

INTERFACES BETWEEN MENTAL HEALTH AND SUBSTANCE USE SERVICES AND POLICE



A toolkit for police agencies and health authorities to guide them in working together to address the needs of people with mental health and/or substance use issues

2018

EXECUTIVE SUMMARY

This toolkit provides clear and practical guidance to police agencies and health authorities on working together in the delivery of mental health and substance use (MHSU) services. The aim of the toolkit is to support effective and integrated responses to individuals with MHSU needs.

Problem statement

Individuals with MHSU issues within BC are increasingly interfacing with police agencies. There is a need throughout BC for integrated and collaborative approaches between police agencies and health authorities to better meet the needs of people with MHSU issues and their families.

Purpose of the toolkit

The toolkit aims to provide evidence to support the development of locally appropriate protocols and strengthen collaboration between health authorities and police agencies across the province. The toolkit and supplementary documentation can be used to inform new protocol development or revise existing protocol between the health authority and local police agency.

Toolkit structure

Part 1: Police-Health Mental Health and Substance Use Collaboration

1. Overview of Police Involvement in Mental Health and Substance Use Services
2. Privacy and Information Sharing Protocols

Part 2: Joint Crisis Response in alignment with the *Mental Health Act*

1. Visual Pathway: Mental Health and Substance Use Crisis Response
2. Section 28 Police apprehension
3. Form 4 Medical Certificate + Form 10 Police Apprehension
4. Form 21 Police Apprehension (Director's Warrant – extended leave recall)
5. No Police Apprehension

Each section includes an exploration of **key issues**, an overview of **current initiatives** that includes links to example policies, protocols and procedures and **opportunities for improvement** identified by key informants.

“It is tremendously valuable when you have police officers that spend time working with a team of health professionals, getting to know people with mental health and substance use challenges, who then go back into the police department and share that knowledge with others [...] it tends to shift the culture.”

– *Healthcare provider*

METHODOLOGY

Research involved an initial literature review and a series of key informant interviews. The main focus of the literature review was academic publications and grey literature from 2000 to 2016, including reports and other publications predominantly from British Columbia, but also spanning the rest of Canada, the United Kingdom, the United States and Australia.

Key informants, who were directly engaged at various points throughout the research process, included provincial government ministries, health authorities, municipal police agencies, and RCMP detachments. These groups helped to identify key issues in mental health and substance use related police-health interactions and provided examples of what was working well and what could be improved in their jurisdictions. Informants also reviewed early drafts of the toolkit and provided input on how to best create a practical and useful final product. Please refer to Appendix 6 for acknowledgements.

DISCLAIMER

This toolkit has been assembled to reflect the current practices in British Columbia. Many of the practices included are formalized and documented through policies, protocols, memoranda, and other agreements.

If documentation was available for reference, we included the name of the document and where possible, provided hyperlinks to enable access to the full text. Other practices that have not yet been formally documented are presented in the toolkit as they were described to us by key informants.

The authors of this toolkit do not make any claims about the efficacy or appropriateness of the practices described. While many practices have undergone formal evaluation, some have not and may not be appropriate for all jurisdictions or health authorities in BC.

LIMITATIONS

This toolkit only documents policies, practices and protocols developed by health and police agencies in British Columbia, operating in accordance with BC legislation such as the *MHA*, which differs from that of other provinces and countries. Any information or guidance derived from other jurisdictions may not be of relevance.

The scope of the toolkit is limited to health and police services in British Columbia's mental health and substance use sector and does not include an exploration of issues specific to children and youth or Indigenous communities.

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INTRODUCTION

Individuals living with mental health and/or substance use (MHSU) issues can come into contact with police during periods of illness. There is a need throughout the province for integrated and collaborative approaches between police agencies and health authorities to better respond to individuals in crisis and connect them to appropriate MHSU services.

Many jurisdictions have begun to address this need. Initiatives have emerged from joint efforts between municipal police agencies, Royal Canadian Mounted Police (RCMP) detachments, and health authorities. Programs such as Integrated Mobile Crisis Response Teams (IMCRT) and Assertive Community Treatment (ACT) that partner MHSU services with police and other community partners have been successful in responding to crisis and supporting individuals.

This toolkit was developed to highlight the work of jurisdictions that have experienced success in the area of police-health coordination and to support other jurisdictions in the development and execution of police-health partnerships. While each region is influenced by available resources, distribution of healthcare facilities and population demographics, the information contained herein is intended to educate and support police officers and health personnel in the development of locally appropriate protocols and ultimately strengthen the interfaces between sectors.

The toolkit is divided into two parts. Part 1 provides a discussion of police involvement in MHSU services and cross-sector information sharing. There is an exploration of **key issues**, an overview of **current initiatives** that includes links to example policies, protocols and procedures and **opportunities for improvement** identified by key informants. The latter half of the section provides an overview of provincial and federal privacy legislation and principles for better information sharing.

Part 2 provides guidance on MHSU crisis response and the *Mental Health Act (MHA)*. A visual pathway is provided to assist frontline staff in assessing a crisis situation and acting in accordance with provincial and federal legislation. A brief summary of each component of the pathway has been provided here:

2.1 Mental Health and Substance Use Crisis Response

Police officers, who are commonly first responders in times of mental health and substance use emergencies, and healthcare providers often work together to support the assessment, care and safe transport of an individual in crisis. Protocols between police and health agencies clarify how police officers and health personnel collaborate and share information appropriately to support the individual with MHSU needs and to connect them to the MHSU system of care. Healthcare providers play a critical role in assessment, triage and discharge decisions.

2.2 Section 28 Police Apprehension

Section 28 of the *MHA* authorizes police to apprehend an individual if satisfied that an individual is behaving in a way that will endanger their own safety or the safety of others and they apparently have a disorder of the mind that requires treatment and that seriously impairs the individual's ability to react appropriately to their environment or to associate with others. If an individual is apprehended under the *MHA*, the police officer must take the individual to a physician for examination. If the physician completes a medical certificate for the involuntary admission of the individual, they may be admitted to a designated facility. If the physician does not complete a medical certificate for the involuntary admission of the individual, the individual must be released.¹

2.3 Form 4 Medical Certificate + Form 10 Police Apprehension

Section 22(6) of the *MHA* authorizes anyone to apprehend an individual for the purpose of admission to a designated facility within 14 days after a medical certificate of involuntary admission (Form 4) has been issued for the individual, and also authorizes the transportation, admission and detention for treatment of the individual in or through a designated facility.

A judge or justice may issue a Form 10 warrant if satisfied that the person is a person with a mental disorder, who requires treatment through a designated facility to prevent substantial mental or physical deterioration, or for their protection or the protection of others and cannot be suitably admitted as a voluntary patient, and that

the process for involuntary admission on the basis of a medical certificate cannot be used without unreasonable delay. The warrant authorizes the involuntary admission and detention for treatment of the individual named in the warrant for 48 hours without a medical certificate, after which time the person must be discharged, unless two medical certificates are received.

2.4 Form 21 Police Apprehension (Director's Warrant – extended leave recall)

Section 39 (3) of the *MHA* authorizes a Director of a designated facility to issue a warrant in Form 21 directing police to apprehend and return an individual to a designated facility. A Director can recall an individual to a designated facility if the conditions of the individual's leave or transfer to an approved home are not being met.

Similarly, if an individual leaves a designated facility without authorization, section 41 of the *MHA* authorizes a Director to issue a warrant in Form 21 directing police to apprehend and transport the individual to a designated facility. The warrant must be issued within 60 days of the date when the individual left the designated facility, unless the individual leaves while charged with an offence, or while subject to a sentence of imprisonment, or the

Director thinks that the individual is at risk of harm or that there is a risk of harm to others. However, an individual may be apprehended and transported without a warrant, within the first 48 hours after the individual has left a designated facility without the proper authority.

2.5 No Police Apprehension

There are circumstances where a police officer encounters an individual experiencing a MHSU-related crisis, who does not meet the criteria for apprehension under the *MHA* and has not committed a criminal offence. The police officer should strive to resolve the crisis and support the individual to access appropriate healthcare services.

Please note:

Appendices 2 and 3 provide a list of procedure documents and emerging initiatives from jurisdictions across BC. Each document or initiative is described in brief and accompanied by a link or source if available. Some documents have not been approved for public distribution by the appropriate governing agency. The contact information for the agency's Freedom of Information office has been provided in those cases.

PART 1: POLICE-HEALTH MENTAL HEALTH AND SUBSTANCE USE COLLABORATION

1.1

OVERVIEW OF POLICE INVOLVEMENT IN MENTAL HEALTH AND SUBSTANCE USE SERVICES

Since the early 1990's, the Ministries of Health and Public Safety and Solicitor General, health authorities, the RCMP and municipal police forces have been collaborating to better serve individuals with MHSU needs. Service coordination, continuity of care, and where appropriate, diversion away from the justice system have become priorities for police and MHSU providers.²

In recent years, the number of service models and specialized MHSU programs featuring collaboration between police officers and MHSU services has increased. These models and programs include, at a high level, police officer units with specialized training in MHSU issues (identification, intervention and support) and formal partnerships to develop joint service-delivery relationships between police officers and MHSU service providers.³

Key issues

Police officers and MHSU service providers often work together to support individuals who experience MHSU issues. Research has documented higher rates of repeat interaction with law enforcement among individuals with co-morbid mental health and substance use disorders in British Columbia. The rate of repeat apprehension is significantly reduced for individuals with no mental health diagnosis or a non-substance related mental disorder.⁴ There is a need for integrated treatment and support from health, justice and social services for individuals with co-occurring disorders.⁵

Police officers are often called upon to respond to mental health and substance use related incidents, where they de-escalate crisis situations, assess whether criminal activity has occurred, apprehend an individual and/ or connect them to health services. Health personnel provide assessment and treatment of individuals who are transported to a medical facility by police. They are responsible for making triage and discharge decisions and for arranging ongoing treatment if required and/ or desired by the individual.

