CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

Building Capacity:
Mental Health & Police Project

Prince George
Final Report & Action Plan

Compiled by the
Prince George Steering Committee

June 2007

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Community Overview:

Prince George is a community just over 77,000 people at the crossroads of Highway 97 and Highway 16 where the Fraser and Nechako Rivers converge. It is consider the capital of Northern BC and is a major centre for resource, transportation activity and a service center for many surrounding communities.

The Prince George Building Capacity: Mental Health and Police Project began in November 2006. We were one of three communities within BC chosen for the second phase of this project which was funded by the BC Provincial Health Services Authority. The project funding was for a seven month term ending June 2007.

Prince George is the centre of the Northern Health Authority which covers almost 2/3 of the Province. It is divided into 3 Health Service Delivery areas of which Prince George is in the Northern Interior. Prince George Regional Hospital is a regional referral hospital which serves the city of Prince George but acts as a referral source for approximately 151 000 people. It is a designated psychiatric hospital with a 20 bed adult unit and an 8 bed youth unit. The unit also has 4 seclusion beds which are not considered a part of the 20 bed capacity number. The Emergency department at PGRH treats about 50,000 patients per year averaging 5-6 psychiatric patients per day. Some days the number of psychiatric visits have been as high as 12 per day.

Key Informants:

Individuals and agencies within the community were identified and interviewed for their perspective regarding existing services and how they see people in a mental health crisis being responded to in our community. Their input was valuable in seeking a true community overview of emergency responses. We were looking for an understanding of how existing agencies work and their background in the community. We also wanted to bring an understanding of individual's and agencies' mandates and roles in emergency responses to mental health crisis to the table.

Key Informants represented various community service agencies such as the John Howard Society, municipal government, Native and Métis Bands, Academia from the University of Northern BC, Central Interior Native Health, Physicians and Psychiatrists, representatives from the in-patient unit at Prince George Regional Hospital and Managers from the Northern Health Authority. Despite concerted efforts by the local coordinator meetings with the local MLAs and MPs were not possible. The local coordinator spoke briefly at a regional *Conversations on Health* Forum.

The Steering Committee:

The initial meeting of the committee was held on December 22, 2006. The real working committee meetings started January 11, 2007 and ran consecutively every two weeks until May 31, 2007.

Function of:
The steering committee is comprised of representatives from all relevant sectors, including: police, health authority, hospitals, community mental health service providers, mental health consumers and family members, paramedics and addictions services. The goals for the steering committee were:

- Completion of a community overview of current emergency response and police practice in mental health crisis situations
- Development of a community specific plan of action to improve emergency and police responses to people with mental illness in crisis
- Strengthening of key partnerships to support a more collaborative response to people in mental health crisis

Committee Members:

Canadian Mental Health Association (CMHA)	Glen Schmidt
Canadian Mental Health Association (CMHA)	Linda Doran
RCMP	Insp. Kirke Hopkins
RCMP	Cst. Tobi Araki
BC Ambulance	Supt. Mike Michalko
Métis Association of BC	Rose Bortolon
NHA -Mental Health	Beth Ann Derksen
Crisis Line	Verna MacLeod
PG Fire Rescue	Deputy Chief John Lane
MH service recipient	Barb Toews
Central Interior Native Health	Maria Brouwer
BC Schizophrenia Society (BCSS)	Kathryn Lestage
NHA-Addictions	Sheena McDermid
Family Member	Pat Smith

See appendix for the committee's Terms of Reference

Community Mapping:
This process was very informative and served a greater purpose. It allowed the members of the committee to develop a true understanding of each agency role and a clearer picture of each others' mandates and scope of practice. The examples that our family member and consumers told gave a picture as to what it is like when they or other consumers or families become involved with first responders and other agencies. This information sharing was very valuable. At times, the questions were difficult to deal with, but the committee members listened to each other and admitted at times things do go wrong but all members showed a level of dedication to this project that was very positive for all and gave a sense that changes could/would be made.

At times, this process allowed us simple solutions by offers of "..next time that happens call me directly and here's my number…" or "you were calling the wrong number here's the right one". The following is a listing of our committee

members' agencies and groups they represented and what their mandate and/or response are to someone in a mental health crisis.

***Crisis Line**:* Sometimes a person will ask for help and then permission is received to call ambulance or CRU. If the risk is high for harm to self or others then ambulance (911) is called. Sometimes the crisis line will receive feedback in the form of call reports covering such things as overly long waits at the hospital, simplified assessments, poor treatment regimes and a general reluctance to return to the hospital. Crisis line is funded primarily through NHA: Mental Health. The NHA is working on establishing a system of how/when to refer mental health patients in crisis. A mental health professional would call a person in mental health crisis with their permission.

Métis Provincial Council: The Métis Provincial Council usually becomes involved after hearing about a mental health incident involving a Métis person. The council expressed concerns with cultural awareness and the automatic assumptions of alcohol and/or drug use with Métis people in mental health crisis rather than symptoms of a mental health illness.

Ambulance Service: When the ambulance service is called it is a dispatch decision whether to send the police. Emergency calls (911) are sometimes monitored for a few seconds after transfer to determine if there is a need for police. The police may become involved if there is a history or threat of violence. Ambulance will attend and wait until the all clear sign is given by the police and then enter the scene. Once a person in a mental health crisis is being transported by ambulance to the hospital, police may follow for support. If a person in mental health crisis calls the emergency line (911) rather than a third party and more concise information is received regarding the nature of the mental health emergency then usually fewer agencies/persons will attend the scene. The more accurate the information usually equals a better and more appropriate response to the mental health emergency.

