those that have an evaluation component; and

(ii) The development of written, signed protocols between the police and individual hospitals.

Where good evaluations and written protocols exist, not only is there is much greater confidence in program stability and development, but police wait times are demonstrably shorter.

EFFECTIVE PROGRAM EVALUATION

Police/mental health emergency liaison programs vary enormously in the staffing, approach and comprehensiveness of the services they provide. Like the development of Early Psychosis programs, it appears the expansion of services is "evolutionary" rather than revolutionary across the province. We owe a debt of gratitude to many dedicated, competent and passionate individuals for continuing to move forward to advance the principles and practices of community police/mental health liaison services. In spite of apparently positive gains to date, greater support is required for such partnerships if they are to produce optimal outcomes for people with mental illness in BC communities.

Program evaluation is an extremely important element of any service delivery system. Without assessment of a program's outcomes, it is difficult to know whether a service is meeting its anticipated goals. Developing and incorporating program-specific logic models could strengthen the evaluation of police/mental health liaison initiatives.

A generic program logic model template (including evaluation questions) proposed at the 2005 Canadian Association of Chiefs of Police Conference on Police/Mental Health Systems generated interest and enthusiasm. It is evident that using such a model could help facilitate evaluation research on police/mental health liaison initiatives. The presentation also discussed the challenges involved in conducting evaluations plus subjects for future research related to evaluating police/mental health liaison initiatives, such as the social sequelae of police/mental health liaison initiatives, police training, lived experience, and police structures and systems.[59]

As noted, communities that have succeeded in creating mental/health liaison services are also facing the challenge of evaluating their effectiveness, particularly given the importance of accountability for public spending and the use of evidence-based best practices in police and mental health services. One of the reasons that there is very little evaluation and research on the effectiveness of such programs is because many police services and mental health agencies are extremely limited in their ability to conduct such evaluations. Without the allocation of resources for evaluation, many promising police/mental health liaison initiatives may not continue because they are dependant solely on good will, hard work, and the ability of caring professionals to go "above and beyond" (and sometimes around) the limitations of their individual systems.

The proposed generic program logic model (see Figure 1) is particularly interesting because it is rooted in the *community resource base* framework and in *community policing* principles. Therefore its stated program goals are to produce favourable outcomes for people with mental illnesses and their families, rather than simply reducing police costs. Inherent in this concept is the premise that "any door is the right door" if it is a pathway to care. Police interactions with people suffering from mental illness are seen as *frequent and desirable*.

The logic model's three stated goals are:

Goal 1: To maintain community safety

Goal 2: To improve services for people with mental illness (PwMI) and their families

Goal 3: To reduce the criminalization of people with mental illness (PwMI)

- See *Figure 1*

The model's ten objectives relate clearly and in very specific ways to each other and to the above-stated goals. Note, for example, that Objective 6 is to minimize time spent by *generalist patrol officers* on 911 calls, rather than minimizing the amount of time spent by officers overall on calls regarding people with mental illness. (See Table 1.)

Figure 1: *Template of a Police/Mental Health Liaison Program Logic Model*

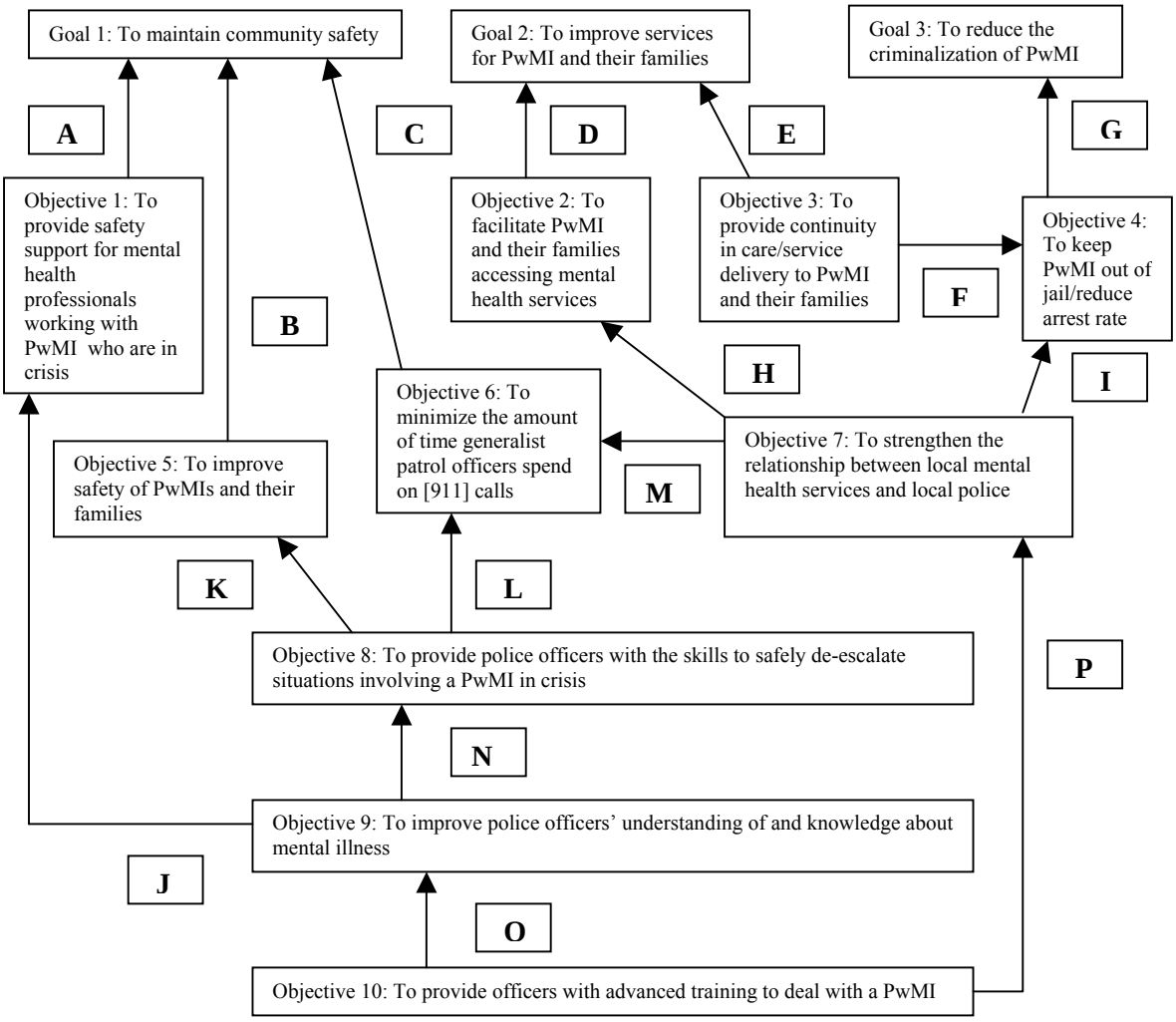


Table 1: *Underlying Assumptions Linking Goals and Objectives*

Path in Figure 1	Assumption(s)	Path in Figure 1	Assumptions
A	A1. *Police presence is needed where violence is occurring or is at risk of occurring because of mental illness symptomology*. Safety is of paramount concern to police officers. They have a protective role to play in society; they are obligated to protect persons from themselves and others. Persons with a mental illness who experience symptoms that are manifested as or result in violent behaviour pose a safety risk to themselves and/or mental health professionals working with that person.	B	B1. *Persons with a mental illness and their families are part of the broader community that relies on police assistance*. Persons with a mental illness who experience symptoms that are manifested as or result in violent behaviour pose a safety risk to themselves and/or their families. It should be noted that persons with a mental illness are more likely to cause harm to themselves than to others (Kirby & Keon, 2004)
C	C1. *The sooner generalist patrol officers are freed from dealing with PwMI/EDP calls for service, the sooner they are available to respond to other emergency calls for service.*	D	D1. *Police contact is the entry point into the mental health system for many persons with a mental illness and their families.*
E	E1. *Continuity in community mental health service (of which police are a part) delivery facilitates recovery from mental illness.*	F	F1. *Having a specialized team of officers means that they will get to know people in the neighbourhoods where they work. As a result, officers will be more likely to know a person's history and have established a relationship with the person and thus be less likely to have to deal with a crisis situation by way of arrest.* Cordner (2000) observed that in regard to dealing with persons with mental illness, an officer's familiarity with such persons and their families and local mental health system supports can significantly impact on how incidents are dealt with.
G	G1. *Arresting persons with a mental illness results in their criminalizing by channeling them into the justice system. We are more likely to foster recovery if we avoid criminalizing them.* A key goal of police/mental health liaison initiatives is to reduce criminalization of persons with a mental illness (Lamb, Weinberger & DeCuir, 2002). However, to the extent that police contribute to criminalizing persons with a mental illness it is not the attitude of the officers generally that is the root cause of criminalization (Cotton, 2004) but rather an inadequate mental health system (Schnapp, Nguyen & Nguyen, 1998)	H	H1. *A police/mental health liaison initiative will make it easier for persons with a mental illness and their families to access mental health services*. Police/mental health liaison initiatives become an additional community support for persons with a mental illness, which, in turn increases the number of persons with a mental illness who are referred to the mental health system rather than jail (Lamb, Weinberger & DeCuir, 2002.
I	I1. *A strong positive working relationship between mental health service providers and police officers makes it easier for generalist patrol police officers to receive assistance from someone with more training in dealing with persons with a mental illness.* I2. *Intervening earlier is more likely to result in fewer arrests and concomitantly, more persons with a mental illness receiving proper mental health supports, including treatment. In consequence, they will be less likely to come to attention of police again by virtue of their behaviour (i.e., risk of harm or perceived risk of harm to self or others.)*	J.	J1. *Police officers with specialized training will be better than officers without specialized training at diffusing situations in a way that minimizes the risk to mental health professionals.*
K	*Police officers with specialized training will be better than officers without specialized training at diffusing situation in a way that minimizes the risk of injury to a person with a mental illness and his or her family.*	L	L1. *Once officers with specialized training are on scene, generalist patrol officers are no longer needed on scene.*

M	M1. *If there exists a strong positive working relationship between the mental health and police sectors, including trust and confidence in each other's skills and abilities, then police officers can readily access mental health services for persons with a mental illness who are in crisis.* Coordinated service delivery between policing and mental health agencies is important to detect and facilitate the treatment of mental illness. Because police are often the only community resources accessed to deal with crisis situations involving persons with mental illness (Lamb, Weinberger & Gross), police/mental health liaison services result in better care for persons with mental illness (Fry, O'Riordan & Geanellos, 2002; Lamb, Weinberger & Gross, 2004).	N	N1. *If police officers' knowledge of mental illnesses and how to interact with persons with a mental illness increases then they will be more effective in resolving crisis situations on scene*. Officers can develop expertise in assisting persons with a mental illness in crisis when officers have specialized training and subsequently practice their skills and apply their knowledge regularly (Cordner, 2000)
O	O1. *General police training is insufficient with respect to responding optimally to persons with a mental illness who are in crisis*. Recent research has demonstrated that Canadian police officers are not more knowledgeable about mental illness than are Canadian firefighters (Cotton & Zanibbi, 2003). Basic constable training provided by police training centres and/or acquired through in service training at police agencies often involves minimal time spent on mental illness per se and typically does not include time spent with persons with mental illnesses and their families (Hails & Borum, 2003). If officers have a heightened sense of risk of violence they may act in ways in interactions with persons with a mental illness that beget greater distress and/or violent behaviour (Watson, Corrigan & Ottati, 2004). Research shows that police officers want more training in how to support persons with a mental illness (Cooper, McLearen & Zapf, 2004; Lamb, Weinberger & Gross, 2004). O2. *If additional training is provided it will be effective in increasing knowledge and translated into improved job confidence and improved job performance*. While it is assumed that training will result in better performance (Cordner, 2000), Pinfold et al.'s (2003) study of police officers' knowledge, attitudes and behaviours towards persons with a mental illness pre and post training on how to work with persons with a mental illness found that 70% of officers understood key messages of the training but in only 30% of cases did officers indicate there had been positive impacts on police work. Cotton & Zanibbi (2003) observed that it may be the least knowledgeable of officers who actually display the best techniques for dealing with persons with a mental illness in interactions with them and that this is an area for future research.	P	Having more knowledge about mental illness will bolster the ability of officers to work closely with mental health practitioners.

The authors of above generic logic model advise people who consider adapting it for their own programs that the goals and objectives presented in the model are "illustrative rather than exhaustive."

If, for example, a police/liaison service changes from strictly providing crisis support to providing ongoing support, additional objectives can be added. By the same token, since programs vary some pathways shown in the generic model might not be applicable to all types of police/mental health liaison initiatives. Path O, for example, is only relevant for programs that include additional police training. Where police officers work in tandem with community mental health staff and have no additional formal training as part of their program, Path O would not be applicable.

There is also flexibility in how the objectives can work as program activities carried out by program staff (i.e., police officers and sometimes mental health workers) — which will depend on the local community context within which such services are provided.[60]

THE AEIOU APPROACH

It is also suggested that when a program's purpose is captured in a logic model, good evaluation questions can be formed by using a framework such as the AEIOU approach.[61]

The AEIOU approach uses five categories of evaluation questions:

- Accountability (Did the program planners do what they committed to doing?);
- Effectiveness (How well was the program done?);
- Impact (What changes resulted from program activities linked to stated program objectives?)
- Organizational context (What factors, structures, policies, or events in the organization or broader environment helped or undermined the program in meeting its goals and objectives?)
- Unanticipated consequences (What significant impacts occurred due to the program that were not anticipated?).

The model's authors also provide some sample questions relevant to evaluating police/mental health liaison programs (see Table 2.)

