CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

BUILDING CAPACITY:
Mental Health and Police Project

Final Site Report
Salmon Arm Canadian Mental Health Association
June 2007

Respectfully Submitted by
Rhonda Bailey, BSW

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Mental Health and Police Project Summary

Interactions between people with mental illness and the police are increasing. A recent review (2004) estimates that between 7-15% of police contacts are with people with mental illness and the frequency of interaction between police and people with mental illness is increasing. In 1998, a CMHA BC Division study found that over 30% of people came into contact with the police during their first experience trying to access mental health care in BC.

The Canadian Mental Health Association, BC Division has increasingly been focused in this area. In 1999, CMHA participated in a Coroner's Jury investigating the shooting death of a person with mental illness who had 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. CMHA responded and began The Mental Health & Police Project in order to identify and improve services to individuals in a psychiatric emergency.

Phase 1: 2005
In 2004, with funding from the Provincial Health Services Authority and the Vancouver Foundation, CMHA BC began work with six BC communities to begin to identify areas for improvements in the link between police and mental health services and systems. We called the project Building Capacity: Mental Health and Police Project (BC:MHAPP). The project was conducted in six BC communities (Cranbrook, Delta, Nanaimo, Vancouver, Williams Lake and Richmond) and took place over a period of 6 months during 2005. In each community, a local coordinator was hired part-time to develop a committee of relevant parties from the community to help guide the project including:

- People with mental illness
- Family members
- Police
- Ambulance Service Personnel
- Mental Health and Addictions Professionals
- Hospitals
- Community Organizations Serving the Needs of Persons with Mental Illness

Each steering committee began work on community reports, maps and action plans . Due to the short term of the project, committees continued to work together after the project formally ends to achieve the action plan items.

Phase 2: 2006/07
BC Mental Health and Addiction Services, Provincial Health Services Authority had generously provided funding to build on the first phase of the mental health and police project from 2005. This latest phase will cover four areas:

- Development of the project in three additional communities (Salmon Arm, Kelowna and Prince George). The new sites were chosen by early September. Coordinators for the new sites were in place by Fall 2006, with wrap-up late Spring 2007.
- An external evaluation of the 2005 project, directed by Dr. Marina Morrow from SFU's Faculty of Health Sciences. The evaluation will begin in September, with a final report in November.
- Each of the original six sites were eligible to receive funding to fulfill activities identified in their action plans from 2005. This phase will end in July 2007.
- Systemic change and mental health within the police workforce, including a literature review and recommendations. These last two pieces will both end July 2007.

Study in Blue and Grey Report

As a result of CMHA's involvement, in 2003 we completed a research report Study in Blue and Grey – Police Interventions with People with Mental Illness: A Review of Challenges and Responses which examined key components of effective police response 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 both the necessary skills to play this role and the means to collaborate with mental health systems to jointly solve this problem

Our community of Salmon Arm and area:

In the heart of British Columbia's famous Shuswap Lake recreation area is the town of Salmon Arm, the Northern Gateway to the Okanagan. Nestled on the south shores of Shuswap Lake, ideally situated mid way between Calgary and Vancouver, Salmon Arm is the largest city in the Shuswap area.

The first white settlers arrived in this valley in 1888. Salmon Arm first started as a railway camp during the construction of the Canadian Pacific Railway (CPR), later developing into a logging, farming and dairy centre.

Salmon Arm is surrounded by outstanding natural beauty, clean waterways, provincial parks and an abundance of green space. All this lends itself to making tourism one of Salmon Arms' fastest growing business sectors.

Salmon Arm has a mild, yet distinct four season climate, and superior year-round recreational amenities. The area boasts abundant art and craft work of various cultures, including aboriginal selections.

The beautiful Shuswap Lake takes its name from the Shuswap Indians, northernmost of the Great Salishan Family, and one of the largest tribes in the interior of British Columbia. Once numbering over 5,000, these people were fishermen and hunters, roaming in bands through the vast land of lakes and forests, reaching 240 kilometers to the west, east and north. Salmon Arm takes its name from the southwest arm of the Shuswap Lake, due to the large runs of salmon that used to run up the creeks that empty into the lake.

The area has retained a unique rural quality that is reflected in the richness and diversity of the communities throughout the Shuswap. Residents have a keen sense of pride and satisfaction in protecting their quality of life. It is this balance that appeals to residents and visitors alike.

Salmon Arm's economy is a diverse mixture of forestry, agriculture, tourism commerce, and manufacturing. A growing industry in the Salmon Arm area is the ever-popular agri-tourism. These farms includes wineries, berry farms, orchards, cheese plants, dairy farms, corn fields, pumpkin and gourd patches, canning and cider pressing, petting zoos, and much more.

Population: 17,150 (Including all surrounding areas of Enderby, Sicamous and Sorrento population is 35,000)

Location: Salmon Arm is located on the Trans-Canada Highway 1, at the southern tip of Shuswap Lake, 68 miles (108 km) east of Kamloops and 38 miles (60 km) north of Vernon.

Community Hospitals

There are 16 Community Hospitals operating in the Interior region. Each plays an important role in the network of hospitals. Interior Health has developed different levels to more effectively meet the health care needs of the people it serves.

There are two levels of Community Hospitals, "Level 1" and "Level 2".

"Level 1" Community Hospitals may provide:

- Laboratory and radiology (x-ray) services.
- Emergency services that may be available 24 hours per day, depending on the facility.
- Acute care beds for patient admissions for general medicine, observation, assessment, convalescence and palliative care.
- Low-risk obstetrical care in rural or remote areas.
- Outpatient ambulatory care procedures

"Level 2" Community Hospitals provide the same services as "Level 1" Community Hospitals such as laboratory and radiology (x-ray) services and acute care beds. They also offer:

- 24-hour emergency services with registered nurse (RN) triage.
- Obstetrical care.
- Some core physician specialties such as internal medicine and low complexity general surgery including ambulatory care day surgery.

Thompson/Cariboo/Shuswap Health Service Area Community Hospitals
Level 1 –

Clearwater - Dr. Helmcken Memorial Hospital (may offer low risk obstetrics)
Lillooet - Lillooet District Hospital (obstetrics)
Merritt – Nicola Valley General Hospital (no obstetrics)
100 Mile House – 100 Mile District General Hospital (obstetrics)
Revelstoke – Queen Victoria Hospital (obstetrics)

Level 2 -
Salmon Arm – Shuswap Lake General Hospital
Williams Lake – Cariboo Memorial Hospital

Kootenay Boundary Health Service Area Community Hospitals
Level 1 –

Grand Forks – Boundary Hospital (obstetrics)
Nakusp – Arrow Lakes Hospital (may offer obstetrics)
Nelson – Kootenay Lake Hospital (obstetrics)

Okanagan Health Service Area Community Hospitals
Level 1 –

Oliver – South Okanagan General Hospital (no obstetrics)
Princeton – Princeton General Hospital (no obstetrics and no surgery)

East Kootenay Health Service Area Community Hospitals
Level 1 –

Creston – Creston Valley Hospital (obstetrics)
Fernie – Elk Valley Hospital (obstetrics)
Golden – Golden & District Hospital (obstetrics)
Invermere – Invermere & District Hospital (low risk obstetrics)

Kelowna General Hospital (KGH) is the Central Okanagan's primary acute care health facility. It is one of two Interior Health tertiary referral hospitals (the other being Royal Inland Hospital in Kamloops), offering high-level, and specialty medical care.