Fire Department: The Fire Department only attends a mental health crisis situation if called by the ambulance dispatch. They attend if it is life threatening and they are closer or if ambulance is unable to respond immediately. Firefighters in Prince George have all 3 levels of first responder training and there is new training coming that has a marginal increase in training for mental health issues.

***Dispatch information**:* In Prince George all 911 calls are first received by the RCMP dispatch and then rerouted to ambulance or fire if requested. The RCMP dispatch will sometimes stay on the line for a few seconds to monitor the call to determine if police involvement or additional resources are needed. The RCMP dispatch is located in the 5th Ave North District building. Fire dispatch is located in the main hall on 7th Ave and they use algorithms by use of numerical values to determine the response. Ambulance dispatch is in Kamloops which serves everything beyond Hope, all dispatchers are trained Paramedics and have in-car

experience. They use the American Medical Priority Assessment to determine response.

Community Response Unit (CRU): Two ways of access.

First – call or walk in to office. The definition of crisis is defined by the person who is seeking assistance. Admin staff will determine if there is an immediate need. If so, they will be asked to come in or can be attended in the community once safety risk is determined.

This is done through the Synapse program which is a computerized charting system of all mental health clients who are being or have been served by Northern Health. All persons have a caution page which lists any applicable risk information. Staff will attend in the community in pairs or if needed will phone the RCMP for support. If the hospital is needed then an on call CRU nurse assigned to the hospital is notified that they are coming. If needed, police can accompany or detain the person. If it is determined that it is not an immediate need the policy is the person will be contacted within two days by a CRU nurse.

Second – Seven days a week (as of Jan 15, 2007) from 9:00 am to 9:30 pm there is an emergency on call nurse from CRU either at the hospital or within 5 minutes of the hospital for the Emergency department. This nurse will assist the ER staff in the primary assessment. The plan is to have this nurse assist with having doctors see the person in crisis, inform triage if there is someone coming in from the community and provide assistance where needed in the ER when someone is in a mental health crisis.

Note: The future plans of CRU include a program that allows for a staff member available to all physicians to call after 9:30 pm to receive support and information that is needed. Synapse is available to all nurses and doctors in ER that take the training. Also, there are plans for a model of this CRU team across the NHA service delivery area.

BC Schizophrenia Society (BCSS): If a crisis occurs on-site then several options can be implemented. Staff may be able to deescalate a situation and then assist in getting further help. CRU or a case manager may be contacted and asked to speak with the person in crisis or the client may be taken to the hospital. The person's peers and friends on site may comfort and calm the person in crisis as well. Through education series for family members and people living with a mental illness, many crisis situations are avoided because family members know how to better support their relatives. People who live with an illness are engaged in recovery through education programs and support groups. Everything BCSS does is peer informed and peer implemented providing a variety of meaningful recovery opportunities for both family members and the people who live with a mental illness. Crisis is most often avoided by the simple results of being informed and empowered through education and support.

RCMP: People with a mental health crisis will always be taken to the hospital. The RCMP will accompany ambulance to hospital. When a person is detained under the Mental Health Act the officer cannot leave them once in custody until released to/seen by a physician.

Time has been tracked to help the ER/hospital make operational improvements regarding triage time between arrival at the hospital by the RCMP and attendance of a physician. There are cases where the wait times for officers are inordinately long, over 4 hours. If a person has not been identified as a person with a mental health issue and seems "not right" then a member calls the hospital whether in the community or in cells.

Paramedics can be used to assist in getting buy in by individuals in mental health crisis to go to the hospital. The RCMP may accompany ambulance for safety reasons. Situations with violent behaviours or weapons are deemed not safe for ambulance so RCMP become involved. Ambulance determines the level of assistance needed. The support of Family and/or friends can help control individual behavior or situations. The RCMP cannot hand over an individual experiencing a mental health crisis to family or friends once the Mental Health Act (MHA) has been evoked. Seclusion rooms on the unit at the hospital and quiet rooms in the ER with police in attendance are used under the MHA by police. These rooms can be used to manage any escalation of behavior. Hand cuffs are used for safety until the physician takes over. Representational agreements can be used in a mental health crisis. Some are available on Synapse.

CMHA Advocate: Overriding issues include transportation and safety. Need to consider the use of advocates for individuals to assist the first responders when attending to a person in a mental health crisis. Examples of an advocate may include a family physician, case manager or the Community Response Unit Team, but there is a concern of availability after hours. Consumers need to be encouraged to find someone who can be a support and advocate for them.

CMHA: CMHA generally deals with individual walk-ins or office phone calls. Usually the Director or Advocacy Assistant Aide notifies service providers or emergency services when dealing with a person in mental health crisis. They keep working until they get the person help.

CMHA does community outreach, acute stabilization and works to avoid crisis. They have a broad base of training that allows CMHA professionals to deal with all types of mental illness. They have lifeskill workers in the community that are the "eyes and ears on the ground" and they meet once a week. CMHA works with other community supports like BCSS and the Activity Center of Empowerment (ACE). CMHA also works closely with the family members of people experiencing a mental health crisis.