Table 2: *AEIOU Framework Questions for Evaluating Police/Mental Health Liaison Programs*

Domain	Questions	Domain	Accountability
Accountability	• Were persons with mental illness and their families served by the program? • How was it evident (e.g., presenting behaviour, police records) that a person with a mental illness was being served? • How many persons with a mental illness were served? • How many PwMI/EDP calls for service were dealt with in each of the following ways: referred to a community agency, transported to hospital, arrested or provided with other assistance?	Effectiveness	• Are stakeholders (e.g., persons with a mental illness, family members, police officers involved in the program, generalist police officers not involved in the program, mental health professionals) satisfied with various aspects of the program (e.g., training provided to officers, opportunities to work collaboratively with other stakeholders)? • Did police officers involved in the program learn more about how to assist persons with a mental illness in crisis? • Did police officers feel adequately prepared to provide the service? • What suggestions do program stakeholders have to improve the program?
Impact	• Do more officers volunteer to be in the program than there are positions? • Is there a knowledge transfer process between officers who are part of the program and officers working in other areas (e.g., generalist patrol officers, tactical response unit personnel, criminal investigators)? • Has use of the program increased over time? • Has a written protocol between local police, mental health agencies and hospitals been developed that includes a provision for periodic review? • Has the protocol been subjected to periodic review and modification, as necessary? • Does the police agency have policies and procedures that have had to be revised as a result of the program? • Is there a reduction in the average time spent by generalist patrol officers on PwMI/EDP calls for service now as compared to prior to the program? • Do mental health service providers and police officers have a better understanding of and appreciation for each others' knowledge, skills and abilities?	Organizational Context	• How is the relationship between generalist patrol officers and program police officers? • How is the relationship between police and mental health system components? • How is the relationship between police and mental health system components? • How is the relationship between mental health system components (e.g., hospital emergency room, community mental health agencies? • Is there public/community/political support for the program? • Were there factors (e.g., major criminal investigations) than resulted in a temporary redeployment of one or more police/mental health liaison program police officers temporarily but to an extent as to have had an impact on program success? • Did program officers receive feedback from stakeholders, including police executives and supervisors, that they were perceived as helpful and that the program was valued? • Was there insufficient or inadequate information system support that hindered information sharing? • Do the organizations involved have performance management systems that encourage adherence to program requirements?
Unanticipated Consequences	Is the program being used for more than crisis support (e.g., follow up/monitoring of persons with a mental illness)? Are families/persons in crisis calling for police assistance earlier in a crisis than they were prior to the program being implemented? Is the program assisting or benefiting persons or parties (e.g., providing tips and leads that support criminal investigations) other than those it was intended to benefit? Are new partnerships being formed between work units, teams or programs within the police service? Is the program fostering greater awareness and acceptance of issues related to promoting the mental health of police officers? Are program personnel being called upon by stakeholders to engage in non-program related matters either in a beneficial or detrimental way?		

Some suggestions as to what resources might be available to support an evaluation are:

- Creating partnerships
- Separating design & implementation stages of evaluation
- Collecting data efficiently by using existing databases such as police and hospital records
- Sharing the workload among stakeholders, including families, who are an important but underrepresented group

Some of the perceived challenges to evaluating police/mental health liaison programs are:

- Limited research capacity
- Privacy legislation – although this should not be an insurmountable problem given the ability in BC for public bodies to share personal health information[62]
- Lack of interface and difficulty matching client data in police and mental health system records
- Extent of health care systems change. In British Columbia, planning, coordinating, integrating, managing and funding responsibilities on a local level are primarily the responsibility of the Regional Health Authorities. Hospital and mental health agency catchment areas affect the extent and nature of mental health services that can be accessed by police agencies. Victoria hospital emergency facilities, for example, are used by numerous police and RCMP agencies from Victoria/Esquimalt, Saanich, Sooke, Westshore, Sidney, Central Saanich, and Oak Bay.

In consultation with BC police professionals and emergency personnel, it has been suggested that the chore of matching data in existing police and hospital systems might be facilitated by developing an agreement between hospital, police and community mental health services that specifically pertains to evaluation research data.[63] Resource allocation for such a task could be minimized by forming partnerships with local academic institutions.

Community resource base mental health and community policing in British Columbia provide a good foundation for building police/mental health liaison programs. Using a generic logic model as a template for police/mental health liaison initiatives could enhance capacity of communities to evaluate such initiatives. Evaluation is critical (a) to further knowledge about how programs are successful and (b) to improve accountability.

THE IMPORTANCE OF EVALUATION: VICTORIA EXAMPLE

An excellent program evaluation was recently completed in British Columbia on Victoria's Integrated Mobile Crisis Response Team (IMCRT).[64] The crisis response team represents the culmination of a community consensus building process started in 2002 to improve the efficiency and quality of mobile crisis response services in the Capital Region.

The Victoria IMCRT's stated objective was "to combine varied front-line crisis responder elements into a more efficient, responsive, and interdisciplinary crisis response team that can attend to the full continuum of community crises irrespective of age, preponderance of addictions or mental health issues, or public safety concerns." Part of the original initiative was to conduct a program evaluation on service integration. Data was collected between November 2004 and June 2005. The resulting evaluation provides useful information about the goals, benefits, objectives, performance, and any shortcomings of pairing police with Mental Health Outreach Services to Vancouver Island Health Authority management and the Victoria City Police.

Some of the key improvements documented in the IMCRT evaluation include:

- Decreased emergency room wait times; on average, patrol officers waited 45 minutes in ER when assisted by IMCRT staff versus 121 minutes when patrol officers attended ER on their own.

- Wait times for and coordination with police were virtually eliminated when a plain-clothes officer was on shift.

- Crisis responders were able to attend more than double the amount of high acuity calls when a plain-clothes officer was on shift.

- With the IMCRT officer, response times to crisis calls most frequently occur within 30 minutes, versus several hours historically.

- A marked increase in perceived safety by clinical staff attending to community crisis calls when the IMCRT police officer is on shift.

- Improved privacy/confidentiality for clients.

- Reduced reliance on hospital-based resources; out of 1200 referrals less than 15% were directed to ER, accounting for a 7.8% decrease in the use of hospital resources compared to historical data.

- Improved accessibility and information sharing because police dispatch can immediately access the crisis response team via police radio.

- Patrol officers have direct contact with IMCRT officers enhancing their ability to defer cases to the integrated team.

- IMCRT officers can provide patrol officers with hospital-based information on clients that can impact critical care decision-making on scene and potentially divert patrol officers from attending ER.

- Raised levels of education and awareness for police officers regarding mental health issues. The IMCRT officers report that they have a better understanding of mental health diagnostic criteria and behavioral interventions with the mentally disordered.

The Victoria project's evaluation data analysis also indicated that "the right combinations of professional staff and law enforcement are now attending to crisis situations the majority of the time." Being able to match the right combination of clinical/law enforcement expertise to each specific call promotes the most informed assessment and clinically appropriate disposition, and is clearly making a difference. (See Appendix E, p.51).

Finally, what must be underlined is the fact that the evaluation component for Victoria's Integrated Mobile Crisis Response Team was built into the project from the beginning. As a consequence, program participants did not have to try and accomplish it "off the side of their desks", and the research results provide valuable data for future psychiatric service planning in the south Vancouver Island region.

THE VALUE OF WRITTEN PROTOCOLS

MONTREAL

At the Schizophrenia Society of Canada's 2005 annual national conference in Montreal, Montreal Police presented results of their unique police/mental health liaison program. Within the province of Quebec, the Montreal police are the only police agency that has obligatory mental health training for its officers. The program began in 1996 by setting up a multidisciplinary team to help police who were constantly involved in situations involving people with serious mental illness. A pilot police project was started in the south of Montreal, and in 2001, received a mandate to expand to cover the island of Montreal. Since that time, it has experienced growing success, particularly in the area of training. 20% of all police patrol officers are trained in crisis intervention and 100% receive some training by means of a video presentation. A special mental health training plan was developed to enable police to increase their qualifications in this area, and to ensure that all new recruits will receive training in psychiatric crisis intervention – a program that was slated to start in September 2005.

Observers of the program summed up its success to date in three words, "Education, education, education." Increased knowledge about serious mental illness has brought police officers into active partnerships with a variety of community agencies and professional medical personnel. One side benefit of Montreal's growing police/mental health liaison program has turned out to be a noticeable reduction in police wait times, reported to have gone from an average of 2 – 4 hours to 20 minutes or less.[65] This has been accomplished by the creation of a comprehensive written protocol between Montreal police and hospital authorities. (See Appendix F, p.61.) The Montreal protocol is extremely comprehensive in that it incorporates and reflects each agency's policies and procedures that are specifically linked to legislation.

WINNIPEG

The Winnipeg protocol was created in 2000 specifically to reduce police wait times in hospital emergency. It was signed in 2001 by officials of both the Winnipeg Police Service and the Health Sciences Centre Site of the Winnipeg Regional Health Authority. (See Appendix F, p.53.)

In the document, both parties agreed to a protocol whereby police officers would no longer be required to remain with certain individuals apprehended under the authority of the Manitoba Mental Health Act while they are waiting to be examined in the hospital emergency department. The protocol specifically establishes that once certain criteria have been met, people apprehended under the authority of the Manitoba Mental Health Act can be released to the custody of a security officer employed by the Winnipeg Regional Health Authority's Health Sciences Centre.

Consultation with Winnipeg Police/Mental Health liaison professionals confirmed that their written protocol is working well, and that police wait times have been significantly reduced in most cases to under an hour.[66] The Winnipeg

protocol appears to be somewhat similar to previously discussed arrangements that provided "special constable" status to hospital fire and safety security hospital personnel in Victoria. No incidents that might jeopardize the current Winnipeg protocol agreement were reported by the Winnipeg police/mental health liaison team.

CORNWALL

Cornwall's Emergency Mental Health Response protocols, revised in July 2005, have eight signatories, including various representatives from the Cornwall Community Police, Ontario Provincial Police, local hospitals, and other partners involved in the agreement.

The terms of the Cornwall agreement state that the protocol will be in effect unless it is amended in writing with the consent of all parties, and that the protocol may be terminated by any of the parties giving written notice to the other partners with 60 days notice prior to the termination.

A brief examination of the protocol revealed that in-service training on topics specific to each participant's expertise is to be routinely provided to one another, and that all parties agree to be part of a Mental Health Advisory committee and to meet on a regular basis to discuss local issues regarding interaction between services and discuss and resolve problems that may arise. Evaluation is also mentioned, although it is unclear how it will be accomplished or whether there are any resources specifically allocated for this purpose.

Police wait times, an obvious concern, are bolded and italicized in the protocol document:

> Police will remain with patients transported to the ER for evaluation under section 17 of the Mental Health Act **for a period of up to *one hour* unless** other medical emergencies in the ER make this time frame unrealistic.

The Cornwall protocol is interesting in that it reflects the many partnerships that have arisen at the community level to assist people with mentally illness. Cornwall Community Hospital has a committee that includes police, hospital staff from emergency and inpatient psychiatry, plus members of the emergency crisis team. The Committee meets every second month to review wait times, and Committee members confirm that since implementing the protocol they have indeed reduced the wait time for police to approximately one hour.[67] Formerly they met monthy but no longer find that necessary. It is to be hoped that program evaluation resources will be adequate to continue to sustain and expand Cornwall's police/mental health liaison initiative and enhance regional service planning.

VANCOUVER

Vancouver Police have a written protocol with St. Paul's Hospital regarding admission procedures at St. Paul's for Mental Health Act arrests by Vancouver police officers. Their letter of understanding sets out how Mental Health Act arrests should involve co-operation and efficient processing between police and medical staff. (See

Appendix F, p. 59.) It also includes specific means for resolving differences when consensus cannot be reached on evaluations over safety or the necessity for continued police presence. Vancouver Police District Commanders in the downtown area state that having the written protocol with St. Paul's is extremely helpful in keeping police wait times with psychiatric patients to a reasonable length. By contrast, there is no such protocol with Vancouver General Hospital and individual police officers are often more frustrated by what they perceive as undue delays at VGH emergency.

OTHER VANCOUVER INITIATIVES

Police Mental Health Liaison

Vancouver's original *Car 87* is widely cited in the literature as a model for police/mental health liaison initiatives, and has been replicated in other Canadian centres. In addition, Vancouver Police Chief Jamie Graham actively encouraged the British Columbia Association of Chiefs of Police to establish a mental health sub-committee, which was also adopted at the national level through the Canadian Association of Chiefs of Police (CACP). The CACP subcommittee for Police/Mental Health Liaison is an active group whose online listserve[68] is an invaluable forum for discussion and knowledge transfer between police, doctors, nurses, social workers and other professionals involved in service delivery for people with mental illness and their families throughout Canada.

Increased Family Involvement

Police, sometimes more than health care professionals, note how specific cognitive impairments in executive functioning (planning, prioritizing, decision-making) affect many people with psychiatric illness. As one police officer said, "Sometimes you see that [people with mental illness] are very smart in some ways, but that they can't organize their way out of a paper bag. You just know there's no way they're going to make it out there on their own." As a result, some police reach out to engage family members who can offer support and advocacy. On the other hand, some mental health professionals, even if they suspect that cognitive impairment is a problem, often have overriding concerns about confidentiality that they believe precludes them from involving families as natural allies in supporting their clients. Recognizing this as a systems issue, Vancouver/Coastal mental health authorities are moving ahead by specifically including families in their planning process. [69]

Families struggling to cope with relatives who have serious psychiatric illnesses feel strongly that this type of planning approach—one which includes the family perspective—is an important step forward in preventing psychiatric symptoms from escalating to the point where the police have to become involved:

> *"How can [the system] work if family members, who know the person best, can't even find out what's going on medically and aren't allowed to ask for or give information about an ill person they love and are trying to care for? It's absurd. Families need to have more input so we can all get on with living our lives with dignity*."[70]

Urgent Response Centre

As previously noted, whenever it is consistent with public safety, mentally ill persons should be diverted from the justice system to effective treatment resources. A major theme of the BC Justice Review Task Force's report to the Attorney General is that the primary response to street crime and disorderly behaviour currently comes from the criminal justice system, and that this response is not the most effective.[71] Partnerships between the justice system and the mental health system would increase the likelihood that people with psychiatric disorders are dealt with more effectively. The report emphasizes, however, that such partnerships are hampered by the lack of knowledge in the criminal justice system about the mental health system, and vice versa. It recommended that court systems dealing with people with mental illness should be linked through a dedicated Liaison Officer to hospital and community psychiatric services, as well as to other services such as supported housing and income assistance.[72]

Vancouver/Coastal Health is working towards the creation of an Urgent Response Centre that will bring together health, social and justice services under one umbrella to provide improved health care for people with mental illness and addictions. The target population of the Urgent Response Centre will be people with mental health or addiction problems who cause disorder in the streets, repeat users of hospital emergency departments, and homeless people. The purpose of the consolidation is to try to provide "wrap around services," including appropriate assessments and referrals to services in the community. It would also be available to the Court for referrals and assessments. Having a full range of health and social services on hand would give the Court the ability to impose sentences that address the problems of each offender, instead of the current situation where many people released from jail on terms to attend for treatment simply don't make it, as they lack the capacity or assistance to get there.[73] In addition, it would provide a place for police to bring people in urgent need of sobering, offering triage to determine other needs.

