Vancouver Coastal Health Authority

Providence Health Care

ED MHA Case External Review

August 2012
# External Review:
## Vancouver Coastal Health Authority and Providence Health Care

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Executive Summary

The Vancouver Coastal Health Authority and Providence Health Care initiated this external review following an incident with a patient who had been involved with St. Paul's Hospital and Vancouver Police Department.

The purpose of the review was to examine the current system with a view to providing recommendations and identifying opportunities for improvement that support the provision of optimal care to people with acute mental health and substance abuse service needs, while ensuring public safety.

The review team consisted of:

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The reviewers examined an extensive document reference list (Appendix A) and met with a number of individuals and groups, including: St. Paul's Hospital, Department of Psychiatry; St. Paul's Hospital, Emergency staff; Vancouver Police Department; Ministry of Health; Ministry of Justice/Community Corrections/Community Court; representatives from B.C. Ambulance; Family Practice; lawyers for the crown and defence; Psychiatric Head of Vancouver General Emergency Services; Forensic Psychiatrists; the B.C. Mental Health Association; the Canadian Schizophrenia Society; and focus groups of patients and families.

Over a three-day period, the review team had the opportunity to meet with an impressive range of leaders and providers of mental health and addictions services in the above organizations as well as others in related sectors, as outlined in the interview schedule (Appendix B).

For further context, Appendix C provides a descriptive summary of the mandates, roles, services and connecting relationships of the major players from the mental health and addictions sector as well as related sectors with whom the surveyors met.
There was a tour of the Downtown Eastside including visits to an emergency shelter, a single resident occupancy (SRO) building, and a meeting and orientation at the Community Court. The review team was also fortunate to hear directly from patients and their families during two facilitated focus group sessions.

The framework for the review begins with a focus on the patient and the emergency facility at St. Paul’s Hospital. It will examine other important sectors that influence the services provided to the patient. The conceptual framework for this report is outlined in Figure 1.

**Figure 1: Conceptual Framework Guiding the External Review**

![Diagram](attachment:image.png)

The reviewers found problems existing in the interfaces between the legal system (including the police) and the mental health and addiction systems; issues related to decision-making, transfer of mental health and police-related information, and desired outcomes. We also found a misalignment between supply of and demand for mental health resources within Vancouver.
Summary of Recommendations

Based on observations and analysis, the following summarizes the recommendations of the reviewers. Although recommendations in this report related to the health sector (VCH/PHC) are framed from a site perspective it is understood that the planning and implementation of recommendations would be the accountability of the Regional Mental Health Program. This would ensure that recommendations are implemented with a system focus ensuring that patient care and service is optimized across the region.

We strongly encourage that patients and families are engaged in addressing these recommendations.

Recommendation 1: All patients brought into St. Paul’s Hospital under a Form 4 Mental Health Act certificate should receive a psychiatric assessment. Those patients brought in under Section 28 of the Mental Health Act should be held long enough to complete an appropriate assessment and arrange disposition and have, when indicated, a psychiatric consultation.

Recommendation 2: The following resources should be implemented and accessible to St. Paul’s Hospital:

- An evaluation of the current 4-bed secure observation unit within the ED that includes ascertainment of appropriate number of beds (more than 4) and adequate multi-disciplinary staffing. These beds would fulfill the function of a Crisis Stabilization Unit.
- The secure observation unit in the ED should be managed and overseen by Psychiatry (in close collaboration with the ED to ensure efficient use of resources) so that the individuals with expertise are “front line” in the assessment and management of complex psychiatric patients.
- An enhanced capacity of a low barrier rapid access clinic (Urgent Care Clinic) with outreach into the community that can support the immediate follow-up of patients discharged from the ED.
- A dedicated ACT or similar team (i.e. Acute Home Based Treatment) to follow frequent and persistent patients at highest risk for readmission to the ED and to inpatient care;
- Access to ambulatory mental health and addiction services and supports for individuals who do not require the intensity of services delivered by ACT (e.g. case management programs) beyond that provided by APAC (Acute Psychiatric Access Clinic).

Recommendation 3: Given the increased volume of clients taken to St. Paul’s Emergency for psychiatric assessment, there needs to be clearer means of communicating with the many involved community agencies. Specifically, there should be an identified contact person in the ED or Department of Psychiatry to manage information received from outside agencies and to inform other treatment staff regarding decisions affecting admission and discharge.
**Recommendation 4:** The Mental Health Act allows for extended leave, which allows patients to reside in the community providing they adhere to certain conditions such as treatment. The appropriate use of this extended leave provision should be clarified and optimized to facilitate clinical outcomes, and an educational program about this provision should be undertaken with patient and family involvement.

**Recommendation 5:** Regular access and flow into and out of the Burnaby Centre as a component of a fully integrated system for the complex concurrent disorder population should be streamlined and expedited.

**Recommendation 6:** System integration must include, in addition to the Burnaby Centre, Mental Health and Addiction teams, ACT teams and other low barrier case management teams.

**Recommendation 7:** Collaborative task groups comprising key providers in the health and related sectors (Justice, Corrections, and Housing) should be established. These should be structured with clear terms of reference and meet regularly. Their initial development should be supported by professional facilitation.

**Recommendation 8:** Information management system development should proceed as soon as reasonably possible and a task group should be established involving all relevant stakeholders to promote alignment of information systems.

**Recommendation 9:** A process should be undertaken to clarify the “consistent use” principle of the Freedom of Information and Protection of Privacy Act and to develop protocols for consistent application of this principle. It should include education on privacy issues, “consistent use”, and education on the requirements of 2-way flow of information (family to caregiver, and caregiver to family).

**Recommendation 10:** The Steering Committee should establish an implementation and accountability framework to address the identified themes and recommendations (see figure 2).

**Recommendation 11:** A task group should be established involving all relevant stakeholders to identify opportunities for enhancing coordination and integration of services and to develop and implement strategies for achieving this goal. This may include: a) development of consistent standards for discharge planning and coordination of care at points of transition and handoff, b) exploration of opportunities for cross appointments between organizations, c) exploration of a central access model for individuals with concurrent disorders.
**Recommendation 12:** The Vancouver General Hospital, St. Paul’s Hospital and the Department of Family Medicine should continue to explore promising practices in other jurisdictions to organize care with community partners to better serve the concurrent disorders population.

**Recommendation 13:** Expand on the integration of the Vancouver Police Department with the health care sector as is occurring with ACT teams.

**Recommendation 14:** Include police representation on the existing ED committee.

**Recommendation 15:** The VPD & Vancouver Mental Health and Addictions Collaborative should work to have a clearly articulated and timely dispute resolution protocol between the police department and EDs to handle differences arising from the management of patients apprehended under the Mental Health Act.

**Recommendation 16:** There is a need for formal and informal venues for medical, legal, mental health, police and social support staff working in different agencies to meet and clarify roles, expectations and working relationships. It is recommended that such meetings should be organized through the task group on coordination. Given that there will be inevitable staff changes over time, these meetings need to be scheduled on a regular basis.

**Recommendation 17:** Establish formal contact between liaison staff at Community Court and a designated contact person in St. Paul’s Hospital Department of Psychiatry or Department of Emergency Medicine to review people sent from jail or the Mental Health Program through Community Court.

**Recommendation 18:** It is recommended that legal counsel clarify privacy issues as part of the task group on FIPPA and consistent use provisions. Written guidelines regarding release of information should be available in the ED, Department of Psychiatry and the VPD as part of standard procedure to provide trainees and staff with ready access to relevant policies and procedures.

**Recommendation 19:** There is a need for clarification of the roles and responsibilities of ED and Department of Psychiatry staff in decisions involving discharging clients sent in by community mental health agencies and communicating with those agencies especially outside of business hours. It is recommended that the task force on coordination organize this process.

**Recommendation 20:** Provide education about permissions and restrictions that privacy legislation enables regarding communicating information between family members and the health care sector.
**Recommendation 21:** Provide education that information can be released for continuity of care and there is no legislation that prevents receiving information from families and others.

**Recommendation 22:** A process/protocol should be developed to ensure that the patient and family voice is included in the care delivery process. Education to ensure staff and care providers are open to engaging patient and family participation is required.
External Review: Vancouver Coastal Health Authority and Providence Health Care

The Purpose

The purpose of the review was to examine the current system with a view to providing recommendations and identifying opportunities for improvement that support the provision of optimal care to people with acute mental health and substance abuse service needs, while ensuring public safety.

The Patient

An incident involving a patient discharged from St Paul’s Hospital Emergency Department (ED) was the catalyst for this external review. The young man involved in the incident was homeless; on two occasions on the same day police, under section 28 of the Mental Health Act, took him to St. Paul's Hospital for assessment.

This individual represents an identifiable, low prevalence but high needs, complex group of patients who have multiple contacts with the criminal justice system, in particular, the police system, and with the mental health system.
This group of patients has increasing frequency of police interactions and involvement with multiple mental health and social agencies and systems. The presence of a psychiatric illness concurrent with substance abuse, with or without significant personality factors, results in repeated behavioural crises requiring repeated risk assessments. Thus, they have frequent presentations to hospital EDs for psychiatric assessment. Adequate risk and psychiatric assessments require timely access to history and informative data, which is often unavailable and difficult to obtain. These patients have a poor history of remaining in ongoing mental health care.

