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The Social Arena of Mental Health Act Apprehensions: An Examination of Partnership between Police and Hospital Services

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By

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Abstract

Improvement in the collaboration between police and emergency hospital services in responding to citizens in mental health (MH) crisis has been identified as vital by researchers and service organizations alike (Human Services and Justice Coordinating Committee, 2013). Research suggests that collaboration between these two services is inhibited by a lack of clear communication, protection of patient privacy, insufficient training, siloing of services, and safety concerns for patients and staff (Cotton & Coleman, 2010). Consequences of inadequate cooperation between police and hospital services has resulted in lengthy emergency room (ER) wait times for those apprehended by police officers under the Mental Health Act (MHA), poor patient follow-up, and frustration between services (Cotton, 2004). Recently, some police services have begun to implement formal agreements with local hospitals to enhance collaboration in Memorandums of Understanding (MOUs) in caring for those in MH crisis. The purpose of this study was to investigate these emerging agreements to gain insight into how they collectively framed their partnerships and responsibilities, identified their common objectives, and emphasized significant concerns in the context of MHA apprehensions. A Social Arena (Star & Griesemer, 1989) theoretical framework was used to argue that MOUs act as "boundary objects" (p.393). The boundary object comes into play when the diverse worlds, values and ideologies of the police service and the ER service come together to shape their collaboration, negotiate identities and roles, and bridge gaps in cooperating. Implications of such boundary objects are discussed.

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Introduction

Advances in the understanding of the etiology and treatment of mental illness resulted in wide-scale deinstitutionalization of psychiatric care across Canada beginning in the 1960's, consequently bringing about the transfer of mental health (MH) services from traditional institutional settings into community-based settings (Boschma & Groening, 2010). Unfortunately, inadequate provision of community MH services post de-institutionalization has resulted in a multitude of negative outcomes for those living with mental illness, including a high frequency of relapse, as well as increased hospital readmission rates, homelessness, criminal victimization, and criminalization (Byrick & Walker-Renshaw, 2012; Cotton, 2004; Gur, 2010; Kirby & Keon 2004; Ormston, 2010; Slate, Buffington-Vollom, & Johnson, 2013; Van den Brink et al., 2012; Winters, Magalhaes, & Kinsella, 2015).

Due to the current shortcomings in accessing community-based MH services, the Canadian MH system has become inextricably linked with the emergency care system. Indeed, a significant number of people with serious mental illness (PMI) are attending local hospital emergency departments (EDs) to access MH services (Boschma & Groening, 2010; Hollander, Lee, Tahtalian, Young, & Kulkarni, 2012; Lee et al., 2015; McKenna, Furness, Oakes, & Brown, 2015). The term "revolving door phenomenon" has been used to refer to a pattern whereby patients in MH crisis are admitted to a hospital for acute care, and are too quickly discharged back into the community with inadequate follow-up care and supports in place, only to rapidly become ill and re-hospitalized again (Shen & Snowden, 2014). With the increased reliance on community-based services after psychiatric facilities were closed, the previous pattern of longer stays in psychiatric hospitals was replaced with shorter admission periods. For example, in

Ontario from 1998 to 1999 the average length of stay in a psychiatric hospital was 86.5 days whereas in 2010 it was 63.9 days (Canadian Institute of Health Information, 2010; Sealy & Whitehead, 2004). Such a pattern of short and frequent admissions to care is not conducive to recovery for PMI (Loch, 2014; Markowitz, 2011; Shen & Snowden, 2014)

With the changing pattern in admissions to psychiatric hospitals, the ED and the emergency psychiatric units within general hospitals have now become key providers of acute treatment for PMI. With the increase in reliance on MH services within primary care settings, the roles and responsibilities of nurses to care for individuals in MH crisis have grown substantially (Boschma & Groening, 2010). For example, it has been estimated that in Canada, five to ten percent of presentations to EDs are related to a MH concern (Kirby & Keon, 2004; Tyerman, 2014). In Ontario EDs, the amount of MH presentations increased from 116,000 visits in 2001 to 132,000 visits in 2007 (Durbin, Lin, & Zaslavska, 2010). An emerging role among ED nurses resulting from an increase in emergency psychiatric care is working directly with police officers when presenting to the ED with a client apprehended from the community under the authority of the Ontario Mental Health Act (Mental Health Act, RSO 1990, c. M. 7). Once an individual has been apprehended under this Act, the police officer must escort the individual to the nearest Schedule 1 psychiatric facility, this is the local ED.