In addition, Integrated Case Management models that provide long-term support for individuals with MHSU needs have demonstrated varying degrees of success. Some models incorporate police to assist healthcare providers in implementing care plans, ensure the safety of healthcare professionals and individuals and help individuals to navigate the criminal justice system.⁶ Assertive Community Treatment (ACT) programs have the strongest empirical base for supporting individuals with severe and persistent mental illness.⁷ Most studies show that ACT is effective at reducing hospital use and hospital-related costs for high users of emergency departments (ED) and inpatient care. The literature also acknowledges improvement in terms of the frequency of police involvement; for example, data received from BC's 21 ACT programs indicates significant reductions in police officer contact.⁸

Many joint police/health models have not undergone systematic evaluation of effectiveness or efficiency. Researchers attribute the lack of evaluative evidence to the absence of national standards for collecting information about such models involving MHSU service providers and police officers.⁹ Additionally, overlap among geographic boundaries for services and multiple access points for individuals seeking care may

make measuring outcomes difficult. While we do not have empirical evidence to support the use of these models, best practice outcomes indicate reductions in criminalization, improved access to essential services for people in crisis, and reductions in use of first responders and utilization of emergency departments.¹⁰

In BC, the number of programs, policies and protocols that support police officer involvement in MHSU services are highly dependent on geographic area. While existing joint teams are working well to support better responses to MHSU needs in urban areas, rural or more remote areas are less likely to have joint teams in place.

A key issue for integrated response teams and partner agencies is formal understanding of parameters for privacy and information sharing. In collaborative teams, information sharing is a critical component of police officers and health partners working together effectively.¹¹ Appropriate and timely information sharing can help police officers have a richer understanding of how to support individuals with MHSU needs¹² and aid health personnel in providing care for individuals who interface with the justice system.

Current Initiatives

In BC, three models of MHSU services with established police and health interfaces were identified for inclusion in this toolkit:

1. Integrated Mobile Crisis Response Services
2. Integrated Case Management and Outreach Services
3. Mental Health and Substance Use Liaison

Integrated Mobile Crisis Response Services

The model pairs a police officer with a mental health professional in a police vehicle to respond to mental health and substance use emergencies in the community. Some examples include:

Health/Police Crisis Mobile Units, est. 1987

Crisis mobile units pair a nurse with a police officer in a police vehicle and currently operate in RCMP detachments in Surrey (Car 67), Kamloops, and Prince George. The police officers who work in crisis mobile units have additional training in mental health beyond what is provincially mandated.¹³ Additional information can be found [here](#).

Car Programs, est. 1978

Vancouver Police Department's (VPD) Car 87/88 is the first documented Canadian co-response police/mental health model.¹⁴ It pairs a mental health nurse with a police officer in plain clothes to respond to mental health emergencies. The Car 87/88 model provides on-site emotional and mental health assessments, crisis intervention, and referrals to appropriate services,¹⁵ while using police and community resources to support diversion from the criminal justice system. More information can be found [here](#).

Integrated Mobile Crisis Response Team (IMCRT)

IMCRT is a partnership between Island Health's Adult Mental Health and Substance Use Services, their Child, Youth & Family Mental Health Services and the local Chiefs of Police Committee. IMCRT provides short-term support and stabilization through local mobile crisis response. IMCRT is comprised of plain-clothes police officers and child and youth healthcare providers who deliver services to individuals and families across the lifespan.¹⁶ Please refer to Appendix 1 to access the MOU detailing the partnership. For further information, click [here](#).

Integrated Case Management and Outreach Services

The service-delivery model partners MHSU services in local health authorities with community agencies to support recovery of individuals either by providing short-term stabilization and risk mitigation or long-term care planning. Individuals supported by these services live with complex mental illnesses and/or substance use disorders. Some examples include:

Assertive Community Treatment (ACT) Teams, est. 2008

ACT teams are recovery-oriented service models that partner MHSU services in local health authorities with community partners.¹⁷ The Vancouver Police Department and the Victoria Police Department are the only two agencies that have police officers fully embedded in ACT teams. The BC Ministry of Health program standards recommend a staff-to-client ratio of one full-time equivalent staff person for every 10 individuals in urban areas and

one full-time equivalent staff person for every eight individuals in rural and remote areas.¹⁸

ACT uses a psychosocial rehabilitation (PSR) approach and has been proven to facilitate community living and recovery for persons who are living with persistent MHSU disorders, have severe symptoms and impairments and have not benefited from traditional outpatient programs. The services are provided on an ongoing basis, allowing for relapses and recovery as an individual finds their own way back to health. The ACT team is mobile and delivers the majority of services in community locations such as an individual's home, workplace, parks, or recreation locations.

The role of multi-disciplinary healthcare providers within ACT teams is to provide rehabilitation, healthcare assessment and treatment.¹⁹ ACT teams include a sufficient number of staff from the core mental health disciplines (e.g., registered nurse, social worker, occupational therapist, substance abuse specialist, and vocational specialist), a minimum of one peer support specialist and a program or administrative support staff. The team as a whole is responsible for ensuring that clients receive the services they need to live in the community and reach their personal goals. For further information on ACT teams click [here](#) and for further information on the ACT program standards click [here](#).

Assertive Outreach Team (AOT)/ Community Outreach and Assertive Services Team (COAST)

AOT/COAST are multidisciplinary programs based out of regional health authorities that provide outreach services to adults in the community. Vancouver's AOT is a partnership between the Vancouver Police Department and Vancouver Coastal Health. The program focuses on short-term stabilization and risk mitigation, compared to the long-term planning and intervention of ACT teams. Similar to Car 67/Car87/88 models, the AOT program pairs a MHSU service provider with an officer in a police car.²⁰

COAST is a multidisciplinary team in the Northern Health Authority with social workers, nurses, psychiatrists, community support and peer support

workers. The program offers Assertive Community Treatment and was established to provide services to adults experiencing serious and persistent mental illness. The function of the program is to assist people in moving towards recovery and to facilitate a higher level of independence in the community.²¹

Mental Health and Substance Use Liaison

The model situates a Liaison Officer in a police agency to co-ordinate services from healthcare to law enforcement for the purposes of responding to an individual in crisis, facilitating outreach assessments, managing risk, monitoring case managed individuals and supporting review panel and extended leave processes. An example:

Mental Health Liaison Officers (MHLOs)

Surrey RCMP's Police Mental Health Intervention Unit involves MHLOs who work with community partners and agencies to provide long term solutions for individuals whose mental health needs directly impact their contact with police. Individuals either have a significant number of police contacts related to their mental health needs or high risk incidents where mental health is a significant component.

Opportunities for Improvement

Key informants from police and health services provided insight into what can be improved across British Columbia. A distinction has been made between urban centers and rural and remote regions.

Urban areas	Rural & remote areas
<ul style="list-style-type: none"> • Increased clarity about the MHSU system of care and expectations for police involvement in health authority services. • Additional supports for individuals with intellectual disabilities, who may also have concurrent MHSU issues, particularly when they come in contact with the criminal justice system. • Improved continuity of care for individuals with severe mental illness and/or severe substance use who are transient. 	<ul style="list-style-type: none"> • Increased access to Telehealth services linked with rural MHSU treatment centres to support community-based MHSU services in smaller communities, in particular additional support for individuals with MHSU needs when they leave police custody. • The establishment of formal liasons within the local health authority MHSU services and local police agency to streamline communication about collaborative activities. • A greater health presence when police support individuals experiencing MHSU-related crisis. • Clarity about policies and responsibilities of police and BC Ambulance when transporting individuals to a designated mental health facility, including those who have a history of aggression or potential for violence. • Increased coordination and more consistent relationship building between police and healthcare providers to support individuals with MHSU needs before they experience crisis. • Greater cooperation among front-line police officers to improve police/health interfaces.

PART 1: POLICE-HEALTH MENTAL HEALTH AND SUBSTANCE USE COLLABORATION

1.2

PRIVACY AND INFORMATION SHARING PROTOCOLS

Information sharing between police and MHSU service providers is a critical aspect of effective collaboration. A reciprocal flow of information is essential to prevent risk of harm and to provide compassionate and respectful care for individuals with MHSU issues. Response protocols that enable efficient and appropriate information sharing are described as a key attribute of successful police-health programs.²²

Police may request additional information from health authorities in circumstances where they are trying to locate an individual, better understand a situation or seek information for an investigation.²³ The requirement for compliance with a request varies depending on the circumstance. While a production order may be required in a criminal investigation, disclosure of information at the request of a police officer attempting to locate a missing person or assess a situation may require the persons receiving the request to exercise judgement in regards to what and how much information needs to be shared. Alternatively, healthcare providers may require some information from police that was collected at the scene of apprehension in order to assist them in carrying out a more comprehensive assessment and providing the most effective care.²⁴

Key issues

Information sharing is important for adequate care provision regardless of organization, environment or activity.²⁵ Barriers to effective information sharing include a difference in professional ideologies, strict or inconsistent professional codes of conduct, a lack of role clarity and trust between frontline staff, limited understanding of legal requirements and organizational policies, separate databases for personal information and fear of infringing an individual's privacy rights.^{26 27} While there are information sharing guidelines, legislation, protocols, advice and codes of practice within the criminal justice and health systems, barriers continue to inhibit the exchange of information.

Police often arrive at a scene with limited information about an individual's health, behavior, disability, culture, history or treatment,²⁸ all of which can assist police to better understand, approach and appropriately control a situation. Similarly healthcare providers treating/supporting an individual for the first time may require health information collected by the police in order to provide appropriate care. The exchange of information or lack thereof can have a significant impact on collaboration between police and health care providers²⁹ and continuity of care for the individual. Insufficient information sharing can contribute to unintended consequences such as disempowered individuals, less effective service delivery, a duplication of efforts by multiple agencies and higher administrative costs.³⁰

Key informants confirm that effective information sharing is one of the most important aspects of successful police-health collaboration. Trust, a common language and role clarity were described as necessary for effective communication and oftentimes played a bigger role in enhancing information sharing practices than written protocols.

In urban areas, key informants described information sharing practices as working well in crisis situations, but lacking in regards to longer-term planning and less urgent situations such as assessment and treatment. A police officer's or healthcare provider's participation on a joint team increased their confidence in sharing information among their team members.