Addiction Services – NHA: There are four main programs

- Adult Withdrawal Management Program (AWMP) – Detox
- Outpatients – counselor and RP group
- Nechako Treatment Program – residential
- Methadone Clinic

This a very similar referral process to CRU. Addiction Services can do consultation if an individual is identified with drug issues. Addictions works closely with Mental Health and Community Services
There is a comprehensive intake process/assessment and the case manager can be anyone in the community. The RCMP are used in the residential program to remove people not part of the program. Addiction Services use ambulance rarely, other than an escort to ER services at PGRH.

Consumer #1: Experiences go back 25 years, to age 13. At a young age, she feared the police as her dealings with the police were very confrontational. These experiences have affected her responses today. She was tossed into backs of cars, legs caught in car doors and physically immobilized. Good things that happened with RCMP involvement were when the officer took time to talk and find out what was going on. This was done to discern family issue and not illness. They took time to listen and allowed husband/family member to escort to the hospital. Bad encounters include being handcuffed, being physically immobilized and receiving physical injury.

Consumer #2: This person was committed under the Mental Health Act. Once, a female RCMP officer came to get her and this officer spent about an hour talking to her about the options available to her. On another occasion she had run from her home and was tackled, handcuffed and thrown into police car. She felt this was overkill as she is small and has ankle problems which affect her mobility. The RCMP had another consumer who had left a hospital after being brought there for mental health reasons and was heading for the river. When she came upon the scene with the officer they had a hold of the consumer and were physically pulling at her. When assistance was offered with explanation of background the officer seemed relieved and allowed her to speak with the consumer and assist in getting this other consumer to the hospital.

UNBC: Glen Schmidt spoke of a study/program in Manitoba and Saskatchewan where responders did not wear uniforms and had assistance from other agencies who were also not wearing uniforms. A First Responder without a uniform is often better as it removes a trigger.

Central Native Interior Health**:** Is a primarily health care site with a staff of doctors and nurses, counselors with approx 1700 patients. Most patients are addicted and the center has a low threshold of behaviors, meaning they will tolerate actions and behaviours that other agencies don't. In 3 years RCMP only called twice. They manage most crises in-house and often the person just needs someone to talk to or food or shelter. They have an open door policy and will do whatever it takes to calm person down. Was great when Community Policing Office (CPAC) was next door, when they needed them, they were firm in approach but respectful. First Responders need to give options to allow the person say in what the resolution of their crisis will be. Work with BIG and Fire-pit (Positive Living North) and both have great resources. First Responders need to recognize that universal precautions are enough to protect them when dealing

with consumers who may have HIV/Aids. Responders need to be willing to take time and use least intrusive methods of response first.

Family Member: Son started with problems at age 9 seen as behavioral or bad parenting. Too young for psych so put on pediatrics. In grade 8 was hearing voices and some seizure activity, Mother would him take to emergency and wouldn't be believed or told he was pretending. Received no treatment just seclusion. At times son would ask to go to the hospital but always ended up in seclusion. If he got meds he would often end up over medicated. Finally driven to Children's Hospital in Vancouver and got partial diagnoses there. Good response is to talk him down and allow him to smoke. Usually response is poor and includes handcuffs, threatened with tazers, been red-flagged at Emergency as an addiction issue, been shoved and put into choke hold. Family has lost trust in the system and worry about retaliation if they complains or of not being believed or situation trivialized.

Focus Groups:

Focus groups were identified as a means within the information gathering process of the committee. We identified four groups whom we felt would provide us with a true picture of our community and what responses are occurring as well as what is working and not working for them.

These groups were:

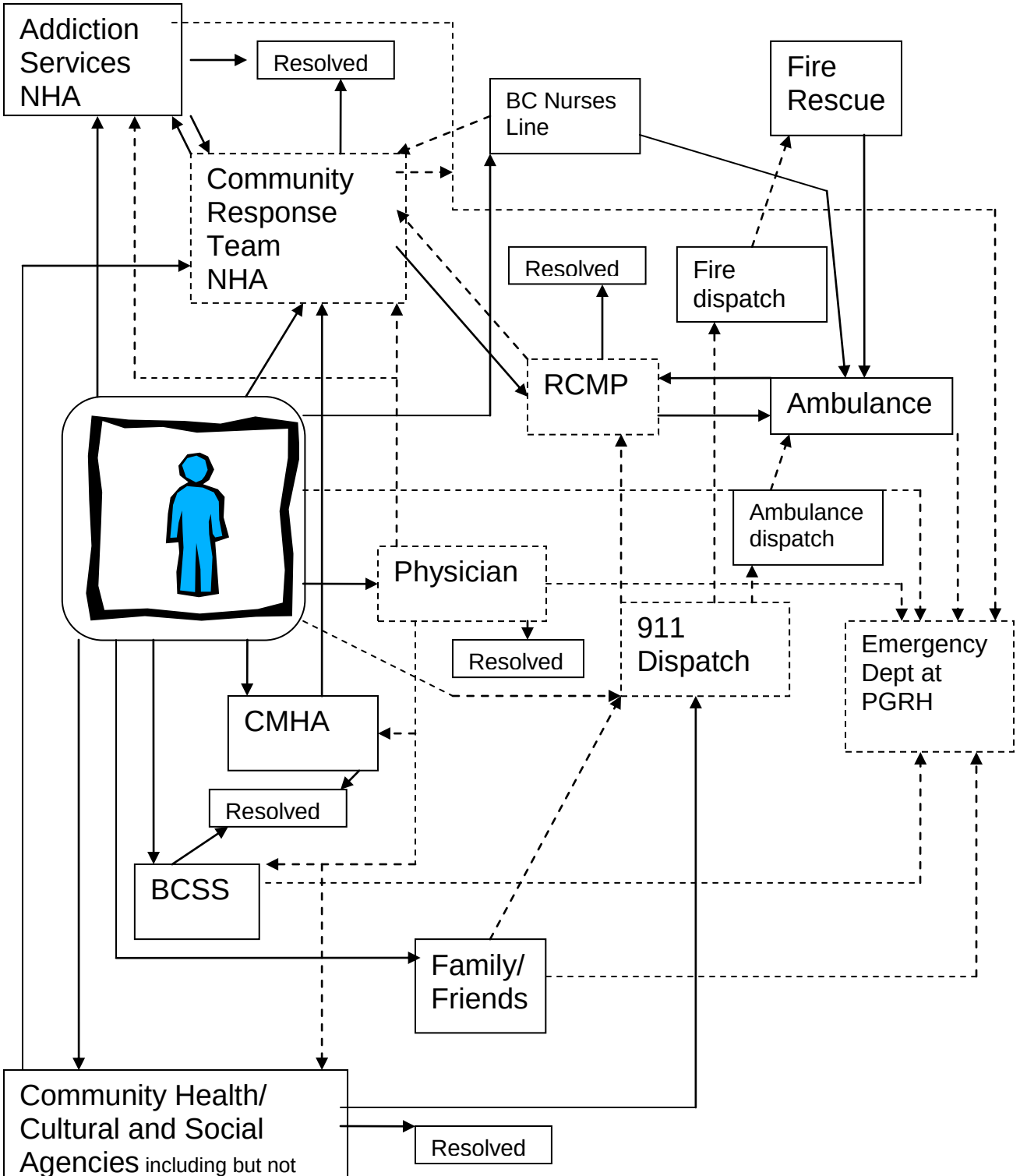
- Consumers who had interactions with first responders,
- Family members of persons with mental illness who had interactions with first responders,
- Non-uniformed first responders
- Uniformed first responders.

Our success with these groups was very limited. Advertising for these groups was done through letters and posters, word of mouth, identification of individuals by committee members, and Mary Lu spoke to both a family education group and the local consumer advocacy group as well as radio interviews asking for individuals to participate.

Prince George Community Map:

The next page contains our community map of the responses available to persons in crisis in Prince George. The solid lines represent that which works well; the broken lines represent areas of concern for us as a committee. The areas we have concerns does not necessarily represent a failure or lack of services but an area that we feel could work better or that there is a need for a clearer pathway to the service needed.

This map represents the options and possible responses for adults in our community, there are different agencies and pathways for youth.



Prince George Map of interactions of persons in a mental health crisis

Solid line represents little or no concerns

Broken line represents areas of concerns or where issues have been identified.

Building Capacity: Mental Health and Police Project

March 2007

Prince George Action Plan:
Upon completion of the community mapping, the committee began to address issues/themes that had been raised. We grouped similar themes and then addressed each group as to a solution and who would oversee the action.

Issue:
- Cultural issues representing the cultural diversity of Prince George
- Lack of knowledge and understanding of mental illness and the Mental Health Act.
- Education of consumers and families as to rights role and mandates of first responders

Solution:
To provide education to all first responders this includes but is not limited to RCMP, Fire Rescue, Ambulance Service, Crisis Line, Mental Health And Addictions staff, Community Response Team, and Hospital Security.

Action:
Education – Linda, Mike and Kathryn to develop a resource and information package listing all available education resources, their content, length and contact information. Once developed, this package will be taken out into the community for distribution and information sharing. This package will be started on during the summer and an update will be presented for the first meeting in the fall of 2007.

Issue:
- Hospital security's level of knowledge and education about Mental Health
- Need a clear process of complaint resolution involving hospital security

Solution:
Require further training of security in mental health, crisis training that is supported by the Northern Health Authority.

Action:
Committee to write letter to Mike Hicky and copy to Anne Cooke and Michael McMillan asking for further training, ER only assigned security and clearer complaint processes for the public.
Mary Lu will draft**,** Beth Ann to provide follow through

Issue:
1. ER -lack of movement and timely response and treatment
2. Lack of available beds elsewhere within hospital which causes backlogs including the psychiatric In-patient Unit
3. Lack of alternative housing or space within the community

Solution:
Car 87 type program to improve community triaging and response.
Distinct clinical pathway in the Emergency Department
Letters of concern regarding the lack of space in the hospital ER and In-patients units and supportive housing in the community.

Action:
Car 87 Program – Beth Ann and Kirke to work on protocol
Beth Ann to develop poster outlining Clinical pathway which will be posted in the ER for staff and patients. Also Beth Ann has spoken to Cheryl Dussault (ER Head Nurse) about crisis procedure and utilization of CRU Nurses, will also be speaking to ER doctors.
Letters – drafted by Mary Lu: a) concerning lack of space in the ER and in-patient units to be sent to Michael McMillan and the incoming CEO. Beth Ann to follow up.

b) Lack of community housing to be sent to all 3 levels of government, PGRH Chairman, Anne Howard – BC Housing and Erica Moore – PG Housing Committee. Linda and Pat to follow up.