There are a number of factors that contribute to this situation:

1. A significant one has been the reduction in the number of psychiatric hospital beds. Between 1985 and 1999, the average number of days of care in psychiatric hospitals in Canada decreased by 41.6 per cent (Sealey & Whitehead, 2004). Some community services were developed but they do not adequately replace the care that was provided in psychiatric hospitals. The planning for ancillary services post-deinstitutionalization was generally inadequate.

2. Simultaneous to deinstitutionalization there were changes in mental health legislation (Gray, Shone, and Liddle 2008). Over the last few decades, mental health law reform has tended to increase rights protection for people involuntarily detained in hospital. In many Canadian provinces, legislation allows for dangerous persons only to be detained with few provisions for involuntary treatment. However, the B.C. Mental Health Act allows for the involuntary detention and compulsory treatment of individuals in need of care and supervision to prevent their mental or physical deterioration or for protection of themselves or others. The movement of mental health care to the community accounts for greater impact on other parts of the system, such as police and criminal justice.

3. The third factor is the increased numbers of homeless people on Canadian streets, many with a history of mental illness. Laird (2007) observed that the number of homeless people has tripled in some metropolitan areas. Riordan (2004) noted 56 per cent of homeless people have a history of mental illness of which the majority also has substance abuse problems. Vancouver is exceptional in having individuals with mental illness, substance abuse and homelessness concentrated in a very small geographical area – the Downtown Eastside.

**Risk Assessment and Management in the ED:**

Risk assessment and management is the process of predicting and reducing the likelihood of adverse events. There is substantial, empirically based literature on the prediction of violent and criminal behaviour in the fields of corrections and forensic psychiatry. The
literature is increasingly being applied to the assessment and management of mentally ill patients in civil settings. This literature has particular relevance for the population of mentally ill people with concurrent substance abuse, personality dysfunction and frequent disruptive and/or criminal behaviour.

There are many inherent methodological problems in conducting risk assessments of mentally ill people in general, let alone within the ED. A central problem is the difficulty in predicting violent behaviour. Even with the most sensitive of instruments that identify the majority of people who might commit a violent act, there will be very high rates of false positives. This leads to the phenomenon that psychiatrists over-predict violence by a large measure. A partial answer to the limitation of assessment instruments is to identify groups within the mentally disordered population that have higher potential for violence or criminal activity through actuarial data such as mental illness concurrent with past criminal history, antisocial behaviours and substance abuse.

A second critical problem is the determination of short vs. long-term prediction of violence. Most empirical studies of risk instruments require long-term follow-up to generate statistically significant data. The resulting instruments have broad accuracy in identifying risk of violent behaviour in comparison groups in time periods of a few months to years but not in the next few days or weeks.

A third critical limitation is the obvious problem that an individual’s situation may change quickly and radically after discharge e.g. if he or she consumes substances or returns to chaotic, high stress environments such as the Downtown Eastside.

There are three broad methods employed to assess risk of future violent behaviour: clinical judgment, actuarial risk instruments and structured professional judgment instruments. Traditionally MDs in hospital settings employ clinical judgment methodology, which allows flexibility, especially in the ED, where there may be high patient volumes and limited information available. Unfortunately, empirical studies reveal that clinical judgment has limited accuracy with some suggesting that it is no better than chance at predicting whether or not a person may become violent.

Actuarial instruments have greater accuracy as they are based on empirical data, have good inter-rater reliability and are reproducible. These instruments are frequently used in correctional environments where they have proven to have moderate ability to predict recidivism. They have little utility in most civil mental health settings.

Structured professional judgment instruments employ a combination of actuarial assessment with clinical judgment. They are meant to inform clinical judgment, not replace it. Instruments such as HCR-20 or COVR have been evaluated in mental health settings and demonstrate moderate ability to predict violent behaviour. While these instruments are routinely used in forensic psychiatric settings, they are not commonly used in civil psychiatric settings.
These instruments require extensive time and effort to acquire the necessary background information and to critically analyze the data. They have great utility in inpatient settings in identifying those patients at greater risk and also targeting areas of intervention that may reduce risk. Unfortunately, they have not been studied in the ED setting where limited time and information might reduce the accuracy. These instruments do have utility, though, as even with limited information there may be sufficient data to identify those people who require admission to allow further gathering of information in order to accurately assess risk.

An advantage of structured professional judgment instruments is the use of empirically demonstrated factors predicting increased future risk that may guide targeted interventions to reduce risk. The HCR-20 has a risk management component that is designed for use in inpatient settings but also illustrates the particular problems in risk management faced by MDs assessing and treating patients at St. Paul’s. The five items rated in risk management are:

1. Discharge plans lack feasibility
2. Exposure to destabilizers
3. Lack of personal support
4. Non-compliance
5. Stress.

These five items are commonly seen in the majority of Downtown Eastside patients seen at St. Paul’s Hospital. Without adequate interventions in each domain, these patients will continue to be at high risk for violent behaviour despite psychiatric hospitalization.
St. Paul’s Hospital: Emergency Department and Urgent Psychiatric Services

St. Paul’s Hospital is an inner city hospital with a mandate to provide excellent care to Vancouver and residents of British Columbia. St. Paul’s has evolved as the hospital that addresses the health care issues associated with Vancouver’s Downtown Eastside because of close proximity to this neighbourhood. The personnel at St. Paul’s are highly engaged with and devoted to providing the highest quality of care to this complex, high needs population.

St. Paul’s ED has approximately 73,000 patients registering per year. Over the last three years there has been an increase of approximately 35% per cent in the number of patients with mental health and/or addiction issues presenting to the ED. This increase largely reflects patients from the Downtown Eastside. Additionally, the St. Paul’s ED receives approximately two-thirds of all Vancouver patients arriving in police custody under the B.C. Mental Health Act. Despite this increase in mental health and addiction-related patient volumes, there have been minimal additional resources designated to manage this population.

The case that prompted this review is reflective of the complex nature of the psychiatric and non-psychiatric issues the ED staff and consultation services must address to adequately assess risk and provide timely acute care management, all within finite hospital resources.

Physical Plant and Layout

For a high volume, inner city ED, the space and layout poses challenges. Small spaces and high volumes result in complex, agitated patients being in very close proximity to others. The psychiatric quiet rooms are very small and the surrounding space does not appear to provide a calming environment for individuals in crisis while waiting for, or in the midst of, urgent assessment. Moreover, with the existing layout, the staff have limited options to use space to, for example, separate multiple agitated patients to manage their care.

Model of Care

The current model of care is common to all patients: triage by the ED triage nurse, assessment by an ED RN and MD, and referral to Psychiatry if the ED MD requests consultation. The ED MD may also receive input from either social workers or Clinical Nurse Leaders (CNL). The social workers and CNLs are employed within the ED. The social work role appears to be loosely defined, with variability in individual social worker’s hospital practices and liaison with community resources. The ED has two types of CNL, both employed by the ED. The ED CNL is a role with significant responsibilities for managing the ED nursing team. The CNL devoted to the patients with mental health and addiction issues appears to have fewer management responsibilities and a less defined role...
in relation to assessment and management of patients. Moreover, because the psychiatric CNLs are ED employees, Psychiatry does not have direct oversight or input into this role.

The ED MDs are assessing every patient who registers in the ED. This arrangement ensures that every patient has been medically assessed; however, the review team learned that ED physicians are conducting assessments on patients brought to the ED under Section 28 of the Mental Health Act and discharging them to the community without input from Psychiatry. The referral sources interviewed during the review repeatedly raised a concern that patients were being assessed very quickly and being discharged in a way that was not addressing the risks identified by the referring sources. Given the high volume and acuity of the St. Paul’s ED patients, there is likely considerable pressure to conduct assessments as rapidly as possible. In other jurisdictions, complex patients who present under the Mental Health Act are typically held for prolonged assessment to both comprehensively assess risk and to understand the need for services.

**Vancouver Psychiatric Acute Care Services**

The two main hospitals providing acute psychiatric services in Vancouver are Vancouver General Hospital and St. Paul’s Hospital. As mentioned above, the volume of complex psychiatric patients presenting to St. Paul’s ED has increased substantially and patients presenting with police under the Mental Health Act are heavily skewed toward St. Paul’s. Vancouver General has a 20-bed Psychiatric Assessment Unit (PAU) designed to handle acute assessment and management of psychiatric patients presenting to the ED. The PAU at Vancouver General is also staffed with a relatively large number of psychiatrists (10), which may help with rapid assessments and quick patient turnover. St. Paul’s has a 4-bed secure observation unit in the ED and a 13-bed psychiatric assessment unit (PASU) upstairs. The 4-bed secure observation unit in the ED is managed by the ED. The 13-bed PASU is on another floor within St. Paul’s Hospital and has a mandate to receive agitated patients from the ED and to provide rapid assessment and referral to services (if patients can be discharged) or rapid management of agitation and referral to other inpatient services (if patients require longer hospitalizations). The average length of stay on the PASU is 3-4 days.

The Psychiatry department at St. Paul’s Hospital also has an Acute Psychiatric Assessment Clinic (APAC); a resource to provide rapid access to patients seen in the ED who require urgent follow-up but do not require admission. Accordingly, if a patient requires admission, there is a 4-bed secure area in the ED to observe and assess the patient and a 13-bed PASU to manage agitated patients prior to discharge or admission to less acute inpatient units. If the patient can be discharged and is appropriate for the APAC (clinic eligibility criteria are not known), the patient can be referred to this resource for rapid follow-up.