The Shuswap Lake General Hospital provides acute and long term care for the residents of Salmon Arm and surrounding areas. The facility has 43 medical surgical beds, 7 pediatric beds, 8 maternity beds and 25 extended care beds. It is one of British Columbia's 19 Community Cancer Centers. Due to the fact that Shuswap Lake General Hospital is not a designated psychiatric ward, our clients who need psychiatric care are sent to Vernon Jubilee Hospital in Vernon BC.

Vernon Jubilee Hospital

In 1895, after a diphtheria epidemic struck Vernon, a committee led by Mrs. F Cameron began to canvas the city and surrounding district for a much needed cottage hospital. 1897 marked the incorporation of and opening of Vernon Jubilee Hospital. Since then, VJH has provided outstanding inpatient, ambulatory and extended care services to its patients.

Today, Vernon Jubilee Hospital has 125 acute care beds at VJH and 395 residential care beds throughout Vernon, Armstrong and Enderby. Over 100,000 out patient visits are made each year to the hospital. VJH serves the community as an acute care regional hospital offering a variety of medical and surgical specialties. Community based programs such as Home Health, Public Health, Mental Health and a wide variety of Seniors care programs all work in tandem with the hospital to ensure complete and continuing health care for patients beyond their hospital stay. As one of four Service Area Hospitals operating in Interior Health's network of health care facilities, Vernon Jubilee Hospital (VJH) provides hospital services to residents of the North Okanagan.

Established in 1897, Vernon Jubilee Hospital provides:

- General, acute and long term care
- Medicine and surgery
- Psychiatry
- Maternity
- Pediatric
- Continuing care

Regional Hospitals

Interior Health's system of Regional Hospitals brings together the best people, equipment and expertise to provide specialized care in Cranbrook, Trail, Vernon, Penticton, Kelowna and Kamloops. Each Regional Hospital is responsible for providing core medical and surgical specialty services to patients throughout its service area.

Service Area Hospitals in Cranbrook, Trail, Vernon and Penticton provide acute care beds, obstetrical care and all the other services you can expect at a Community Hospital.

They also offer:

- Laboratory (Lab Level 3) and radiology/diagnostic imaging services.
- 24-hour emergency services, ideally with in-house physicians. Emergency services at a service area hospital provide a higher level of trauma care than a community hospital.
- Core physician specialties such as internal medicine, general surgery, orthopedics, anesthesia, obstetrics, gynecology, pediatrics, psychiatry, radiology, pathology and emergency medicine.
- Some sub-specialized, physician services for medical and surgical programs.

The Regional Hospitals in Kelowna and Kamloops offer the same services as the four Service Area Hospitals, but with added levels of care. These facilities, known as Tertiary Referral Hospitals, also provide:

- 24-hour emergency services that may include trauma services.
- Advanced diagnostics such as magnetic resonance imaging (MRI), nuclear medicine and cardiac catheterization.
- Higher levels/sub-specialties of almost all medical and surgical services.
- Tertiary services for patients with multi-system failure and those requiring vascular surgery, thoracic surgery or neurosurgery.

RCMP

Salmon Arm Detachment is situated on the southern tip of the Salmon arm of Shuswap Lake and the Trans. Canada Highway bisects the municipality. Salmon Arm Detachment consists of both municipal and provincially funded police resources. The population of the District of Salmon Arm is 16,200 and the rural area consists of 8,000 persons. The Shuswap Lake area is a popular summer tourist area where the population can triple in addition to the population that is traveling through the area on the Trans. Canada Highway.
Salmon Arm Detachment consists of seventeen municipal, five provincial officers and eight auxiliary constables. The rank structure consists of a Staff Sergeant. in charge with a Sergeant., three Corporals. and seventeen Constables. Salmon Arm does not have a dedicated First Nations Community Policing member.

The Detachment provides service to three First Nations Communities: Adams Lake Band, Neskonlith Band and Little Shuswap Lake Band which are part of the Secwepemc Nation. The main Band offices are in the Chase Detachment area but each band also has communities in the Salmon Arm area.

Adams Lake Band:
Chief Ron JULES has been the chief of this band for a number of years. The reserve is made up of a number of areas and their traditional area spans land from the Trans Canada

Highway to Barrier including the Sun Peaks Resort. They are involved in the logging industry and also lease a number of properties on the lakeshore of Shuswap Lake (Scotch Creek) and the southern portion of Adams Lake. The reserve in Salmon Arm is within the District Municipality of Salmon Arm and they lease a number of properties to businesses along the highway which provide substantial revenue for the band.

Neskonlith Band:
Chief Art ANTHONY has been chief for the past two years and they have changed their direction in dealing with the police. Chief and Council welcome the RCMP on their land and are actively seeking opportunities to work together and improve relationships. The band has constructed a Community building on the reserve in Salmon Arm and have dedicated a room for use by the police and other agencies. Elder Mary THOMAS and her family are strong advocates of working with the RCMP to find solutions to the youth problems in the area.

Little Shuswap Band:
Chief Felix ARNOUSE has been chief for a number of years and they are very supportive of the police and are interested in working with the RCMP to resolve issues dealing with youth and other policing concerns. The reserve also leases a number of properties to people on the Shuswap Lake in the Chase area. The band has constructed the Quaaout Lodge on Little Shuswap Lake and have over the past year expanded it to provide for large meetings, conventions or other events. The reserve land at Salmon Arm consists of only residential properties for their band members and is quite small.

Community-Based Problem Solving
Salmon Arm Detachment has open communication with Chief and Counsel of the three bands we provide policing service to. We have access to a community office at the Neskonlith Community Center where we meet with representatives of the band on a monthly basis to discuss ways to improve our working relationships. The Detachment is open to working with the Bands in dealing with crime and concerns in alternative processes.

Restorative and Alternative Justice
Salmon Arm does not have a dedicated program for alternative justice at this time. However, we have utilized conferences, diversion and Chief and Councils to resolve cases in appropriate areas.

Crime Prevention
DARE: Salmon Arm provides the DARE program to a number of Schools within the Detachment area depending on the availability of trained instructors.

Provincial Auxiliary Program
Salmon Arm has eight trained auxiliary members who provide assistance to the regular members of the Detachment and increase the uniformed presence in the Detachment area.

School Liaison Program
Dedicated regular members of the RCMP are assigned specific schools to provide a visible presence and to increase the positive interaction with the students and teachers.

Citizens Patrol
Salmon Arm has an active COP group that provides a valuable service to our community. It increases our efforts to respond effectively to situations that require a police presence.

Police-Community Relations
The Detachment Commander meets with the Chief and Council of each First Nations Community periodically throughout the year. Informal meetings with councilors and band members are held on a case by case basis and / or to meet to discuss areas of mutual concern to improve the interaction between the police and the First Nations Communities.

Salmon Arm has an active Police-based Victim Assistance program that is based out of the Detachment. They consist of a full time manager and a number of volunteers who provide this service to all victims within the Detachment area.

Ambulance

The British Columbia Ambulance Service is Canada's only provincially-operated ambulance service, and provides emergency pre-hospital treatment and transportation by ambulance to the public and visitors to BC.

Not all BC communities, particularly in the more isolated and rural areas have 911 service. In some areas it may be necessary to look in the emergency pages section of the phone book for the emergency ambulance number, or to go through the telephone operator.

All telephoned requests for ambulance service are directed to one of three regional dispatch centers, which provide call-taking and call assessment services, as well as communications links which facilitate contact with and the dispatch of ground ambulances. If an air ambulance is requested, the regional dispatch centre will put the caller into contact with the Provincial Air Ambulance Coordination Centre in Victoria (PAACC).