The importance of effective information sharing is demonstrated by the consequences of inappropriate

or unlawful disclosure. Instances where an individual's mental health and substance use history and criminal justice involvements are wrongfully disclosed can impact the individual's ability to participate in the workforce, be involved in volunteer activities or even obtain housing. Health authorities and police have an ethical and legal obligation to protect personal information about individuals and staff.³¹ Indeed, "healthcare information is perhaps the most intimate, personal, and sensitive of any information maintained about an individual."³² Recently, the decision to NOT include information regarding mental health contacts, including section 28(1) apprehension under the *MHA*, in police information checks in BC was published in the *British Columbia Guideline for Police Information Checks*.³³

Current Initiatives

Training on privacy and information sharing varies by police agency; however, all police officers in BC are mandated to take Crisis Intervention and De-escalation (CID) training that equips them with techniques to de-escalate crises using verbal and non-verbal communication and addresses provincial privacy policy.

Six procedure documents related to privacy and information sharing between police and healthcare were sourced through the environmental scan. The documents apply to releasing information to law enforcement, sharing information within joint teams, Privacy Impact Assessments (PIAs) for police apprehension under the authority of the *MHA* and joint intervention programs. Please refer to Appendix 1 to access each document in full.

1. Request by law enforcement for release of information (Form, 2014)
2. Release of patient information to law enforcement personnel in urgent/ emergency situations (in the absence of patient consent, court order, or search warrant) (Policy, 2006)
3. Island Health Regional Assertive Community Treatment (ACT) program information sharing agreement (2014)
4. Memorandum of agreement regarding information sharing in connection with the *MHA* (2014)
5. Privacy impact assessment PIA #2014-13 (Project: Information sharing with Vancouver Police Department regarding patients brought to the hospital by police under the *MHA*)

6. Privacy impact assessment PIA #2014-14 (Project: Vancouver Coastal Health-Providence Health Care – Vancouver Police Department Joint Intervention Programs)

In addition to procedure documents, principles for effective information sharing have been gathered from relevant literature and key informants to help police agencies and health authorities to develop locally appropriate procedures, protocols and policies:

- Develop protocols to enable health and police agencies to meet the needs of individuals with an eye towards consistency throughout the province, where appropriate.
- Develop standardized guidelines for collecting information on police interactions with individuals with MHSU needs.³⁴
- Ensure health and police agencies have a mutual commitment to using protocols to enhance information sharing and that both parties are aware of the location, purpose, and utility of protocols, policies, procedures and accompanying documentation for proper uptake.
- Ensure that protocols, policies, procedures and accompanying documents are available to front-line police and healthcare providers to consistently manage routine, urgent and emergent requests for information.
- Provide ongoing cross-education between front-line workers (police and health) for common crisis de-escalation strategies.³⁵

Overview of BC privacy legislation

In BC, police and healthcare providers must adhere to all applicable provisions of Provincial Statutes, particularly the Freedom of Information and Protection of Privacy Act (FIPPA) and the Personal Information Protection Act (PIPA). FIPPA applies to police officers who work for a municipal police agency and healthcare staff who work for a BC health authority. Private practitioners or organizations such as not-for-profit service providers fall under PIPA.

BC's Freedom of Information and Protection of Privacy Act legislates the access and privacy rights of individuals in relation to British Columbia's public sector. FIPPA establishes an individual's right to access records and/or their own personal information

in the custody or under the control of a public body (including agents and service providers to a public body). An individual's consent is not always required under FIPPA for the collection, use or disclosure of their personal information. FIPPA provides that a public body may collect, use or disclose an individual's personal information, "to carry out a program, activity or service."³⁶

The **Personal Information Protection Act** (PIPA) applies in the private sector in BC. It describes how an "organization" must handle personal information of employees and the public, and creates common-sense rules about collecting, using and disclosing that personal information. PIPA also gives individuals the right to access their personal information in the possession of an organization and to request that their personal information be corrected if they believe it is incorrect or incomplete. With some exceptions, the individual's consent is required under PIPA for the collection, use or disclosure of the individual's information.³⁷

The Canadian Mental Health Association, BC Division, has developed resource guides to serve as reference tools for practitioners, individuals and families that access the mental health and substance use system of care. The purpose of the guides is to improve understanding and application of BC's privacy legislation. The guides include:

- BC Privacy Legislation for Frontline Staff in the Private Sector– Fact Sheet³⁸
- Information Sharing for Young People Receiving Health Services – Fact Sheet³⁹
- Privacy for Families of Young People with Mental Health or Substance Use Problems – Fact Sheet⁴⁰

Overview of Federal privacy legislation

The Privacy Act provides individuals the right to seek access to their personal information held by the federal government and governs the collection, use, disclosure, retention and disposal of personal information. The Act applies to RCMP detachments and police agencies that provide law enforcement at the federal level. The majority of municipal police agencies, whose policing does extend beyond local jurisdiction, operate under provincial legislation and should refer to FIPPA for questions regarding the collection, use and disclosure of personal information.

Opportunities for Improvement

Key informants identified the following opportunities for improved information sharing:

Urban areas	Rural & remote areas
<ul style="list-style-type: none">• Improved access to pertinent information about individuals who are on the caseload of integrated programs for police (e.g. ACT).• Better consent procedures for individuals to engage in MHSU services who have not previously accessed services.• Information gaps that occur when individuals cross health authority boundaries.• Reciprocal information sharing between police in mental health units and health professionals in Emergency Departments	<ul style="list-style-type: none">• Formalized information sharing agreements between police and the health authority.• Consistency in information sharing processes between police and health in non-urgent situations.• Better information sharing as it relates to case management and care planning, where situations are not urgent.

PART 2: JOINT CRISIS RESPONSE IN ALIGNMENT WITH THE *MENTAL HEALTH ACT*

2.1

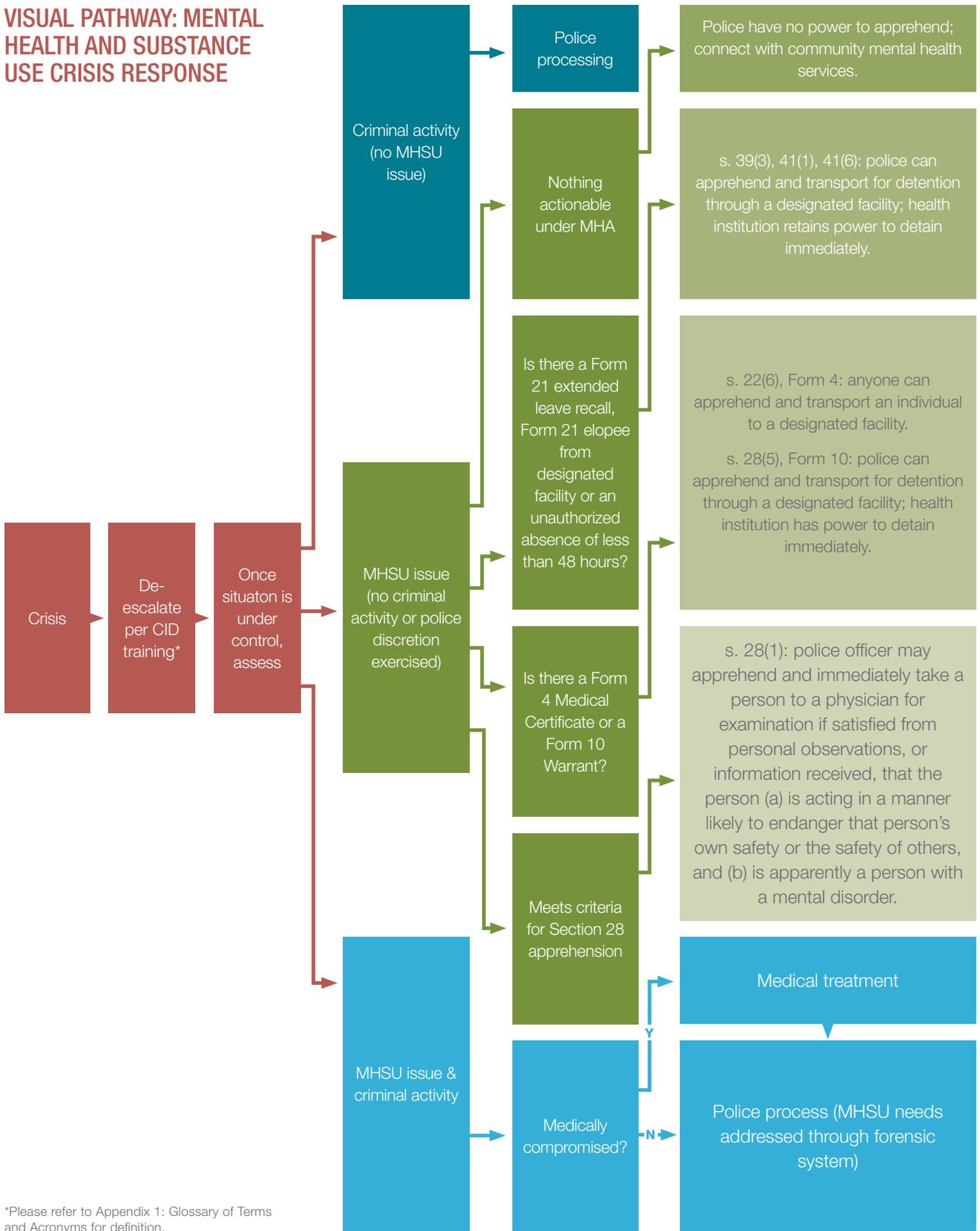
2.1

VISUAL PATHWAY: MENTAL HEALTH AND SUBSTANCE USE CRISIS RESPONSE

Police officers are likely to interact with healthcare providers when they encounter or are called to apprehend an individual who is experiencing a MHSU-related crisis. BC's Ministry of Health defines a mental health or substance use crisis as "acute disturbance of thinking, mood, behaviour or social relationship that requires an immediate intervention, involves an element of unpredictability that is usually accompanied by a lack of response to social controls, and may be defined as a crisis by the individual, the family, or other members of the community."⁴¹

Under these circumstances, police employ de-escalation techniques to control the situation, then assess whether or not criminal activity has occurred. An individual is processed through the criminal justice system if they commit a crime; however, if a crime occurred and the individual exhibits signs of a MHSU condition, the police officer would seek immediate treatment for acute physical injuries and address the individual's MHSU needs through the forensic system in accordance with due process.