Based on city-wide psychiatric patient volumes and flow, the patients are not being seen where the resources reside for acute management of emergency psychiatric patients. There
may be opportunities to either re-align where the service resources reside (e.g. increase capacity at St. Paul’s Hospital) or to re-align where patients are sent for assessment and management (e.g. have patients sent preferentially to Vancouver General). The Downtown Eastside likely accounts for the majority of this patient volume and given St. Paul’s is in closer proximity to the Downtown Eastside, increasing psychiatric resources at St. Paul’s may be the better solution.

Multiple groups (police, ambulance, community agencies, etc.) are involved in bringing patients for emergency psychiatric assessments. The logistics involved in re-directing patients who present on their own or are brought by police, ambulance or a myriad of community agencies would be complex and challenging.

A City of Vancouver administrative report in 2009 stated, “St. Paul’s Hospital bears much of the burden of delivering emergency services for those with mental illness and the impact on this inner city hospital is significant.” In addition, Vancouver Coastal Health estimates that there are approximately 2,100 individuals in the Downtown Eastside alone that constitute “a population in crisis.” While considerable investments have been made in health, housing and social supports since 2009 to achieve housing first goals, the mental health and addictions sector appears to be under daily siege, attempting to respond to high volumes of challenging individuals with complex, concurrent disorders. Given its proximity to the Downtown Eastside with a concentration of poor, homeless and nearly homeless individuals with serious mental illness and addictions, St. Paul’s ED receives the majority of patients in crisis from that neighbourhood.

The city ambulance service indicated that it adheres closely to catchment areas and thus transports individuals on a priority basis from the Downtown Eastside to St. Paul’s ED. Similarly, local shelters and agencies refer to St. Paul’s as their nearest Emergency. The Vancouver Police Department indicated that on average they apprehend six individuals daily under section 28 of the Mental Health Act and that two-thirds are taken to St. Paul’s ED.

This trend is borne out by a review of the police report, *Mental Health Act Hospital Wait Times Analysis*, December 2011. “The report shows that from January 2009 to December 2011, patients were sent to St. Paul’s Hospital or Vancouver General Hospital approximately 90 per cent of the time, with the percentage taken to St. Paul’s increasing each six-month period. St. Paul’s Hospital received the majority of subjects taken to Vancouver hospitals by police, at 53.6 per cent for 2011-12. Vancouver General received 36 per cent of admissions, making for a rather significant disparity of 17.6 per cent, (559 vs. 375 individuals), considerably greater than the 2010 difference of 10.2 per cent.”

Upon review of the available resources, St. Paul’s Hospital would benefit from more resources (beds and adequately trained, multi-disciplinary staff) dedicated to providing a secure environment to adequately assess and manage complex psychiatric patients within the ED (as opposed to patients who have been admitted to PASU). Moreover, the Psychiatry department should be managing these resources so that the individuals with expertise in assessment and management of acute, complex psychiatric patients have the responsibility
of oversight of the secure observation unit. An increase in the number of secure beds with a concurrent evaluation of staffing requirements will likely facilitate assessment and management of complex psychiatric patients within the ED.

**Accessibility of Critical Information in the ED**

During the site visit, timely access to information was a recurring issue. Difficulties with access to information occurred across sectors (e.g. police wished they had access to health assessments when deciding how to intervene with individuals they know have been brought to St. Paul's ED or elsewhere for assessment and the St. Paul's ED and psychiatry staff expressed a similar need to have access to police records, although the police provide reports within hours of dropping individuals off at the ED) and within sectors. The St. Paul's staff stated that the health record system used in ambulatory settings is not uniform and not everyone has access to this information. Similarly, St. Paul’s does not have access to health records at Vancouver General and vice versa.

The privacy issues preventing health sector access to police records and vice versa will be challenging. However, the difficulties with access to information within and between health care agencies has more to do with information technology issues than privacy and the information technology issues can be resolved.

**The Role of ED Assessment**

When discussing the case and, more broadly, the management of patients who have complex presentations and may be at high risk of harming themselves or others, there was confusion about the role of the ED. Specifically, agencies (the police, health care providers within the correctional system, etc.) were perplexed about why individuals they deemed both high risk and suffering from mental illnesses were assessed briefly in the ED and discharged. The police, Vancouver General Hospital and St. Paul’s Hospital have formed committees that may be a forum for discussing the roles and intersection between police and the health care sector (the most common source of misunderstanding). If this committee is the only forum to engage in a discussion between police and hospital, it is critical to ensure that fruitful developments are clearly communicated to front-line workers in both sectors. It would also be helpful to expand the type of work that is likely occurring on this committee to include other stakeholders that are experiencing the same kinds of communication and role clarification issues with the ED.

**Crisis Response Centre**

It is evident that there is a need for better alignment of resources in order to match capacity at St. Paul’s with the burgeoning demand and geographic imperative of the Downtown Eastside. Given that transition of patients from the ED was a primary reason for initiating the external review, it would be prudent to explore the continuum of care inwards and outwards from the major pressure point and transition point of care, namely the ED. Currently, the limited options at St. Paul’s ED consist of assessment and discharge or referral for psychiatric consult and possible admission to PASU beds that are
continuously full. It is evident that a more robust, coherent and integrated range of options is needed.

Many interviewees from different organizations and sectors advocated for a crisis response centre as an alternative to the ED and as a solution that will provide an immediate, safe, responsive care environment and help prevent broken transitions in care. While all were using the same terminology it was apparent that there are divergent views on what a crisis response centre would look like and how it would function. Some perceive it as a stand-alone community-based organization, others see it located at the Burnaby Centre, and still others see it as linked to an acute care hospital. Indeed, there may be other perspectives too. What is clear is that there is not a common vision for the proposed model.

Until there is a common vision for such a centre it is not possible to proceed with plans for its development. The reviewers believe that a crisis response centre unattached to existing structures and resources would likely add further fragmentation to the health system. Lacking integration with other essential components such as acute care, it would add another care silo. It also would be at full capacity in a short time.

The reviewers believe that augmentation of the existing four-bed holding unit in the St. Paul’s ED would be beneficial, as described in the section above. Various holding bed models exist but they all share common features: the capacity for extended assessments and rapid management of patients who are medically stable but in crisis. The advantage of these beds is that crisis intervention can occur in a safe and supervised setting by an interdisciplinary mental health team without requiring a more formal admission to a psychiatric inpatient unit. The availability of holding beds attached to an ED acts as a buffer between the ED and the inpatient unit and allows for adequate assessment and risk management of patients in crisis while ensuring that inpatient resources are available to patients who require longer periods of assessment and treatment.

**Rapid Access to Crisis Support after ED Discharge**

Many patients may not require hospitalization if crisis support care is accessible in a short period of time following ED discharge. The reviewers learned of an urgent crisis clinic (the Acute Psychiatric Access Clinic or “APAC” has been established by the Department of Psychiatry at St. Paul’s Hospital. This type of service is very valuable to an ED and to the psychiatric team managing patients in the ED. The reviewers encourage further enhancement to the concept of a low barrier rapid access clinic that allows for greater access by patients that typically find it challenging to meet specific appointment slots.

**The Need for a new ACT Team and a Continuum of Care.**

Assertive Community Treatment (ACT) is an evidence-based model of care for individuals with severe and persistent mental illness. Vancouver currently has one ACT team (At Home) at full capacity for at least the next year and the Vancouver General ACT Team at about 50 per cent capacity while building gradually towards accepting new clients. Even
when it is at full capacity of 90 to 100 clients, it will not be able to satisfy the current need for intensive, assertive care for the large cohort of patients that can benefit from this model of care. The Vancouver Intensive Supervision Unit (VISU), which functions like an ACT team, is a Corrections-sponsored service, dedicated to serving the forensics population and with a current caseload of 65 active and 20 maintenance clients.

There is evidence in the literature to recommend ACT teams as effective interventions for people with severe mental illness. Local analysis based on the distribution of individuals with harms related to drug use (HIV, Hepatitis C and other infections; overdose deaths and arrest numbers) suggests that 12,000 to 15,000 of these individuals spend a significant portion of their time each year in the Downtown Eastside. Based on the available literature, it is reasonable to expect rates of concurrent mental illness in between 50 and 70 per cent of this population (The Burnaby Centre 2012, unpublished).

It is evident that there is a critical mass of patients who would benefit from the creation of a new ACT Team and that such a team would relieve severe pressures on the acute care system. The ACT team should be structurally integrated with an acute care hospital.

ACT teams are cost-effective for individuals with severe persistent mental illness because the care provided, while costly, is less expensive than hospitalization, the only other alternative for these individuals. Intensive case management is a less costly mode of comprehensive treatment for individuals who do not need the level of care provided by ACT teams. Beyond intensive case management, multi-disciplinary, clinic-based, outpatient support is one step less intense than case management and can provide care for a large number of patients with less intense needs.

There are many different ways to implement models of care. Currently, there appear to be relatively few options for patients who present to the ED with complex psychiatric presentations. We have described a few modes of care delivery that are evidence-based (ACT and intensive case management) and that have been widely implemented.

The extended leave provision under the Mental Health Act is viewed as a beneficial intervention that is underutilized. Extended leave for involuntary patients is authorized under section 37 of the Mental Health Act. It is intended to be a voluntary therapeutic intervention used to optimize an involuntary patient’s potential for community living through the provision of support for treatment and compliance once out of hospital (Guide to the Mental Health Act, 2005). The patient may be recalled to a designated facility for inpatient treatment under certain conditions. This provision is seen as a valuable enabler to compliance with treatment regimens while in the community. It was reported as being used to great advantage in many instances and a missed opportunity in others.