911

Police, fire or ambulance? Emergency assistance is as close as your telephone 24 hours a day. The 911 emergency telephone service is provided for residents of the Central, North and South Okanagan, and Columbia Shuswap areas from the Communications Centre located in Kelowna. The Regional District of Central Okanagan administers the general operations of the Communications Centre in partnership with the RCMP.

The Southeast District Operational Communications Center is the largest RCMP dispatch center in Canada. They take all 911 calls for the southern half of the Province, with the exception of the lower mainland. The calls are transferred off to Police, Fire or Ambulance. If the calls are transferred to Police the Southeast District Operational Communications Center deals with these emergency calls. Files will be created and dispatched to members working in the policing area. The Southeast District Operational Communications Center also handles all of the non-emergency Police calls for service that require dispatching to members 24/7.

There are approximately 110 employees working in the Southeast District Operational Communications Center, a total of 49 detachments in our policing area with approximately 900 regular members working in these detachments. In 2005, 275,000 Police files were generated from the Southeast District Operational Communications Center. As of 2001, there were approximately 575,000 people living in this policing area. This number dramatically increases during the summer season.

People In Need (P.I.N.) Crisis Line

In 2006, the Crisis Line received 635 calls from the Shuswap area, the majority of those call were from Salmon Arm. The top five concerns for these calls were related to: Mental Emotional Health (19.3% of total calls); Family (15.4%); Financial (4.1%); Suicide (3.9%) and Addiction (3.3%). Callers requesting referrals and information made up 20% of total calls). MHES was accessed for callers 98 times or 15.4% of the calls.

The service to callers includes active listening skills, allowing an individual to talk about their situation without judgment or advice. Calls are answered by volunteers who have been trained to assess a callers needs.

These needs range from providing emotional support and/or a referral to a community agency, connecting an individual to mental health services or providing life-saving intervention. An intervention is carried out by accessing Emergency Communications (E-Comm). At this point volunteers are often able to provide a 911 operator, RCMP officer or ambulance attendant with specific information about a caller, such as whether they are alone, if weapons are involved, the method of a suicide attempt, if the person has a mental illness and how they can gain access to the premises.

Crisis Line service is very different than E-Comm service; E-Comm is strictly an emergency service.

There are 3 Fte staff at the Crisis Line and in 2006 there was an average of 28 volunteers.

Interior Health Mental Health and Addictions Services

Mental Health can be defined as the ability to think, feel and act in ways that enable one to enjoy life and cope with the challenges that come along. Mental Health "problems" or "difficulties" are terms that can be used to describe temporary reactions to a painful event, stress or external pressures, or to drug or alcohol use, lack of sleep or physical illness. This terminology may also be used to describe long-term psychiatric conditions, which may have significant effects on an individual's functioning.

The mission of Interior Health Mental Health Services is to deliver Mental Health and Addiction services promoting stable, healthy and productive lives. We recognize that different age groups have different needs and we provide specialized services for children, youth, adults and older adults. The services we provide include:

- Prevention Services
- Primary Care Services
- Community Support Services
- Crisis/Urgent Services
- Secondary Community Services
- Secondary Residential Services
- Secondary Acute Services
- Tertiary Residential Services
- Tertiary Acute Services

The Five Teams for Adult Mental Health and Addictions Services in Salmon Arm are:

Adult Short Term Assessment and Treatment (ASTAT)
This program for individuals age 19 and older offers assessment and short term intervention for adults (over 19 years) experiencing acute mental health problems which may put them at risk for more prolonged illness, and/or endangering themselves or others. Reasons may include:

- Anxiety
- Depression
- Suicidal Behaviors
- Adjustment Problems
- Complicated Bereavement
- Personality Disorders

Referrals are accepted from individuals (self refer) Physicians, Hospitals and other community agencies.

ASTAT services include:

- Initial Assessment
- Individual, Family and/or Group Programs
- Referrals and consultations to other agencies
- Psychiatric Assessments
- Education
- Prevention
- Medication

Group programs include an anxiety group, a borderline skills group, a depression program and a transitional support group. This team is comprised of a team leader and 3 clinicians serving the Salmon Arm area.

Adult Community Support Services (ACSS)

This community based team consisting of a team leader and 2.2 case managers serves primarily individuals age 19 and older who are experiencing a serious and persistent mental illness. A multi-disciplinary team provides community support, assessment, treatment, consultation, and supported housing to help achieve independence and improve the quality of their lives. Other agencies funded by Mental Health provide rehabilitation and recreation to further promote independence. Services are for the Salmon Arm, Sorrento, Enderby and Sicamous area and include:

- Psychiatrist and Consultation
- Case management
- Community Liaison & Outreach
- Comprehensive Psychiatric Assessment
- Individual Therapy
- Referrals & Consultation to other agencies
- Education
- Prevention
- Medication Management
- Supported Housing Programs

Early Psychosis Intervention (EPI) provides early intervention for youth 17 – 30 years old. The goals of the program are to improve short and long term prognosis, increase speed recovery, decrease hospital admissions, decrease risk of social and economic damage, reduce psychiatric complications, minimize family disruption, preserve personal assets, social skills, role functions, social and environmental supports and reduce relapse risk.

Concurrent Disorders provides consultation, case management and therapy for clients of the Mental Health Centre affected by serious mental disorders and alcohol and drug addictions.

Mental Health Emergency Services (MHES)/Intake
This mobile team which consists of 2.4 clinicians provides urgent assessment for individuals experiencing emotional mental crisis in the community as well as psychiatric consultation to the hospital emergency department. They also assume the mental health intake function to triage referrals and bridge or link people to appropriate services which may include brief solution focused follow up. Referrals accepted from PIN Crisis Line, self referral, family members and friends, Physicians or hospitals and other community agencies.

Alcohol and Drug Services
This team consisting of a team leader and 3 clinicians offer drop in, individual, family and group counseling. Assessments and referrals to various treatment centers are provided, as well as harm reduction information and education.

Elderly Services:
The Elderly Services Team (EST) of four is a multi disciplinary team of social workers, nurses, community outreach workers, family physicians and a geriatric psychiatrist. The EST works closely with the senior, their family and service providers including the family physician and Community Care Health Services staff. The EST provides assessment, treatment, follow up, consultation and education, case management, psychosocial support, and liaison with the Public Guardian and Trustee, for seniors 65 years of age or older who are experiencing the following:

- Complex dementia with associated psychiatric or behavioral problems. An exception is adults under 65 years of age who have complex dementia
- Depression, bipolar affective disorder, anxiety, delusional disorders
- Longstanding psychiatric disorder with age related complications

Child and Youth Mental Health Services

The CYMH Interim Urgent Response serves children and youth 18 years of age and under presenting to their local primary service agency in an acute mental health crisis state. These children and youth display behaviours, thoughts and feelings that are considered by the individual, family or others to be markedly different from their normal state and which seriously interfere with the activities of daily life. “Primary service agency” in this context refers to the Shuswap Lake Hospital Emergency Department and relevant Shuswap Lake Hospital Wards in general.