VISUAL PATHWAY: MENTAL HEALTH AND SUBSTANCE USE CRISIS RESPONSE



2.1

*Please refer to Appendix 1: Glossary of Terms and Acronyms for definition.

If the individual has not committed a criminal offence or the officer uses discretion not to pursue charges, the *MHA* might apply. There are three actions a police officer may take under the *MHA*:

1. Section 28(1) apprehension and transport of an individual to a physician for examination
2. Form 4 medicate certificate or Form 10 judge's warrant for apprehension, transport and detention of an individual through a designated facility
3. Form 21 Director's warrant for apprehension, transport and return of an individual to a designated facility where they have violated the conditions of their leave or left without having been released on leave

The sections that follow outline the legislation, key issues highlighted by the literature and informants, current initiatives, and opportunities for improvement. There is also a discussion of what can be done in a situation where an individual does not meet the criteria for certification under the *MHA*, but still requires access to services for a MHSU issue. As mentioned previously, please refer to Appendices 1 and 2 for further insight into promising practices from various jurisdictions across BC.

Key issues

Over the past 10 years, police departments in BC have noted an increase in the amount of crisis situations, suicide-related calls and, more generally, mental health related police incidents.⁴² In fact, between 2010 and 2014, responses to incidences with a mental health component in RCMP jurisdictions in BC increased by 32%.⁴³

Often, untreated or under-treated MHSU needs contribute to behaviour that can lead to self-harm and harm to others, requiring a crisis response.⁴⁴ Individuals with significant behavioural difficulties associated with their MHSU needs access crisis and emergency services at a disproportionately higher rate.⁴⁵ Crisis calls can be among the most unpredictable and dangerous types of calls for responding officers and for the individual experiencing a crisis.⁴⁶

Key informants said that MHSU-related crisis response depends on the size of the community and the resources available. In larger urban areas, support for

individuals in crisis may be through response teams and mobile units such as car programs. In rural and remote areas, crisis response requires collaboration among community-based MHSU services across multiple geographical boundaries and multiple police detachments since programs and facilities such as joint intervention teams and MHSU treatment centres are limited.⁴⁷

Ambulance services have the potential to play a significant role in crisis response – especially in rural and remote areas. Key informants noted that there is need for clarity about roles and responsibilities of ambulance services in responding alongside police and healthcare providers and described ambulance involvement as a way to expand transportation options for individuals who are experiencing a MHSU-related crisis and may not be at risk of overdose or immediate injury. Currently, Vancouver is the only police department in the province with ambulance transport for mental health-related incidents.

Current Initiatives

Healthcare and police protocols

Police/health protocols are normally found in agreements that outline joint service delivery and information disclosure agreements. These agreements are often Memoranda of Understanding (MOUs), Memoranda of Agreement (MOAs), Privacy Impact Assessments (PIAs), or Information Sharing Agreements (ISAs). These documents often have protocols for physical safety and security, information sharing, record keeping, and dispute resolution. Please refer to Appendix 1 for examples.

PIAs are used to determine whether information sharing protocols meet FOI legislative requirements. For example, the PIA for Car 87/88, ACT, and AOT describes how caseloads are determined, how records are to be kept and how releases of information are to be conducted for the purpose of determining compliance with the legislation.⁴⁸

Training materials for police

In BC, Crisis Intervention and De-escalation (CID) training is mandatory for all first responder police officers and frontline police supervisors.⁴⁹ Based on the Memphis model⁵⁰ and developed from the Vancouver

Police Department's (VPD) Crisis Intervention Training (CIT), CID training is a mandatory provincial program designed to equip personnel with techniques to de-escalate crises using verbal and non-verbal communication. In addition to the initial training, all police are required to recertify every three years.⁵¹ An evaluation of the VPD's CIT shows that participating in the training enhanced police officer's awareness and knowledge of mental illness and increased their confidence in the utilization of skills learned during training.⁵²

VPD's Crisis Negotiation Program provides specific training to select officers designated as negotiators for managing critical incidents, including those incidents involving individuals with MHSU needs who are in crisis. In these situations, the police officer provides advanced de-escalation and negotiation. The training involves a two-week course, followed by a one-week recertification course every three years. In addition, there are six mandatory crisis negotiation training days throughout the year. The facilitated sessions include incident reviews, discussions on training, deployment issues, and presentations on local and relevant topics. Negotiators also have the option to participate in a number of multi-agency training scenarios scheduled throughout the year.⁵³

Training materials for healthcare

All hospitals operated by BC's health authorities use a standardized set of colour codes to denote emergency situations, including missing individuals and aggression. These standardized hospital colour codes became effective on February 1st, 2011 and were mandated to be implemented across the province by March 31st, 2012. The purpose of the colour codes is to efficiently communicate a standardized message to hospital staff without evoking undue stress in patients, residents or hospital visitors.⁵⁴

The Provincial Clinical Suicide Framework for BC (2011)⁵⁵ provides a strategy for mental health and substance use services to align with best practice standards for suicide risk management. The Framework is structured to provide administrative and clinical leads in BC's health authorities with steps for developing a protocol that incorporates best practice standards in suicide assessment, treatment, monitoring and documentation.

In addition, healthcare providers who work with first responder police officers are often required to familiarize themselves with basic safety rules and police equipment, as well as federal and provincial privacy legislation. For example, healthcare staff who work on integrated teams from Fraser Health Authority must familiarize themselves with RCMP equipment including:⁵⁶

- Portable radio;
- Police vehicle radio;
- Emergency light switches;
- 10-33 buttons on portable radio (these codes denote emergency/ need for immediate assistance) on vehicle console and elsewhere in the vehicle;
- Location of handcuff key and police vehicle key; and
- Location and basic functions of firearms use.

Generally, healthcare providers on joint teams are only responsible for initiating or undertaking actions connected with mental health diagnostic or treatment duties. In situations where there is a threat of violence, healthcare providers are often advised to "not encroach upon the scene."⁵⁷

Integrated Crisis Response Teams

The core components of successful joint crisis response initiatives have been listed here:

- A generic MOU between regional health authorities and police agencies describing roles and responsibilities for providing assistance to an individual experiencing a MHSU-related crisis, including protocol for information sharing
- A shared, common language between police and health to assign resources and manage risk in a timely way, e.g., defining the risk of MHSU-related events by colour (red is high risk, yellow is medium risk, green is low risk)
- A formal liaison in police agencies to provide support to individuals in crisis, facilitating outreach assessments, working alongside a nurse and connecting individuals to local MHSU services.
- Individualized care plans developed by liaison officers and healthcare teams to script treatment from crisis to hospital, through to discharge and back to community.
- Supportive informal relationships between mental health workers who attend crisis situations.

Opportunities for Improvement

Key informants identified the following opportunities for better joint MHSU crisis response:

Urban areas	Rural & remote areas
<ul style="list-style-type: none">• More support from ambulance services for transporting individuals who are experiencing a MHSU-related crisis and may not be at risk of overdose or immediate injury.• Increased care planning to support individuals who are chronically at risk of suicide.	<ul style="list-style-type: none">• Education for frontline staff in acute care about the role of the police, as well as training on how to establish and maintain a therapeutic environment to minimize seclusion, consistent with provincial secure rooms and seclusion standards.⁵⁸• Greater understanding about how to engage intoxicated individuals experiencing a MHSU-related crisis. Police are asked to take individuals to holding cells, which may not be the appropriate place for them.• Increase in designated Observation Units under the <i>MHA</i> in rural hospitals in order to reduce incarceration in local police cells and expedite mental health treatment.• Opportunities for relationship building among the regional health authority and multiple police detachments, which may span large geographical boundaries.• 24/7 crisis service access through telehealth initiatives in communities that require an individual to be transported to a larger community.• More support from ambulance services and the development of guidelines for doctors to provide minimal sedation to individuals with complex behaviours when being transported by BC Ambulance over long distances.• Clarification of the definition of individuals managing MHSU issues (currently called ‘emotionally disturbed’ in police records) to improve record keeping and statistics.

PART 2: JOINT CRISIS RESPONSE IN ALIGNMENT WITH THE MENTAL HEALTH ACT

2.2

SECTION 28 POLICE APPREHENSION

Police are responsible for determining if an individual is behaving in a way that will endanger the individual's own safety or the safety of others and if they meet the criteria for apprehension under section 28(1) of the *MHA*. When an individual is detained under the *MHA*, the police officer must accompany the individual to a physician for examination. Often this means transporting the individual to the nearest designated mental health facility. Until a certificate of involuntary admission in Form 4 is completed by the physician and the individual is admitted into a designated facility, the individual remains in the custody of the police. If no certificate is issued, the individual must be released from custody. A certificate of involuntary admission is only valid for 14 days.⁵⁹

The physician is responsible for determining whether or not the individual meets the criteria for an involuntary admission under section 22 of the *MHA*. Individuals who do meet the criteria, and for whom a medical certificate of involuntary admission is completed, may be admitted and detained for up to 48 hours. A second medical certificate prepared by another physician is required in order for an individual to be detained for longer than 48 hours.

The apprehension of an individual under section 28(1) of the *MHA* is involuntary.⁶⁰ An individual is taken into custody and transported for examination by a physician with or without the individual's consent.

2.2

Key issues

The process for a physician to examine an individual and complete a Form 4 varies by region. In terms of prioritization, individuals who are apprehended under section 28(1) of the *MHA* and brought to an emergency department are often given a low triage priority,⁶¹ unless a life-threatening physical issue is also present. A lack of physician availability to conduct a *MHA* assessment can result in extended wait times for the individual and police that consume a significant amount of police resources and cause undue stress and strain on the individual.