Recommendation 1: All patients brought in under a Form 4 Mental Health Act certificate should receive a psychiatric assessment. Those patients brought in under Section 28 of the Mental Health Act should be held long enough to complete an appropriate assessment and arrange disposition and have, when indicated, psychiatric consultation.
**Recommendation 2:** The following resources should be implemented and accessible to St. Paul’s Hospital:

- An evaluation of the current 4-bed secure observation unit within the ED that includes ascertainment of appropriate number of beds (more than 4) and adequate multi-disciplinary staffing. These beds would fulfill the function of a Crisis Stabilization Unit.
- The secure observation unit in the ED should be managed and overseen by Psychiatry (in close collaboration with the ED to ensure efficient use of resources) so that the individuals with expertise are “front line” in the assessment and management of complex psychiatric patients.
- An enhanced capacity of a low barrier rapid access clinic (Urgent Care Clinic) with outreach into the community that can support the immediate follow-up of patients discharged from the ED.
- A dedicated ACT or similar team (i.e. Acute Home Based Treatment) to follow frequent and persistent patients at highest risk for readmission to the ED and to inpatient care;
- Access to ambulatory mental health and addiction services and supports for individuals who do not require the intensity of services delivered by ACT (e.g. case management programs) beyond that provided by APAC.

**Recommendation 3:** Given the increased volume of clients taken to St. Paul’s Emergency for psychiatric assessment, there needs to be clearer means of communicating with the many involved community agencies. Specifically, there should be an identified contact person in the ED or Department of Psychiatry to manage information received from outside agencies and to inform other treatment staff regarding decisions affecting admission and discharge.

**Recommendation 4:** The Mental Health Act allows for extended leave, which allows patients to reside in the community providing they adhere to certain conditions such as treatment. The appropriate use of this extended leave provision should be clarified and optimized to facilitate clinical outcomes, and an educational program about this provision should be undertaken with patient and family involvement.
The Health Sector

As discussed previously, over a three-day period, the review team had the opportunity to meet with an impressive range of leaders and providers of mental health and addiction services as well as others in related sectors, as outlined in Appendix B and C.

Observations

All of those interviewed demonstrated an exemplary commitment to addressing the needs of individuals with severe mental illness and addictions. The senior leaders of key organizations have demonstrated over time that they are seeking solutions in a collaborative manner and have established high-level discussions to address issues.

Similarly, at the point of care, it is evident that providers are keen to work together to improve services and outcomes for their patients and clients but often experience barriers beyond their control. Invariably, all who were interviewed expressed high levels of frustration at being unable to satisfactorily meet their organizational mandates while effectively addressing the needs of their patients. The obstacles and barriers most commonly cited were:

1. Misaligned or inadequate resources and a fragmented continuum of care
2. Barriers to effective communication and collaboration
3. Poor transitions between programs and sectors.

Fragmentation within the Continuum of Care.

The review team observed fragmentation within the continuum of care through various parts of the system. Opportunities for re-alignment and optimal use of resources are described below.

**Bed allocations at the Burnaby Centre** – Of the 100 specialized beds at Burnaby Centre, only 25 beds are allocated for Vancouver residents. Allocation of bed resources should not be on a per capita basis, but on a per capita need basis. For example, the Downtown Eastside likely gives rise to a greater proportion of individuals per capita who need Burnaby’s services than would be predicted simply by looking at the population of Vancouver.

The Burnaby Centre’s six to nine-month hospitalization for complex, concurrent disorder patients is an extraordinary resource; however, the gains accrued from hospitalization for these patients are likely to be undermined by insufficient community-based resources following hospitalization. Put another way, if a patient who is stabilized over six to nine months at the Burnaby Centre returns to the Downtown Eastside, the risk of immediate relapse is extremely high.
**Recommendation 5:** Regular access and flow into and out of the Burnaby Centre as a component of a fully integrated system for the complex concurrent disorder population should be streamlined and expedited.

**Recommendation 6:** System integration must include, in addition to the Burnaby Centre, Mental Health and Addiction teams, ACT teams and other low barrier case management teams.

**Barriers to Effective Communication and Collaboration.**

This was a strong and consistent theme from all sectors throughout the review about barriers that prevent effective communications and collaboration: organizational and service disconnects, lack of understanding of roles, mandates and processes, perceived lack of respect and not feeling listened to.

The most frequently cited issues were:

- **Lack of communication** and feedback when a patient is apprehended under section 28 and the patient is subsequently discharged. This is a major concern of the Vancouver Police and has been documented in a number of “lost in transition” reports. This concern is also shared by others as illustrated in the following example. Health staff connected to the Community Court indicated that they refer about 15 people per month to the EDs for mental health evaluation because of serious concerns about the client’s ability to function safely. While these volumes are small in relation to the overall volume of patients seen in the Emergency, they represent some of the most challenging clients of the Community Court Health Team. The Community Court staff stated that they are careful in triaging only those deemed to be high risk to themselves or others with the expectation that the client will be admitted and/or referred for treatment; they expected to receive communication about a plan of care. They reported that in the majority of cases the client was assessed and discharged in a very short period of time with no communication back to the court. It appears that the court and the hospital each believe the client/patient is being sent to a place of safety which addresses his or her respective perceptions of risk.

There is a need to build rapport, understanding and collegial, collaborative, relationships within and across sectors. This can be facilitated by creating task groups where front-line professionals in various sectors serving the same patients/clients can meet to understand each other’s roles and mandates, build relationships and rapport, trust and respect, and seek opportunities for mutual problem-solving to better serve their populations. It was noted that Vancouver Coastal Health, St. Paul’s and Vancouver Police have recently re-established a liaison committee. Including representation from the health team at the Community Court would enrich this liaison committee.
**Recommendation 7:** Collaborative task groups comprising key providers in the health and related sectors (Justice, Corrections, and Housing) should be established. These should be structured with clear terms of reference and meet regularly. Their initial development should be supported by professional facilitation.

- **Information management systems** (IMS) are different in each hospital and between hospitals and the community. The lack of coherent, consistent and easily accessible IMS for the health sector was noted by numerous interviewees. All concerned identified such a system as an important enabler for quality patient care, a critical communication tool and an essential data collection and planning tool to enable effective systems-level planning, monitoring and evaluation. It is understood that there are plans in progress to develop a more integrated information system in Vancouver.

**Recommendation 8:** Information management system development should proceed as soon as reasonably possible and a task group should be established involving all relevant stakeholders to promote alignment of information systems.

- **Interpretation of privacy requirements** was seen as a significant impediment to communication and information-sharing. The Freedom of Information and Protection of Privacy Act allows disclosure of a client’s personal information without the client’s consent to a third party such as family members, friends and relatives involved in a client’s care. The release of information must be in the best interest of the health of the client. Each release of information must be considered on its merits, in keeping with the standard of reasonable clinical judgment (Guide to the Mental Health Act, 2005, Appendix 13).

The patient’s right to privacy and the health professional’s need to build trust with the patient, coupled with legal and ethical standards, was frequently cited by all concerned as a major reason for not sharing information in either a responsive or proactive manner. Some believe that the right to privacy is used as a shield to avoid engagement with another party. Parents, in particular, voiced major concerns about lack of communication with them at critical points in treatment and decision-making by professionals treating their loved one. They felt that their intimate knowledge of their loved one’s moods and functioning is often discounted by health professionals in all parts of the health system and that this undervalues and undermines their ability to provide essential support either to their loved one or to the professional team.

**Recommendation 9:** A process should be undertaken to clarify the “consistent use” principle of the Freedom of Information and Protection of Privacy Act and to develop protocols for consistent application of this principle. It should include education on privacy issues, “consistent use”, and education on the requirements of 2-way flow of information (family to caregiver, and caregiver to family).
The reviewers note that there has been no shortage of committed leadership from key organizations in the health sector to address thorny issues. A case in point is the creation of the Steering Committee for the external review; however, the extent to which senior level deliberations are translated to action at the front line in a consistent and sustainable fashion is always a challenge. In order to ensure that the identified themes and recommendations throughout this report are systemically addressed, it will be necessary to create a system level, integrative structure and process for planning, implementation, monitoring and accountability for results.

**Recommendation 10:** The Steering Committee should establish an implementation and accountability framework to address the identified themes and recommendations (see figure 2).

**Figure 2: Proposed Organizational Structure for Accountability Framework**

![Diagram of Organizational Structure](image.png)

- Task group #1 – Information Management Systems
- Task group #2 – Consistent Use Protocol
- Task group #3 – Extended Leave Practices
- Task group #4 – Coordination and Integration
The illustration above represents one possible model for the creation of a systems framework. It would consist of broadly representative, inter-sectoral task groups, including front-line staff and would be structured around the identified themes. With expert facilitation and well-defined terms of reference, the task groups would develop work plans to address their assigned mandates. Wherever possible, patient and family input could be provided directly in the task groups or in response to the deliberations of the task groups.

An Inter-Sectoral Leadership Group comprised of senior leaders from key organizations and agencies as well as the chairs of the task groups would receive reports and recommendations. This would ensure a system-level understanding of priorities for action, as well as leadership endorsement of action plans that would enable their implementation.