Team Structure

- 3.5 FTE’s
- 1 FTE dedicated Outreach to Enderby & Sicamous – no Salmon Arm Clients
- 2.5 FTE’s for Salmon Arm
- All Clinicians conduct Intake based on rotating responsibility

- As of June 1st 2007 the .5 will be vacant and 1 SA post will be open due to maternity leave

Service Mandate

- CYMH serves clients with severe Mental Illness as defined by the referral criteria and Intake screening protocol (BCFPI)
- Suicidality, Severe Depression, Anxiety, Psychosis, Severe Adjustment, Concurrent Disorders (see addendum)
- An urgent referral to CYMH will at a minimum offer a telephone consultation
- For appropriate referrals an in-person appointment will be provided – either in Hospital or at CYMH offices
- The in-person CYMH response will provide a Brief Assessment including a MH risk assessment and Suicide Risk assessment
- Recommendations will be shared with the referring worker(s)

Referral Criteria

- Child or youth 18 years and younger presenting to Shuswap Lake Hospital in crisis
- Shuswap Lake staff will make a referral to the Salmon Arm Intake Team The child or youth has, or is suspected to have mental health and/or co-morbid addictions issues
- S/he must be in crisis: there is a perceived risk of safety to self or others and/or in a a state of acute deterioration of normal functioning
- S/he will be experiencing acute psychiatric and/or emotional crisis, including adjustment disorders
- S/he must live within the catchment area

Response

- Hospital Staff will call Salmon Arm CYMH Intake Team as required
- CYMH Urgent Response Hours of Operation 830 am – 430 pm Monday – Friday
- CYMH Intake: 250 832 1719
- **Telephone Response to initial referral**: within 90 minutes
- **Service Response:** CYMH currently commits to a response time of 72 working hours at the latest; normally however a CYMH response will occur within 24 working hours
- ***There is currently NO CYMH Urgent Response after-hours provision***
- ***For after-hours crisis response professionals should contact first-line emergency services as needed***

CYMH Serves children and youth age range 0 to 19

Priorities:

- Life-threatening behaviours: Suicidal acts or threats, or violent/dangerous homicidal behaviour
- Referral procedure: Life threatening emergencies accepted, depending on staff availability within 72 hours. Child's physician must be notified and arrangements made for this child to be assessed by their physician.
- Serious Mental Disorders:

Includes disorientation, hallucinations, psychosis, cognitive/thinking impairment, and bizarre behaviours. This does not include Substance Misuse as a primary presenting problem, however Concurrent Disorders are accepted.

- Other Mental Disorders:

Includes depressive/affective mood disorders, withdrawal, severe anxiety disorders (separation anxiety, avoidance, overanxious and phobic symptoms).

- Sexual Abuse:

Formal disclosure must be completed prior to referral and an application for criminal injuries completed. A contracted service in most communities Sexual Abuse Intervention Program (SAIP).

- Behavioural Disorders:

Behaviour and conduct disorders, must fit criteria for conduct disorder. This includes services for children 0 – 12 with sexual behaviour problems. This is a contracted service in some communities.

- Eating Disorders:

This is a contracted service in some communities.

- Severe Behaviour / Attentional Disorders:

Includes psychiatric assessments, treatment recommendations, and behaviour management for ADHD, Oppositional Defiant Disorder, and Conduct disorder. Psychiatric consultation for Pervasive Developmental Disorder.

- Critical Incident Stress Debriefing

For C & Y who have witnessed a death or serious injury in motor vehicle accidents, suicide, or disasters

Also:

- Case Consultation Services, Facilitate and gate-keeping of community and tertiary psychiatric services, and community education

Areas to Improve On, Recommendations and Action Plans

Areas to Improve On	Recommendation	Local Action	Provincial Action
Emergency Mental Health Services Children and Youth	To inform senior managers that this area has been identified. A delegate from Child and Youth Mental Health Services and Adult Mental Health Services meet quarterly to continue building relationships and bridge gaps for individuals transitioning to adulthood.	A letter was sent to Cliff Cross, Senior Manager Adult Mental Health, North Okanagan, Barry Fulton, Mental Health Manager, Interior Region, Kemp Redl, Community Services Manager, North Okanagan and Nenad Katalinic, Team Leader Child and Youth Mental Health N. Okanagan stating who we were and what we identified. An article appeared in the local newspaper and a response was given by Nenad Katalinic stating that as a group they are aware of the gap and are in the process of working in partnership to improve the services to children and youth.	The group determined that if we did not receive a response we would forward the letter to Honorable George Abbott, Minister of Health and Honorable Tom Christensen, Minister of Children and Family Development.
Inconsistent interpretation of the Mental Health Act (MHA)	RCMP to collaborate more with Mental Health Emergency Services (MHES) to clarify roles and responsibilities pertaining to the MHA	MHES be available to attend with RCMP in the event of a call. Mental Health and RCMP to meet regularly to review the MHA and the role of RCMP under the MHA	

RCMP members orientation to Salmon Arm and local emergency contacts and agencies	Implement in the new recruit orientation package to meet with Adult Mental Health team leader, Child and Youth Mental Health team leader, Ministry for Children and Family Development (MCFD) team leader. Have a working knowledge of Assisted and Supported living homes in the catchment area and other related agencies. New Officers can attend a networking meeting with MHES, Adult Mental Health liaison workers, and other agency delegates A designated liaison officer will attend quarterly meetings with other first responder service providers	All new officers will be given an information wallet size card with how to access MHES, MCFD contact and other relevant emergency numbers. Each organization such as Adult Mental Health, RCMP and CMHA will assign a liaison person to be the first contact and their name will appear on the information cards	
Inconsistent communication and information sharing between service providers	To continue to improve developing information systems	RCMP and Interior Health to review the Service Agreement already in place between Interior Health Authority and RCMP Williams Lake Detachment	

		RCMP Salmon Arm Detachment is upgrading their computers in the Fall of 2007. This may result in accessing more detailed information about clients, their history and their mental health status. Meetings have commenced between RCMP and Emergency staff to have a better understanding of roles pertaining to the MHA Emergency staff have begun case reviews in a timely manner which is assessing what is working well and what can continue to be improved on	
Education and Training	RCMP, Ambulance and other relevant service providers investigate courses such as Mental Illness First Aid (MIFA) and Non Violent Crisis Intervention Training (NVCIT)	A trained facilitator of MIFA will host a course in Salmon Arm open to community members, RCMP, Ambulance at the end of June 2007	Ongoing encouragement to provide more mental illness training at basic training for new RCMP recruits and Paramedics
Weekend access to MHES	Increase MHES hours on the weekend to midnight MHES be available in the community to clients, family members and other community service agencies	Emergency department and RCMP to track crisis calls on weekends All community agencies obtain	

		accurate contact numbers for MHES	
Treatment of community members in the event of a psychiatric crisis including timely triage and admittance	To continue improving the service for individuals in the community in a crisis situation including developing an appropriate 'secure room' and having the ability to triage in the 'secure room' Have the 'secure room' remain available for psychiatric emergencies only regardless of bed shortages	Shuswap Lake General Hospital is undergoing renovations in the Fall of 2007 this will include a new 'secure room'	
Concurrent Disorders	To develop a better understanding of concurrent disorders and the increased prevalence	A concurrent disorders workshop is offered by a trained facilitator through Canadian Mental Health Association (CMHA)	
Sustainability of the Mental Health and Police Project	To continue to meet quarterly as a group	A meeting is set for September 20 2007 and a representative from CMHA, Adult Mental Health, Emergency Department, P.I.N. Crisis Line, RCMP, Child and Youth Mental Health and BC Ambulance Services have committed to attend.	