Research has demonstrated that there has been a rise in interactions between police and PMI across North America in recent decades (Brink et al., 2011; Durbin et al., 2010; Livingston et al., 2016; Wilson-Bates, 2008). Between 2003 and 2007 the rate of Ontario police encounters with PMI increased on a per-capita basis by 38% (Council of Canadian Academics, 2014; Durbin et al., 2010). These encounters represent a significant strain on police resources as it has been estimated that 5-30% of calls for police service involve PMI (Brink et al., 2011; Livingston

et al., 2016; Wilson-Bates, 2008). Ontario statistics indicate that in 2007 over 40,000 police encounters involved PMI and of these encounters 16,000 involved a MHA apprehension (Durbin et al., 2010).

As a result of the increase in MHA apprehensions, the ED has become an area of increased pressure and tension between police officers and nurses (Hoffman, Hirdes, Brown, Durbin, & Barbaree, 2016; Ormston, 2010; Pasqualone, 2015; Tyerman, 2014; Usher, 2015; White et al., 2008; Winters et al., 2015). This conflict has cumulated into calls for enhanced collaboration between police and health services, given identified shortcomings such as a lack of clear communication between services, issues of privacy, unclear roles and responsibilities, insufficient training for police and hospital staff regarding mental illness and the services offered by other social services, and lengthy hospital wait times (Carter, Cassidy, & Bhimani, 2012; CMHA, 2015; Coleman & Cotton, 2010; Cotton & Coleman, 2010; Forchuk, Jensen, Martin, Csiemik, & Atyeo, 2010; Hoffman et al., 2016; Hollander et al, 2012; Mckenna, Furness, Oakes et al.,2015; Mckenna, Furness, Brown et al., 2015; Pasqualone, 2015; Polland et al., 2005; Winters et al., 2015).

The lack of communication between police and health services has been identified as a shortcoming due to the collaborative nature of MHA apprehensions, which require police and health care providers to work together to care for PMI. Without effective communication between police and health services the care provided to PMI is disjointed and elevates safety concerns for police officers, ED staff and PMI (McCann, 2013). The predicament behind effective communication between these two services has been attributed in part to issues of privacy on both sides (Hoffman et al., 2016). Police and health services are both charged with the task of upholding the protection of individuals' privacy rights. These privacy rights are

protected under the following acts: Personal Health Information Protection Act (2004), Municipal Freedom of Information and Protection of Privacy Act (1990), and the Freedom of Information and Protection of Privacy Act (1990). Given these Acts, the police services and hospital staff do not openly share all information with one another.

In addition to issues of communication, police and health services experience frustration in terms of their roles and responsibilities for apprehensions under the Ontario MHA (Lamb, Weinberger, & DeCuir, 2002). When an apprehension occurs, the police officer determines if the PMI is dangerous to self or others, or is experiencing severe mental illness symptoms that impairs their ability to provide for their own basic needs (Mental Health Act, RSO 1990, c. M. 7, s.17). The officer then transports the individual to the ED where a physician assesses these identical criteria to decide whether to admit the individual involuntarily into the emergency psychiatric care. During this interaction between the police and hospital staff there tends to be confusion and frustration based on a lack of expertise in MH on the part of the police officers (Cotton, 2004; Hoffman, 2013; Markowitz, 2011). On the other hand, the hospital staff come to their opinion about the apprehension based on their expertise and the unit bed capacity, which tends to differ from that of the officers. At this point the officers become frustrated because they have spent a long time in the ED and the crisis often dissipates over the course of time thus resulting in the physician evaluating a different set of features compared to what the officer was dealing with prior. In addition to time spent in the ED, officers want to be prioritized. Furthermore, officers are frustrated by the futility of their role in contributing to the revolving door system and the fact that they view this work as belonging to the health sphere (Godredson, 2011; Hoffman, 2013; Markowitz, 2011).