While no one imagines that Vancouver's Urgent Response Centre will solve all the problems caused by fragmented mental health care service delivery, it is hoped that this initiative will help reduce the number of people with mental illness and addictions currently caught in the "revolving door" cycle that exists in both our health care system and our criminal justice system. There is also hope that individuals with serious psychiatric illness will have a better chance to eventually receive the continuity of care and other supports they need to manage their illness in the community. To the extent that this occurs, the Urgent Response Centre project should naturally help alleviate the problem of police wait times in hospital emergency departments.

NEXT STEPS

Several key themes consistently arose and were repeated during the consultation and research undertaken for this report. These concerns were all strongly voiced, and have been incorporated into the report's *Recommendations* on page 5:

- Lack of communication and coordination of services.

- Need for more planning and resources for existing police/mental health initiatives.

- Assertive strategies required to increase awareness of existing legislation.

- Need for continued support and growth of early psychosis intervention programs in BC.

- Current access to hospital beds and to ongoing clinical treatment and other services is unsatisfactory in most communities. More and better coordination and continuity of care for people with serious and persistent illness is required. Several participants mentioned mandated case management or assertive case management for this population, and this view is reflected in the literature and in BC's own *best practices*. .

British Columbia is fortunate in having good tools available to work with in terms of legislation, such as our Mental Health Act, and clear guidelines for using the Freedom of Information Act with respect to information sharing. There are also some model mental health liaison programs. Along with the excellent example set by programs such as that in Victoria, a generic logic model could also assist in helping other communities develop and sustain their programs. Innovative programs exist, but without adequate resources to evaluate progress and track outcomes, they will be unable to add to the body of knowledge that is needed for proper planning, and indeed, some may even be difficult to continue. Everyone consulted clearly agreed on the need for written protocols between police and hospital emergency services, and many expressed an interest in receiving copies of the protocols appended to this report with a view to perhaps adapting them for their own communities.

Early Psychosis Intervention (EPI) also elicits universal approval, and was consistently mentioned in consultation as a hopeful and important part of the overall picture. There is widespread agreement amongst police, clinical professionals and families in British Columbia that early intervention is crucial if we are to move forward in providing a better quality of life for people with mental illness in our communities. Many of the existing concerns could be avoided with earlier intervention, education, and the continuing care and treatment that are all part of EPI best practice. BC has a unique Child and Youth Mental Health Plan, which includes training for BC physicians and a regional service delivery model. This was also mentioned as something that deserves

increased support. Families, professionals, and police who participated in consultations also noted that Adult Mental Health and Ministry of Children and Family Development service providers need to work more closely together in this area to coordinate efforts so that young people are not suddenly without care just because they have moved from age eighteen to nineteen.

THREE STEPS NOW

From the list of Recommendations, three steps are identified that could be acted on immediately by regional health authorities and police to help reduce police wait times with psychiatric patients in BC's hospital emergency rooms:

1. To develop written protocols between individual police departments and the hospitals they are involved with in assisting psychiatric patients. Written protocols have proven to be extremely useful in several jurisdictions across Canada. In Appendix F, a number of examples of written protocols between police and hospital emergency departments are offered that could be adopted or adapted for use by BC service providers.

2. To ensure that *all professionals* in British Columbia whose work brings them in contact with people with mental illness know about the BC *Guide to the Mental Health Act*. Not only does this document have advice specifically for police, doctors, other professionals and families, it also clearly explains the meaning and use of the Act, includes legal forms *and* guidelines on information-sharing for the purposes of continuity of care. The *Guide to the Mental Health Act* is readily available online from the BC government website at www.health.gov.bc.ca/mhd/mentalhealthact.html

3. To encourage evaluation of existing and new police/mental health liaison programs in British Columbia and to allocate resources specifically for this purpose. There is no doubt that police/mental health liaison programs will continue to grow as both police and regional health authorities advance the principles and practices of community mental health liaison services. Evaluation is critical to understanding outcomes, furthering our knowledge of how such programs are successful, and improving accountability. A generic *logic model* is presented in this report to help facilitate the evaluation of police/mental health liaison programs, and an example of a high-quality BC program evaluation is also provided. Both the logic model and the example of a successful evaluation from an already-existing BC program should be useful tools for helping others design individual program evaluations.

By working with the police and other professionals and beginning with the above three steps, Regional Health Authorities can help alleviate some of the long wait times police experience with patients at local hospital psychiatric emergency departments in their communities.

At the same time, the larger communication and systems issues mentioned in this report must also be addressed in order to bring about meaningful change.

APPENDIX A

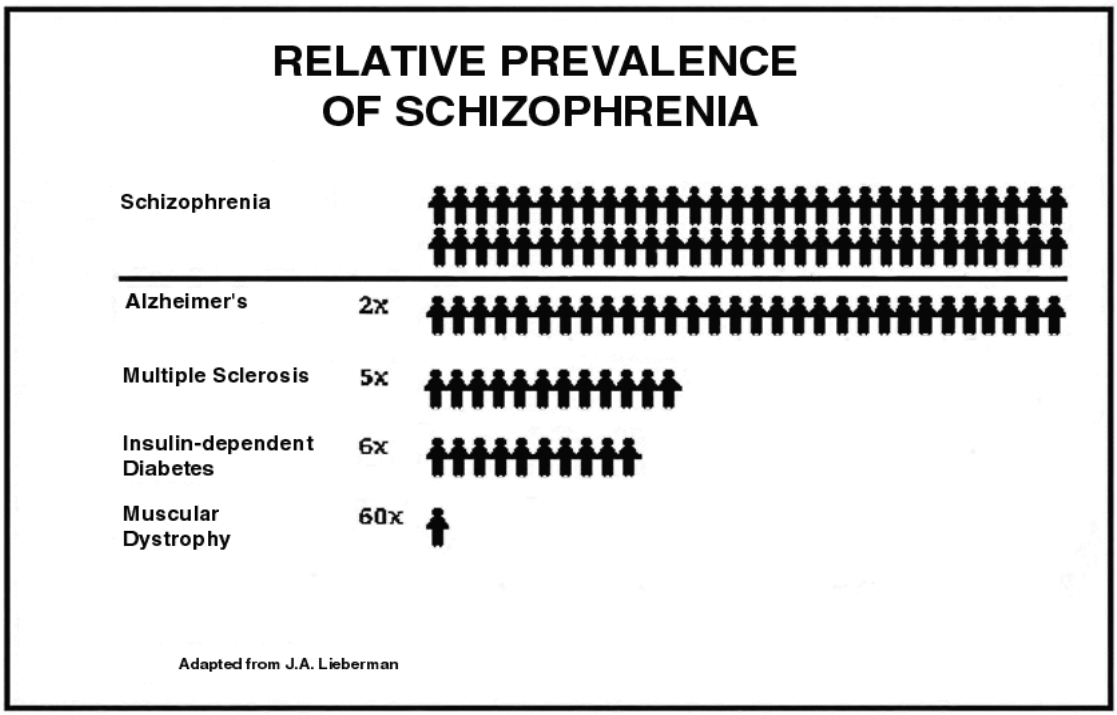
Economic Burden of Schizophrenia in 2004 *

- Estimated number of Canadians with schizophrenia = **234,305**
- Estimated direct healthcare and non-healthcare costs = **$2.02 billion**
- Productivity loss estimate (mortality plus morbidity, including high unemployment rate of people with schizophrenia due to illness) = **$4.83 billion**
- Total estimated cost for the year 2004 = **$6.85 billion**
- Percentage of total costs due to loss of productivity = **70%**

The economic burden of schizophrenia in Canada is very high—despite improvements in medications and resources for patients with schizophrenia.

The most significant cost factor of schizophrenia is lost productivity due to seriousness of symptoms and lifelong nature of the illness (onset generally mid teens to early twenties.)

Programs to improve patient symptoms and ability to function have potential to increase workforce participation and to reduce the cost of this severe mental illness in Canada.



Australia and Denmark both recognize schizophrenia as a national health concern. Australia has had mandated case management for schizophrenia for several years. In 2000, Denmark established mandatory outcome indicators for stroke, hip fracture, schizophrenia, acute surgery, heart failure, and lung cancer. (See Appendix B, p.43 – *Danish Schizophrenia Indicator Project)*

* From The Economic Burden of Schizophrenia in Canada in 2004. *Current Medical Research Opinion* 2005;21(12):2017-2028 Goeree, R; Farahati, F; Burke, N; Blackhouse, G; O'Reilly, D; Pyne, J; Tarride, J-E. Posted 01/06/2006 Medscape

APPENDIX B

THE DANISH NATIONAL INDICATOR PROJECT

- Established in 2000
- 6 indicator sets developed covering 96 individual clinical indicators
- Mandatory participation by all hospitals and relevant clinical departments in Denmark.

DISEASES

- Stroke
- Hip fracture
- Schizophrenia
- Acute surgery
- Heart failure
- Lung cancer

INDICATORS

- Strategic markers that monitor quality of care
- Measure the extent to which set targets are achieved
- Evaluating health care quality is impossible without the use of relevant indicators that are:
    - *Valid* - able to measure exactly what we want to measure
    - *Sensitive* – able to correctly reflect occurring changes
    - *Specific* - to avoid measuring changes due to external factors not related to objectives and targets
    - *Evidence based*

The use of indicators should be followed by professional assessment, evaluation and interpretation.

PERSPECTIVES

- Research
- CME
- Quality development
- Clinical guidelines
- Patients pathways
- Audit

BASIC PRINCIPLES

- Health professionals develop evidence-based standards and indicators for all major diseases
- Health professionals assess and interpret results before public release of data

Schizophrenia: Indicators, Standards and Prognostic Factors

Indicator Concept	Indicator	Type	Standard	Data resource	Prognostic factors
1. Diagnostic Testing	Proportion of incident schizophrenia, who have been tested for a. psychopathology a. cognitive function b. needs for social support	Process	b. 98 % of the patients with incident schizophrenic have their psycho-pathology evaluated by a specialist c. at least 50 % have had their cognitive function evaluated by a psychologist d. at least 80 % have had their social needs evaluated by a social worker	Medical record	
2. Contact	Proportion of schizophrenic patients that have been in contact with treatment system	process	At least 75 % of patients (whose treatment completion is not planned), are in contact with the treatment system.	Medical record	
3. Psychopathology	Proportion of patients that experience relapse of productive psychosis	Result	No more than 25 % of the incident patients experience relapse of productive psychosis No more than 50 % of the prevalent patients have more than one episode of productive psychosis	Medical record	gender, education, drug and alcohol abuse, duration of untreated psychosis
4, Medical treatment (medicine)	Proportion of patients who receive anti-psychotic medication	Process	At least 90% receive anti-psychotic medication	Medical record	
5. Side Effects	Proportion of patients whose side effects have been evaluated	Process	At least 90% have side effects evaluated At least 50% have side effects evaluated using a standard scale (questionnaire UKU- test)	Medical record	
6. Family intervention	Proportion of patients whose family members were offered the ability to contact the treatment system as well as informational sessions about the disease	Process	At least 90 % of the incident patients family members are offered the ability to contact the treatment system At least 50 % of the prevalent patients family members are offered the ability to contact the treatment system	Medical record	
7. Psychoeducation (education about disease)	Proportion of patients who have participated in informational sessions about the disease	Process	At least 90 % of the patients have participated in informational sessions about the disease At least 40 % of incident and 20 % of prevalent patients have received psychoeducation from a standardized manual	Medical record	
8. Global assessment of functioning	Proportion of patients whose global assessment function (GAF) score is above 30	result	At least 85 % have GAF score of at least 30 when discharged from hospital or when seen during an annual outpatient evaluation	Medical record	age, gender, education, drug and alcohol abuse, length of time with untreated psychosis

APPENDIX C

DANNY'S STORY

On July 6, 2003 Danny was seen knocking over newspaper boxes and café tables in the West End. He was arrested and held overnight to attend at the provincial court in Vancouver the next morning. He was held in custody because of his lengthy criminal record, which is primarily for property offences. On July 7th, he was brought before the court for a bail hearing. In court, he began screaming so much that the judge adjourned the case overnight so he could be seen by a doctor.

If Danny had been assessed before court, the judge would have had the relevant medical information at his first appearance.

Danny was seen by a psychiatric nurse overnight, and reappeared in court on July 8th. The medical report indicated he was "mentally fit" to understand the proceedings. So he was released on bail with conditions including that he report to the Forensic Outpatients Clinic, and take his medications as prescribed for as long as he consented to.

His conditions also required that he report to his probation officer if he withdrew his consent to take the medications prescribed. Upon hearing this, Danny said to the judge, "If you think I am going to follow these conditions, you're crazy". He was then released, and ordered to return to court on July 16 for another appearance before a judge.

The law in Canada requires offenders to consent to taking medical treatment when courts make this a condition of their release on bail.