Lessons Learned

a) Upon developing this committee, most members had a pre-existing working relationship which only enhanced the work that was accomplished. We had a large group of members each bringing something to the table. One recommendation is to have a smaller core group of representatives from Consumers, Mental Health, R.C.M.P.

Emergency Department and only a couple of agency delegates. Then ask other individuals to come to a meeting as an invited guest to speak on their particular issues with service and gaps they have identified in their work. This would then not tie up valuable time for members who only have a small involvement in the project.

b) The timing between meetings seemed very quick and perhaps it would have been more beneficial to have monthly meetings for a longer period of time.

c) Having a template of timelines and what needs to be covered when would be helpful. Building relationships is very important and is the foundation for any partnership work that is accomplished. Perhaps having some team building in the beginning would accelerate that process so the group could move forward into goals and action plans.

Committee Members

Rhonda Bailey, Coordinator; Canadian Mental Health Association Salmon Arm & District Branch

Signature: _____

Dawn Dunlop Pugh, Executive Director, Canadian Mental Health Association Salmon Arm & District Branch

Signature: _____

Darren Gulka, RPN Team Leader / Case Manager Adult Community Support Services, Early Psychosis Intervention Salmon Arm Mental Health

Signature: _____

Sharon Durant, Executive Director, PIN Crisis Intervention Society

Signature: _____

Sara Inskip, Representative for SAFE Society, Women's Shelter

Signature: _____

Terry Jobe, Critical Care Nursing Leader, Shuswap Lake General Hospital, Salmon Arm

Signature: _____

Cst. Kale Pauls, RCMP

Signature: _____

Cst. Jason Nash, RCMP

Signature: _____

Jan Cotterell, Program Coordinator, Community Based Victim Services Salmon Arm, BC

Signature: _____

Lisa Ruttle, Consumer

Signature: _____

Mickie Jewell, Consumer

Signature: _____

Darcy Gollan, RCMP and Chair of CMHA Salmon Arm Board of Directors

Signature: _____

Russ Balance, Acute and Transitional Services Program Manager Vernon Mental Health Centre

Signature: _____

Guests:

Nancy Tarrant, Social Worker Little Shuswap Indian Band
Alison Negrieff, Psychiatric Social Worker, Kamloops Adult Forensic Psychiatric Community Services
Nenad Katalinic , CYMH Team Leader, North Okanagan District
Neil Profili, St. John's Ambulance Services, Salmon Arm
Rick Honcharsky, Salvation Army Salmon Arm
Alison Nadeau, CYMH Clinician, Salmon Arm
Gina Johnny, Band Chief, Adams Lake Indian Band
Tami Lund, Team Leader, Ministry for Children and Family Development
Fiona Peebles, Consumer

Appendix 1:

BC Mental Health Timeline

1850 British Columbia's first recorded case of insanity: shortly after arriving in Victoria, a deranged Scottish immigrant allegedly assaults J.S. Helmcken, the jail doctor. The "maniac" is placed on the next ship back to Scotland.

1864 An infirmary for women is opened in Victoria, and includes a handful of female "lunatics" among its patients. However, treatment for mental illness is non-existent. Most mentally ill people are left to fend for themselves or, if deemed dangerous or troublesome, are locked in the crowded city jails of Victoria and New Westminster.

1872 BC's first asylum for the insane opens: Royal Hospital, a converted cottage that previously served as Victoria's quarantine hospital, is re-converted to house the mentally ill.

1873 The Insane Asylums Act is passed, BC's first legislation addressing mental illness.

1878 The overcrowded Victoria asylum is closed and its 36 residents are moved to the newly-built Provincial Asylum for the Insane in New Westminster.

1883 Work therapy is introduced; asylum residents are put to work in the gardens.

1897 The legislature passes the Hospitals for the Insane Act, stipulating that mentally ill persons could be committed to hospital under an Urgency Order, which required two medical certificates. The asylum in New Westminster is renamed the Provincial Hospital for the Insane (PHI).

1899 PHI population surpasses 300. In the absence of social services, the hospital is housing developmentally disabled people and unwanted, physically handicapped children along with psychiatric patients. Complaints are heard of serious overcrowding, poor hygiene and living conditions, and inadequate care.

1901 The psychiatric literature lists the principal causes of insanity as heredity, intemperance, syphilis and masturbation.

1904 To relieve overcrowding, 48 male patients are transferred to a small asylum in Vernon, and the BC government purchases 1,000 acres in rural Coquitlam as the site for a new mental hospital – the beginning of Riverview Hospital.

1905 Using mostly patient labor, housed on-site in temporary buildings, the Coquitlam site is cleared and diked, and Colony Farm is established to grow food for the PHI.

1909 Construction begins on the new "Hospital for the Mind" on the slopes above Colony Farm; the locale would become known as Essondale, in honour of Dr. Henry Esson Young, the cabinet minister who advocated the new hospital.

1912 John Davidson, Provincial Botanist, establishes western Canada's first botanical garden and arboretum on the Essondale grounds. Davidson would move the garden to the new UBC campus in 1916, but the unique collection of trees remains to this day. Meanwhile Colony Farm gains a reputation as the best farm in Western Canada, employing the latest in farming techniques to produce over 700 tons of crops and 20,000 gallons of milk in a year.

1913 The Hospital for the Mind is officially opened, taking 300 of the most seriously ill patients (all male) from the overcrowded New Westminster facility. The new building is widely considered the state of the art in psychiatric hospitals of the time. It would later be renamed the Male Chronic Building -- and in 1950, West Lawn. Access from Vancouver is by rail only.

1919 BC's first forensic psychiatric facility opens: the Provincial Mental Home for the Criminally Insane, at Colquiz on Vancouver Island, with an initial intake of nine patients transferred from PHI. By year's end Colquiz would house 99 inmates.

1920 Two permanent dormitories are added to the growing complex at Colony Farm, providing 75 beds for patients working on the farm.

1924 The Acute Psychopathic Unit (later called Centre Lawn) opens at Essondale, originally used for testing and recommending treatments for new admissions.

1930 The 675-bed Female Chronic Unit (later called East Lawn) opens, allowing most of the female residents of PHI to transfer to Essondale. BC's first training school for psychiatric nurses is established in the new building. The hospital's first occupational therapist is hired, followed a year later by the first social worker.

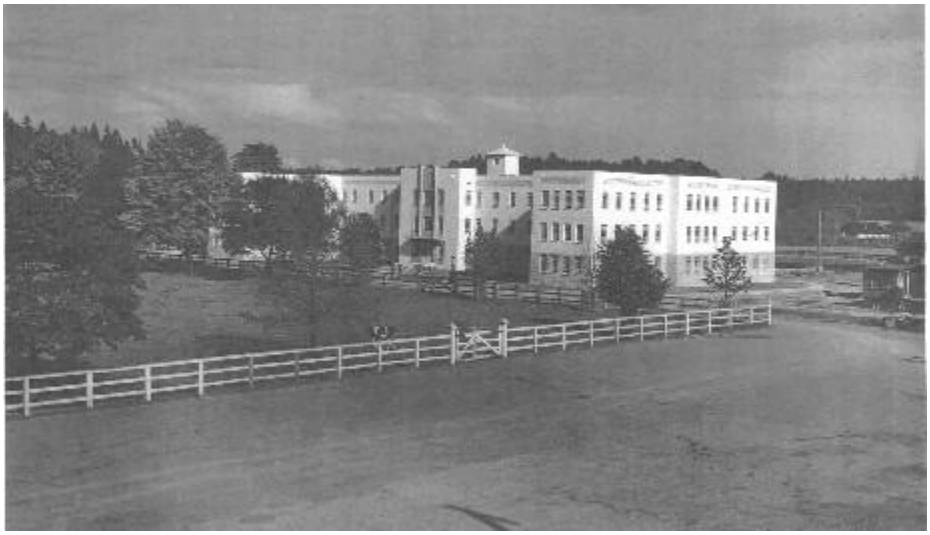
1932 The first graduates from BC's school of psychiatric nursing receive their diplomas.