Issue:

- Communication between agencies for referring or getting appropriate service
- To know who/agency to call and having the contact information

Solution:
Ensuring information is readily accessible
Action:
Exchange of business cards with Community Response Team contact information for all RCMP, Ambulance and Fire Rescue and to all other agencies. Beth Ann will have cards made up for distribution before the end of May.
Consumer ID Cards – Pat will research information about types of cards, information and examine why some programs have worked and others haven't. She will also examine the guardianship act. She will present her findings and recommendations to the committee this fall.

Issue:

- Develop relationship/understanding between consumers and uniformed first responders this being RCMP, Fire Rescue and Ambulance.

Solution:
Provide information and opportunities to develop that understanding and relationship
Action:
Free coffee or a form of social invitation to uniformed first responders at ACE, Connections and Iris House.
Kathryn/Pat, Linda and Mary Lu to follow up and report back to committee and then invitations will be sent out to uniformed first responders as soon as possible.

Issue:

- Lack of general/family physicians available for patients with a mental health illness.
- Lack of Synapse trained physicians

Solutions:
Make Synapse training available to all physicians and mandatory for all resident doctors to receive before psych rotations.
Assist in removing barriers to obtaining a family physician through the Northern Medical Program (NMP) and the Physicians council at PGRH.
Action:
Mary Lu and Beth Ann will address both resident doctors at the Northern Medical Program and the PGRH Physicians Council regarding above issues.
Mary Lu has arranged for scheduling of Synapse training for residents.

Action plan overview:

Community level: The most common theme that arose within our community was a need for education. We would like to see education that provides training about mental health, crisis training, rights and responsibilities of first responders and consumers and families. We need more training on cultural issues and opportunities to learn to reduce the stigma of having a mental illness. We have some of this training located here at an introductory level such as the Mental Health First Aid facilitated by CMHA and the partnership training facilitated by BCSS. The most valuable training we have seen for first responders is the Crisis Intervention Training. This course is currently being coordinated out of E-division of the RCMP in the Lower Mainland with plans to move it provincially within two years. Currently this course can be attended by persons from outside of the Lower Mainland. A quicker and better community option is for a team (police and mental health rep at a minimum) to attend the course and audit the training, and stay an extra day to meet with Cst. Lara Davidson. She is willing to instruct us in developing the training for our own community. Most of the presenters in this training provide their presentations free of charge (as they are already employed) and are from the community (another way to develop those relationships).
During the community mapping process our attention became drawn to the security staffing at Prince George Regional Hospital (PGRH). Common themes we heard included:

- Individual security staff often become frustrated and aggressive when dealing with consumers in crisis
- Security staff are frequently disrespectful towards consumers in their actions and language.
- Security staff are viewed as heavy-handed or reluctant to become involved with a mental health consumer in crisis and are not an appropriate resource to respond

Emergency Physicians have expressed concerns over the ability of hospital security staff to manage individuals in a mental health crisis and as a result RCMP are in the Emergency Department for extended periods to ensure safety. This results in long delays in officers returning to duty. A letter requesting further education for the security staff and additional security was sent to Mike Hickey at the NHA. See Appendix for a copy of letter.

During discussions of our community we become aware quickly that we had common themes we felt could be remedied by an increase in supportive housing in Prince George. We feel that the lack of supportive housing has

contributed in part to the lack of timely movement through the Emergency department at Prince George Regional Hospital. There are usually 30+ alternate levels of care patients waiting in the hospital for supportive and alternative housing which keeps patients in the ER. When someone is lacking appropriate housing with support systems, the hospital often becomes the default resource for support whether or not the person's reason is medical or acute care. A letter was sent to various government and agencies regarding our recommendations for more supportive housing. Please see Appendix for a copy.

Another theme we heard during the community mapping process from several sources including consumers, families, physicians, first responders and advocacy groups involved the lack of space and timely treatment within the hospital. We recommend an increase in beds both in the ER and Inpatient units. We also suggest the hospital examine means to reduce the number of persons coming to the ER. Solutions such as increased hours of Community Response Clinicians within the ER, a separate triaging system for persons with a mental illness, a better defined clinical pathway for persons in a mental health crisis would assist. A letter regarding these recommendations was sent to Cathy Ulrich and Michael McMillan. See Appendix for a copy of this letter.

The committee has sent a request to speak to the Physicians Council at PGRH regarding the lack of General Practitioners who are willing to provide care to a patient with mental illness and address the recommendation we have that all physicians should be trained on Synapse for easier and quicker response to a patients mental health records. We have one physician in town, who will be receiving the training to address to comment that the training is too difficult and too long. We thank Dr. Turski for his commitment.

The Northern Medical Program Resident Placement Coordinator has agreed to have all residents receive synapse training as part of their orientation and training program. The current first and second year residents have been address regarding their future role in the system and the response was extremely positive with suggestions of how to improve the fee structure for patients with a mental illness to clinics and how they can affect needed change. They are being scheduled for their synapse training this month.

Regional level:

Themes at a regional level are as same as the community levels. It is the recommendation whatever actions are put in place in regards to training, housing, education be a regional approach especially in regards to the Northern Health Authority and all first responders.