The Provincial Court and probation office are located at the corner of Cordova and Main Streets. The Vancouver Forensic Commission and Outpatient Clinic is located in the 300 block of West Broadway, some thirty blocks away, directly through the heart of the skid row area. No arrangements were made to ensure he got to the clinic.

On July 16th, Danny did not come to court as required by the judge on the last court date. The judge issued a warrant for his arrest. On August 3rd, witnesses phoned the police with reports of Danny masturbating on a busy commercial street in the West End.

The police arrested him and he was held in custody overnight. The police report indicated he had no fixed address. At court, he refused to talk to a lawyer or a doctor, and spoke nonsense. Observing this behaviour, the judge ordered that he be held in custody so that a psychiatric assessment could be done within the next 30 days.

The location of these offences is significant because street crime and disorderly conduct, which used to be more concentrated in the Downtown Eastside, have spread across the Downtown area.

On September 2nd, Danny was brought back to court. The psychiatrist's assessment had uncovered a long history of psychoactive substance abuse, drug-induced psychosis and mild mental retardation, and that he had been an inpatient at Riverview Hospital in 2000. Once again, he met the definition of mental fitness for court purposes. He pleaded guilty to the disturbance charge from July 6th. The judge imposed a

suspended sentence and followed the psychiatrist's recommendation and ordered Danny to report to the Forensic Psychiatric Outpatient Clinic and take treatment as prescribed as long as he consented.

This was Danny's second identical order to attend the Psychiatric Outpatient Clinic. There was no information before this judge to show whether he had ever actually attended the outpatient clinic, or if he had any place to live. No attempt was made to specifically address his addiction problems either.

Back in the West End, Danny was sitting in an Internet café after midnight on September 18th. He appeared to be falling asleep, and an employee asked him to leave. He punched the employee in the face a destroyed a computer printer by pushing it off a table. He was once again arrested by the police and held in jail for court.

The next day, the information before the court made reference to Danny's addiction to crystal methamphetamine, but made no mention of his psychiatric history or assessments. Crown Counsel knew there had been a probation order made recently, but did not know its precise conditions. This time, Danny was released on bail on the condition he stay away from the café where the latest incident had occurred.

There was no built-in mechanism to alert justice system personnel to the fact that Danny had recently undergone a psychiatric assessment.

Given sufficient time, case histories could be assembled by each relevant component of the justice system, but there is currently little interface between systems to exchange information. The heavy volume and fast pace of remand courts in Vancouver allows little time to assemble background information.

The two most recent files were not correlated, so the judge on the September 2nd sentencing dealt only with the mental health issues, and the judge on the September 19th bail hearing was not aware of the mental health issues, and although aware of the addiction, did not address that issue. Neither attempted to address the homelessness issue.

On September 22nd, Danny was arrested for being in the vicinity of the Internet Café, contrary to the terms the judge placed on him when he was released the last time. He was annoying customers and staff at another coffee shop in the same area. He was charged with a new offence of breaching the conditions of his release on bail. When he was arrested, he had a glass pipe and several needles in his pockets, and admitted he was addicted to crystal methamphetamine.

When he was brought to court on September 24th, the duty counsel assigned to represent Danny told the court he could not get clear instructions from him. An overnight psychiatric assessment was ordered. The psychiatrist who saw him recommended that the judge order a futher, 30 day in custody assessment, which was completed on September 27th.

This order was made with no knowledge by the court of the previous court-ordered psychiatric assessment approximately one month before.

On October 18th the Forensic Psychiatric Services Commission notified the Court that Danny was still on their waiting list to be assessed and they had no report prepared for the hearing on mental fitness. At that point the judge conducted the fitness hearing by making her own inquiries of Danny and decided he met the legal test for mental fitness.

Crown Counsel asked the court to keep him in custody this time, but he was released and ordered not to go near either of the cafes in the West End, and once again to report to the Forensic Outpatient Clinic and to take his medication.

It is not uncommon for the waiting lists to be too long for assessments to be completed by the date ordered by the court. Judges can be reluctant to detain a person longer for this reason alone.

Danny failed to appear at his next court date on October 22. Warrants for his arrest were issued. The same day the police were called back to the coffee shop in the West End because Danny was refusing to leave. He was arrested on the outstanding warrants. He told the police he didn't care about the criminal charges and would continue to do what he pleased. He was taken to jail over the weekend.

When he appeared in custody in court on the 25th of October, with the assistance of a lawyer, he pleaded guilty to the assault, mischief and breach of bail charges. The judge gave credit for the time Danny had already spent in custody and sentenced him to 15 days total in jail on all charges. When he was released he would be on probation for one year with the same terms he had on bail, requiring him to stay away from the cafes, report to a probation officer and take treatment and prescribed.

These were exactly the same terms he was released on when sentenced on September 6th. Over the four month period, there were four separate police reports filed with Crown Counsel, 10 different Crown Counsel handled the files and Danny appeared before 4 different judges and an unknown number of Justices of the Peace. Each time he came to court, he appeared as one on a list of numerous persons charged with crimes (sometimes up to 50 a day in Bail Court, and up to 150 in Remand Court), many charged with much more serious offences. Up to 40 mentally ill offenders may appear in the courts at Main Street in Vancouver on any day.

Danny was just one of many. The situation facing him upon his release from the October 25th sentence would be no different than it was on July 6th when this story began, despite having appeared before the court 9 times. He would still be homeless, with an untreated mental disorder and drug addiction and he would be right back on the street in the West End.

This is a true story and Danny is a real person (Danny is not his real name).

APPENDIX D

HOSPITAL EMERGENCY DEPARTMENT TRIAGE SCALE

The *Triage and Acuity Scale* for Canadian emergency departments was developed and endorsed by the Canadian Association of Emergency Physicians, the National Emergency Nurses Affiliation of Canada, and L'association des médecins d'urgence du Québec.

The triage scale describes levels of acuity and time to see a physician. Time responses are ideals (objectives), not established care standards. They are based on patient focus – what most of us would want for family members or ourselves – plus the need for timely intervention to improve outcomes. Since it is access to appropriate care not simply physician assessment, the time from triage to see a physician is not a strict requirement and may change based on the introduction of delegated care plans or verbal review with physicians.

Level I *Resuscitation*	Time to physician: Immediate	Threats to life or limb (or imminent risk of deterioration) requiring immediate aggresive interventions.
Level II *Emergent*	Time to physician assessment/interview: 15 minutes	Potential threat to life, limb or function, requiring rapid medical intervention or delegated acts
Level III *Urgent*	Time to physician: 30 minutes	Could possibly progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living.
Level IV *Less Urgent* (semi urgent)	Time to physician: 1 hour	Conditions that relate to patient age, distress, or potential for deterioriation or complications that would benefit from intervention or reassurance within 1-2 hours.
Level V *Non Urgent*	Time to physician: 2 hours	Conditions that may be acute but non-urgent as well as conditions that may be part of a chronic problem with or without evidence of deterioration. Investigation or intervention for some of these illnesses or injuries could be delayed or even referred to other areas of the hospital or health care system.

Psychiatric symptoms categorized as Level II include:

- Agitated symptoms and/or depression symptoms
- Known to require close observation
- Attempted Suicide
- History of attempted suicide
- Aggressive and/or violent behaviour
- Symptoms of instability (pacing, muttering, clenched fists, etc.)
- Overdose (conscious)

Psychiatric patients who may seem to have minor or insignificant problems from the providers point of view but be frustrated by a lack of availability of other health care options that are community specific are categorized as Level V.

APPENDIX E

Victoria's Integrated Mobile Crisis Response Team (IMCRT) Review

Key Findings

GENERAL GOALS	OUTCOMES
Increase the number of crisis calls that can be attended to in any given shift.	**Crisis responders were able to attend more than double the amount of high acuity calls when the plain-clothes officer was on shift.**
Decrease Emergency Room Wait Times.	**On average, patrol officers waited 45 minutes in ER when assisted by IMCRT staff versus 121 minutes when patrol officers attended ER on their own.**
Reduce the amount of time spent coordinating a joint response (e.g. communicating with dispatch, officers on scene, road supervisor, etc.) and decrease in time waiting for police assistance.	**IMCRT wait times for and coordination with police is virtually eliminated when plain-clothes officer was on shift.** **With the IMCRT officer, response times to crisis calls are most frequently occurring within 30 minutes, versus several hours historically.**
Enhanced ability to respond flexibly to fluctuations in service demand in a timely manner.	**An advantage of the IMCRT officer is not being restricted when a response can occur, which results in more clients seen in a timely manner and the ability to respond flexibly to fluctuations in service demand and proportion of high acuity calls.**
Improve privacy/confidentiality for clients.	**Introduction of plain-clothes police officer has resulted in positive initial feedback from other service providers and families, related to the level of intrusion.**
More effectively address staff and public safety issues.	**More efficient transfer of public safety related information between police and clinical staff, thereby more effectively managing risk for the public and for crisis responders.** **Clinical staff reports a marked increase in perceived safety attending to community crisis calls when the IMCRT police officer is on shift.**
Reduced Reliance on Hospital-Based Resources.	**Out of 1200 referrals less than 15% were directed to ER.** **This accounted for a 7.8% decrease in the use of hospital resources compared to historical data.**
Improved Accessibility/Information Sharing	**Police dispatch can immediately access the team via police radio.** **Patrol officers have direct contact with the IMCRT officers enhancing the ability of patrol officers to defer cases to the integrated team.** **IMCRT officers can provide patrol officers with hospital-based information on client's that can impact critical care decision-making on scene and potentially divert patrol officers from attending ER.**

Matching the right combination of clinical/law enforcement expertise to each specific call, thereby promoting the most informed assessment and clinically appropriate disposition.	**Data analysis reveals that the right combinations of professional staff and law enforcement are attending to crisis situations the majority of the time.**
Raise the level of education for police officers regarding mental health issues.	**The IMCRT officers report that they have a better understanding of mental health diagnostic criteria and behavioral interventions with the mentally disordered**.
Respond to Inquest jury recommendations related to improved partnership between police agencies and VIHA.	**The functional integration of plain-clothes police officers into EMHS was examined by and supported in the recommendations from two public inquests (Pagnotta 2004, Camaso 2005).**

APPENDIX F
POLICE/HOSPITAL PROTOCOLS

WINNIPEG PROTOCOL

Transfer of Custody of Mental Health Patients Agreement

The Agreement was signed in 2001 by the **Winnipeg Police Service (WPS)** and the **Health Sciences Centre Site (HSC)** of the **Winnipeg Regional Health Authority (WRHA)**.
The WRHA and the WPS have agreed to a protocol whereby Police would no longer be required to remain with certain persons apprehended under the authority of the Mental Health Act (MHA), whilst awaiting examination in the Emergency Department of the HSC.
The protocol establishes that once certain criteria have been met, persons apprehended under authority of certain MHA sections could be released to the custody of a Security officer employed by the WRHA/HSC.

The criteria required to affect a custodial transfer is as follows (noting that the wording below was prepared for Police.

1. **Police apprehend a person under one of the following Mental Health Act sections:**
   a) Section 8(1) - Application for Involuntary Psychiatric Assessment issued by a physician, or
   b) Section 11(2) - Order for Involuntary Medical Examination issued by a justice, or
   c) Section 12(1) – Emergency Apprehension by a Peace Officer

2. **Police have assessed which hospital would be the most appropriate for the person to receive care** – using the following priority (unless otherwise directed by either a Section 8(1) Application or Section 11(2) Order), and will be attending HSC.
   a) Hospital where the persons Psychiatrist attends, or
   b) If no prior psychiatric history – hospital where the person's family physician attends (or where they have previously received medical care), or
   c) Hospital nearest the person's residence.

3. **The WPS Divisional Shift Supervisor will notify HSC Security Supervisor** (at 787-1943 or 787-4567) that a MHA apprehension has been made, that the unit is attending to HSC and give an estimated time of arrival.

4. **Upon arrival at HSC Emergency WPS Officers <u>must</u> take the person for assessment by the Triage Nurse – no exceptions – do not take to Police Room.** Officers are responsible for informing the Triage Nurse of the reason for the

apprehension, plus any/all details surrounding the person's apprehension and behaviour since their apprehension.

5. **The Triage Nurse, based on information from Police** (and if applicable the Order or Application) **will determine if the patient meets "triage criteria". The Triage Nurse will either direct the patient to the Police Room or another area of the Emergency department.**

6. **The HSC Security Supervisor** (not a Security Officer) **will now assess whether or not the criteria has been made to affect a custodial transfer from Police to HSC Security Officers. The criteria for the custodial transfer are:**
   a) That steps 1 through 5 have been completed.
   b) That the potential for violence is under control, and presents limited risk to HSC staff, the patient or others.

7. **If the HSC Security Supervisor deems the custodial transfer criteria is met, he/she will make available a sworn HSC Security Officer to accept and continue custody of the patient for an examination under the Mental Health Act.** WPS Officers will turn over the custody of the patient and supply the Security Officer with the following information:
   a) Particulars of the patient,
   b) Incident Report # and Officers #s,
   c) Details of the patient's apprehension and behaviour since apprehension, and
   d) Any historical information relating to the patient or the incident.

8. **WPS Officers are only required to return to HSC and re-take custody of the patient if, while in the custody of HSC staff, the patient becomes violent, and the situation becomes out of control.**

If Supervisors or Officers encounter problems with the transfer of a Mental Health patient to HSC Security, the Supervisor should immediately notify the Duty Officer. The Duty Officer will attempt to resolve the problems if deemed necessary. Supervisors and Officers should make every effort to ensure that any such problems are dealt with in a professional manner. Also, please forward a detailed explanation of what occurred to the attention of Staff Sergeant Rick Brereton, WPS Mental Health Liaison Officer. He will attempt to resolve future such problems through his contacts at HSC.

TRANSFER OF CUSTODY OF MENTAL HEALTH PATIENTS AGREEMENT

The administration of the Winnipeg Regional Health Authority and the Winnipeg Police Service have agreed to establish a protocol whereby police would no longer be required to remain with certain persons apprehended under the authority of the Mental Health Act, whilst awaiting examination in the Emergency Department of the Health Sciences Centre.