1934 The Veterans' Unit (the first section of what would later become Crease Clinic) opens at Essondale.

1936 The former Boys' Industrial School (built in 1920) is converted to the Essondale Home for the Aged, later known as Valleyview.

1940 BC's Mental Hospital Act is amended, deleting all references to "lunatic" and "insane"; this year also sees the first male graduates from the nursing school.

1942 Electro-convulsive therapy (ECT) is introduced, followed soon after by sulfa drugs, then psychosurgery; all of BC's mental health facilities are reported to be seriously overcrowded.



1946 The first female physician is hired at Essondale; however, the hospital will remain gender-segregated until the early 1960s.

1949 Crease Clinic of Psychological Medicine opens, after the second half of the building is constructed (a mirror image of the first half, built in 1934). At Colony Farm, the Veterans Unit (Riverside Building) opens, the forerunner of today's Forensic Psychiatric Hospital.

1950 Provincial Mental Health Services are amalgamated; New Westminster's Provincial Hospital for the Insane is renamed Woodlands School, repurposed as a residential facility for the developmentally disabled.

1951 Essondale reaches its peak population of 4,630 patients. Pennington Hall opens, providing recreational services to patients.

1955 230-bed Tuberculosis Unit (now called North Lawn) opens at Essondale. The introduction of improved medications, along with the opening of community mental health centres, boarding homes, and general hospital psychiatric wards, results in the start of a decline in Essondale's patient population.

1959 Essondale's last major patient residence, Valleyview 300, opens. The former Tranquille provincial tuberculosis sanitarium in Kamloops is converted to a residential facility for the developmentally disabled.

1964 The Colquiz forensic facility is closed and its patients transferred to Riverside Unit at Colony Farm.

1965 The BC Mental Health Act is introduced, bringing a number of administrative changes.

1966 Essondale is renamed Riverview Hospital, although Valleyview continues to operate independently until 1986.

1972 The BC School of Psychiatric Nursing moves from Riverview to the BC Institute of Technology. The following year sees the last graduating class from the Riverview program.

1974 BC's Forensic Psychiatry Act is enacted, creating the Forensic Psychiatric Services Commission (FPSC) to provide mental health services for persons in conflict with the law. Over the next two years Riverside Unit at Colony Farm is transformed into the Forensic Psychiatric Hospital. FPSC opens its Vancouver clinic, the first of what would later become a province-wide network of regional clinics.

1983 With Riverview's population continuing to fall, West Lawn is permanently closed. Farming operations at Colony Farm are discontinued.

1985 Signaling a nationwide trend to de-institutionalizing the developmentally disabled, Tranquille is closed; Woodlands will close in 1996.

1988 The BC Mental Health Society is established and takes over management of Riverview; the society's provincially-appointed trustees are replaced by a community-based board of governors in 1992.

1990 The Mental Health Initiative introduces a comprehensive plan for the development of mental health services throughout the province. It focuses on replacing Riverview with smaller, more specialized regional facilities.

1992 The Crease Clinic becomes the second large Riverview building to close; the building will later embark on a second career as a filming location.

1994 Riverview establishes Canada's first Charter of Patient Rights. After investigating patient complaints, the BC Ombudsman releases a report titled "Listening – A Review of Riverview Hospital". The two events signal a change in Riverview's relationship with its patients and family members.

1997 The new state-of-the-art Forensic Psychiatric Hospital opens at Colony Farm, replacing the original Riverside Unit.

1998 The Ministry of Health releases a new Mental Health Plan for BC, to be

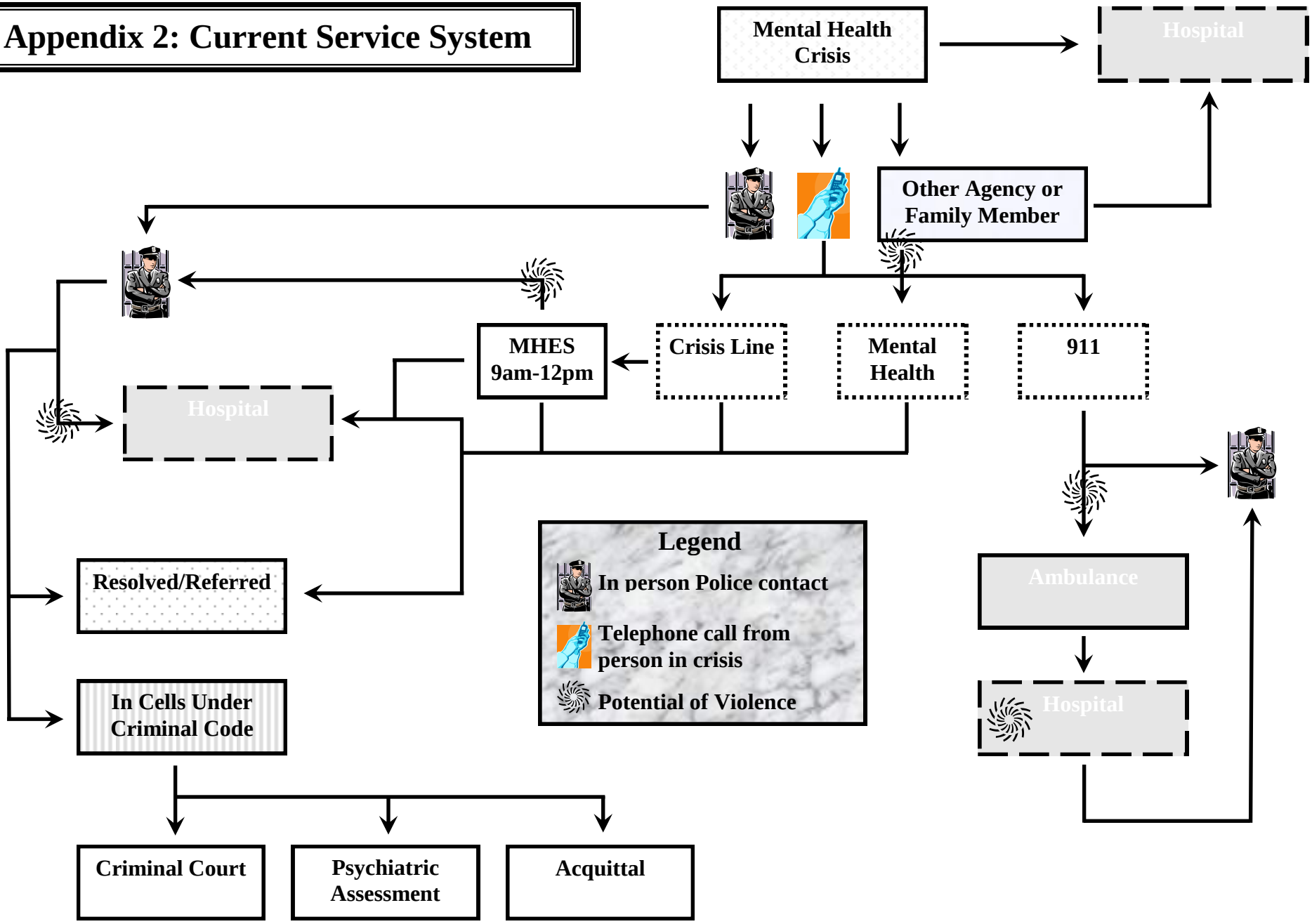
implemented over seven years. The plan envisions a health care system where people with mental illness have access to necessary care as easily as to physical health care, with priority for specialized services based on medical risk or extent of disability.