An Executive Steering Group made up of key decision makers in the health, housing, Justice and Corrections sectors, would receive reports and recommendations from the Inter-Sectoral Leadership Group that require inter-sectoral decision-making, resource commitment, policy development and modification and/or timely removal of barriers.

**Poor Transitions between Programs and Sectors.**

Most of the interviewees identified poor transitions as being a major contributor to fragmentation of care and services, resulting in patients “falling through the cracks.” All of the issues that are described above under Barriers to Effective Communication and Collaboration contribute to poor transitions in care. Another specific concern identified was inconsistent discharge planning practices. In some instances, discharge planning was seen as excellent while in others, it was almost non-existent. “The discharge plan is a list of shelters” was how some interviewees summarized the issue.

According to a think tank on homelessness sponsored in 2010 by the Toronto Central Local Health Integration Network, the elements of an effective discharge planning model include: a plan for discharge, ensuring appropriate services are available at the discharge location, providing accompaniment to the discharge destination, linking community case management services to ED, and developing networks that would support improved communication between ED and community services. Other components include placing community support workers in hospital EDs and creating formal information-sharing opportunities between EDs and community services.

A contributing factor to poor transitions is a lack of clarity about roles and mandates between organizations and sectors. This impedes communication and planning for mutual patients of different organizations. Even in instances where individuals from different organizations are co-located and attempt to work as teams, there are barriers to communication; co-location does not mean integration and so, other enablers are necessary to foster seamless care planning and delivery.
There was evident enthusiasm to pursue opportunities to enhance coordination, planning and delivery of services. Some good examples on which to build include the Community Court Health Team, VISU which has a Vancouver Police officer embedded in the team, the HIP team and the ACT teams. Cross appointment would facilitate relationship-building between organizations, individuals, and teams through colleague-to-colleague information-sharing and more open access to data and information systems across organizations.

Centralized structures and processes exist in certain areas to facilitate coordination, integration and communication such as central access for the Withdrawal Management System and the centralized referral process at the Burnaby Centre. Centralized access structures can be valuable resources for individuals and for systems to promote ease of access, avoid duplication, and share and use data for planning, monitoring and evaluation purposes, particularly in planning for the needs of high repeat users of services.

Other jurisdictions within Canada and internationally have had promising success with the development of central access systems with indications of more integrated care supported by standardized intake and assessment, system navigation and referral services including transitional and supportive housing, financial trusteeship, income support, and ongoing addiction counseling and support through a flexible, recovery-oriented, harm reduction model.

**Recommendation 11:** A task group should be established involving all relevant stakeholders to identify opportunities for enhancing coordination and integration of services and to develop and implement strategies for achieving this goal. This may include: a) development of consistent standards for discharge planning and coordination of care at points of transition and handoff, b) exploration of opportunities for cross appointments between organizations, c) exploration of a central access model for individuals with concurrent disorders.

Having a consistent and easily accessible primary care provider is important for care delivery, coordination and advocacy, particularly for patients with concurrent disorders. St. Paul’s is fortunate to have a large group of family physicians associated with the hospital, many of whom provide office-based and community outreach services for vulnerable and marginalized populations.

**Recommendation 12:** The Vancouver General Hospital, St. Paul’s Hospital and the Department of Family Medicine should continue to explore promising practices in other jurisdictions to organize care with community partners to better serve the concurrent disorders population.
Vancouver Police Department

During the site visit for the external review, the reviewers met with the Vancouver Police Department on two different occasions. The first visit was during the tour of the Downtown Eastside and the second was an hour-long meeting.

The Department is highly engaged in the challenges that arise from the Downtown Eastside. The challenges (from a police perspective) and police engagement are highlighted in the “Lost in Transition” report. The report documents mental health as a highly prevalent indication of requests for police involvement and factors contributing to the recurrent need for police involvement in the Downtown Eastside.

Safety and Role Confusion

Vancouver Police involvement with individuals with complex mental health presentations is complicated. Police officers must decide whether to arrest individuals for a criminal offence and transport to jail or to invoke the Mental Health Act and bring individuals to an ED for assessment. The Department has a number of resources to help with this situation, among them Car 87 (see Appendix C).

When an individual is brought to the ED, the police provide a verbal report and then, have a policy to FAX a written report to the ED within hours of the drop-off. The meetings with police described repeated incidents where individuals who were dropped off at an ED were back on the street “within hours.” This was a recurrent complaint amongst many stakeholders who send individuals to the St. Paul’s ED for assessment.

The police perspective is that when they bring individuals to the hospital, they expect that individual to receive a comprehensive assessment and, hopefully, to be hospitalized for stabilization. They have taken into consideration two issues: 1) that the individual is not safe to be in the community; and 2) that the individual’s primary issue is an untreated mental health or addiction issue. Consequently, the confusion that arises when an individual is seen back on the street within hours of being dropped off at the ED is understandable.

Recommendation 13: Expand on the integration of the Vancouver Police Department with the health care sector as is occurring with ACT teams.

Recommendation 14: Include police representation on the existing ED committee.

Recommendation 15: The VPD & Vancouver Mental Health and Addictions Collaborative should work to have a clearly articulated and timely dispute resolution protocol between the police department and EDs to handle differences arising from the management of patients apprehended under the Mental Health Act.
St. Paul’s Mental Health Services and Legal Involvement

During the review, the review team met with representatives from Legal Counsel, Crown Counsel, the Defence bar, Corrections Services of B.C., Community Court and B.C. Forensic Services which provided valuable information regarding the complex interaction between Mental Health Services in Vancouver Coastal Health and the justice system. All the representatives are committed to providing the best care and management possible to what all agreed were a very complicated, complex and troubling population of individuals with combined criminal, mental health, addictions and social problems.

There are inherent difficulties in multiple areas that have complicated the working relationships between agencies. These problems can be roughly summarized as: difficulties in communication, different expectations regarding roles, duties and functions, varying interpretations of privacy legislation and a lack of formal venues for communication that might enable better understanding and working relationships.

In outlining the issues raised in the review, it is helpful to walk through the process of how a person with mental disorder/substance abuse may interact with the legal system and how the legal system intertwines with components of the mental health system, especially at the various points of potential diversion from the criminal justice system into the mental health system. The description of the process is found in Appendix D.

Communication

In review of the pre-trial diversion process, the reviewers learned of a number of problems in communication between court and medical staff. Jail staff complained that persons they sent for evaluation to St. Paul’s would often be returned in a very short time with no explanation why they were not kept in hospital. It was not clear to either the reviewers or jail staff if these persons had actually been seen by a psychiatrist or discharged by the ED physician. Likewise, psychiatrists at St. Paul’s complained that people were arriving with little or no information save for the Mental Health Act certificate and they had to rely on self-report to assess whether or not to admit the person. There was no apparent formal or informal communication between jail medical and nursing staff and St. Paul’s mental health staff.

Communication difficulties were again described in trial/post-trial diversion. The Court may send the person to St. Paul’s but if he or she is not admitted there is no information sent to the Mental Health Program at Community Court and there may be a delay in following the person. Further, in the case leading to this review, personal information has been removed.
Further misunderstanding of the available resources were noted in the expectation that the information sent in 2010 would be available to psychiatric staff in 2012 despite the fact that the person did not arrive from Court and was not seen by ED staff. It would seem this information was lost in the annual 70,000 ED admissions.

In discussion with jail and Community Court staff, there was concern regarding the level of commitment by Vancouver Coastal Health to the provision of services. Vancouver Coastal provides a worker but the role is primarily case management and not direct service. They noted that the case manager attempted to send people to services that were simply not available, especially for clients who are highly resistant to any treatment or intervention. Inadequate housing, poor communication amongst various social agencies and what was perceived as a lack of accountability and coordination among non-profit organizations further complicate the situation.

Justice Community Corrections manages the actual programs used by the Community Court. The programs were reviewed with the acting Provincial Director and the Manager of the Mental Health Program, Case Management Program and the Drug Treatment Court. B.C. Corrections operates VISU that is well-staffed and effectively operates as an equivalent to an ACT team with 65 active and 20 “maintenance” clients who are under probation control.

VISU provides care to persons with complex behavioural, mental health, substance abuse and criminal problems with daily supervision, medications and housing support that seemed well-suited to the needs of the population. They noted that informal communication among staff working in the Downtown Eastside was very effective. They also regularly coordinated care with St. Paul’s Mental Health Services when clients required admission. While they noted gaining admission was difficult, once a client was in hospital, they were able to communicate well, especially regarding discharge planning. This seemed a particularly effective program that integrated various disciplines to arrange the type of care required by this population although it was clear that more such teams were needed given the numbers of seriously mentally ill people in the Downtown Eastside.

All staff working in the jails and community corrections shared the view that it was exceedingly difficult to gain admission to the psychiatric inpatient units. Staff felt physicians in the ED did not give sufficient weight to the observations and opinions of community mental health and correction workers who expressed concerns that their clients were deteriorating in the community and needed hospitalization.

It was difficult to estimate the number of people not admitted whom they felt needed admission. In contrast, psychiatric staff stated, at times, they simply disagreed with the opinions of workers in the community regarding the need for admission. They indicated their decisions were often guided by concerns that hospitalization may actually cause harm, especially in patients with personality disorders who may experience psychological
regression in hospital. It was evident that there were limited opportunities to discuss these issues in a very busy ED environment.

There was general consensus that the extended leave provisions of the Mental Health Act were effective in facilitating readmission when required. Approximately 30 per cent of clients are currently on extended leave and it was recommended that this provision be used more frequently.