The disconnect in responsibilities can lead to a lack of trust, ineffective teamwork and a diminished sense of professional identity (White et al., 2008). In typical work settings the police service tends to be the service that possesses the authority and control in situations. However, when the police respond to PMI with the healthcare system, they are no longer the only authority figure in the situation. Police and hospital staff must learn to work together even if their role overlaps with that of the other service.

Research Gap

To overcome these barriers, police and hospital organizations have recently begun to implement collaborative formal agreements, such as Memorandums of Understanding (MOUs) to guide MHA apprehensions. MOUs often determine the nature of these partnerships and are therefore important objects of analysis. Presently, a minimal amount of research has examined the new forms of collaborative solutions to help reduce identified barriers of communication, privacy, unclear roles and responsibilities, insufficient training, and lengthy hospital wait times (Hollander et al., 2012). Most studies examining the impact of MH care reforms on community services have focused on the perceptions of the police service and the respective challenges they face when responding to PMI (Cotton 2004; Cotton & Coleman, 2008b; Cotton & Coleman, 2010; McAndrew & Sutton, 2004). Due to their novelty the content of formal agreements between police and hospitals has not been investigated.

Objective of Research Study

The objective of this research study was to gain insight into how collaboration is defined and outlined by hospitals and police services as guided by MOUs. A thematic analysis of service agreements between Ontario hospitals and police services was conducted to identify how they framed their partnerships and responsibilities, what they identified as shared goals, and, areas of

significant concern that were emphasized. A Social Arena (Star & Griesmer, 1989) theoretical framework was used to argue that MOUs act as "boundary objects" where the diverse worlds, values and ideologies of the police service and the ED service come together to shape their collaboration and negotiate identities and roles.

An analysis of these MOUs identified three common themes of roles and responsibility, safety and collaboration. The theme of safety uncovered that the MOUs are framed as a risk management tool and that they prioritize organizational efficiencies over patient care. The theme of roles and responsibilities identified that the MOUs reinforced the boundaries between police and hospitals. Lastly, the theme of collaboration shows exactly how the services expect to work together. It essentially represents the best practices section of the MOUs because it outlines what they expect from the services and how they will operationalize these procedures in practice.

Chapter One contains the literature review that examines how the role and responsibility of mental illness has shifted over time and how it has impacted the response to MH by the police and the health care system. The literature review is divided into main sections that outline the historical perceptions of mental illness, and the role of the police and health care system in responding to mental illness. Also incorporated into the literature review is a description of the current problems being faced, such as the challenges of deinstitutionalization, pathways to MH care, and collaboration between the police and hospital EDs. The literature review is concluded with a discussion on the lack of collaboration between the services and the future collaborative methods being incorporated into police services and hospitals.

Chapter Two describes the theory of Social Worlds (Star & Griesmer, 1989) and the related concept of boundary objects. Chapter Three focuses on the methodology used to conduct this research project. Constructivist grounded theory was used to thematically analyze the data

from *N*=22 MOUs between Ontario-based hospitals and the police services concerning MHA apprehensions. Three main themes were identified in the data: roles and responsibilities, safety, and collaboration.

Chapter Four outlines the key legislation identified within the sampled MOUs that guided the interactions between police and hospital staff during encounters with PMI and during MHA apprehensions. This chapter also discusses the present study's research findings concerning the key goals and purposes as put forth by the sampled MOUs.

Chapter Five overviews key findings related to the three key themes found in the MOUs: roles and responsibilities, safety, and collaboration. This chapter describes the key roles and responsibilities laid out for the police and hospital services as identified within the MOUs. The chapter further discusses the theme of safety as it is portrayed within the MOUs. The theme of safety is divided into physical safety, safety of the individual, safety of the police service, safety of the emergency medical services (EMS) and safety of the hospital staff. Finally, the results chapter discusses collaboration between the police and ED services and how it is framed within the MOUs. The theme of collaboration is divided into subsections that have been identified as barriers to collaboration between the police and hospital services, including communication, information sharing and training.

The thesis concludes with a discussion of the key results found from the analysis of the MOUs and an argument that MOUs are acting as boundary objects to guide the collaboration between the police and hospital services. This study adds to the growing literature on MH and interactions among police, hospitals and PMI. This research will help to further elaborate the collaboration and the areas where research still needs to be conducted. A further contribution of

this study is the framing and argument that MOUs are a boundary object where diverse services negotiate roles and responsibilities, safety and collaboration.