A Regional Community Response Team system where a clinician can be accessed 24 hours a day by phone or by pager would be of great benefit to hospitals, physicians, first responders, consumers and families.

Provincial Level:

Having a provincial standard for mental health training and crisis respond training would benefit all first responders and consumers. A program like the Crisis Intervention Training currently coordinated out of E-division of the RCMP in

the lower mainland, would provide a common level of training that could set the provincial standard of response that is appropriate, respectful and a benefit to any community where the first responders live or work.

Committee Summery:

The Prince George Committee has made a commitment to continue their work. Meetings for the next twelve months have been scheduled for every two months starting in September 20, 2007 at 8:00 am. This time was a benefit to most as they came from home to the meetings and did not go to their office and get distracted or having to manage something else. The facilitator role will be shared between John Lane, Deputy Fire Chief and Linda Doran, Executive Director of the local branch of CMHA. The committee would like to thank both these individuals for stepping forward. The action plan is an ambitious one but it represents the level of commitment the members are making to the project and our community.

Education is a large theme that resounded through every agency, every interview, and every story. We as a committee support the Crisis Training program that is being delivered out of the Lower Mainland Division of the RCMP by Lara Davidson and want to stress the importance of that program being made available not only regional, but also provincially and nationally. As the Study in Blue and Grey states "...more people with a mental illness live in the community. Unfortunately, community supports have not expanded proportionately to make up for the loss of institutional services or for the increased need brought about by an expanding population." This increasing role by not only the police but by all first responders needs to be addressed in their education so they have the skill, knowledge and resources to make an appropriate response.

Several themes that also became evident involve the Northern Health Authority (NHA), concerns with Emergency Department regarding wait times, need for increased hours for the Community Response nurse in the ER, lack of beds both in the ER and In-patient units, a need for a better triaging system for persons with a mental illness, more training in terms of mental illness and crisis response is needed with all levels of staff and the contracted security staff at the hospital. We heard that services cannot be accessed without a family physician but there is a lack of doctors in the community and reluctance for existing family physicians to add a person with a mental illness to their caseload. We heard a number of times that there is no where else to go except the ER. We ask what would assist in diverting persons from the ER. Our suggestions include a second walk-in clinic or expansion of both space and hours of the existing clinic, more triaging and resources in the community. We would like to recommend that the NHA build upon our steering committee to address these concerns, we have members on the committee that are willing to assist and support the NHA.

Recommendations for Future:

The timeline of the project needs to be longer. There were project goals that were not fully met or could have meet with greater success with more time. A year would allow for at least 3 months of setting up the committee, interviewing

key informants, development and recruitment for focus groups. Additional time for committee meetings to assist in the starting of the action plan would also be beneficial. To have the program coordinator over the summer to assist in the action plan and then assist in the re-gathering of the committee members in September would help in the ongoing work and commitment of the committee.

Within this community the location of the coordinator outside of the CMHA office had both positive and negative results. The placement at the Community Response Unit allowed greater access to people and information for the NHA. Although CMHA was clearly identified in several ways both in letterhead, titles and liberal use of the CMHA name and logo as being the leader of the project, people were contacting the coordinator through the NHA email and phone system and meeting her at a NHA office. The majority of committee meetings were also held at a NHA boardroom. This did lead to some confusion as to whether it was a CMHA or NHA driven project.

It was regrettable that, despite repeated requests, we were unable to have an ER representative at the table, or have consistent input from the hospital. The Head of ER met with the coordinator and a committee member on one occasion but full participation within the committee would have been the most beneficial to all. Several requests were made to the Director of Patient Care Services for a representative to attend the committee meetings with no results. The committee expressed a great deal of frustration with the limited involvement of the hospital.

Of the four focus groups we tried to start only two had the opportunity to start. The Consumer focus group met twice with very low attendance, we received some valuable information and comments from the first meeting. The second meeting did not go well as a consumer who attended had some issues with MEIA and was extremely argumentative and sabotaged the meeting.

The uniform focus group met once with representatives from RCMP, Fire and Ambulance, their suggestions for change and education were very helpful. The next two scheduled meetings did not occur as members were called away or for a variety of other reasons.

The family member and non-uniformed groups never met. Different times and days of the week were tried for the meetings with no change of attendance or response.

The time frame for the focus groups to get them up and running and develop a working group is far too short. It took almost three months to get people interested in attending the two groups we had. This did not allow for development of a cohesive group and it did not allow enough time for input on the action plan or complete the information gathering process.

Appendix

Building Capacity: Mental Health and Police Project
Steering Committee Terms of Reference

Background/context

In 1999, CMHA BC Division participated in a Coroner's Inquest investigating the shooting death of a person with mental illness who had a confrontation with police while seeking mental health care. The jury recommended that police receive training on how to respond more effectively in future situations. As a result, BC Division completed a research report Study in Blue and Grey which examined key components of effective police responses to people with mental illness and strategies for implementation of such responses within existing service systems. The key findings of this report are that police have become the de facto "first responders" in our mental health system and that they lack the necessary skills to play this role and the means to collaborate with mental health systems to jointly solve this problem.