The protocol establishes that once certain criteria have been met, persons apprehended under the authority of certain Mental Health Act sections could be released to the custody of a Security officer employed by the WRHA/HSC. This agreement takes effect July 1, 2000. The criteria required to affect a custodial transfer is defined as follows:

1) That the person was apprehended by police under:

   a) Section 8(1) Application for Involuntary Psychiatric Assessment or,

   b) Section 11(2) An Order for Involuntary Medical Examination or,

   c) Section 12(1) of the Mental Health Act (Emergency Power), and,

2) police officers have reported to Emergency Department Triage Nurse and provided information of the apprehension, and

3) the potential for violence is under control, and presents limited risk to HSC staff, the patient or others.

The guidelines used by the magistrate for Section 11(2), “An Order for Involuntary Medical Examination” should also be used under Section 8(1), “Application for Involuntary Psychiatric Assessment” and 12(1) “Emergency Power” to ensure that individuals receive care in the most appropriate hospital. These guidelines, listed in a sequential order, can be summarized as follows:

1) individuals should be taken to the hospital where their Psychiatrist attends,

2) individuals with no prior psychiatric history should be taken to the hospital where their family physician attends (or where they have previously received medical care),

3) individuals should be sent to the hospital nearest his/her residence.

By agreement, all but emergency apprehensions (per 1(c) above) and those applications for involuntary psychiatric assessment (per 1 above) where the physician completing the “Form 4” or the person applying for the order for exam has indicated to the police or the magistrate that the patient is at risk for serious harm to self or others

unless he/she is taken into custody as soon as possible, will be carried out between 1500 and 2400 hours, Sunday and Monday; and, 0800 to 1600 hours, Tuesday through Saturday. The Winnipeg Police Divisional Shift Supervisor will notify the HSC Security Supervisor at 787-1943 or 787-4567, and advise that an apprehension has been executed, and an estimated time of arrival. Within the scheduled times, HSC will make available sworn security staff (Special Constable) to accept and continue custody of the patient for an examination under the Mental Health Act. The Security Officer will advise the Duty Security Supervisor of the arrival of Police and patient. Once the Security Supervisor is satisfied that the criteria for the Custodial Transfer have been met, the transfer will take place.

For apprehensions under Emergency Power outside of the scheduled times, Police will contact the Security Supervisor on duty at the Health Sciences Centre, by telephoning 787-1943 or 787-4567, and request that she/he attend at the Emergency Department in order to continue detention of the patient for an examination under the Mental Health Act. Once the criteria have been met and staff are available, the Security Supervisor will assign a sworn Security Officer (Special Constable), to take charge of the patient.

Upon arrival at the Health Sciences Centre with any patient, Officers should proceed immediately to the Triage Nurse and not directly to the Police Room. If the patient meets certain triage criteria, the Nurse will place them in the Police Room. If the triage criteria are not met, the patient will be directed to another area of the department. Police should not leave before the patient is triaged. In all cases Police will ensure all necessary particulars are provided to the Security Supervisor and/or the Security Officer taking charge and control of the patient, including the officers' badge numbers, the patient identity, the complaint report number, details surrounding the patient's apprehension and behaviour exhibited by patient since their apprehension. Any other historical information known by the Police will also be provided. The Security Officer will note this information on his/her report.

If, while in the custody of HSC staff, the patient becomes violent, and the situation becomes out of control, HSC Security will contact Winnipeg Police, and request that they return to re-establish control. Police response will be timely.

Police may obtain the following information for the call history:

1) Names of the Security Supervisor and Security Officer, and;

2) Emergency Department Triage Nurse's name, and;

3) Time the Security Supervisor/Officer was asked to initiate custody, and;

4) Time Security Officer took custody of the patient.

In the event the physician decides not to admit the person as a patient, or not to apply for an involuntary psychiatric assessment and transportation for the person is required back to the place of apprehension, it is understood that hospital staff will arrange transportation for the patient. This arrangement is necessary in order to comply with section 15(3) of the Mental Health Act.

The protocol will continue to be followed by all parties, unless and until, parties agree to amend the procedure.

If either party experiences problems with the process, they will contact the other party to discuss and review. Parties as indicated below:

Signed on behalf of:

_____	_____
Signature – WRHA / HSC Site	Signature – Winnipeg Police Service
_____	_____
Date	Date

Protocol letter of understanding regarding admission procedures at St. Paul's Hospital for Mental Health Act arrests by Vancouver Police Officers

Mental Health Act arrests involve co-operation and efficient processing between police and medical staff.

Emergency arrest provisions are covered in the Mental Health Act as follows:

Section 28

(1) A police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations or information received that a person:

(a) Is acting in a manner likely to endanger that person's own safety or the safety of others

(b) Is apparently a person with a mental disorder.

Once a Mental Health Act arrest has been made by a police officer, the police officer's interests are to pass the arrested party over to the care and custody of medical personnel in an expedient manner, complete required reports and return to service.

The hospital staff's interests are to receive documented information on the circumstances of the patient and their arrest, as well as safe custody of the patient and hospital staff until the patient is in a secure room. St. Paul's hospital is considered a Mental Health Facility, however, the emergency department itself has limited resources with which to deal with aggressive patients.

<u>When Emergency Health Service transports a patient to St. Paul's Hospital Emergency</u>:

(1) Police officers should immediately transmit their PRIME report; then phone transcription at (604) 717-3054, (604) 717-3055 or (604) 717-3056, requesting the file be dealt with as a priority and that a copy be faxed to (604) 806-8573, attention of the Comox Nurse. Police members should ensure that the Emergency Room Triage Nurse receives a copy of the report.

(2) St. Paul's Hospital Emergency Room Triage Nurse and the Comox Nurse in charge will prioritize the placement of the patient in a secure room. Usual processing time is approximately 15 minutes, however, the speed of this may be affected by space and/or staffing.

(3) In concert with the police, hospital security, the Triage Nurse and the Comox Nurse in charge, an evaluation should be conducted as to the immediate physical threat a patient is to themselves or others at the hospital. As Hospital security is limited in their resources to oversee violent patients, police presence will be required until the patient is in a locked area.

Police and medical staff require a means of resolving differences when consensus cannot be reached on evaluations over safety or the necessity for continued police presence. Therefore;

(4) In the event consensus over safety cannot be reached between agencies, a Police supervisor and the St. Paul's Hospital Emergency Comox Nurse in charge will be called to resolve the matter.

(5) Hospital staff will also be advised if further police action is contemplated (such as requesting hospital staff to notify of a patient's pending release when there is an outstanding arrest warrant.)

03.01.15

PROTOCOL FOR COLLABORATION
BETWEEN

CENTRE HOSPITALIER DE L'UNIVERSITÉ DE MONTRÉAL
(CHUM)

AND

THE MONTREAL POLICE SERVICE
(MPS)

PAGE

PREAMBLE

The purpose of this protocol is to establish the procedures for collaboration between the Montréal Police Service (MPS) and the hospitals that are part of the Centre hospitalier de l'Université de Montréal (CHUM) and to clarify the roles and responsibilities of both signatories in the following situations:

1. Actions to be taken regarding a person with mental health problems;
2. Actions to be taken regarding a detained person with mental health problems;
3. Reporting crimes committed by a person with mental health problems;
4. Disappearance of a patient;

The collaborative procedures set forth in this protocol must be carried out with respect for hospital users (patients and visitors), for hospital staff, and in compliance with the policies and procedures of the organizations concerned.

CHAPTER 1

Police and Hospital Intervention Regarding Persons with Mental Health Problems

Application of the *Act respecting persons whose mental state presents a danger to themselves or to others* (R.S.Q., c. P-38.001)

A police officer who, pursuant to the *Act respecting persons whose mental state presents a danger to themselves or to others* (R.S.Q., c. P-38.001) transports a person to a hospital, is responsible for the surveillance and custody of that person until such time as the health care team assumes full and safe custody of that person.

If the patient's state of health is precarious or requires emergency care, the police officer must call Urgences-santé [Montreal's ambulance service] to transport the person to the hospital. A police escort must accompany the ambulance and the patient at all times. In all other cases, the police officer may take the person to the hospital in his or her patrol car.

1.1. Montreal Police Service (MPS) Responsibilities

1.1.1. Before arrival at Emergency:

If possible, before arriving at Emergency, the police officer should notify the Division du traitement des appels (DTA) [*police call centre*] which will then call the assistant head nurse in Emergency at the telephone numbers listed in Appendix 1, and do the following:

- Advise the nurse of the imminent arrival of the person and the police;
- Provide the nurse with information regarding the person's mental state and specific behavioral characteristics (violence, aggression, mental health-related symptoms, escape risk, need for restraints, etc.);
- Provide the nurse with any other information pertinent to receiving and treating the person.

1.1.2. Upon arrival at the hospital:

Upon arrival at Emergency, the police officer in charge of the person must meet the triage nurse in order to do the following:

- Let the nurse know that they have arrived;
- Give the nurse his or her name and officer number and obtain the nurse's name and number, for noting in their respective reports (incident report and triage log);
- Register the person;

- Confirm the information already provided and give any other information pertinent to the patient's treatment;

- With the triage nurse, assess the manner in which the patient should be controlled, and, as required, restrain or isolate the person;

- Get directions from the triage nurse for the appropriate place to take the patient while waiting for medical assessment.

The police officer must also do the following:

- Accompany the patient and guard the patient until hospital staff take over fully and safely;

- Use the telephone and report room designated by the triage nurse;

- Give a copy of the incident report to the triage nurse;

- If a doctor requires that the consultation take place without the police officer being present or that the person's handcuffs be removed, the police officer in charge of the person must, if the person is a threat to the safety of others or is an escape risk, meet with the doctor and advise him or her of that fact.

  If, despite this Notice, the doctor decides to conduct an examination treat the patient without the police being present and with the person's handcuffs removed, where the person's handcuffs are removed, the police officer in charge of the person must complete the form Notice the doctor entitled "NOTICE TO PHYSICIAN" (Appendix 2).

1.2. CHUM Responsibilities

The triage nurse must ensure that the patient and police officer are seen as soon as possible. The triage nurse interviews the police officer responsible for the patient in order to do the following:

- Confirm the information already provided by the DTA dispatcher and note any other pertinent information;

- Register the patient;

- Assess the patient according to the Triage and Acuity Scale (TAS);

- Assess the need to control the patient and as required, restrain or isolate the person;

- Record the officer's name and number in the triage log;
- Direct the police and the patient to an appropriate place and, where possible, to a place adapted to the needs of both the officer and the patient;
- Ensure that staff take over surveillance of the patient as soon as possible so that the officer can leave as quickly as possible;
- Inform the police of the patient's status for police report purposes.

CHAPTER 2

Police and Hospital Intervention Regarding a Detained Person

Where a detainee's physical or mental state is precarious and requires medical treatment, that person must be taken to a hospital.

Where a detainee's state of health requires emergency care, the police officer must call an ambulance to transport the detainee to a hospital. A police escort must accompany the ambulance and detainee at all times. In non-emergency situations, the detainee is taken directly to the hospital by the police.

2.1. MPS Responsibilities

2.1.1. Before arrival at Emergency:

Where the person comes directly from a place requiring police intervention, the arresting police officer must inform the DTA [call center] so that the dispatcher can call the assistant head nurse in the emergency ward concerned, at the telephone number indicated in Appendix 1.

If the person comes from an operational support division (detention), the supervisor of that division must call the assistant head nurse in Emergency.

The purpose of the call is to do the following:

- Advise the nurse of the imminent arrival of the detainee and the police;
- Provide pertinent information on the state and specific condition of that person (violence, aggression, mental health-related symptoms, escape risk, need for restraints, etc.);
- Provide any other pertinent information helpful for receiving and treating the detainee.

2.1.2. Upon arrival at the hospital:

Upon arrival at the hospital emergency ward, the police officer guarding the detainee meets with the triage nurse in order to do the following:

- Let the nurse know that they have arrived;
- Give the nurse his or her name and officer number and obtain the same information from the nurse, for recording in their respective reports (incident report and triage log);
- Register the person;
- Confirm the information provided and give any other information pertinent to the detainee's treatment;
- With the triage nurse, assess the manner in which the detainee should be controlled and, as required, have the detainee restrained or isolated;

- Have the triage nurse direct the detainee and police officers to an appropriate place to guard the detainee while waiting for care, in accordance with both the patient's state and hospital constraints.

The police officer must also do the following:

- Use the telephone and report room designated by the triage nurse;

- If a doctor requires that the consultation be conducted alone without the police being present or that the detainee's handcuffs be removed, the police officer in charge of the detainee must, if in the circumstances the detainee is a threat to others or is an escape risk, ask to see the doctor to advise him or her of that fact.

  If nevertheless the doctor decides to conduct the examination alone without the police being present or have the detainee's handcuffs removed, the police officer in charge of the detainee must complete the form Notice the doctor entitled "NOTICE TO PHYSICIAN " (Appendix 2).

2.2. CHUM Responsibilities

The triage nurse must ensure that the detainee and police are received as soon as possible.

The triage nurse must interview the police officer responsible for the custody of the patient in order to do the following:

- Assess the detainee's medical condition;

- Confirm the information provided by the MPS and note any other information that the nurse considers pertinent for treating the detainee;

- Assess the need to control the detainee and, as required, have the detainee restrained or isolated;

- Direct the police officer and the detainee to an appropriate place for guarding the detainee while waiting for treatment, in accordance both with the detainee's state and hospital constraints;

- Ensure that the name and number of the police officer accompanying the detainee are recorded in the triage log.