All key informants from health and police were aware of long wait times at the ED and identified process delays as a catalyst for further collaboration between sectors. A number of initiatives were identified to enable future reduction of wait times such as provincial apprehension forms, emergency department intake record tools, algorithms that map apprehension process and regular reports of wait times. These would enable health authorities and police agencies to collect data to identify why and where delays are occurring and propose tailored solutions.

After the physician examines the individual, they may determine that the person does not meet the criteria to be involuntarily admitted to a designated facility.⁶² The time delay between initial police apprehension and physician examination can have implications on whether or how the individual receives medical care.⁶³ If the criteria set out in the *MHA* are not met, an individual must be released; however, since the ER is often the only accessible entry point for MHSU services, an individual may then be left without options for treatment. While the stabilization of the individual is a positive outcome, without treatment or additional supports, their condition may escalate to a point of crisis soon after their release. Police may encounter the individual a few days (or even a few hours) later and have to reinitiate the process of involuntary apprehension.⁶⁴

Privacy and Information sharing

Key informants identified limitations on information sharing between police and healthcare providers in supporting section 28(1) apprehension under the *MHA*. There is a common reluctance amongst both police officers and health personnel to disclose personal information for fear of violating an individual's privacy

rights. The consequence is often that valuable insight into the individual's health and well-being is lost or inadequately communicated. Hospital staff may provide an officer with information about how an individual with MHSU needs can be treated to minimize potential negative outcomes for that individual, the officer and the public.⁶⁵ Police officers can reciprocate by providing information gathered at the scene of apprehension. For a more fulsome discussion of the legislation, policies and practices guiding information sharing, refer to section 1.2 Privacy and Information Sharing

Current Initiatives

Five procedure documents that are relevant to section 28(1) apprehension under the *MHA* have been sourced through the environmental scan. Please refer to Appendix 1 to access the full text.

1. Burnaby Hospital Emergency Department (ED) Police Triage Process for Patients Apprehended under the *MHA* (2015)
2. Protocol letter of understanding regarding admission procedures at St. Paul's Hospital for *MHA* apprehension by Vancouver Police Officers (2015)
3. Kelowna Mental Health, Kelowna General Hospital, Emergency Department & RCMP Protocols
4. Operational | *MHA* Apprehension | 19.7 (2013)
5. Care of the Patient who is escorted by police (2013)

Key informants shared a series of strategies their police agency or healthcare facility has used to improve the process for section 28(1) apprehensions. The strategies listed have not been attributed to any particular agency or facility to remove geographic-specificity and assist jurisdictions in adapting approaches that are most suitable for their service areas.

Strategies to improve individual care

- A formal liaison between police and MHSU services to establish a safety plan to help support individuals apprehended under the *MHA* obtain access to appropriate mental health and/or substance use services
- Police participation in "Grand Rounds" (a teaching tool and ritual of medical education and in-patient care, consisting of presenting the medical problems and treatment of a particular patient to an audience consisting of doctors, residents and medical students)

to increase understanding of how an individual is supported by the health authority when apprehended under the *MHA*

Strategies to reduce ED wait times

- Police call ahead to a healthcare facility to support the triage process
- Police alert ED staff when a 90-minute wait time threshold has been reached
- Quarterly meetings or ongoing committees involving transit police, local police, and health authority staff to establish forums for policy and procedure changes
- Improved intake forms that highlight the crisis triage rating scale for police and include additional information to expedite assessment for ED staff
- MOUs for section 28(1) apprehension across health authorities and police jurisdictions rather than at each hospital that includes an agreement on wait times
- A streamlined intake procedure for physician examinations under the *MHA* conducted in a designated area of the hospital or designated facility

Opportunities for Improvement

Key informants identified the following opportunities for improving police-health interaction and process for section 28(1) apprehensions.

Urban areas	Rural & remote areas
<ul style="list-style-type: none"> • Enhanced training for doctors who are less involved with police and may not be as efficient in assessing individuals who are brought in under section 28(1) of the <i>MHA</i>. • Increase uptake of the section 28(1) form in the Ministry of Health’s Guide to the <i>MHA</i> (2005). As the form is often printed on one side, police may miss the crisis triage rating scale on the back of the form. Initiatives such as HealthIM and the interRAI Brief Mental Health Screener are beginning to address this issue. • Examine why a significant portion of individuals brought into the ED under section 28(1) of the <i>MHA</i> (up to 70% in some jurisdictions) are not admitted for involuntary treatment. 	<ul style="list-style-type: none"> • Develop memoranda of understanding for section 28(1) apprehension under the <i>MHA</i> • Leverage existing knowledge developed in urban areas to address significant wait times at the ED.

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2.3

FORM 4 MEDICAL CERTIFICATE + FORM 10 POLICE APPREHENSION

Under section 22 of the *MHA*, a Director of a medical facility may admit an individual to that facility and detain them for up to 48 hours for examination and treatment on receiving one medical certificate for involuntary admission completed by a physician. The certificate in Form 4 must state that the physician has examined the individual on the date specified and that the physician is of the opinion that the individual has a mental disorder.

The criteria for certification include: (a) the individual is suffering from a mental disorder that seriously impairs the individual's ability to react appropriately to their environment or to associate with others; (b) the individual requires psychiatric treatment in or through a designated mental health facility; (c) the individual requires care, supervision and control in or through a designated mental health facility to prevent the individual's substantial mental or physical deterioration, or for the individual's own-protection or the protection of others; and (d) the individual cannot suitably be admitted as a voluntary patient. Admission must occur within 14 days of the physician examination and completion of the medical certificate.

2.3

Section 22(6) states:

A medical certificate completed [meeting the criteria outlined prior] ... is authority for anyone to apprehend the person to be admitted, and for the transportation, admission and detention for treatment of that person in or through a designated facility.⁶⁶

After a Form 4 medical certificate has been issued anyone can apprehend and transport the individual to a designated facility. In practice, however, police officers or first responders, such as paramedics, are most often responsible for apprehension and transport. The designated facility has the power to admit and detain the individual upon arrival. The police officers or the person(s) responsible for transport may leave after they have transferred the care of the individual to the staff of the designated facility.

The responsibilities of a police officer are similar under section 28(5), when a judge or justice issues a Form 10 warrant for the apprehension and transport of an individual for treatment in a designated facility. A warrant may be issued if the judge or justice is satisfied that the applicant for the warrant has reasonable grounds to believe that (a) the individual is suffering from a mental disorder and (b) requires treatment in a designated facility. The criteria for certification is the same as that

stated under section 22 of the Act. A judge's warrant can only be sought and obtained when section 22 cannot be used without reasonable delay. After an individual has been apprehended and transported to a designated facility, a physician at the designated facility has to examine the patient and determine whether a Form 4 medical certificate should be completed and, if so, arrange for appropriate admission of the individual.

Section 28(5) states:

A warrant issued [by a judge or justice in accordance with section 22] is authority for the apprehension of the person to be admitted and for the transportation, admission and detention of that person for treatment in or through a designated facility.⁶⁷

Unlike section 22(6), which authorizes any person to apprehend and transport an individual on the basis of a medical certificate for the individual's involuntary admission, a warrant issued by a judge or justice under section 28(4) directs police to apprehend and transport the individual named in the warrant. A warrant is also authority for the Director of a designated facility to admit and detain the individual named in the warrant. Custody of the individual transfers to the Director once the individual is admitted.

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2.4

FORM 21 POLICE APPREHENSION (DIRECTOR'S WARRANT – EXTENDED LEAVE RECALL)

Section 39 (3) of the *MHA* authorizes a Director of a designated facility to issue a warrant in Form 21 directing police to apprehend and return an individual to a designated facility, on the basis that the conditions of the individual's leave from the designated facility or transfer to an approved home are not being met.

Similarly, if an individual leaves a designated facility without having been discharged, released on leave or transferred to an approved home, section 41 of the *MHA* authorizes a Director to issue a warrant in Form 21 directing police to apprehend and transport the individual back to the designated facility. The warrant must be issued within 60 days of the date when the individual left the designated facility, unless the individual leaves while charged with an offence, or subject to a sentence of imprisonment, or the Director thinks that there is a risk of harm to the individual or others. However, an individual may be apprehended and transported without a warrant within the first 48 hours after the individual has left a designated facility on an unauthorized basis.

2.4

Missing Residents (elopee from a designated or non-designated mental health facility)

Individuals receiving treatment in healthcare facilities, who leave without appropriate discharge or consent procedures are considered to be “missing residents.” Police and health services often play a joint role in finding and returning individuals who go missing from healthcare facilities. The literature on absenteeism shows that police are involved in returning between 13% and 33% of individuals who go missing from a hospital.⁶⁸

Studies show that cognitively impaired individuals, and individuals experiencing deteriorating mental health are at significant risk of harm to themselves and others,⁶⁹ and evoke significant anxiety for facility staff.⁷⁰ Four risk factors associated with absenteeism have been identified: 1) self-harm and suicide, 2) violence and aggression, 3) vulnerability to self-neglect or death, and 4) reduced confidence in management and treatment provided by the facility.⁷¹

Although psychiatric symptoms can propel someone to leave, there are also a number of other reasons why individuals depart from healthcare facilities, including feelings of fear, isolation, loneliness, homesickness, and/or boredom. Practical reasons for choosing to leave a facility without proper authorization have also been listed and include concerns for home and/or property, as well as financial and familial responsibilities.⁷²

Although rates of vulnerable individuals who go missing from healthcare facilities in BC are not available, a number of incidents have occurred in BC that have resulted in death. As of September 1, 2016, BC Provincial Policing Standards on Missing Person Investigations make it a requirement for police agencies to have protocols in place with local mental health and substance use services, hospitals and nursing homes to facilitate missing person investigations involving patients or residents (British Columbia Provincial Policing Standards – Subject 5.1.7. Prevention and Intervention). Provincial Policing Standards are binding on all police agencies in BC.

Health authority privacy offices are responsible for developing protocols to guide the release of information to law enforcement if an individual goes missing from a healthcare facility with a view to assisting police in locating missing individuals and in carrying out related law enforcement investigations. In addition, police officers must develop protocols to guide the release of information to healthcare providers to support a reciprocal information sharing relationship.