2001 The BC government announces a new administrative structure for health services, comprising five geographically-based regional health authorities plus the Provincial Health Services Authority (PHSA), which is responsible for specialized, province-wide services. Riverview and the Forensic Psychiatric Services Commission are among the agencies placed under PHSA.

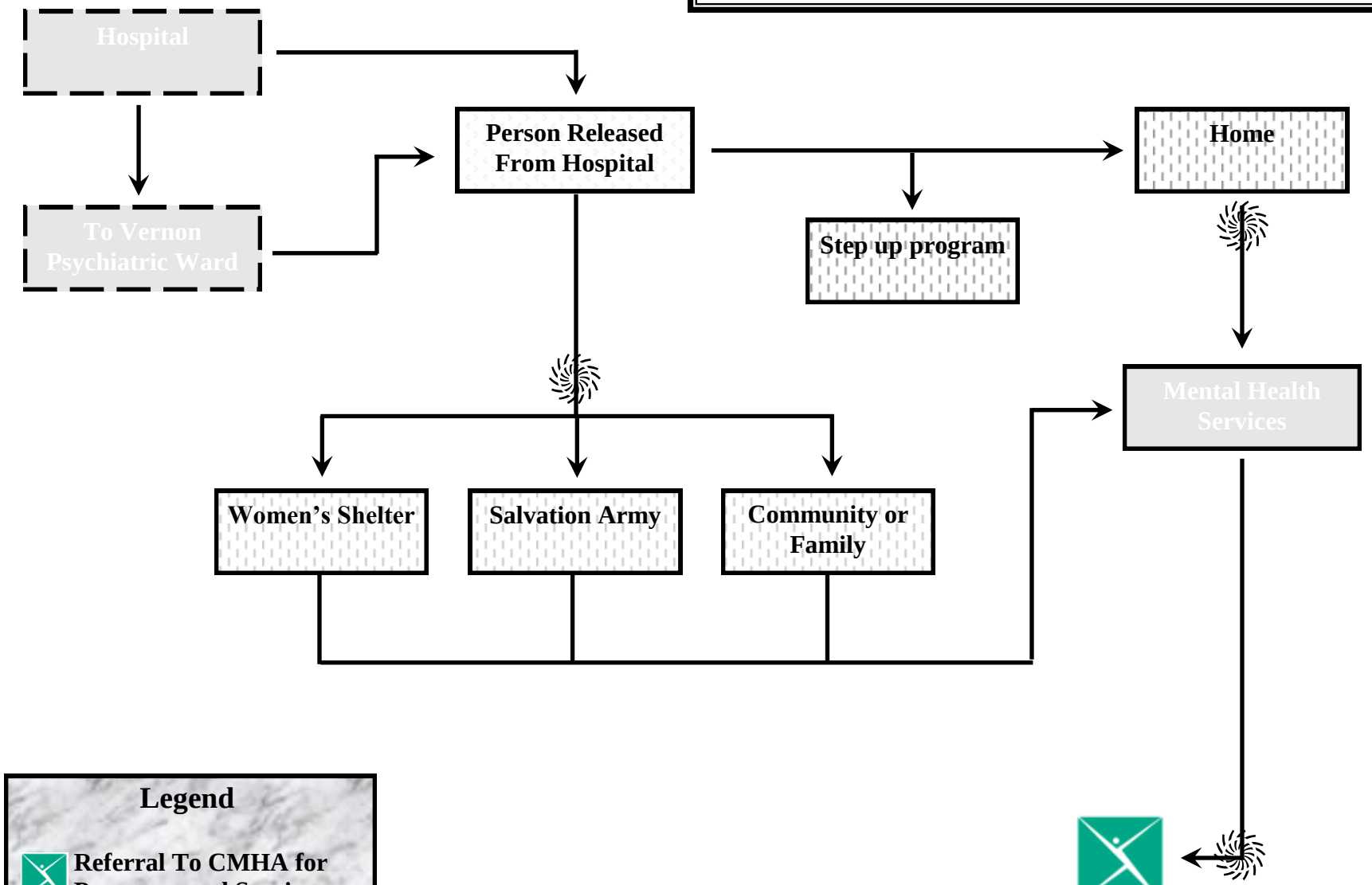
2002 Riverview Redevelopment Project is announced. The aging institutional buildings at Riverview are to be gradually phased out, replaced by new tertiary care facilities located in all five geographic regions of BC, in a carefully planned "bed for bed" replacement process.

2005 With patient transfers to new regional facilities continuing to reduce Riverview's population, the 75-year-old East Lawn building is clo

Appendix 2: Current Service System



Appendix 3: Current Agency Service System



Appendix 4:

Shuswap Lake General Hospital

601 – 10th Street NE
Salmon Arm, BC V1E 4N6

Tel.: (250) 833-3600
Fax: --

Population Information

Table 1. Population by Local Health Area
Salmon Arm LHA

LHA Population (2004)	LHA Population (2009)	% Growth (2004 – 2009)	Population 65+ (2004)	65+ as % of Total (2004)	Population 75+ (2004)	75+ as % of Total (2004)
32,371	33,738	4.2%	6,547	20.2%	2,982	9.2%

Table 2. Age-Standardized Acute / Rehab, Residential Care, Home Care, and Home Support Utilization Rates by Local Health Area (2002/03)
Salmon Arm LHA

	Acute / Rehabilitation				Residential Care	Direct Care (Total)	Home Support
Year	LHA Cases per 1,000 Population	LHA Days per 1,000 Population	LHA Surgical Procedures per 1,000 Population	LHA Surgical Day Care Cases per 1,000 Pop'n.	Days per 1,000 Population	Visits per 1,000 Population	Hours per 1,000 Population
1998/99	112.0	618	47.8	72.4			
1999/00	115.5	645	47.0	88.9			
2000/01	113.9	613	45.4	85.3			
2001/02	101.8	546	40.5	86.4			
2002/03	89.2	520	41.2	79.2	1,640.1†	249.5†	917.3†

† Preliminary data from the Continuing Care Data Warehouse (CCDW) December 2003 Refresh.