2.3. Conditions specific to detention in a hospital

- The police are responsible for guarding the detainee anywhere in the hospital and must therefore accompany the detainee when taken elsewhere in the hospital and examined, as required by his or her medical condition. The medical staff must advise the police whenever the patient must be moved;

- Custody of the detainee is ensured by one or two police officers depending on the nature of the intervention. If the duration of custody so requires, the police officers shall co-ordinate their replacement to ensure that the detainee is under constant guard. Police must introduce themselves to the **head nurse** when they come on duty.

- Upon completion of the arresting officers' reports, co-ordination of custody is transferred by the supervisor of the police station (NPS) where the arrest took place to the supervisor of the operational support division in the police station supervisor's area.

2.4. Termination of police custody

2.4.1. Release upon promise to appear

2.4.1.1. MPS Responsibilities:

- Where the nature of the case and the public interest does not warrant keeping the detainee in custody until trial, the patient must be released by the police officer upon a promise to appear in court on the date and time fixed and, where applicable, on certain conditions.

- The police officer in charge of the detainee's custody shall advise the assistant head nurse that custody is terminated and that he or she intends to leave the hospital, subject to the following conditions:

A. If the detainee is in the hospital's care, the police may leave **without further formality**. NOTE: the formulation suggested regarding full and actual surveillance does not apply in criminal matters but only in the case of a person with mental health problems, which topic is dealt with in B. In such a case, if the person is already admitted, he or she is therefore under hospital control, which ensures effective custody.

B. If the detainee is not the hospital's care but nevertheless appears to be a danger to himself or others, the police must, before leaving, discuss the matter with the doctor **or** assistant head nurse to ensure that hospital staff are capable of real and complete surveillance of the person.

2.4.1.2. CHUM Responsibilities:

- The assistant head nurse advised of the termination of custody must ensure that the person is actually under the hospital's care and confirm this to the police.

- Where person appears to be a danger to himself or others and has not yet been admitted, the assistant head nurse must arrange for actual and full surveillance as soon as possible.

2.4.2. Termination of custody after appearance

2.4.2.1. Appearance in Court

- If the detainee's state allows, he or she is transported to court to file an appearance, subject to authorization by the attending physician.

- If the detainee cannot be transported to court because of his or her state or treatment, court appearance takes place as provided for in the next point.

2.4.2.2. Hospital appearance

- If the detainee cannot be transported to court because of his or her state or current treatment, the supervisor of the operational support division advises the assistant head nurse of the procedure for hospital appearance.

- After the hospital appearance, the supervisor of the operational support division shall inform the assistant head nurse whether the patient has been released or must remain in custody, which continues under the authority of correctional services.

CHAPTER 3

Reporting of Crimes Committed by a Patient

An act deemed unacceptable outside a hospital is also deemed unacceptable when it occurs inside a hospital. Therefore, a police officer called on to intervene regarding a patient (hospitalized under observation or registered) who commits an offence inside a hospital should respond in the same way he or she would if the person was outside the institution.

3.1. Responsibilities of the CHUM

3.1.1 When a patient commits a crime, the head nurse of the department in question, or his or her representative, after having secured the patient, convenes a meeting of the multidisciplinary team for a discussion and decision regarding reporting the crime for possible prosecution.

3.1.2 If a decision is made to report the crime, the head nurse or his or her representative calls 911 to summon the police.

3.1.3 In no circumstances shall the reporting of a crime result in cutting short the hospital stay of a patient considered disruptive or burdensome or in transferring the patient for administrative reasons.

3.1.4 After taking into consideration the patient's condition, case history and required treatment, the doctor or head nurse or their representative must inform the police whether, despite that a crime has been reported, it is preferable that the patient remain hospitalized or be taken into custody by the police.

3.1.5 The hospital will make available the staff members involved in the incident reported so that they may meet with police for reports to be made and an investigation undertaken.

3.2. Responsibilities of the MPS

3.2.1 Police officers responding to a call regarding a crime committed by a hospital patient shall follow the same procedures used in other cases for securing the crime scene, meeting witnesses and preparing reports.

3.2.2 In no circumstances shall the police prepare an incident report for administrative purposes only (i.e. only to record the incident and where hospital staff prefer not to file a formal criminal complaint).

3.2.3 After discussing the danger presented by the patient with the doctor and the head nurse or his or her representative, and after taking into consideration the seriousness of the offence, the police officers determine if the patient should remain hospitalized despite having reported the incident for possible prosecution or having decided that the patient should be arrested and detained for a court

appearance. If necessary, police officers will discuss the matter with their supervisor to make an appropriate decision in the circumstances.

3.2.4 The supervisor of the NPS involved in the file will inform the head nurse of the department concerned of the progress of any complaint regarding crimes committed in the care unit. To this end, the supervisor will request that the investigating officer report on the status of "second level" complaints (that is, incidents where there was no immediate arrest) and, as regards other incidents, will make the necessary inquiries with the NPS police officers.

CHAPTER 4

Disappearance of a Patient

For the purpose of this protocol, "disappeared" means any patient who is incapacitated, confused or presents a danger to himself or herself or others and whose absence from the hospital cannot be explained.

4.1. CHUM Responsibilities

- Before declaring that a patient has "disappeared", the assistant head nurse of the department involved or his or her representative will make inquiries within the care unit and with the person's family, significant other or legal representative. Unless the patient is found, the assistant head nurse will have the security service of the hospital verify that the patient is not somewhere in the hospital.

- The hospital's security service, upon being notified of the disappearance, must immediately search for the patient on the premises and in the vicinity of the hospital.

- Before notifying the MPS of the disappearance, the assistant head nurse of the department involved, or his or her representative, in collaboration with the patient's nurse, will review the patient's condition in the hours preceding the disappearance (legal status, treatment plan, suicide or homicide risk) as well as the external danger factors (weather, state of health, etc.) in order to determine if the patient, his or her relatives, those close to the patient or any other person is at risk and whether to advise the police of this risk. The assistant head nurse will also notify the head nurse or the activities coordinator.

- Where relevant, the assistant head nurse of the department involved, or his or her representative, shall inform the family, significant other or legal representative by phone of the patient's disappearance. The CHUM security service shall advise the MPS of the disappearance by contacting 911.

- The "PATIENT DISAPPEARANCE" form (Appendix 4) must be filled out by hospital staff and faxed to the NPS responsible for the search or given to the police officers upon their arrival.

- If a patient reported missing is found or located by someone other than an MPS police officer, the nurse in charge of the case must immediately notify the officers in charge of the search or 911, the security service, the head nurse or the activities coordinator.

- In the event the patient returns of his own volition, the nurse responsible must immediately notify the police officers in charge of the search or 911, the security service, the head nurse or the activities coordinator, in order to cancel the notification of the disappearance, and must also notify the patient's family, significant other or legal representative.

- Any member of the hospital staff who notices signs of mistreatment on the patient upon his or her return must if the patient consents, immediately notify the police.

4.2. MPS Responsibilities

- The NPS in charge of the search must, upon receipt of the "PATIENT DISAPPEARANCE" form, confirm the notification of disappearance by assigning it an incident number.

- The NPS must also communicate the incident number to the assistant head nurse of the department in question, or his or her representative, by phone or fax so that he or she can record the number in the patient's medical file.

- The police officers must follow the proper procedures as set out in Procedure 249-6 of the MPS Manual.

- During the search, the police officers must stay in touch with the assistant head nurse of the department in question, or his or her representative, to keep him or her abreast of any steps taken and the status of the file

- When the missing patient is found, the police officers must accompany him or her back to the care unit or, where necessary due to the person's condition, to Emergency.

CHAPTER 5

Protocol Management

5.1. Reporting an Incident

If, due to the conduct of a person or an organizational issue, a particular problem arises regarding the application of this Protocol, the parties agree to report the incident and to collaborate to find a joint solution to the problem.

5.1.1. Reporting by the CHUM:

Within the institution, the head nurse or assistant head nurse of Emergency or the department in question or the hospital's activities coordinator (for the evening and the night) will communicate with the police officers involved. As soon as possible, the supervisor will take any measures necessary to resolve the problem.

If necessary, an incident report drawn up following the format of Appendix 3 will be sent by the head nurse of the department in question to the police officers' commanding officer. The commanding officer will verify the status of the case and the steps taken to correct the situation and report back to the head nurse.

5.1.2. Reporting by the MPS:

If an exceptional problem is encountered by the police officers in charge of responding to an incident, they must inform their supervisor. The supervisor will call the head nurse or assistant head nurse of Emergency or of the department involved (daytime) or the activities coordinator for the hospital (for evening and night) at the phone numbers indicated in Appendix 1. The head nurse or assistant head nurse or activities coordinator must immediately take measures to remedy the problem.

If necessary, an incident report in the format of Appendix 3 should be sent by the supervisor to the head nurse, and a copy sent to the Director of Professional Services. The head nurse will verify the status of the file and the steps taken to rectify the situation and report back to the supervisor and hospital staff involved.

5.2. Issues Related to Internal Procedures

In the event of misunderstandings resulting from the application of internal procedures or directives of the participating organizations, the Director of Professional Services of the hospital in question and the commanding officer of the unit involved will meet to find a solution to the issue.

5.3. Follow-up Regarding Incidents and Other Issues

Follow-up regarding incidents reported and other issues will be undertaken by a committee made up of persons designated by each of the parties. If the committee decides that changes should be made to the Protocol, the changes will be proposed and incorporated in the Protocol after agreement and signature of each of the parties.

CHAPTER 6

Term of the Protocol and Follow-Up

6.1. Term of the Protocol:

This protocol shall be in force for an initial period of one year as of the date of its signature. It will be renewed for a similar period, unless one of the parties gives written notice of at least one month indicating its intention to terminate the collaboration.

6.2. Follow-up to the Application of the Protocol:

Follow-up regarding application of this Protocol will be undertaken by a committee made up of persons designated by each of the parties. If the committee decides that changes should be made to the protocol, the changes will be proposed to each of the parties and incorporated the protocol after agreement and signature of each of the parties.

The parties have signed in Montreal this _____2006.

For the Montreal Police Service (MPS)	**For the Centre Hospitalier de l'Université de Montreal (CHUM)**
_____	_____

APPENDIX 1

Telephone List of the Relevant Parties

CHUM:

Doctor Charles Bellavance
Director of Professional Services
CHUM (Saint-Luc, Notre-Dame et Hôtel-Dieu)
1560 Sherbrooke St. East
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Tel.: (514) 890-8000, ext. 8003
Fax: (514) 412-7568
Charles.bellavance.chum@ssss.gouv.qc.ca.

Doctor Louise Clément
Assistant Director of Professional Services
CHUM (Saint-Luc, Notre-Dame et Hôtel Dieu)
1560 Sherbrooke St. East
Montreal, Quebec, H2L 4M1
Tel: (514) 890-8000 ext. 14168
Fax: (514) 412-7226
Louise.clement.chum@ssss.gouv.qc.ca

Colombe Gagnon
Head Nurse
CHUM (Hôtel-Dieu)
3840 Saint-Urbain St.
Montreal, Quebec, H2W 1T8
Tel.: (514) 890-8000, ext. 15002
Fax: (514) 412-7216
Colombe.gagnon.chum@ssss.gouv.qc.ca.
Assistant Head Nurses: ext. # 15180
Louise Deshaies (day), Francine Poulin (evening), Claire Landry (night)

Activities Coordinator
CHUM (Hôtel-Dieu)
Evening-Night during the week **et**
Day-Evening during weekends:
(514) 890-8000 dial 01 and ask the operator for the coordinator on duty

Micheline Ulrich
Administrative Assistant for Nursing Care
CHUM (Hôpital Notre-Dame)
1560 Sherbrooke St. East
Montreal, Quebec, H2L 4M1
Tel.: (514) 890-8000, ext. 28416
Fax: (514) 412-7576
Micheline Ulrich.chum@ssss.gouv.qc.ca.

Marc Pépin
Head Nurse
CHUM (Hôpital Notre-Dame)
1560 Sherbrooke St. East
Montreal, Quebec, H2L 4M1
Tel.: (514) 890-8000, ext. 26327
Fax: (514) 412-7650
Marc.pepin.chum@ssss.gouv.qc.ca.
Assistant Head Nurses: ext. 24801
Manon Bourque et Claire Lebel (day)
Manon Pelletier (evening), Noëlla Perron (night)

Activities Coordinator

CHUM (Notre-Dame)
Evening- Night during the week **and**
Day- Evening – Night during weekends:
(514)890-8000 dial 02 and ask the operator for the coordin on duty

Nathalie Caya
Head Nurse
CHUM (Hôpital Saint-Luc)
1001 St-Denis St.
Montreal, Quebec, H2X 3H9
Tel.: (514) 890-8000, ext. 36359
Fax: (514) 412-7406
Nathalie.caya.chum@ssss.gouv.qc.ca.
Assistant Head Nurses: ext. 34551
Diane Croteau (day), Steven Hamel, (evening),
Louise Gauthier (night)

Activities Coodinator:
CHUM (Hôpital Saint-Luc)
Evenings during the week: (514) 230-7315
Nights during the week: (514) 230-8234
Day- Evening during the week: from 7:30am to 7:30pm: (5 230-7315
Evenings-Nights during weekend: from 7:30pm to 7:30am: (514) 230-8234

MPS: Telephone List of Relevant Parties

The telephone list for the relevant parties of the MPS to be completed.

APPENDIX 2

"Notice to Physician" Form

City of Montreal

NOTICE TO PHYSICIAN
HANDCUFFED PERSON

INCIDENT NUMBER

NAME AND ADDRESS OF HOSPITAL CENTRE

INFORMATION ON THE PERSON DETAINED

SURNAME AND FIRST NAME	DATE OF BIRTH

We, the undersigned, police officers with the Montreal Police Service, have determined that the person whose name appears above represents an imminent, grave and serious threat to his or her security and the security of others for the following reason (s):

☐ violent ☐ unstable ☐ escaped from legal guardians ☐ suicidal

For this reason, we are of the opinion that he or she must remain under our constant surveillance and handcuffed, including during those times he or she will be dealing with a physician.