Several police agencies reported working closely with the health authorities (including mental health and substance use services and EDs) to establish protocols for individuals who go missing. Some of these initiatives include Health Authority Code Yellow (missing patient) policies, risk assessments for individuals who go missing and have returned, and discussions on how to categorize calls that come through police emergency communication channel systems (either as missing or as eloped). Both police and health representatives highlighted the importance of locating individuals who go missing after they experience a MHSU-related crisis or express suicidal intent.

See Appendix 2 “Code Yellow (Missing Residents)” for an example policy.

This section will focus primarily on Form 21 extended leave recall issued under section 39 that states:

39(1) The release of a patient on leave or the patient's transfer to an approved home under section 37 or 38 does not, of itself, impair the authority for the patient's detention under this Act and that authority may be continued, according to the same procedures and to the same extent, as if the patient were detained in a designated facility.

(2) Subject to the regulations, a patient who is on leave or has been transferred to an approved home under section 37 or 38 may, if the conditions of the patient's leave or transfer are not being met, be recalled

(a) to the designated facility from which the patient was released or transferred, or

(b) to another designated facility, if the transfer to that facility is authorized and agreed to under section 35

(3) Subject to the regulations, the Director of a designated facility who recalls a patient under subsection (2), or to which a patient is recalled under subsection (2) as a result of a transfer under section 35, may issue a warrant in the prescribed form for the patient's apprehension and transportation to the designated facility to which the patient is recalled.

(4) A patient who is recalled under subsection (2) while on leave that has lasted 6 or more consecutive months is deemed, for the purposes of sections 23 to 25, to have been admitted under section 22 (1) on the date of return to a designated facility as a result of the recall.

Section 37 of the *MHA* provides for the extended leave of an involuntary patient from a designated facility. The rationale for this is that extended periods of leave increase an involuntary patient's potential for living in the community by providing support for treatment compliance outside a hospital or in-patient facility.⁷³

While on extended leave, an individual must adhere to the conditions outlined in the leave authorization (Form 20) provided by the physician overseeing their care. If an individual is not adhering to the conditions of their extended leave, for example, they are not taking their medication as prescribed; the individual may be recalled to

a designated facility under section 39(2). Failure to comply with a recall may result in the Director issuing a warrant under the authority of section 39 (3) for the individual's apprehension and transportation to the designated facility.

Key issues

While collaboration between police and health is integral to ensuring the well-being of the individual, key informants reported that there were no specific written policies or protocols in their jurisdictions to support the process and clarify roles and responsibilities of the personnel involved. Furthermore, in rural and remote areas, there remains some uncertainty as to where to return the individual and key informants expressed a desire for more clarity as to whether the request for transport was under section 28 of the *MHA* (Form 10 Judicial Warrant) or section 39 (Form 21 Director's Warrant – extended leave recall).

There is limited information on interactions between the individual, mental healthcare providers, and police in this area. According to a report from one designated facility in BC, approximately 30% of their clients were on extended leave at the time the report was released. It was recommended that extended leave provisions be used more often.⁷⁴ Ministry of Health data indicates that approximately 2601 individuals were placed on extended leave provision in 2016/17 and that the number of individuals who are released from facilities and recalled under section 39(3) has nearly tripled in the last eight years.⁷⁵

Privacy and Information sharing

In a recent coroner's inquest conducted in BC, the jury recommended that the use of extended leave in BC continue. This includes ensuring that leave forms are disclosed as permitted and appropriate under the *Freedom of Information and Protection of Privacy Act*. (*FIPPA*)⁷⁶ Recommendations were also made to: (1) to involve the individual in the development and review of extended leave provisions and (2) to share information with the individual and their caregivers as soon as is feasible.

Current Initiatives

Training materials for police and healthcare

The [Guide to the MHA](#) assists police and healthcare providers in understanding extended leave provisions. Appendix 6 provides instructions for how to complete

a Form 20 Leave Authorization, as well as a table with descriptions of additional related forms that include the form name, intended use and when these forms should

be used. Within this table, there is guidance for the use of a Form 21 that is used for extended leave recall situations.

Opportunities for Improvement

Key informants identified the following opportunities for improving procedure related to section 39(3)

Urban areas	Rural & remote areas
<ul style="list-style-type: none"> • Enhance understanding of the purpose of section 39(3) extended leave recall under the <i>MHA</i> among police detachments. • Clarify the purpose of section 39(3) extended leave recall under the <i>MHA</i> through education that addresses knowledge gaps (e.g., what is the process when an individual on extended leave is struggling to comply with the treatment plan voluntarily in the community?) • Clarify jurisdictional confusion for individuals missing or recalled to healthcare facilities by the issue of a Form 21. • Improve information sharing among health, police and BC Corrections to ensure that extended leave certificates do not lapse while an individual is on trial. • Specify immediate risk on a Form 21 • Clearly communicate to police when a Form 21 is cancelled on the grounds that an individual has returned to the designated facility of their own accord or they have been discharged from care. 	<ul style="list-style-type: none"> • Increase education about the purpose of a Form 21 for extended leave recall. Key informants noted that Leave Recall requests have been mistaken as requests for section 28(1) apprehensions under the <i>MHA</i> by police. • Clarify protocols when multiple police agencies are involved with an ACT client due to jurisdictional boundaries, for example, individuals who live in one community and seek supports in another community. • Enable police and health to work together to manage the risk of individuals who are on extended leave leaving a healthcare facility against medical advice. • Address issues related to police key informants reporting insufficient bed availability for individuals who have been recalled from extended leave. • Increased clarity regarding where police should bring individuals after they have been located

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2.5

NO POLICE APPREHENSION

There may be circumstances where a police officer encounters an individual experiencing a MHSU-related crisis, who does not meet the criteria for apprehension under the *MHA* and has not committed a criminal offence. The police officer may discern that the individual is a person with a mental disorder yet determine that they do not pose a safety risk to themselves or others. In such an instance, a police officer should try to connect the individual to their case manager or for those unattached, connect them with local community mental health and/or substance use services. Ideally police agencies work with MHSU service providers in their jurisdictions to develop a resource database that a police officer can reference to determine where to transport the individual for non-acute services if the individual voluntarily agrees to that course of action. Some police officers may already be part of an integrated team and be familiar with the individual or appropriate health personnel to be able to direct them appropriately. If such a database is not in place or the police officer does not work as part of an integrated team, local community health clinics or not-for-profit MHSU service providers are good options. The police officer should strive to resolve the crisis and support the individual to access appropriate healthcare services.

Key issues

At the systems level, information sharing is a known barrier for providing continuity of care for individuals who interface with the MHSU system and police. Two major information sharing barriers referenced in the literature are a lack of provincial databases on mental health-related police calls and a need for standardized reliable methods for identifying persons with mental illness in police, court and jail databases.⁷⁷

In BC, Coroner's Inquests have resulted in recommendations to hold formal, scheduled meetings with MHSU providers and police to help build co-operation and an understanding of privacy and mental health.⁷⁸ This recommendation is supported by the

literature, which recommends that community-based mental health resources inform policing decisions.⁷⁹

Current Initiatives

Training materials for police and healthcare

In some areas of the province, joint working groups have formed with representatives from police and local mental health and substance use service providers. These groups discuss common systems issues, focus on collaboration and map out proper care pathways for individuals in crisis who are in need of MHSU services. In urban areas, MHLOs are involved in joint meetings. The participating persons span the health system as well as policing and the criminal justice system.

“Seven percent of our interactions with people result in an arrest. If you look at it from that perspective, 93% of the time we are doing something other than arresting somebody. We are trying to figure out how to quantify that.”

– *Police officer*

CONCLUSION

In BC, innovation and a common goal to improve our system of care for individuals with mental health and/or substance use needs has led to collaborative service models and specialized programs between police officers and healthcare providers. This report provides an overview of the interface between police and MHSU services and discusses the experience of service providers, principles for privacy and information sharing, and evidence-based tools, protocols and best practices for police involvement in crisis response and MHSU services.

Police officers, health leaders and public administration have a responsibility to establish local protocols to ensure that standardized guidelines for collection, use, and dissemination of information about police and health interactions are adhered to and that ongoing education for front-line workers is available to support effective collaboration and information sharing. The goal of this report is to facilitate that education and support ongoing efforts towards further collaborative approaches between police agencies and health authorities to better meet the needs of people with MHSU issues and their families.

GLOSSARY OF TERMS AND ACRONYMS

ACT (Assertive Community Treatment) is a full-service mental health program that provides wrap-around services for individuals with severe mental health needs and/or substance use issues.

Car Programs are mobile crisis response programs in which a police officer is teamed with a registered nurse or a registered psychiatric nurse to provide on-site assessments and interventions for individuals with psychiatric needs. The nurse and the police officer work as a team in assessing, managing and deciding the most appropriate action.

CAD (Computer Aided Dispatch) is a computer system that assists 911 operators and dispatch personnel in handling and prioritizing calls. The system creates a log of calls, dispatches police officers to incidents and provides them with up-to-date information.

CID (Crisis Intervention and De-escalation) training is mandated for all police officers in BC and equips them with techniques to de-escalate crises using verbal and non-verbal communication.

Elopee is an individual subject to involuntary detention under the *MHA* who is on unauthorized leave. A police officer has the authority to apprehend an elopee and return them to a designated facility without warrant within 48 hours of their departure as per section 41(6) of the Act.

Extended Leave is a provision under the *MHA* that allows an individual receiving involuntary mental health treatment to be released from a designated mental health facility to the community if they adhere to specific conditions. Conditions can include ongoing compliance with the individual's care plan, adherence to pharmacological treatment, housing arrangements, and/or involvement in rehabilitation. Extended leave may continue as long as the individual remains subject to involuntary status under the *MHA* or until the patient is recalled to hospital.⁸⁰

Form 4 Medical Certificate is a certificate completed by a physician and issued under section 22 of the *MHA* for involuntary admission to a designated facility. Two Form 4 Medical Certificates must be issued by two different physicians in order to detain a person for more than 48 hours.