Chapter One: Literature Review

Throughout history the term mental illness has been used to refer to a multitude of different symptoms and characteristics inhabited by people in societies. The differences in perception of what constitutes mental illness can be attributed to the various ideas of health. Historically there have been three main conceptions of health, these being the pathogenic approach, the salutogenic approach and the complete state model (Keyes, 2007). The pathogenic approach is derived from the Greek work *pathos*, meaning suffering or an emotion evoking sympathy. In this approach, health is viewed as the absence of disability, disease and premature death. The salutogenic approach is derived from the word *salus*, meaning health (Keyes, 2007). This approach views health as the presence of positive states of human capacities and functioning in thinking, feeling and behavior. The complete state model is derived from the word *hale* meaning whole and strong (Keyes, 2007). In this approach, health is considered to be a complete state, consisting of the presence of a positive state of human capacities and functioning as well as the absence of disease or infirmity (Keyes, 2007). These conceptions of health have influenced the development of broad definitions and categories of MH and mental illness. For example, the concept of mental illness has many different interpretations, meanings and definitions across societies as well as throughout history. The World Health Organization has defined mental health as:

> a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community (2001, p.1).

The Schizophrenia Society of Ontario defines mental disorder/mental illness as;

> a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with ordinary demands of life (2008, p.7).

Whereas mental health is defined by the Schizophrenia Society of Ontario as:

> an appropriate balance between the individual, his or her social group, and the larger environment. These three components combine to promote psychological and social harmony, a sense of well-being, self-actualization and environmental mastery (2008, p. 7).

Considering how mental illness is defined as a state of being balanced, the term MH crisis focuses on how a person deals with the event rather than with the specifics of the event itself. For example, James (2007) define a crisis as…

> …crisis is a perception or experience of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms. (2007, p. 3)

The challenge associated with providing a clear definition of mental illness and MH is the idea of distinguishing between "normal" and "abnormal" experiences of health and thus creating a clear line between the two. Differences over time have changed the perceptions of what constitutes MH thus adding to the difficulties behind establishing a clear definition of MH and mental illness (Foucault, 1965; Pilgrim, 2009)

Historical Perspectives

The understanding of MH and illness have been influenced by broader societal attitudes. Changes in attitudes over time have occurred due to advancements in science and a greater medical understanding and social awareness of mental illness. Historically, mental illness was associated with religious concepts, such as possession by the devil and evil spirits, and was thus

avoided by the fields of medicine and law (McLachlin, 2010). Up until the 19th century, people with mental illness were mostly cared for within their homes by their family members (Boschma & Groening, 2010; Slate et al., 2013; Videbeck, 2011). Only individuals whose behaviour was deemed dangerous to themselves or others were confined in prisons or separate wings in a local poor house (Boschma & Groening, 2010). The earliest forms of institutional treatment in Canada date back to the 19th century (Boschma & Groening, 2010). In the latter half of the 19th century and the beginning of the 20th each province had opened an asylum (Boschma & Groening, 2010). Institutional care and involuntary confinement became the dominant form of treatment for mental illness until the latter part of the 20th century (Boschman & Groening, 2010; McLachlin, 2010; Kirby & Keon, 2004; Slate et al., 2013).

As of the 1960s and 1970s, the confinement model of treatment for individuals with mental illness was coming under attack (Kirby & Keon, 2004; McLachlin, 2010; Slate et al., 2013). This change arose based on public reactions to the patient abuse occurring within the institutions as well as a better understanding of the causes of mental illness and potential treatment options. The treatment of those with mental illness shifted towards community-based care with more effective measures to treat mental illness such as the introduction of more effective psychotropic medication and the realization that PMI could be more successfully treated in the community where they were not isolated from their families (Sealy & Whitehead, 2004). With the recognition that individuals could now manage and treat their mental illness within the community, a trend of deinstitutionalization began (Sealy & Whitehead, 2006). Without adequate community resources, those with mental illness in the community are faced with a high frequency of relapse, and increased hospital readmission rates, increased homelessness, criminal victimization and criminalization (Byrick & Walker-Renshaw, 2012;

Cotton, 2004; Gur, 2010; Kirby & Keon 2004; Ormston, 2010; Slate, et al., 2013; Van den Brink et al., 2012; Winters, et al., 2015). Due to the shortcomings of the current community-based MH system, the Canadian MH system has now become inextricably linked with the primary health care system. A lack of community services has led to people relying on emergency services to access MH care (Boschma & Groening, 2010; Hollander et al., 2012; Lee et al., 2015; McKenna, Furness, Oakes et al., 2015).