We have formally notified the physician:_____(Name of physician) of the danger to which he or she is being exposed and is exposing the nursing staff and patients of the hospital in requiring that this person have his handcuffs removed and released from our supervision.

DIRECTIVES OF THE TREATING PHYSICIAN TO POLICE OFFICERS

SIGNATURE OF POLICE OFFICER (RANK AND/OR STAFF NUMBER)	SIGNATURE OF POLICE OFFICER (RANK AND/OR STAFF NUMBER)	
SIGNATURE OF TREATING PHYSICIAN	**INITIALS OF OFFICERS IF REFUSAL TO SIGN**	**DATE (YEAR-MO-DAY)**
RECIPIENTS →	ORIGINAL: UNIT	COPY (IES):

F.XXX-XX (2003-09-10) Method – to be completed

APPENDIX 3

INCIDENT REPORT

From: _____

Institution		Telephone	Fax	Email
q **Hôpital Hôtel-Dieu**	PSD:	890-8003	412-7568	charles.bellavance.chum@ssss.gouv.qc.ca
Head Nurse:		890-8000, ext. 15002	412-7216	colombe.gagnon.chum@ssss.gouv.qc.ca
q **Hôpital Notre-Dame**	PSD:	890-8003	412-7568	charles.bellavance.chum@ssss.gouv.qc.ca
Head Nurse:		890-8000, ext. 26327	412-7650	marc.pepin.chum@ssss.gouv.qc.ca
q **Hôpital Saint-Luc**	PSD:	890-8003	412-7568	charles.bellavance.chum@ssss.gouv.qc.ca
Head Nurse:		890-8000, ext. 36359	412-7314	nathalie.caya.chum@ssss.gouv.qc.ca
q **Operational Support South**	:	280-0271	280-0671	To be completed:NOTE:Is this the only number that must be filled in?

TO:_____

Date and Time of Incident: _____

Description of the Incident: _____
_____
_____
_____
_____

Desirable Outcome: _____
_____
_____

Steps Taken: _____
_____
_____
_____
_____
_____
_____
_____

Prepared by:	Title:	Signature:	Tel.:
Recipients:			

➥ xxi

APPENDIX 4

Patient Disappearance Form

CHUM

☐ HÔTEL-DIEU
☐ HÔPITAL NOTRE-DAME
☐ HÔPITAL SAINT-LUC

Incident Number	Date:	Time of the Call:

PATIENT DISAPPEARANCE

Room Number:	Time of the Disappearance:	State of Health (confused, ROH)
Patient Mobility (wheel chair, walker, canes, etc.)	Smoker Yes/No	Accompanied: Yes / No If yes, number of persons:

UNAUTHORIZED ABSENCE

COURT ORDER:

☐ CIVIL ORDER (SPECIFY NATURE OF TREATMENT AND CONDITIONS ATTACHED TO SAME)
☐ CRIMINAL ORDER (SPECIFY IF IS COURT OR TAQ (ADMINISTRATIVE TRIBUNAL OF QUEBEC) AND CONDITIONS ATTACHED)
☐ NO ORDER BUT "PERSON DANGEROUS TO SELF OR OTHERS" (NOTE: A PERSON IN OPEN-DOOR TREATMENT MAY ALWAYS LEAVE. THAT PERSON CAN THEREFORE NOT BE ON AN UNAUTHORIZED ABSENCE. TO INDICATE THAT A PERSON PRESENTS A DANGER AND NEEDS TO BE LOCATED, IT IS NECESSARY TO INDICATE "PERSON DANGEROUS TO SELF OR OTHERS"

DESCRIPTION

Surname, First name:		Age:	Sex: M / F
Language spoken:		Nationality:	
Height:	Weight kg_lbs	Eyes: Glasses (regular, sun) Yes / No	
Hair (long, short, curly / moustache, beard): Colour:		Distinctive marks or features (jewellery, scars, tattoos):	

DRESS

Shirt, sweater, tie (striped, logos): Colour:	Pants, skirt, dress, shorts (brand, style): Colour:
Tuque, hat, cap (logos): Colour:	Coat (style, long, short, brand, logos): Colour:
Shoes (sport, dress, boots, etc.): Colour:	Hospital robe: Yes / No House coat: Yes / N o Colour:

RISK FACTORS: (epilepsy, diabetes, hallucinations, confusion, mistrustful, risk of suicide, aggressive, dangerous, other) **Specify and give short explanation to help guide police**			
Other relevant information and follow-up (Contact information for relatives, person found, etc.)			
PREPARED BY:	TITLE:	SIGNATURE:	TELEPHONE:
RECIPIENTS:			

1) NOTE: The form must include a place to indicate whether the person is the subject of a civil or criminal order or presents a danger to himself or herself or others since the extent of the police authority depends on this information.

2) NOTE: If this report must be faxed to the neighbourhood police station, the fax number must be included.

*****The form must be in legal format, similar to police reports.**

APPENDIX 5

Committee Responsible for Follow-up Regarding Application of the Protocol, Incidents Reported and Other Issues

The committee is composed of the following people:

CHUM	MPS

TO BE COMPLETED

APPENDIX 6

GLOSSARY

CHUM	Centre Hospitalier de l'Université de Montréal [*University of Montreal Hospital Centre*], which includes three institutions: ▪ Hôtel Dieu de Montréal, ▪ Hôpital Notre-Dame, ▪ Hôpital Saint-Luc
COMMANDING OFFICER	Person in charge of a unit of the Montreal Police Service (MPS)
ACTIVITIES COORDINATOR	Person (manager) on duty evenings, weekends and on statutory holidays who acts as a resource person regarding any clinical or administrative issues for the hospital.
DETAINEE	Person arrested by the police and under their control because suspected of having committed an offence or regarding whom an arrest or imprisonment warrant is outstanding
DTA	Logistical dispatch division (Police Call Centre): Unit of the MPS responsible for answering, dispatching and following-up on calls
TAS	Triage and Acuity Scale
TRIAGE NURSE	Nurse responsible for the initial evaluation of a patient upon his/he arrival at the emergency
ASSISTANT HEAD NURSE	Nurse who assists and replaces the head nurse in administrative matters
PATIENT	A person hospitalized or under observation in a hospital
NPS	Neighbourhood police stations
MPS	Montreal Police Service
SUPERVISOR	Police officer supervising officers for whom he is responsible and whose activities he coordinates

APPENDIX G:
POLICE CONTACTS IN BRITISH COLUMBIA

B.C. ASSOCIATION OF MUNICIPAL CHIEFS OF POLICE

	EXECUTIVE FOR 2006 / 2007 President (Chair) - C/Cst. Dan Maluta Vice President - D/C/Cst. Bob Rich Secretary / Treasurer - C/Cst. Paul Hames	
1.	**Abbotsford Police Department** 2838 Justice Way Abbotsford, BC V2T 3P5 Chief Constable Ian Mackenzie Phone General Executive Fax Email Assistant: Susan Willms Email	 604-859-5225 604-864-4809 imackenzie@abbypd.ca 604-864-4724 swillms@abbypd.ca
	Deputy C/Cst. Rick Lucy Email	 rlucy@abbypd.ca
2.	**Central Saanich Police Service** 1903 Mt. Newton Cross Road Saanichton, BC V8M 2A9 chief Constable Paul Hames Fax Email Assistant: Elizabeth Trudeau Email	 250-652-0354 paul.hames@csaanich.ca 250-652-4441 liz.trudeau@csaanich.ca
	Deputy C/Cst. Clayton Pecknold Email	 clayton.pecknold@csaanich.ca
3.	**Delta Police Department** 4455 Clarence Taylor Crescent Delta, BC V4K 3E1 Chief Constable Jim Cessford Phone General Executive Fax Email Assistant: Diane Hansen Email	 604-946-4411 604-946-4682 jcessford@police.delta.bc.ca 604-940-5009 dhansen@police.delta.bc.ca
4.	**Nelson Police Department** 606 Stanley Street Nelson, BC V1L 1N4 Chief Constable Dan Maluta Phone General	 250-354-3919

	Fax Email Assistant: Shana Paivarinta Email	250-354-4179 chief@nelsonpolice.ca 250-505-5653 administration@nelsonpolice.ca
	Inspector Henry Paivarinta Email	 Inspector@nelsonpolice.ca
5.	**New Westminster Police Service** 555 Columbia Street New Westminster, BC V3L 1B2 Chief Constable Lorne Zapotichny Phone General Fax Email Assistant: Simone Gardner Email	 604-525-5411 604-529-2401 lzapotichny@nwpolice.org 604-529-2412 sgardner@nwpolice.org
	Deputy C/Cst. Mike Judd Email	 mjudd@nwpolice.org
6.	**Oak Bay Police Department** 1703 Monterey Avenue Victoria, BC V8R 5V6 Chief Constable Ben Andersen Fax Email Assistant: Carol Jenkins Email	 250-592-9988 bandersen@oakbaypolice.org 250-592-2424 cjenkins@oakbaypolice.org
	Deputy Chief Constable Ron Gaudet Email	 rgaudet@oakbaypolice.org
7.	**Port Moody Police Department** 3051 St. John's Street Port Moody, BC V3H 2C4 Chief Constable Paul Shrive Phone Fax Email Assistant: Barbara Blackwood Email	 604-461-3456 604-461-1734 paul_shrive@portmoodypolice.com 604-469-4652 barbara_blackwood@portmoodypolice.com
	D/C/Cst. Pat Fitzgerald Email	 pat_fitzgerald@portmoodypolice.com
8.	**Saanich Police Department** 760 Vernon Avenue Victoria, BC V8X 2W6 Chief Constable Derek Egan	

	Phone General Executive Fax Email Assistant: Heather Putney Email	250-475-4321 250-475-6138 degan@saanichpolice.ca 250-475-4322 hputney@saanichpolice.ca
	Deputy C/Cst. Mike Chadwick Email	 mchadwick@saanichpolice.ca
9.	**Vancouver Police Department** 2120 Cambie Street Vancouver, BC V5Z 4N6 Chief Constable Jamie Graham Executive Phone General Executive Fax Email Assistant: Kim Carter Email	 604-717-2950 604-665-3417 jamie.graham@vancouver.ca 604-717-2964 kim.carter@vancouver.ca
	Deputy C/Constable Max Chalmers Email Assistant: Janeen Curley Email	 max.chalmers@vpd.ca 604-717-3086 janeen_curley@city.vancouver.bc.ca
	Deputy C/Constable Jim Chu Email Assistant: Jean Sinclair Email	 jim_chu@city.vancouver.bc.ca 604-717-3191 jean_sinclair@city.vancouver.bc.ca
	Deputy C/Constable Doug LePard Email Assistant: Aimee Szymczak Email	 doug.lepard@vancouver.ca 604-717-3705 aimee_szymczak@city.vancouver.bc.ca
	Deputy C/Constable Bob Rich Email Assistant: Colleen Andersen Email	 bob.rich@vpd.ca 604-717-3164 colleen_andersen@city.vancouver.bc.ca
10.	**Victoria Police Department** 850 Caledonia Avenue Victoria, BC V8T 5J8 Chief Constable Paul Battershill Fax Email Assistant: Jo-Anne Zimmerman Email	 250-384-1362 battershillp@police.victoria.bc.ca 250-995-7217 zimmermanJ@police.victoria.bc.ca

	Deputy C/Cst. Geoff Varley Email	 varleyg@police.victoria.bc.ca
	Deputy C/Cst. Bill Naughton Email	 naughtonb@police.victoria.bc.ca
11.	**West Vancouver Police Department** 1330 Marine Drive West Vancouver, BC V7T 1B5 Chief Constable Scott Armstrong Phone General Executive Fax E-mail Assistant: Jennifer Steeksma Email	 604-925-7300 604-925-5938 scottarmstrong@westvancouverpolice.ca 604-925-7309 jennifersteeksma@westvancouverpolice.ca
12.	**Combined Forces Special Enforcement Unit of BC** P.O. Box 42529 New Westminster, BC, V3M 6H5 Chief Officer Marianne Ryan Fax Email Assistant: Stephanie Rust Email Assistant: Sue Harper Email	 604-777-7810 marianne.ryan@cfseu.bc.ca 604-777-7841 stephanie.rust@cfseu.bc.ca 604-777-7806 sue.harper@cfseu.bc.ca
13.	Greater Vancouver Transportation Authority Police Service - GVTAPS 307 Columbia Street New Westminster, BC V3L 1A7 Chief Officer Bob Kind Fax Email Deputy Chief Officer Ken Allen Email Transition Coordinator: Beth Nielsen Email Admin Assistant: Cheryl Day Email	 604-540-8336 robert.kind@gvtaps.bc.ca ken.allen@gvtaps.bc.ca 604-515-8358 beth.nielsen@gvtaps.bc.ca 604-515-8336 cheryl.day@gvtaps.bc.ca

	ASSOCIATE MEMBERS	
14.	Ministry of Public Safety & Solicitor General Kevin Begg, Assistant Deputy Minister and Director of Police Services Policing and Community Safety Branch PO Box 9285 Stn Prov Govt Victoria, BC V8W 9J7 Fax Email Assistant: Nicole Butterfield Email	Membership Date: 250-356-7747 kevin.begg@gems2.gov.bc.ca 250-387-1100 nicole.butterfield@gems8.gov.bc.ca
	Sam MacLeod - Associate Director Email Assistant: Melinda (Mindy) Dick Phone Email	Samuel.macleod@gov.bc.ca 250-387-6943 Melinda.dick@gems8.gov.bc.ca
15.	Justice Institute of British Columbia Police Academy 715 McBride Blvd. New Westminster, BC V3L 5T4 Mike Trump, A/Director Fax E-mail Assistant: Susan Huffman Email	 Membership Date: September 2003 604-528-5754 mtrump@jibc.bc.ca 604-528-5767 shuffman@jibc.bc.ca
16.	RCMP North Vancouver Detachment 147 E 14th Street North Vancouver, BC V7N 2N4 Superintendent Gord Tomlinson Pager Email Assistant: Kelly Weeks Email	Membership Date: 604-667-5405 gord.tomlinson@rcmp-grc.gc.ca 604-990-7474 kelly.weeks@rcmp-grc.gc.ca

ROYAL CANADIAN MOUNTED POLICE DETACHMENTS IN BRITISH COLUMBIA

Some detachments use a third party service called ECOMM when you dial 911. Those detachments are identified by an *****.