Form 10 Warrant is a warrant issued by a Provincial Court judge or a justice of the peace under section 28(5) of the *MHA* that provides authority for a peace officer to apprehend and transport a person to a designated facility for a physician's examination.

Form 21 (Director's Warrant – Apprehension of Patient) provides authority for a "peace officer" to apprehend and transport a patient to a designated facility. If an involuntary patient leaves the hospital without permission (elopes), up to 60 days following the unauthorized leave, the Director may issue a Form 21 (Director's Warrant - Apprehension of Patient). This directs a peace officer to apprehend and return the person to the designated facility.⁸¹ A Director's Warrant may also be issued if a patient has been recalled but fails to return to a designated facility.

FIPPA (Freedom of Information and Protection of Privacy Act) legislates the access and privacy rights of individuals in relation to the public sector in BC. FIPPA establishes an individual's right to access records and their own personal information in the possession of a public body and sets out the terms under which a public body can collect, use, and disclose the personal information of individuals.

Health Authorities are regional statutory bodies which authorize, plan and deliver healthcare services within specified geographic areas in BC. The regional health authorities in BC are: Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health, and Island Health. In addition, the Provincial Health Services Authority oversees co-ordination of specialized healthcare services and the First Nations

Health Authority plans, designs, manages, and funds the delivery of First Nations health programs and services.

ISA (Information Sharing Agreement) is a written document describing the terms and conditions of the exchange of personal information in compliance with the provisions of applicable legislation. Some examples of ISAs include agreements between service providers, researchers, or other public bodies or organizations.

MOA (Memoranda of Agreement) is a written document describing terms and details of a cooperative relationship among parties wishing to work together on a project or meet an agreed upon objective. An MOA usually precedes a more detailed contract or agreement.

MOU (Memorandum of Understanding) is a formal arrangement between two or more parties. Organizations can use MOUs to establish official partnerships. MOUs are not legally binding, but reflect the parties' commitment to a matter and mutual respect.

MHA (Mental Health Act) is provincial legislation that provides authority, criteria and procedures for the detention, transport and involuntary admission and treatment of individuals who meet specific criteria in relation to their mental health. It also sets out a process for patients to have their detention reviewed by the Mental Health Review Board and provides for voluntary admissions.

MHLO (Mental Health Liaison Officer) is a police officer who works with community partners and agencies to conduct risk assessments, facilitate risk management and coordinate crisis response for individuals who have either a significant number of police interactions related to their mental health needs or are involved in high risk incidents where mental health is determined to be a significant component.⁸²

Mental Health Review Board is an independent tribunal to conduct hearings to decide whether persons committed/ detained at any mental health facility in British Columbia should continue to be detained based on the criteria set out in section 22 of the *MHA*. In addition, a separate British Columbia Review Board operates under the Criminal Code of Canada and holds hearings/ reviews dispositions for persons found not criminally responsible or unfit to stand trial on account of a mental disorder.

PRIME (Police Records Information Management Environment) is an organizational scheme for police records in British Columbia that streamlines the records management system (RMS), links it to the Computer Aided Dispatch (CAD) system and is accessible to police officers on the road using their mobile workstations.

PIPA (Personal Information Protection Act) describes how a private sector "organization" must handle personal information of employees and the public and provides rules for collecting, using and disclosing that personal information

PIA (Privacy Impact Assessment) is a process used to evaluate and manage privacy impacts and ensure compliance with privacy protection rules and responsibilities.

Section 28 of the MHA states that "[a] police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person (a) is acting in a manner likely to endanger that person's own safety or the safety of others, and (b) is apparently a person with a mental disorder". The police officer must accompany the individual to a physician for examination and retain custody of the individual until the assessment is complete.⁸³

Procedure documents related to police involvement in MHSU crisis response and services have been sourced through an environmental scan. They are examples of memoranda of agreement, information sharing agreements, memoranda of understanding and guidelines that govern joint police/health initiatives in BC. Many documents can be viewed in their entirety in the Supplementary Documents compendium attached to this toolkit. Others have not been approved for public distribution by the appropriate governing agency. The contact information for each agency's Freedom of Information office has been provided in lieu.

Please note: The environmental scan took place in 2015. Since then multiple jurisdictions have developed additional documents that may fit within the scope of this toolkit, but are not represented here. Notably, Fraser Health has a series of agreements with local police agencies to facilitate collaboration in supporting people with mental illness and/or problematic substance use. Please contact Fraser Health's Freedom of Information Office for additional details:

Suite 400, Central City Tower
13450 102 Avenue
Surrey, BC V3T 0H1
Fax: 604-587-4666
Email: FOI@fraserhealth.ca

Title	Agencies Involved	Description	Source
1.1 Overview of Police Involvement in Mental Health and Substance Use Services			
Integrated mobile crisis response team memorandum of agreement between Island Health and Area Chiefs of Police Committee (2012)	Island Health, Mental Health and Addiction Services; Child, Youth and Maternal Health; Area of Chiefs of Police Committee; and the City of Victoria	The MOA governs South Vancouver Island's IMCRT, which promotes diversion from acute care, links individuals to community services and provides a community-based mobile crisis response service.	Supplementary Documents (page 4)
Information sharing agreement between Vancouver Coastal Health Authority and Vancouver Police Department and Providence Healthcare Society (2014)	Vancouver Coastal Health; Providence Health Care; and Vancouver Police Department	The ISA provides a mutual agreement for information sharing among police and health agencies in three joint intervention programs: Car87/88, Assertive Community Treatment and the Assertive Outreach Team.	Vancouver Coastal Health F.O.I. Office 11th Floor, 601 W. Broadway Vancouver, BC V5Z 4C2 Fax: 604.875.4593 Email: foi@vch.ca
Memorandum of understanding between Fraser Health Authority and Royal Canadian Mounted Police "E" Division respecting Surrey Detachment "B67" delivery of joint emergent services and disclosure of information relating to mental health situations (2010)	Fraser Health; and the RCMP "E" Division	The MOU is for the continuation of Surrey's Detachment "B67" whereby the Fraser Health Authority and the RCMP "E" Division jointly respond to police calls involving mental health or domestic violence.	Fraser Health Freedom of Information Office Suite 400, Central City Tower 13450 102 Avenue Surrey, BC V3T 0H1 Phone: 604.587.4437 Fax: 604.587.4666 Email: FOI@fraserhealth.ca

Title	Agencies Involved	Description	Source
1.2 Privacy and Information Sharing Protocols			
Request by law enforcement for release of information (Form, 2014)	Vancouver Coastal Health	The form and incumbent policy state the procedures for releasing personal information or belongings to law enforcement agencies within VCH sites, facilities, departments, units and programs when there are requests by law enforcement for release of information.	Supplementary Documents (page 22)
Release of patient information to law enforcement personnel in urgent/emergency situations (in absence of patient consent, court order or search warrant) (2006)	Island Health	The policy document describes procedures for releasing personal information or belongings of patients and residents to police agencies.	Supplementary Documents (page 24)
Island Health Regional Assertive Community Treatment (ACT) program information sharing agreement (2014)	Island Health Regional ACT teams; Victoria Police Department; Saanich Police Department; RCMP Detachments; Ministry of Social Development & Social Innovation; and Ministry of Public Safety & Solicitor General	The health-authority wide agreement outlines information sharing guidelines related to the ACT teams on Vancouver Island. The ISA details the governance structure of ACT, describes accountability processes and reporting for regional ACT teams, and outlines data collection, use and disclosure.	Island Health Information Stewardship, Access and Privacy 1952 Bay Street Victoria, BC V8R 1J8 Phone: 250.519.1870 Toll-free: 1.877.748.2290 Fax: 250.519.1908 Email: privacy@viha.ca
Memorandum of agreement regarding information sharing in connection with the <i>MHA</i> (2014)	Vancouver Coastal Health; Providence Health Care; and Vancouver Police Department	The MOA governs disclosure of personal information for individuals who are apprehended by the VPD under section 28(1) of the <i>MHA</i>	Supplementary Documents (page 38)
Privacy impact assessment PIA #2014-13 (Project: Information Sharing with Vancouver Police Department regarding patients brought to hospital by police under the <i>MHA</i>)	Vancouver Coastal Health and Vancouver Police Department	The PIA provides analysis of the risks surrounding the process of information sharing from police to health under the <i>MHA</i> for care and safety.	Vancouver Police Department ATTN: Information & Privacy Coordinator 585 Graveley Street Vancouver, BC V5K 5J5 Fax: 604.606.2622 Email: foi@vpd.ca

<p>Privacy impact assessment PIA #2014-14 (Project: Vancouver Coastal Health-Providence Healthcare – Vancouver Police Department Joint Intervention Programs)</p>	<p>Vancouver Coastal Health; Providence Health Care; and Vancouver Police Department</p>	<p>The PIA provides analysis of the risks surrounding the process of information sharing between health and police, specifically information about clients with Car 87 and Car 88 Programs, ACT and AOT programs.</p>	<p>Vancouver Coastal Health Freedom of Information Office 11th Floor, 601 West Broadway Vancouver, BC V5Z 4C2 Fax: 604.875.4593 Email: foi@vch.ca</p>
<p>Quick reference guide: Disclosure of personal information to law enforcement (2013)</p>	<p>Vancouver Coastal Health</p>	<p>The guide outlines disclosure of information procedures for both requests from law enforcement and health-initiated information sharing</p>	<p>Supplementary Documents (page 47) OR Accessible online at: www.vch.ca/Documents/Disclosure-Law-Enforcement-Quick-Reference.pdf</p>