There was uncertainty and confusion among agencies regarding whom to contact at St. Paul’s. Due to St. Paul’s organization, ED staff may, at times, be the primary contact; at other times, psychiatric staff has care of the person. Outside agencies did not necessarily understand the differences or whom to contact especially when CNLs in the ED may not be on duty. There was limited staff in the Department of Psychiatry to manage communication with referring agencies.

**Role Expectations and Functions**

An identified area of concern was the apparent misunderstanding of professional roles and the various systems and organizations involved in providing care and services to this population. Crown Counsel and jail staff believed that if a person were committed under the Mental Health Act, he or she would be admitted and managed from that point onward by the mental health system. In contrast, medical staff made independent decisions to admit or not based on whether the person was thought to meet the Mental Health Act criteria and whether hospitalization might be helpful or not. As a result, individuals that the Crown Counsel and jail staff thought would be admitted, were in fact discharged from the ED. ED physicians or psychiatrists do not inform Crown Counsel or jail staff if the person was discharged or the reasons for discharge.

Medical staff also assumed that individuals with mental disorders who committed offences had ongoing involvement with the criminal justice system even though charges may, in fact, have been dropped or never laid. Complicating the situation further are privacy issues in which medical staff believe they are not allowed to share confidential health information with police, jail staff or Crown Counsel, including whether a person has or has not been admitted. This was particularly disturbing to police officers who brought people to hospital and found them returned to the Downtown Eastside the next day.

Medical/psychiatric staff did not have a clear understanding of the mandate and role of Forensic Psychiatric Services. Medical staff often referred to patients who had criminal charges as “forensic” even though they were not actually involved with Forensic Services. There was a mistaken perception that persons with mental illnesses involved with the courts would come under the care of Forensic Services. As noted in Appendix C, the mandate of Forensic Services is quite limited and the majority of mentally ill people either on probation or diverted from the criminal justice system will not be involved with Forensic Services. Many social and mental health services were reluctant to provide care to people with criminal involvement making it particularly difficult to arrange community treatment alternatives to admission.
Mentally disordered offenders may be managed under the Not Criminally Responsible by Reason of Mental Disorder [NCRMD] provision of the Criminal Code. The NCRMD provisions are rarely used and, if used, apply only to serious offences. Once found NCRMD, the person is under control of the Review Board which has sweeping powers to enforce compliance with attendance at treatment, housing, behaviour controls, drug screening, etc. The combined legal controls and treatment and rehabilitation services are well suited to the needs of the complex, multi-problem people seen on the Downtown Eastside but given the restrictions of the legal process, very few will actually be involved in the forensic system.

It was evident from the review that there were no formal or informal venues of communication that would allow for resolution of misunderstandings. It was also evident that the nature of this complex population does not lend itself to being managed in any one system. While people who commit a very serious offence may warrant prolonged incarceration or a NCRMD verdict, the majority of this population will receive very limited time in a corrections setting. Likewise, most chronically ill patients will not be admitted for prolonged periods given the limited resources and will be managed primarily in the community where they will face repeated crises that will aggravate their addiction and mental illness. The majority will continue to involve community mental health, corrections and social systems.

Privacy issues

In the discussion with various legal, medical and community staff, there was confusion and frustration over the interpretation of the limits in exchanging information. Vancouver Police has called for open communication with mental health services and are particularly frustrated that ED physicians and psychiatrists do not share information with them. They re-affirmed the recommendations made in “Lost in Transition” and strongly argued for an active role in ACT teams including access to medical data.

The information-sharing agreement signed December 16, 2011 between the Vancouver Police Department and Vancouver Coastal Health was provided for review. This agreement allows sharing of information between the two organizations regarding “ACT-eligible” clients for the purpose of protection of police or staff under section 33.2 [e] of FIPPA. “ACT-eligible” clients are those with concurrent mental health and substance abuse disorders.

FIPPA Section 33.2[e] states: “A public body may disclose personal information referred to in section 33 inside Canada as follows:
(e) to an officer or employee of a public body or to a minister, if the information is necessary for the protection of the health or safety of the officer, employee or minister.”

In review of the agreement, however, there seems to be some confusion regarding the limits of information to be shared between Vancouver Police and Vancouver Coastal Health.
There is a suggestion in the text that could be interpreted to allow greater sharing of information than that allowed for safety or protection issues.

The reviewers met with risk management personnel, legal counsel and numerous service providers and observed that there is a lack of clarity amongst service providers as to the extent to which critical information can be shared, and should be shared, between providers in the different sectors and agencies working with this population.

**Recommendation 16:** There is a need for formal and informal venues for medical, legal, mental health, police and social support staff working in different agencies to meet and clarify roles, expectations and working relationships. It is recommended that such meetings should be organized through the task group on coordination. Given that there will be inevitable staff changes over time, these meetings need to be scheduled on a regular basis.

**Recommendation 17:** Establish formal contact between liaison staff at Community Court and a designated contact person in St. Paul’s Department of Psychiatry or Department of Emergency Medicine to review people sent from jail or the Mental Health Program through Community Court.

**Recommendation 18:** It is recommended that legal counsel clarify privacy issues as part of the task group on FIPPA and consistent use provisions. Written guidelines regarding release of information should be available in the ED, Department of Psychiatry and the VPD as part of standard procedure to provide trainees and staff with ready access to relevant policies and procedures.

**Recommendation 19:** There is a need for clarification of the roles and responsibilities of ED and Department of Psychiatry staff in decisions involving discharging clients sent in by community mental health agencies and communicating with those agencies especially outside of business hours. It is recommended that the task force on coordination organize this process.
People with Mental Illness and their Families

The experiences and perspective of people with mental illnesses and their families was obtained through two facilitated focus groups. One group consisted of seven individuals with mental illness and one family member and the other group was comprised of 16 family members of people with mental illness. In addition, three family members shared their experiences during a telephone conversation.

There was considerable consistency between the two groups as to the themes and issues discussed. These issues can be summed up as problems with Communication, Coordination, Continuity and Common Sense.

Both patients and families felt that often they are not listened to or acknowledged by health care professionals. They were in agreement that better outcomes and care were obtained when there was a strong advocate present to speak on the person’s behalf.

As one mother expressed it, “what we DO all need is someone to give us the respect of listening – carefully and with empathy ... I think it’s crucial that the hospital or community team or police or whomever, be receptive to RECEIVING INFORMATION either on the phone, in person or preferably for busy professionals, in short, written FAXed notes.”

Families believed that the Freedom of Information and Protection of Privacy legislation is inconsistently interpreted, misunderstood, and used as a barrier to communication and getting information. The Ministry of Health’s, Guide to the Mental Health Act, states, “Public bodies may release necessary personal information to third parties without the consent of the client where disclosure is required for continuity of care or for compelling reasons if someone’s health or safety is at risk.” It goes on to say, “if a provider believes it is in the best interests of the client to disclose personal information to the family so they can provide care to the client, the health care provider may do so [section 33.2(a)].”

Families were also concerned about the inconsistent or wrong interpretation of the Mental Health Act which allows for the involuntary detention of people who require care to prevent substantial mental or physical deterioration and provides for compulsory treatment of all involuntary patients. They did support the use of extended leaves as very helpful and felt that they were being used for short duration with negative consequences.

Both groups expressed dissatisfaction with continuity of care. A person with a mental illness felt that an individual had to do something drastic to get care. A family member was concerned about the rapid discharge of patients from ED even when they arrive by ambulance. There appeared to be little communication or connection to family doctors. Referral processes were often slow or non-existent. There were limited community resources, long waiting times and few bridging services. Stable supported housing was in short supply and placements to obtain job skills were few. The need for better coordination and cooperation between mental health and addiction services was identified.
People with mental illnesses identified the need for a quiet space while waiting for ED assessment as the chaos in ED was confusing and anxiety-inducing. They also identified boredom as being a problem on inpatient settings.

Families expressed frustration with the lack of accountability. They were not informed when the person was discharged from ED or when extended leaves were ended. No one was responsible for care after discharge and the burden fell on the family. No one communicated with them when plans went wrong.

Families were divided on the Downtown Eastside. Many felt that accommodation needed to be provided away from the area but one family felt positive about the SRO being the only housing that tolerated their son’s behaviour after he had failed to be maintained in other types of housing.

We strongly encourage that the patients and family voices are represented in addressing the recommendations contained within this report.

**Recommendation 20:** Provide education about permissions and restrictions that privacy legislation enables regarding communicating information between family members and the health care sector.

**Recommendation 21:** Provide education that information can be released for continuity of care and there is no legislation that prevents receiving information from families and others.

**Recommendation 22:** A process/protocol should be developed to ensure that the patient and family voices are included in the care delivery process. Education to ensure staff and care providers are open to engaging patient and family participation is required.
Social Determinants of Health

There is abundant literature to demonstrate the importance of social determinants of health for individuals and communities. Stable housing, freedom from threat and violence, adequate income, food security, and supportive communities are paramount in promoting a sense of well-being. Most of the patients who are the subject of this review are homeless and live with severe mental health issues and addictions. As a result, they have significant functional impairments that interfere with their ability to perform activities of daily living and they also experience social exclusion, including discrimination. (Homeless Intervention Program 2009).