Function of the Steering Committee

The steering committee will be comprised of representatives from all relevant sectors, including: police, the mental health system, hospitals, community mental health service providers, mental health consumers and their family members, paramedics and addictions services. The goals for the steering committee are:

- Completion of a community overview of current emergency response and police practice in mental health crisis situations.
- Development of a community specific plan of action to improve emergency and police responses to people with mental illness in crisis.
- Strengthening of key partnerships to support a more collaborative response to people in mental health crisis.

Roles of the Steering Committee/Coordinator

The role of the steering committee is to meet regularly and work collaboratively to meet their goals. The members of the steering committee who work within a public organization (e.g. police, mental health system, hospital, ambulance service) have an additional role of liaising between their organization and the others at the table to improve collaboration and to create and/or recommend systemic changes in their organizations to improve emergency responses to persons with mental illness in crisis.

The role of the coordinator is to facilitate the work of the steering committee by providing information and support, organizing, chairing, and facilitating steering committee meetings, keeping minutes and facilitating the exchange of information and drafting the report of the steering committee, which will include the community overview identified and prioritized issues and plan of action.

The coordinator will also promote the work of the steering committee, field calls from media and other interested parties and conduct research as necessary.

Role of Individual Committee Members

The role of the committee members is to:

- Attend committee meetings.
- Share their specialized knowledge and information at the table.
- Obtain information within their sector which may be of use to the steering committee to achieving its goals.
- Respectfully hear and consider the knowledge and experience of others at the table.
- Collaborate in achieving the goals of the steering committee in completing the community overview and plan of action.
- Develop strong and sustainable partnerships which will continue beyond the term of the project.

General

Membership – A list of committee members and contact information will be provided at the first meeting of the steering committee.

Chair - Meetings will generally be chaired by the Coordinator.

Agenda – The coordinator will draft and distribute the agenda to committee members and interested parties a minimum of 2 days prior to scheduled meeting. It is the responsibility of members to forward any agenda items to coordinator a minimum of 3 days prior to scheduled meeting. Please send via email to MaryLu.Spagrud@northernhealth.ca

Minutes – A committee member will be designated to take minutes during the meeting, after which the coordinator will prepare and distribute by email within 4 working days of the meeting (barring unforeseen circumstances). Minutes will contain action items, persons responsible and due dates, as applicable.

Frequency of Meetings – The committee will meet every two weeks until the end of the project, culminating with the approval of the final report.

Proxy/Alternatives – Committee members must be willing to commit to attending committee meetings regularly, to maintain continuity and to build collaborative relationships. When a member cannot attend it would be beneficial to send a proxy who is familiar with the function and work of the committee.

Committee Objectives – Key objectives for our project will include:

- Completion of a community mapping process of current police practice in mental health crisis situations.
- Development of a community specific plan of action to improve police responses to people with mental illness in crisis.

Strengthening of key partnerships to support a more collaborative response to people in mental health crisis.

CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

June 13, 2007

Attn: Mike Hickey, Director Plant Services
Anne Cooke, Director Patient Care Services
Michael McMillan, Chief Operating Officer

On behalf of the Prince George Building Capacity: Mental Health and Police Project committee I am writing to provide recommendations to improve the security staffing at Prince George Regional Hospital.

The Building Capacity project is designed to examine responses by police and other components of the emergency services and health care system to people with mental illness who are in crisis and make recommendations for improvement.

The steering committee is comprised of representatives from all relevant sectors, including: police, the mental health system, hospitals, community mental health service providers, mental health consumers and their family members, paramedics and addictions services. The goals for the steering committee are:

- Completion of a community overview of current emergency response and police practice in mental health crisis situations.
- Development of a community specific plan of action to improve emergency and police responses to people with mental illness in crisis.
- Strengthening of key partnerships to support a more collaborative response to people in mental health crisis.

During the community mapping process our focus was became drawn to the security staffing at Prince George Regional Hospital (PGRH). Observations came from physicians, consumers, advocacy agencies, family members, RCMP and staff within the NHA. Common themes we heard included:

- Individual security staff are often become frustrated when dealing with consumers in crisis
- Security staff are viewed as reluctant to become involved with a mental health consumer in crisis and are not an appropriate resource to respond

Emergency Physicians have expressed concerns over the ability of hospital security staff to manage individuals in a mental health crisis and as a result RCMP staff in the Emergency Department for extended periods to ensure safety. This results in long delays in officers returning to duty.

We would like you to know there is a perception in the community if complaints are made about the security staff there is no follow through or resulting disciplinary actions. Most persons we spoke to thought the security staff were Health Authority Employees and did not realize that it is a contract service.

We strongly recommend the security staff at the hospital receive better mental health and crisis training. We recommend the following four options.

1. Mental Illness and First Aid
   Facilitated by Canadian Mental Health Association (CMHA) it is a general knowledge course about mental illness, how to respond and when assistance should be called.

2. Partnership Presentations
   Facilitated by BCSS, these programs are designed to reduce stigma and discrimination and creating empathy.

3. Crisis Intervention Training
   This course is currently being coordinated out of E-division of the RCMP in the lower mainland. This course can be attended by persons form outside of the Lower Mainland. We hope to see this course being offered in our community in less than two years.

4. Develop an In-house Training Program
   Using consumers, psychiatrists, RPNs, and other community agencies, design and administer a course for your staff specific to PGRH.