Title	Agencies Involved	Description	Source
2.2 Section 28 Police Apprehension			
Burnaby Hospital Emergency Department (ED) Police Triage Process for Patients Apprehended under the <i>MHA</i> (2015)	Burnaby Hospital ED and Fraser Health Authority	A document describing Burnaby Hospital ED police triage process for individuals apprehended under the <i>MHA</i> . Its purpose is to ensure individuals who are apprehended and transported by police to hospital are triaged in a timely manner so that police can return to community.	Supplementary Documents (page 49)
Protocol letter of understanding regarding admission procedures at St. Paul's Hospital for <i>MHA</i> apprehension by Vancouver Police Officers (2015)	St. Paul's Hospital and Vancouver Police Department	A letter of understanding that outlines procedures for section 28(1) apprehension under the <i>MHA</i> by police officers, and protocols for police and health service providers when ambulance services transports individuals to St. Paul's Hospital Emergency Department.	Supplementary Documents (page 50)
Kelowna Mental Health, Kelowna General Hospital, Emergency Department & RCMP Protocols	Interior Health and the RCMP	The protocol established the role between Kelowna General Hospital Emergency staff, Mental Health staff and the RCMP in the event that an individual is apprehended under the authority of Director's warrants, judge's warrants, Form 4 medical certificate or section 28(1) of the <i>MHA</i> .	Interior Health Freedom of Information Office 505 Doyle Avenue Kelowna, BC V1Y 0C5 Phone: 1.855.491.6789
Operational <i>MHA</i> Apprehension 19.7 (2013)	Comox Valley RCMP Detachment	An operational manual that provides guidance for apprehension, treatment, and support of persons who are subject to section 28(1) of the <i>MHA</i> .	Supplementary Documents (page 51)
Care of the patient who is escorted by police (2013)	Vancouver Coastal Health Authority and Providence Health Care	A systems map that outlines the flow of individuals who are escorted by police. The map starts with police accompanying the individual to the ED for an apprehension under the <i>MHA</i> and/ or arrest under the Criminal Code	Vancouver Police Department ATTN: Information & Privacy Coordinator 3585 Graveley Street Vancouver, BC V5K 5J5 Fax: 604.606.2622 Email: foi@vpcd.ca

Title	Agencies Involved	Description	Source
2.4 Form 21 Police Apprehension (Director's Warrant – extended leave recall)			
Mental health and substance use adult in-patient service Royal Jubilee Hospital – Patient care centre and psychiatric emergency services unauthorized absence from facility [Form] (2015)	Island Health	The form is a communication tool that should be filled in parallel to a Form 21 (Director's Warrant) to assist the healthcare provider in conveying information to police	Island Health Information Stewardship, Access and Privacy 1952 Bay Street Victoria, BC V8R 1J8 Phone: 250.519.1870 Toll-free: 1.877.748.2290 Fax: 250.519.1908 Email: privacy@viha.ca
Checklist for issuing a Form 21 (Warrant)	Victoria City Police and health care providers issuing a Form 21	The checklist helps healthcare providers issue a Form 21 (Director's Warrant) by clarifying steps and providing information sharing guidelines.	Government of British Columbia Information Access Operations PO Box 9569 Stn Prov Govt Victoria, BC V8W 9K1 Phone: 250.387.1321 Fax: 250.387.9843 Email: FOI.Requests@gov.bc.ca
Code Yellow (Missing Resident) (2002)	St. Joseph's Health Care London, Ontario	The policy document outlines the steps to be taken in a Code Yellow situation (missing resident), including roles and responsibilities of the healthcare staff, when police should be notified and what information should be shared with police and others (e.g., next of kin). There are also instructions for how to proceed when a resident is found.	Supplementary Documents (page 55)

Title	Agencies Involved	Description	Source
2.5 No Police Apprehension			
Partnership agreement between Vancouver Coastal Health – City of Richmond and the Royal Canadian Mounted Police, Richmond Detachment, including YVR (2013)	Vancouver Coastal Health Authority – Richmond, Richmond RCMP and YVR	An agreement defining the partnership between Vancouver Coastal Health (VCH), and the Richmond detachment of the RCMP – including YVR (airport). It clarifies roles and responsibilities of all parties toward individuals experiencing a MHSU-related crises or who are in need of healthcare and/or police support.	Supplementary Documents (page 62)
Victoria Integrated Community Outreach Team (VICOT) Privacy Impact Assessment	Island Health	To create VICOT, Island Health put in place a Privacy Impact Assessment that describes the program’s mission, purposes and objectives, and provides a thorough description of information sharing protocol from referral through to discharge.	Victoria Police Department ATTN: Information & Privacy Section 850 Caledonia Avenue Victoria, BC V8T 5J8 Fax: 250.384.1362
Partnership Agreement: Community Corrections, Island Health, Victoria Integrated Community Outreach Team (VICOT) Downtown ACT, Pandora ACT, Seven Oaks ACT, Ministry of Social Development & Social Innovation, Victoria Police Department (2015)	Community Corrections, Island Health; Victoria Integrated Community Outreach Team; Downtown ACT; Pandora ACT; Seven Oaks ACT; Ministry of Social Development & Social Innovation; and Victoria Police Department	The agreement was developed to formalize the partnership between ACT teams and partner agencies across City of Victoria.	Victoria Police Department ATTN: Information & Privacy Section 850 Caledonia Avenue Victoria, BC V8T 5J8 Fax: 250.384.1362

Title	Agencies Involved	Description
2.1 Mental Health and Substance Use Crisis Response		
Police emergency mental health teleconsultation quality improvement pilot project	Vancouver Police Department; and St. Paul's Hospital Acute Behavioural Stabilization Unit	The proof of concept project aims to enhance clinical access to information to support triage and discharge decisions. The front-line units of the VPD and health staff at VGH Access and Assessment connect by two-way video during encounters with individuals experiencing a mental health crisis. The video connection enables the clinician to interview the police officer and individual in crisis at the scene of first response and gather contextual information.
Island Health telemental health expansion project	Island Health	The project provides persons in remote and rural communities with video access points to healthcare providers. Various telehealth suites, equipped with video technology are situated across Vancouver Island.

Title	Agencies Involved	Description
2.2 Section 28 Police Apprehension		
1.6 Incident Investigations: 1.6.24(i) Transportation of Persons Apprehended under the <i>MHA</i> (2015)	Vancouver Police Department	The policy was developed by the VPD and states a preference for ambulance services to transport individuals apprehended under the <i>MHA</i> to hospital. The practice supports an understanding of mental health concerns as first and foremost medical issues. Police may take over transportation under specific circumstances: (a) if an individual is not suffering from a physical medical condition that would require them to be seen by a health professional prior to hospital admission; (b) there are no significant hygiene or biohazard concerns; (c) there are no officer safety concerns. The policy stipulates that any decisions to transport a person apprehended under the <i>MHA</i> by police vehicle must be documented in the General Occurrence (GO) report and demonstrate how the individual met the preceding criteria.

APPENDIX 4: REPORTING REQUIRED BY LAW

The following table outlines information that must be reported by police officers or health personnel in situations involving individuals with MHSU issues. Please note that this is not a comprehensive list of all circumstances under which there is a duty to report.

Law	Who must report	Report to agency	Information to be reported
Death by violence, etc. <i>Coroners Act, section 2</i>	Any person	Coroner or Peace Officer.	Facts and circumstances supporting a belief that a death has resulted from violence, negligence, suicide, during pregnancy, etc. (see section 2 for details)
Death of patient in a designated facility or private mental hospital within the meaning of the <i>MHA Coroners Act, section 4</i>	Administrator of designated mental health facility or hospital	Coroner	Facts and circumstances relating to the death of a person who dies while a patient at a designated mental health facility (see section 4 for details)
Risk of significant harm <i>Freedom of Information and Protection of Privacy Act, section 25</i>	Public body	Public or an applicant who made an information request.	Information necessary to avert a risk of significant harm to the environment or to the health or safety of the public or a group of people.
Gunshot or stab wound <i>Gunshot or Stab Wound Disclosure Act</i>	Healthcare facility	Police	Name and location of a person treated for a gunshot or stab wound

Law	Who must report	Report to agency	Information to be reported
Patient dangerous to drive <i>Motor Vehicle Act</i> , section 230	Psychologist, Optometrist, Medical Practitioner or Nurse Practitioner	Superintendent of Motor Vehicles	Name, address and medical condition of a patient who is dangerous to drive and continues to drive.
Child in need of protection <i>Child, Family and Community Services Act</i> , section 14	Any person	Director of Child Protection, or person designated by the Director	Information necessary to protect the child from harm

APPENDIX 5: SUMMARY OF ALL HYPERLINKED DOCUMENTS

Section	Subheading	Resource	URL
1.1 Overview of Police Involvement in Mental Health and Substance Use Services	Health/Police Crisis Mobile Units, est. 1987	Royal Canadian Mounted Police: Enhancing police response to mental health situations	http://bc.rcmp-grc.gc.ca/ViewPage.action?siteNodeId=14&languageId=1
	Car Programs, est. 1978	The Vancouver Police Department: Police and community response unit	http://vancouver.ca/police/organization/investigation/investigative-support-services/youth-services/community-response.html
	Assertive Community Treatment Teams, est. 2009	Assertive Community Treatment: The BC assertive community treatment program	http://www.act-bc.com/
		British Columbia Program Standards for Assertive Community Treatment (ACT) teams	http://www.health.gov.bc.ca/library/publications/year/2008/BC_Standards_for_ACT_Teams.pdf
Integrated Mobile Crisis Response Team	Island Health: Integrated mobile crisis response team (emergency mental health)	http://www.viha.ca/mhas/locations/victoria_gulf/access-crisis/imcrt.htm	
2.4 Form 21 Police Apprehension (extended leave recall)	Training Materials for Healthcare and Police	Guide to the <i>Mental Health Act</i> : 2005 Edition	http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

The toolkit has been developed by the Canadian Mental Health Association BC Division on behalf of the Ministry of Health (Mental Health and Substance Use Branch) and the Ministry of Public Safety and Solicitor's General (Policing and Security Branch) in consultation with stakeholders in health and police services, including representatives from each health authority, RCMP detachments, and municipal police departments.

The contributions of a variety of individuals are acknowledged here:

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- Lori McMorrان, Crown Counsel
- Lynn Nottle, Sgt, Mental Health Unit, Vancouver Police Department
- Kelly Reid, Director, Mental Health and Addictions Services at Island Health
- Howard Tran, Inspector, Youth Services Section and Mental Health Portfolio, Vancouver Police Department

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