People who are chronically homeless have poorer outcomes, including shorter life expectancies with mortality rates significantly above those of the population overall (O’Connell 2005). When homelessness is exacerbated by serious mental illness, substance abuse as well as chronic medical, social and economic challenges and threats to personal safety, day-to-day life can be overwhelming for the individuals affected. When there is a critical mass and concentration of such individuals in a limited geographic area, it poses a severe challenge for the community they live in and for the institutions and community agencies that serve them. Such is the case with the Downtown Eastside.

Housing

Housing first options were seen by most interviewees as being successful in meeting the basic hierarchy of survival needs. Housing first is seen as a large step forward in getting seriously ill individuals off the street and into supervised living with the opportunity for wrap-around supports; however, others said that the quality of life experienced in some emergency shelters and SROs left much to be desired.

There was a perception held by some in the health, social services, housing, and law enforcement fields that ED visits and/or engagement with the corrections system by some individuals are motivated by a desire for a safe respite away from the chaos of their current living environments. Some organizations and health professionals expressed frustration at providing six to nine months of treatment only to see it undone when the patient chose to return to the environment of the Downtown Eastside, a choice often dictated by lack of options or lack of capacity in supported housing. In some cases this may be contributing to decisions to keep patients longer than necessary in residential treatment in order to consolidate gains and hope for other options to materialize. The downstream system impact of this set of circumstances is that access to scarce treatment resources is impeded and reduced for those in serious need.

In another instance, a well-regarded provider of supported housing indicated that her organization will be withdrawing from the provision of this service for the severely mentally ill because of the extremely challenging natures of the clients, the lack of adequate staffing and staff turnover, and the lack of resources to train and maintain staff. Given this
decision by a reputable organization, one wonders to what extent the withholding or limiting of services is happening in other provider agencies.

Many stated that the neighbourhood has a vibrant character and informal social support system that is accepting and tolerant of behaviours and lifestyles that would not be acceptable elsewhere. There is a social cohesion where people feel a sense of belonging and a sense of community regardless of daily threats and insecurity.

Summary

In summary, in recent years, a great deal of investment and coordinated effort has gone into providing housing options with wrap-around supports for difficult-to-house individuals and significant gains have been made through the housing first strategy. Even with all the investment and supportive services available, there is a critical mass of individuals who face daily risks and threats to health and well-being in the Downtown Eastside. One cannot overstate the profound effect of the social determinants of health on individuals with severe mental health and addictions issues who are living in the Downtown Eastside. Similarly, there are profound effects for the institutions and community organizations that provide care and services for this high needs population. These challenges are complex and multi-factorial. The solutions will involve inter-sectoral innovation; there is much to build on from current collaborations, goodwill and best practices.

While the review team recognizes the importance and impact that the social determinants of health have on this patient population, addressing these issues is beyond the scope and authority of those engaged within this review process. Nevertheless, the review team felt it would be useful to highlight their observations related to the impact of the social determinants of health and, further, to suggest that those disciplines/sectors engaged within this review process work in partnership with other ministries and organizations to address these concerns over time.

Observations:

It would be of value to conduct a needs assessment to determine the full range and number of housing options that must be available to address the needs of individuals who are suffering from concurrent disorders.

When reviewing housing contracts in the future, consideration should be given to accelerating the number of dispersed supported housing options in Vancouver for those who wish to avail themselves of this option.

Health hygiene standards in SROs and shelters warrant attention to promote dignity, respect, optimism and quality of life for residents.

Supportive housing staff need to be adequately trained and sufficient in numbers to meet the needs of residents and sustain housing options.
Appendix A – Document Reference List

Incident Background Prompting Review - External Review Steering Committee

External Review Terms of Reference – External Review Steering Committee

Guide to the Mental Health Act: 2005 Edition: BC Ministry of Health Services

BC Program Standards for Assertive Community Treatment Teams (ACT) (March 31, 2008) – BC Ministry of Health Services

Standards – Designated Observation Units under the MH Act – BC Ministry of Health Services

Standards and Guidelines for Early Psychosis Intervention (EPI) Programs (September 2010) – BC Ministry of Health Services

Homeless Intervention (HIP) Project Service Framework – BC Ministry of Health Services

Integrated MHSU Models of Care Draft Document – BC Ministry of Health Services


Hope & Healing: A Practical Guide for Survivors of Suicide – BC Government

The Provincial Suicide Clinical Framework Summary Document – BC Mental Health and Addiction Services

START (Short Term Assessment of Risk and Treatability) Background Materials – BC Mental Health and Addiction Services

START (Short Term Assessment of Risk and Treatability) Toolkit – BC Mental Health and Addiction Services

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 Resident Orientation Manual: Psychiatry St. Paul's Hospital (Nov 2011 – St. Paul's Hospital

Transferring Care of Psychiatric Patient from VPD/RCMP to Emergency Department (Sept 2011) – Vancouver Coastal Health

Letter of Understanding between VCH and VPD (Dec 2011) – Vancouver Coastal Health/Vancouver Police Department

Information Sharing Agreement VCH – VPD – specific to ACT Team Dec 2011 – Vancouver Coastal Health/Vancouver Police Department

Mental Health Act Hospital Wait Times Analysis July-December 2011 – Vancouver Police Department

Lost in Translation: How a lack of Capacity in the Mental Health System is Failing Vancouver’s Mentally Ill and Draining Police Resources (January 2008) – Vancouver Police Department – Vancouver Police Department
Policing Vancouver’s Mentally Ill: The Disturbing Truth Beyond Lost in Translation Part 2 – Executive Summary (Sept 2010) – Vancouver Police Department

Policing Vancouver’s Mentally Ill: The Disturbing Truth Beyond Lost in Translation Part 2 – (Sept 2010) – Vancouver Police Department

Project Lockstep: A United Efforts to Save Lives in the Downtown East Side (Feb 2009) – Vancouver Police Department

Building Capacity: Mental Health and Police Projects (http://www.cmha.bc.ca/get-informed/public-issues/justice/police) – BC Division: Canadian Mental Health Association – BC Division: Canadian Mental Health Association

Burnaby Centre Functional Plan and Client Referral Package - BC Mental Health and Addiction Services PARIS Primary Access Regional Information System, Dec. 2007 - Vancouver Coastal Health

PARIS (Primary Access Regional Information System), Dec. 2007 - Vancouver Coastal Health

Appendix B – People Interviewed

Blaine Bray, Dr. Bill MacEwan, and Dr. Steve Mathias - PHC Mental Health
Ralph Pauw, Scott Thompson, Howard Tran, and Tahir Humayun - Vancouver Police Department
Allan Shoom - Community Court
Sonja Sinclair - Jail Health
Andrew MacFarlane, Ann McNabb - ACT Teams
Gerrit van der Leer, Anita Snell, Elizabeth Hartney - BC Ministry of Health
Dr. Christian Schuetz - Burnaby Centre
Leanne Heppel - BC Ambulance
Dr. Joe Noone - Psychiatrist
John Jacobson - Forensics
Bill Small, Deborah Hines - Ministry of Justice/Community Corrections
Dr. Lakshmi Yatham, Dr. Michael Krausz, Yasmin Jeta - VCH Regional Mental Health Program
Dr. Sam Iskander - Forensic Psychiatrist
Dina Green - BC Corrections
Katie Huges - Canadian Mental Health Association
Camille Ciarniello, Sarah Harbottle - VCH/PHC In-house Counsel
Dr. Julian Marsden, Dr. Dan Kalla, Dr. Eric Grafstein - PHC Emergency Department
Dr. Garey Mazowita - Family Practice
Dr. Maria Corral - PHC Psychiatry/Mental Health Program
Dr. Soma Ganesan, Laura Case, Kathryn Embacher - Burnaby Centre
Jen Duff, Dr. Anna Nazif, Dr. Carol Richford, David Byres - PHC Mental Health Program/Emergency Psychiatry

Dr. Mark Levy - VGH Emergency Psychiatrist

Patti Stark – Defense Counsel;
Helen James – Crown Counsel;
Andrew Cochrane – Attorney-General’s Office

Marguerite Harden - North Shore Schizophrenia Society

John Grey - Canadian Schizophrenia Society

Dr. Johann Brink - Forensic Psychiatry

Consumer Group

Family Group
Appendix C – Key Players

The following provides a brief outline of some of the key players in the health and legal sectors.

The Vancouver Coastal Health Authority is responsible for governing, managing and delivering quality health care services to people living in the Coastal, Vancouver and Richmond areas, and to all British Columbians requiring highly specialized health services. Vancouver Coastal Health is accountable for the Regional Mental Health Program and in achieving its mandate to provide comprehensive mental health and addiction services, Vancouver Coastal Health directly operates a number of services including Vancouver General Hospital, a major provider of mental health and addiction services. Vancouver Coastal Health also enters into memoranda of understanding with other institutional and community-based organizations for the funding and delivery of services. An impressive and comprehensive range of contracted services is shown in the publication “A Mental Health and Addictions Framework for Services” (Nov 2011) spanning the spectrum of health, housing and social supports for people in need of mental health and addictions services.

The Vancouver General Hospital is operated by Vancouver Coastal Health. Mental health and addictions services include assessment and referral through the ED and a 20-bed Psychiatric Assessment Unit adjacent to the ED. There are 54 inpatient beds at the Health Centre at VGH as well as UBC is affiliated with Vancouver General and operates the 15-bed Mood Disorders Clinical and Research Unit. This inpatient unit is a provincial resource that specializes in the assessment and treatment of patients who require hospitalization for mood disorders (depression and bipolar disorder) as well as first episode psychosis service. At UBC there are also 10 beds of neuropsychiatry and 25 BC psychosis beds that act as a provincial resource. The Vancouver Intensive Supervision Unit (VISU), which is an Assertive Community Treatment Team (ACT), is also affiliated with Vancouver General.