We also recommend a security position be created that is assigned specifically to the Emergency Department (ED). This would be in addition to existing positions and must include the additional mental health training mentioned above. This would address both the physicians' concerns and would release the RCMP in a timely manner.

We are eager to meet with you to further discuss our concerns if required or to assist you in the implementation of the recommendations.

Thank you for your time and consideration.

Linda Doran
Executive Director
Prince George Branch
Canadian Mental Health Assoc.
555 George St.
Prince George, BC V2L 1R8
250-564-8644
lindadoran@cmhapg.ca

Beth Ann Derksen
Team Leader – Community Response Unit
Mental Health and Addictions
Northern Health Authority
201 -1705 3rd Ave
Prince George, BC
250-565-2540
Bethann.Derksen@northernhealth.ca

CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

June 13, 2007

To: MP Dick Harris
MP Jay Hill
Deputy Premier Shirley Bond,
MLA Pat Bell
MLA John Rustad
Mayor Colin Kinsley
Jeff Burghardt, Chairman of Northern Health Authority
Shane Ramsey, CEO BC Housing
Ann Howard, Director BC Housing
Erica Moore, Chairperson of PG Hosing Committee

On behalf of the Prince George Building Capacity: Mental Health and Police Project committee I am writing to express our desire for more supportive housing within our community.

The Building Capacity project is designed to examine responses by police and other components of the emergency services and health care system to people with mental illness who are in crisis and make recommendations for improvement.

The steering committee is comprised of representatives from all relevant sectors, including: police, the mental health system, hospitals, community mental health service providers, mental health consumers and their family members, paramedics and addictions services. The goals for the steering committee are:

- Completion of a community overview of current emergency response and police practice in mental health crisis situations.
- Development of a community specific plan of action to improve emergency and police responses to people with mental illness in crisis.
- Strengthening of key partnerships to support a more collaborative response to people in mental health crisis.

Within discussions of our community we become aware very quickly that we had common themes we felt could be remedied by more supportive housing for persons living with a mental illness in Prince George. By supportive housing we include high tolerance of behavior, low barrier, psycho-geriatric beds and housing that has a variety of support systems in place. We feel that the lack of supportive housing has contributed in part to the lack of timely movement through the Emergency department at Prince George Regional Hospital. There are usually 30+ alternate levels of care patients waiting in the hospital for supportive and alternative housing which keeps patients in the ER. When someone is lacking appropriate housing with support systems, the hospital often becomes the fall

back resources for support whether or not the person's reason is medical or acute care.

According to the Study in Blue and Grey a lack of supportive housing has been identified as one of the causes for the increase in interactions between persons with a mental illness. "…more people with a mental illness live in the community. Unfortunately, community supports have not expanded proportionately to make up for the loss of institutional services or for the increased need brought about by an expanding population."

We welcome the new Queensway project, Friendship Lodge and we value the potential and the impact it will have within the community. It is the recommendation and hope of this committee that there will be an opportunity for the development of similar projects to increase the number of supportive beds with in Prince George. The committee feels that if more support services were available that it could assist in averting crisis from happening and thus reduce the negative interaction between first responders and persons in a mental health crisis.

We are eager to meet with you and further and discuss our concerns if required or assist you in any initiatives for more supportive housing in Prince George.

Thank you for your time and consideration.

Linda Doran
Executive Director
Prince George Branch
Canadian Mental Health Assoc.
555 George St.
Prince George, BC V2L 1R8
250-564-8644 ext. 28
lindadoran@cmhapg.ca

Pat Smith
Family Member
1131 6th Ave
Prince George, BC V2L 5G5
250-563-5826
patsmith@ace.pgbcss.com

CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

June 13, 2007

To: Cathy Ulrich, Chief Executive Officer
Michael McMillan, Chief Operating Officer

The Building Capacity: Mental Health and Police Project is designed to examine responses by police and other components of the emergency services and health care system to people with mental illness who are in crisis and make recommendations for improvement.

The steering committee is comprised of representatives from all relevant sectors, including: police, the mental health system, hospitals, community mental health service providers, mental health consumers and their family members, paramedics and addictions services. The goals for the steering committee are:

- Completion of a community overview of current emergency response and police practice in mental health crisis situations.
- Development of a community specific plan of action to improve emergency and police responses to people with mental illness in crisis.
- Strengthening of key partnerships to support a more collaborative response to people in mental health crisis.

One of the common themes we heard during the community mapping process from several sources including consumers, families, physicians, first responders and advocacy groups involved the lack of space and timely treatment within the hospital.

On behalf of the Prince George Building Capacity: Mental Health and Police Project committee I am writing to express our desire for more beds in the Emergency Department and In-patient units of Prince George Regional Hospital.

We would like to recommend an increase in beds both in the ER and Inpatient units. We would also like to suggest that the hospital examine means to reduce the number of persons coming to the ER.

Our committee has started the process and would like to assist the Northern Health Authority in the above suggestions. We believe that there are solutions such as increased hours of Community Response Clinicians within the ER, a separate triaging system for persons with a mental illness, a better defined clinical pathway for persons in a mental health crisis.

We are willing to discuss or offer assistance with the above recommendations with you at your convince. Thank you for your time and consideration.

Linda Doran
Executive Director
Prince George Branch
Canadian Mental Health Assoc.
555 George St.
Prince George, BC V2L 1R8
250-564-8644
lindadoran@cmhapg.ca

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