New Roles for Police and ED Staff

With the availability of emergency response services 24 hours a day 7 days a week, such services have become relied upon to respond to PMI in crisis within the community. Police services specifically have been called upon to address PMI within the community due to public stigmatization of PMI as dangerous and unpredictable (Godfredson et al., 2011; Shen & Snowden, 2014; Winters et al., 2015). Post deinstitutionalization the MH system has undergone many changes in how PMI are treated and managed by those working within health care facilities (Boschma & Groening, 2010). Specifically, nurses in both the psychiatric setting and EDs of general hospitals have undergone a paradigm shift in how they respond to persons with mental illness (Canadian Nurses Association, 2005; McArthur & Montgomery, 2004; Pollard, 2010; Tyerman, 2014; Yonge & Austin, 2010). An in-depth description of the police and hospital service roles follows.

Changing Role of the Police in Responding to PMI

The profession of police officially started in Canada when the first police constables began their work in the mid 1600s in Quebec City and early 1800s in Upper Canada. The definition of policing and police work is rather broad due to the large police mandate and the

changes to the mandate and roles over the years. However, Clarke and Murphy (2011) have defined policing as,

> activities of any individual or organization acting legally on behalf of public or private organizations or persons to maintain security or social order while empowered by either public or private contract, regulations or policies, written or verbal (as cited in Griffiths, 2011, p. 63).

Typically, the roles and responsibilities of the police fall into three main categories: crime control, order maintenance and service (Griffith, 2011). Crime control includes activities involved with apprehending criminals, while order maintenance includes any measures used to keep the peace, and service comprises activities that provide assistance to citizens.

The role of the police in the care and control of people with mental illness stems from the notion of *parens patriae* or the state's paternalistic authority dictating protection for citizens with disabilities, who cannot care for themselves (Lamb et al., 2002, p.1). The purpose of granting authority to police services for the care and control of mental illness arose from the idea that some individuals, due to their MH condition, are unable to make capable decisions, including the decision to voluntarily seek treatment (Grainne, 2005). Under the jurisdiction's MHA, the government has granted the police the power and authority to apprehend persons appearing to have a mental disorder who present a danger to themselves or others, or are unable to care for themselves. In Ontario, in order for a police officer to apprehend an individual under section 17 of the Ontario Mental Health Act they must

> [h]ave reasonable and probable grounds to believe that the individual is acting or has acted disorderly, the individual is unable to care for themselves, the individual is suffering from a mental disorder that will likely result in serious bodily harm to

> self or others and that it would be dangerous to proceed by way of a justice of the peace (Mental Health Act, RSO 1990, c. M. 7, para. 27).

When responding to a person who appears to have symptoms of mental illness, officers are required to determine whether or not the individual meets the apprehension criteria set out in section 17 of the Mental Health Act, as well as determine whether or not the individual's actions require arrest and charges for criminal activity. Officers may elect to use their discretion to not lay charges in instances of minor offences.

Research indicates that 60% of interactions police have with PMI involve criminal activity, the remaining 40% involves non-criminal incidents including apprehension and victimization (Van den Brink et al., 2012). Approximately 36 to 55 percent of police occurrences with mentally ill individuals resulted in a MHA apprehension (Charette, 2011; Shore & Lavoie, 2018). These interactions tended to be minor in nature. PMI are often marginalized within the community and tend to face more interactions with the police compared to individuals without a mental illness. A study conducted in London, Ontario on the prevalence of interactions between police and individuals with a mental illness found that compared to those without mental illness, those with mental illness were more likely to come into contact with the police, be arrested and be charged (Hoch, Hartford, Heslop, & Stitt, 2009). With an increase in interactions between the police and persons with mental illness, the police service must work to find more effective solutions to assist the community and people with mental illness.