Facility Information

Table 3. Acute Care Hospital: General Information
Shuswap Lake General Hospital

No. of Acute Care Beds Approved (April 2002)	No. of Acute Care Beds Staffed (February 2004)	No. of On-Site Residential Care Beds (February 2004)	Distance (km) to Major Centre
40	40	0	60km (Vernon)

Table 4. Acute Care Hospital: Selected Utilization Statistics
Shuswap Lake General Hospital

	Acute / Rehabilitation Care					Selected Utilization Statistics				
Year	A / R Cases	A / R Days	Avg. Length of Stay (ALOS)	A / R Weighted Cases	Avg. A / R Weighted Cases	Avg. # of Patients per Day (No ALC)	Newborn Deliveries	Inpatient Surgical Cases‡	Surgical Day Care (SDC) Cases	SDC as % of Total Surgical Cases
2000/01	2,945	15,240	5.2	3,048.2	1.0	41.8	204	670	2,252	77.1%
2001/02	2,808	15,235	5.4	3,223.5	1.1	41.7	208	617	1,958	76.0%
2002/03	2,338	14,007	6.0	2,615.7	1.1	38.4	213	620	2,087	77.1%

‡ Based upon Procedure Codes 14.0+ (Surgical Procedures)

May 2004

Table 5. Acute Care Hospital: Utilization by Patient LHA / HSDA (2002/03)
Shuswap Lake General Hospital

LHA	LHA Description	Cases	% of Total Hosp. Cases
020	Salmon Arm	1,812	77.5%
078	Enderby	264	11.3%
019	Revelstoke	64	2.7%
024	Kamloops	52	2.2%
000	Non-Residents	41	1.8%
	Other LHAs w/ < 1%	105	4.5%
	Hospital Total	2,338	100.0%

HSDA	HSDA Description	Cases	% of Total Hosp. Cases
14	Thompson Cariboo	1,929	82.5%
13	Okanagan	327	14.0%
	Non-Residents	41	1.8%
	Other HSDAs	41	1.8%
	Hospital Total	2,338	100.0%

Table 6. Acute Care Hospital: Alternate Level of Care (ALC) Days
Shuswap Lake General Hospital

Year	No. of ALC Days	ALC Days as % of Total Days
2000/01	1,849	10.8%
2001/02	3,064	16.7%
2002/03	1,403	9.1%

Table 7. Acute Care Hospital Utilization for Acute / Rehab. Cases by Patient Service, Physician Service, and Major Clinical Category (2002/03)
Shuswap Lake General Hospital

Patient Service	Cases	% of Total
Gen Med 15+: General Medicine	905	38.7%
Gen Med 15+: Cardiology	419	17.9%
Gen Surg 15+: General Surgery	270	11.5%
Obstetrics: Delivered	214	9.2%
Gen Med 15+: Neurology	124	5.3%
Gen Surg 15+: Urology	92	3.9%
Psychiatry: General	80	3.4%
Gen Surg 15+: Orthopedic	56	2.4%
Paed Med 0-14: General Medicine	54	2.3%
Gynecology: General Gynecology	27	1.2%
All Other Patient Services	97	4.1%
Total Cases	2,338	100.0%

Physician Service	Cases	% of Total
Family / General Practitioner	1,825	78.1%
General Surgery	349	14.9%
Internal Medicine	149	6.4%
All Other Physician Services	15	0.6%
Total Cases	2,338	100.0%

Major Clinical Category (MCC)	Cases	% of Total
Diseases & Disorders of the Circulatory System	467	20.0%
Diseases & Disorders of the Digestive System	446	19.1%
Pregnancy and Childbirth	244	10.4%
Diseases & Disorders of the Respiratory System	217	9.3%
Diseases & Disorders of the Hepatobiliary System and Pancreas	123	5.3%
All Other MCCs	841	36.0%
Total Cases	2,338	100.0%

Table 8. Acute Care Hospital Utilization for Surgical Day Care Cases by Patient Service and Major Clinical Category (2002/03)
Shuswap Lake General Hospital

Patient Service	Cases	% of Total	Avg. RIW
Gen Surg 15+: General Surgery	1,490	71.4%	0.17
Gen Surg 15+: Orthopedic	256	12.3%	0.22
Gen Surg 15+: Urology	161	7.7%	0.13
Gynecology: General Gynecology	102	4.9%	0.17
Paediatric Dentistry	37	1.8%	0.30
Paed Surg 0-14: General Surgery	13	0.6%	0.14
All Other Patient Services	28	1.3%	
Total Cases	2,087	100.0%	0.18

Major Clinical Category (MCC)	Cases	% of Total	Avg. RIW
Diseases & Disorders of the Digestive System	980	47.0%	0.17
Diseases & Disorders of the Musculoskeletal System	275	13.2%	0.23
Other Reasons for Hospitalization	191	9.2%	0.14
Diseases & Disorders of Skin, Subcutaneous Tissue, & Breast	134	6.4%	0.18
Diseases & Disorders of the Female Reproductive System	101	4.8%	0.17
Diseases & Disorders of the Male Reproductive System	89	4.3%	0.14
Diseases & Disorders of the Nervous System	78	3.7%	0.17
Diseases & Disorders of the Hepatobiliary System and Pancreas	48	2.3%	0.33
Diseases & Disorders of the Kidney and Urinary Tract	48	2.3%	0.12
Diseases & Disorders of the Ear, Nose, Mouth and Throat	43	2.1%	0.28
All Other MCCs	100	4.8%	0.20
Total Cases	2,087	100.0%	0.18

Table 9. Descriptive Overview of Patient Services
Shuswap Lake General Hospital

Summary Statistics for Emergency and Outpatient Services

Emergency Services	
Emergency Visits (2002/03)	Hours of Operation
20,267	24 hours per day 7 days per week

Outpatient Services	
Scheduled Visits (2002/03)	Non-Scheduled Visits (2002/03)
5,211	16,229

Note: Outpatient Services include Emergency Visits

Description of Inpatient and Outpatient Services

Inpatient Services

Service	Notes
Medicine	Including: General Medicine, Endocrinology, Clinical Investigation, Cardiology, Family Practice, Gastroenterology, Metabolic, Oncology, Rheumatology, Palliative Care, 3-bed ICU
Surgery	Including: Bowel Resection, Abdominal Perineal Resections, Mastectomy, Cholecystectomy, Abdominal Hernia Repairs, Hemorrhoidectomy
Paediatrics	
Obstetrics	
Diagnostics	Including: X-Ray, Ultrasound

Outpatient Services

Service	Notes
Clinics	Including: Oncology, GI / Endoscopy, Cardiology, Minor Surgery, Pre-Anaesthetic, Urology, Orthopedics, Gynecology, Blood Transfusions, IV Therapy, BCG Bladder Instillations, Phlebotomy, Paracentesis, Thoracentesis, Casts, Excisions & Biopsies, Ophthalmology, Sigmoidoscopy / Banding, Varicose Vein Injections
Cardiology Clinic	ECG, Stress Testing, Assistance w/ Pacemaker
Rehabilitation	Including: Occupational Therapy and Physiotherapy

Table 10. Physician Specialty (February 2004)
Shuswap Lake General Hospital

Specialty	Total	Specialty	Total
Anesthetist	3	Obstetrician / Gynecologist	--
Anesthetist / Surgeon	--	Ophthalmologist	1
Cardiologist	--	Orthopedics	--
Dermatologist	--	Otolaryngologist	--
Emergency Medicine	--	Pathologist	--
Gastroenterologist	--	Pediatrician	--
General Practitioner	36	Plastic Surgeon	--
General/Thoracic	--	Psychiatrist / Psychologist	1
Geriatric	--	Radiologist	1
Hematology	--	Rehab Medicine	--
Internal Medicine	3	Respiratory Medicine	--
Infectious Disease	--	Rheumatologist	--
Nephrologist	--	Surgeon (General)	3
Neurologist	--	Thoracic Surgeon	--
Neurosurgeon	--	Urologist	--
Nuclear Medicine	--	Vascular Surgeon	--

Table 11. Approximate FTEs (February 2004)
Shuswap Lake General Hospital

Sector	FTEs*
Acute Care	113.3
Residential Care (on site)	0.6
Administration / Business Office	23.8
Maintenance, Housekeeping, and Other Support Services	33.2
Other	0.0
Total	170.9

* Based upon budgeted hours