Headquarters
657 West 37th Ave.
Vancouver, BC V5Z 1K6
Telephone: 604-264-3111

Detachment	Address	Town/City	Telephone
Agassiz	6869 Lougheed HWY BOX 349 V0M 1A0	Agassiz	(604) 796-2211
Ahousaht	400 Campbell ST BOX 280 V0R 2Z0	Tofino	(250) 670-9612
Alert Bay	BOX 370 V0N 1A0	Alert Bay	(250) 974-5544
Alexis Creek	BOX 40 V0L 1A0	Alexis Creek	(250) 394-4211
Anahim Lake	GD V0L 1C0	Anahim Lake	(250) 742-3211
Armstrong	3710 Pleasant Valley,BOX 558 V0E 1B0	Armstrong	(250) 546-3028
Ashcroft	720 Elm ST BOX 100 V0K 1A0	Ashcroft	(250) 453-2216
Atlin	BOX 10 V0W 1A0	Atlin	(250) 651-7511
Barriere	478 Barriere Town RD BOX 360 V0E 1E0	Barriere	(250) 672-9918
Bella Bella	GD V0T 1Z0	Waglisla	(250) 957-2388
Bella Coola	BOX 123 V0T 1C0	Bella Coola	(250) 799-5363
Boston Bar	BOX 340 V0K 1C0	Boston Bar	(604) 867-9333
Bowen Island *	BOX 219 V0N 1G0	Bowen Island	(604) 947-0516
Burnaby Mun	6355 Deer Lake AVE V5G 2J2	Burnaby	(604) 294-7922
Burns Lake	201 HWY 35 BOX 759 V0J 1E0	Burns Lake	(250) 692-7171
Campbell River Mun	275 S Dogwood ST V9W 8C8	Campbell River	(250) 286-6221

Castlegar	440 Columbia AVE V1N 1G7	Castlegar	(250) 365-7721
Chase	226 Shuswap AVE BOX 960 V0E 1M0	Chase	(250) 679-3221
Chetwynd	BOX 117 V0C 1J0	Chetwynd	(250) 788-9221
Chilliwack Mun	45924 Airport RD V2P 1A2	Chilliwack	(604) 792-4611
Clearwater	205 Dutch Lake RD BOX 338 V0E 1N0	Clearwater	(250) 674-2237
Clinton	1204 Kelly Lake RD BOX 429 V0K 1K0	Clinton	(250) 459-2221
Columbia Valley	4936 Athalmer RD BOX 2220 V0A 1K0	Invermere	(250) 342-9292
Colwood (See West Shore)			
Comox Valley	800 Ryan RD V9N 7T1	Courtenay	(250) 338-1321
Coquitlam Dist Mun	2986 Guildford WAY V3B 7Y5	Coquitlam	(604) 945-1550
Cranbrook Mun	31 11TH AVE S V1C 2N9	Cranbrook	(250) 489-3471
Creston	421 16TH AVE S BOX 400 V0B 1G0	Creston	(250) 428-9313
Dawson Creek Mun	1230 102nd AVE V1G 4V3	Dawson Creek	(250) 784-3700
Dease Lake	BOX 130 V0C 1L0	Dease Lake	(250) 771-4111
Duncan (See North Cowichan)			
Elk Valley	607 Douglas Fir Rd, BOX 1450 V0B 2G0	Sparwood	(250) 425-6233
Elkford	2000 Balmer DR BOX 1390 V0B 1H0	Elkford	(250) 865-2232
Enderby	602 Granville ST BOX 219 V0E 1V0	Enderby	(250) 838-6818
Falkland	BOX 129 V0E 1W0	Falkland	(250) 379-2311
Fernie	496 13TH ST BOX 430 V0B 1M0	Fernie	(250) 423-4404
Fort Nelson	BOX 900 V0C 1R0	Fort Nelson	(250) 774-2777
Fort St James	BOX 1510	Fort St James	(250) 996-8269

	V0J 1P0		
Fort St John	10648 100TH ST V1J 3Z6	Fort St John	(250) 787-8100
Fraser Lake	BOX 70 V0J 1S0	Fraser Lake	(250) 699-7777
Gabriola	BOX 100 V0R 1X0	Gabriola	(250) 247-8333
Gibsons (see Sunshine Coast)			
Gold River	BOX 699 V0P 1G0	Gold River	(250) 283-2227
Golden/Field	902 9TH ST BOX 810 V0A 1H0	Golden	(250) 344-2221
Grand Forks	1608 Central AVE BOX 370 V0H 1H0	Grand Forks	(250) 442-8288
Granisle	BOX 370 V0J 1W0	Granisle	(250) 697-2333
Hope	690 Old Hope-Princeton WAY BOX 40 V0X 1L0	Hope	(604) 869-7750
Houston	BOX 490 V0J 1Z0	Houston	(250) 845-2204
Hudson's Hope	BOX 240 V0C 1V0	Hudson's Hope	(250) 783-5241
Kamloops SouthEast Dist	1280 Trans-Canada HWY W V2C 5Y5	Kamloops	(250) 828-3111
Kamloops City	560 Battle ST V 2C 6N4	Kamloops	(250) 828-3000
T'Kumlups Rural	395 Yellowhead Hwy. V2H 1H1	Kamloops	(250) 314-1800
Kaslo	BOX 632 V0G 1M0	Kaslo	(250) 353-2225
Kelowna Mun	350 Doyle AVE V1Y 6V7	Kelowna	(250) 762-3300
Keremeos	BOX 340 V0X 1N0	Keremeos	(250) 499-5511
Kimberley	436 Archibald ST V1A 1N1	Kimberley	(250) 427-4811
Kitimat Mun	888 Lahakas BLVD V8C 2H9	Kitimat	(250) 632-7111
Ladysmith	336 Belaire, BOX 280 V9G 1A2	Ladysmith	(250) 245-2215
Lake Country	3231 Berry RD V4V 1T8	Lake Country	(250) 766-2288
Lake Cowichan	70 Stanley ST BOX 1290	Lake Cowichan	(250) 749-6668

	V0R 2G0		
Langley	22180 48A AVE V3A 8B7	Langley	(604) 532-3200
Lillooet	BOX 710 V0K 1V0	Lillooet	(250) 256-4244
LISIMS/Nass Valley	BOX 232 V0J 1A0	New Aiyansh	(250) 633-2222
Logan Lake	2 Galena AVE BOX 160 V0K 1W0	Logan Lake	(250) 523-6222
Lumby	2208 Shuswap AVE BOX 1050 V0E 2G0	Lumby	(250) 547-2151
Lytton	BOX 69 V0K 1Z0	Lytton	(250) 455-2225
Mackenzie	62 Centennial DR BOX 280 V0J 2C0	Mackenzie	(250) 997-3288
Masset	2042 Collision AVE BOX 39 V0T 1M0	Masset	(250) 626-3991
McBride	BOX 497 V0J 2E0	Mcbride	(250) 569-2255
Merritt	2999 Voght ST V1K 1G9	Merritt	(250) 378-4262
Midway	BOX 10 V0H 1M0	Midway	(250) 449-2244
Mission	7171 Oliver ST V2V 6H2	Mission	(604) 826-7161
Nakusp	BOX 247 V0G 1R0	Nakusp	(250) 265-3677
Nanaimo Mun	303 Prideaux ST V9R 2N3	Nanaimo	(250) 754-2345
Nelson	1010 Second ST V1L 6B6	Nelson	(250) 352-2156
New Aiyansh (see Lisims)			
New Denver	BOX 100 V0G 1S0	New Denver	(250) 358-2222
New Hazelton	3277 Mcleod ST BOX 279 V0J 2J0	New Hazelton	(250) 842-5244
North Cowichan/ Duncan	6060 Canada AVE V9L 1V3	Duncan	(250) 748-5522
North Vancouver	147 E 14TH ST V7L 2N4	North Vancouver	(604) 985-1311
Oceanside	727 W Island HWY V9P 1B9	Parksville	(250) 248-6111
Oliver	BOX 429 V0H 1T0	Oliver	(250) 498-3422

One Hundred Mile House	726 Alpine AVE BOX 37 V0K 2E0	100 Mile House	(250) 395-2456
Osoyoos	16 Eagle CRT BOX 960 V0H 1V0	Osoyoos	(250) 495-7236
Outer Gulf Islands	BOX 122 V0N 2M0	Pender Island	(250) 629-6171
Pemberton	7413 Prospect ST BOX 130 V0N 2IO	Pemberton	(604) 894-6126
Penticton Mun	1168 Main ST V2A 5E6	Penticton	(250) 492-4300
Port Alberni Mun	4110 6TH AVE V9Y 4M9	Port Alberni	(250) 723-2424
Port Alice	1092 Maquinna BOX 99 V0N 2N0	Port Alice	(250) 284-3353
Port Hardy	7355 Columbia ST BOX 86 V0N 2P0	Port Hardy	(250) 949-6335
Port McNeill	2700 Haddington CRES BOX 730 V0N 2R0	Port Mcneill	(250) 956-4441
Port Simpson S/Det	BOX 272 V0V 1H0	Lax Kw'Alaams	(250) 625-3400
Powell River Mun	7070 Barnet ST V8A 2A1	Powell River	(604) 485-6255
Prince George City	999 Brunswick ST V2L 2C3	Prince George	(250) 561-3300
Prince Rupert Mun	100 W 6TH AVE V8J 3Z3	Prince Rupert	(250) 627-0700
Princeton	BOX 490 V0X 1W0	Princeton	(250) 295-6911
Quadra Island	BOX 399 V0P 1N0	Quathiaski Cove	(250) 285-3631
Queen Charlotte	BOX 130 V0T 1S0	Queen Charlotte	(250) 559-4421
Quesnel	584 Carson AVE V2J 2B5	Quesnel	(250) 992-9211
Revelstoke Mun	320 Wilson ST BOX 1480 V0E 2S0	Revelstoke	(250) 837-5255
Richmond *****	6900 Minoru Blvd V6Y 1Y3	Richmond	(604) 278-1212
Ridge Meadows *****	11990 Haney PL V2X 9B8	Maple Ridge	(604) 463-6251
Salmo	BOX 550 V0G 1Z0	Salmo	(250) 357-2212
Salmon Arm Mun	1980 11th AVE NE V1E 2V5	Salmon Arm	(250) 832-6044

SaltspringDet	401 Lower Ganges RD V8K 2V4	Salt Spring Is.	(250) 537-5555
Sayward	BOX 100 V0P 1R0	Sayward	(250) 282-5522
Shawnigan Lake	BOX 95 V0R 2W0	Shawnigan Lake	(250) 743-5514
Sicamous	BOX 340 V0E 2V0	Sicamous	(250) 836-2878
Sidney/North Saanich	9895 Fourth ST V8L 2Z5	Sidney	(250) 656-3931
Smithers	3351 HWY 16 BOX 2020 V0J 2N0	Smithers	(250) 847-3233
Sooke	BOX 40 V0S 1N0	Sooke	(250) 642-5241
Sparwood	607 Douglas Fir RD BOX 1450 V0B 2G0	Sparwood	(250) 425-6233
Squamish	1000 Finch Drive V0N 3G0	Squamish	(604) 892-6100
Stewart	BOX 158 V0T 1W0	Stewart	(250) 636-2233
Summerland Mun	8709 Jubilee RD BOX 17 V0H 1Z0	Summerland	(250) 494-7416
Sunshine Coast *****	Box 188 V0N 3A0	Sechelt	(604) 885-2266
Surrey Mun	14355 57TH AVE V3X 1A9	Surrey	(604) 599-0502
Tahsis	166 Harbour View RD BOX 490 V0P 1X0	Tahsis	(250) 934-6363
Takla Landing	BOX 1240 V0J 2P0	Fort St James	(600) 700-6983
Telegraph Creek	BOX 84 V0J 2W0	Telegraph Creek	(250) 235-3111
Terrace Mun	3205 Eby ST V8G 2X7	Terrace	(250) 638-7400
Texada Island	BOX 20 V0N 1W0	Gillies Bay	(604) 486-7717
Tofino	400 Campbell ST BOX 280 V0R 2Z0	Tofino	(250) 725-3242
Trail & Greater District	3601 Laburnum Drive V1R 2S9	Trail	(250) 364-2566
Tsay Keh	BOX 9000 V0J 2C0	Mackenzie	(250) 993-2155
Tumbler Ridge	315 Founders ST BOX 710	Tumbler Ridge	(250) 242-5252

	V0C 2W0		
Ucluelet	1712 Cedar ST BOX 969 V0R 3A0	Ucluelet	(250) 726-7773
University *	2990 Wesbrook MALL V6T 2B7	Vancouver	(604) 224-1322
Valemount	1435 5TH AVE V0E 2Z0	Valemount	(250) 566-4466
Vanc IAP/Richmond	6900 Minoru BLVD V6Y 1Y3	Richmond	(604) 278-1212
Vanderhoof	181 Columbia ST W BOX 650 V0J 3A0	Vanderhoof	(250) 567-2222
Vernon Mun	3402 30TH ST V1T 5E5	Vernon	(250) 545-7171
Wells	BOX 70 V0K 2R0	Wells	(250) 994-3314
West Coast Marine	4412 Boban V9T 5V1	Nanaimo	(250) 751-8845
West Shore	698 Atkins AVE V9B 3A4	Victoria	(250) 474-2264
Whistler *	4315 Blackcomb WAY V0N 1B4	Whistler	(604) 932-3044
White Rock Mun	15299 Pacific AVE V4B 1R1	White Rock	(604) 531-5527
Williams Lake	575 Borland ST	Williams Lake V2G 1R9	(250) 392-6211

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