Providence Health Care is a distinct Catholic, faith-based organization and operates as an affiliate of Vancouver Coastal Health Authority and plays a key role in service delivery, teaching and research of the Regional Mental Health Program. PHC operates several hospitals including St. Paul’s Hospital - a major provider of mental health and addictions services. These services include assessment and referral through the ED, four quiet room observation beds in the ED, 13 bed PASU (assessment and stabilization unit), a 47-bed, 3 unit secure Psychiatric Inpatient Units including eight eating disorder beds as well as The Urban Psychiatry Program and The Inner City Youth team. A Memorandum of Understanding governs the relationship between Vancouver Coastal Health and Providence Health Care. Collaborative planning and coordination is facilitated through the cross appointment of the CEO of Providence as a member of the Vancouver Coastal Health senior executive team.

The Burnaby Centre for Mental Health & Addiction is a provincial resource for all health authorities in B.C. It provides a 100-bed residential treatment program for B.C. residents
with severe and complex concurrent disorders. Program length is six to nine months. The referring health authority must demonstrate it has exhausted the resources in its region. The clients who are typically referred for treatment at the centre often have serious impairment in functioning (employment, personal safety, housing, etc.) due to complex mental health and addiction issues, high use patterns of specialty hospital, tertiary, or psychiatric emergency services or high involvement with the criminal justice system. Clients must be connected to a mental health and addiction team for continuity of care and discharge planning. The Centre transitioned to new management in the fall of 2011 and has streamlined operations to be more efficient. For example, until recently there were multiple points of referral and entry into the Centre. There is now an effective central intake process for Vancouver.

**Assertive Community Treatment (ACT) Teams**

There are two health-sponsored, evidence-based ACT teams primarily serving the Downtown Eastside. (Three ACT teams in total serve the neighbourhood, as VISU appears to function as an ACT team)

**The Vancouver Coastal Health Downtown Eastside ACT team,** in partnership with Strathcona Mental Health, provides intensive supervision and services for clients with mental illnesses. This ACT team was recently transitioned from Burnaby Centre with a caseload of 30 clients, which is gradually being expanded to a full caseload of 90 clients. Assistance with treatment, housing, living skills, financial management, and health care is provided in addition to supervision of court orders. A police officer was recently embedded in the team to provide input on security issues and to function as a liaison for issues that span the corrections and health sectors (as they often do in this population).

**Rain City Housing’s ACT team** was established under the “At Home /Ce Soir”, Mental Health Commission of Canada’s mental health and housing initiative in five cities across Canada. It is structured as a randomized, controlled trial research study on homelessness targeting those who are living with mental illness and are homeless. 500 homeless individuals primarily in the Downtown Eastside of Vancouver are involved in this research project and receive housing and mental health and addictions services through over 200 scatter-site housing units, congregate housing and supports. The study is structured with the following components

- An ACT team with rent supplements ,
- An Intensive Case Management team with rent supplements and
- A staffed building with clinical and support services.

This initiative is scheduled to run until March 2013. A number of those interviewed by the reviewers indicated that the At Home initiative is at capacity and is not accepting new admissions.

**The Homelessness Intervention Project (HIP)**

HIP was established in 2008 as a collaborative approach to integrate and coordinate housing and supports for people who are homeless. Outreach support services are provided to participating clients by interdisciplinary teams directed and overseen by a clinical case manager or outreach worker from community support agencies under contract to VCH. Client Liaison Workers provide a range of support and wrap-around
services.

The Vancouver Police Department's Car 87 is a long-standing and important community resource for responding to and de-escalating crisis situations in the community. Car 87 is a crisis intervention team consisting of a police officer and a mental health worker (typically a mental health nurse) who intervene in crisis situations where mental health and/or addiction issues are a component. The Vancouver Police Department has also instituted a progressive program for training with the goal of training all officers in dealing with individuals exhibiting serious risk or distress that may be related to severe mental health and addictions issues.

The Community Court is an important focal point where the Justice, Corrections and Health sectors intersect. The Court offers rapid referral to mental health and other social and health services for accused people who have been screened for eligibility. This includes individuals who have repeatedly come in contact with the criminal justice system. Interdisciplinary teams of probation officers, social workers and nurses facilitate the service.

The Drug Treatment Court uses an integrated approach involving a judge, defence counsel, crown prosecutor, probation officer and a partnership with the Vancouver Intensive Supervision Unit (VISU). VISU is a Corrections-sponsored service focused on clients on probation who have multiple mental health/ addiction/behavioural problems who have been charged with offences related to drug addiction. It appears to function essentially as an ACT team and includes psychiatrists, probation officers and mental health professionals. It is reported that VISU currently has 65 active and 20 maintenance clients.

Forensic Psychiatric Services
Forensic Psychiatric Services provides assessment and treatment to people involved with the legal system but with a restricted mandate that would not encompass the majority of people identified in this review. Forensic Services provides psychiatric assessment of persons charged under the Criminal Code of Canada to determine fitness to stand trial or mental state at the time of the alleged offence. Assessments may be conducted in jails [Surrey Pretrial Centre] or in the forensic hospital in Coquitlam. If found unfit or NCRMD, treatment services are provided under the direction of the Review Board with gradually increasing degrees of freedom depending on the response to treatment. NCRMD patients may be given conditional discharge with ongoing outpatient treatment. If further inpatient treatment is required, they may be returned to the forensic hospital. The treatment mandate concludes once the person is given an absolute discharge.

Forensic Services also may provide outpatient services through six clinics in B.C. while the primary mandate is to care for Review Board clients, services may be provided to people on bail or on probation. When the bail or probation period ends, the patient is referred to local mental health services.

Forensic Services does provide a liaison staff to the Community Court to facilitate provision of psychiatric care to diverted persons. There is a regular meeting with police and
probation services to improve communication but it appears Vancouver Coastal Health is not actively involved and there is no communication with St. Paul’s staff. There is an expectation that the mental health liaison would communicate with hospital staff but there seemed to be some confusion regarding the process and whether the communication was with ED staff or psychiatry staff.
Appendix D – Mentally Disordered Offenders and the Criminal Justice System

As in every province, police officers are the initial gate-way into the criminal justice system. Unlike other provinces, however, police in B.C. are not able to lay charges but rather provide information to Crown Counsel who can lay charges. Following arrest, Crown Counsel may decide to lay charges depending on a number of issues including the seriousness of the offense, the likelihood of conviction and whether alternatives to the criminal justice system are available. If a person is arrested, he/she is entitled to representation by lawyers provided through Legal Aid whose primary role and duty is to represent the wishes of the defendant even if those wishes may not be perceived by others to be in the best interests of the accused. Once charged, the defendant has the right to a trial with appropriate legal defence. If convicted, the accused may receive variable sentences including incarceration, probation, community service or alternative measures that may include mental health/addictions treatment. If incarcerated for two years or more, the accused is sent to a federal penitentiary and is managed by federal agencies. If sentenced to less than two years, they are sent to provincial jails and any mental health/addictions needs are the responsibility of provincial health authorities.

If the defendant is severely mentally ill at the time of a serious offence they may argue for a Not Criminally responsible by Reason of Mental Disorder [NCRMD] defence and be sent to the Forensic Psychiatric Services where they will remain under direction of the Review Board. Although the Review Board system offers helpful legal controls and mental health services that may well benefit the group of people who have complex multiple problems, in practice, the vast majority of mentally ill offenders will not meet NCRMD criteria and will not come under the control of the Review Board.

Diversion Pre-Trial
Diversion of mentally disordered individuals in conflict with the law may occur at multiple points in the criminal justice process. Police may decide to forego arrest and bring individuals directly to the hospital ED, under section 28 of the Mental Health Act. Individuals may also be diverted after arrest if there is reason to believe they suffer from a mental disorder. In practice, this may occur directly from jail after the accused is seen by a physician and committed under Mental Health Act at which point they are sent by ambulance to St. Paul’s. Alternatively they may be remanded to Surrey Pretrial Centre where there is an agreement to have the accused evaluated by a psychiatrist with the Forensic Services. Crown Counsel may then decide to drop charges or allow bail and the accused may again be sent to St. Paul’s under a Mental Health Act certificate.

Diversion at Trial/Post-Trial
Diversion may also occur at the trial phase and post-conviction phase of criminal proceedings. The Community Court was specifically established to divert those individuals with mental health or addictions problems whose needs were better met outside the criminal justice system. Diversion is limited to those who committed a summary offence and generally does not include violent offenders. The MOU defines 14 partner organizations, including Vancouver Coastal Health, working toward addressing the needs
of the offenders. The Court handles on average nine cases daily. Crown Counsel reviews the files of arrested individuals while defence counsel interviews their client. The Privacy Commissioner has approved the information transfer to and from Forensic Services and Vancouver Coastal Health to facilitate the decision-making process. If the client pleads guilty, Crown Counsel may recommend probation or bail at which point the person is rapidly assessed by a worker from Forensic, Vancouver Coastal Health or an Aboriginal worker and referred to relevant programs including substance abuse treatment, Aboriginal Justice Program or Mental Health Program. Clients certified under the Mental Health Act are automatically referred to the Mental Health Program.