Police officers have not always been in agreement with their changing role as part of the MH system. For example, Cotton (2004) determined that 50% of a sample of 138 police officers reported that persons with mental illness take up more police resources than what is fair. Police officers also find it frustrating to transport an individual with mental illness to the hospital only

for them to be quickly released (Godfredson et al., 2011; Hoffman, 2013; Markowitz, 2011). As a result of the frustration of an ineffective MH system, law enforcement officials sometimes complain about being overburdened with inappropriate responsibilities for persons with mental illness that they do not view as legitimate police work (Cotton, 2004). Officers are often criticized for not understanding mental illness as well as mishandling situations involving persons with mental illness (Durbin et al., 2010; McKenna, Furness, Oakes et al., 2015; Hoch et al., 2009; Watson & Fulambarker, 2012). Police officers were also in agreement that if MH services were adequate the police would not have to deal with MH related calls (Cotton, 2004). In addition, Trovato (2000) found police officers in Toronto attribute the increase in interactions with PMI to problems in the MH system. Police officers do not feel that responding to MH calls is legitimate police work (Cotton, 2004).

Changing Role of Emergency Nurses in Caring for PMI

Changing the MH care system with a reduced emphasis on the institutionalized setting and enhancing the community-based setting created new roles and responsibilities for nurses and other staff in EDs. The change from institution-based care to community-based care arose from a change in ways of thinking about health and illness (Fernando, 1995). Rather than having a primary focus on the symptoms of illness the focus shifted towards the needs of patients and promoting health (Brencick & Webster, 2000). Nurses are now expected to learn from and apply their MH knowledge towards helping individuals with mental illness who present to primary care locations, such as EDs.

The changes in the responsibilities of nursing staff in EDs and general hospitals can be attributed to changes in legislation over the years. The first piece of legislation that applied to PMI was the 1890 Lunacy Act (Rogers & Pilgrim, 2014) that authorized the detention of

individuals in early asylums. In essence, this legislation marked the beginning of the institutionalized-based care also known as the period of great confinement by Foucault (1960). Within this time period, confinement of PMI was considered by society to be paramount and arose from an underlying fear of the unknown;

> ultimately, confinement did seek to suppress madness to eliminate from the social order, a figure which did not find its place within it; the essence of confinement was not the exorcism of a danger (Foucault, 1960, p. 113).

"Madness" was perceived as deviant and therefore the confinement of PMI was for the correction of these individuals or the suppression of their deviant behavior. By the 1930s the Mental Treatment Act (Rogers & Pilgrim, 2014) introduced the idea of community care and voluntary boundaries so that patients were not fully confined to the institutions (Pilgrim, 2009). After the Second World War, Canadian communities were beginning to reduce the size of institutions and abolish the use of asylums. However, the closure of most asylums was not completed until the late 1980s. The closure of the asylums shifted the treatment of mental illness into the communities and more specifically general hospitals (Rogers & Pilgrim, 2014). Due to these changes, general hospital staff were now relied upon to manage and treat patients with MH concerns because access to services was more difficult.

While the nursing profession has always had a key role in the care of patients with mental illness, the professional role of psychiatric only nursing emerged in the 1950s. Until the end of the 19th century, psychological care consisted of kindness and tolerance toward the patients. Today nursing has been defined as,

> a significant, therapeutic, interpersonal process. It functions cooperatively with other human processes that make health possible for individuals in

> communities…nursing is an educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal and community living (Barker, 2009).

The definition was further condensed by the American Nurses Association; "nursing is the diagnosis and treatment of human responses to actual and potential health problems" (Barker, 2009, p.5). However, some contemporary authorities have argued that it is impossible to define psychiatric MH nursing because "it involves a spectrum of roles, responsibilities and practices, defined by the economics, institutions and policies of the day" (Barker, 2009, p.6). Even with the concerns raised regarding a universal definition of psychiatric MH nursing, the idea of nursing can still be encompassed by the universal common denominator of caring. As stated by Nightingale:

> it is often thought that medicine is the curative process. It is no such thing;…nature alone cures…and what nursing has to do…is to put the patient in the best condition for nature to act upon him. (as cited in Barker, 2009, p. 5)

The nurse has always had a key role in the treatment and care of mental illness and mentally ill patients. However, the attitudes and perceptions of hospital staff are not always supportive of, or positive towards, mental illness (Chambers et al., 2010; Clarke, Usick, Sanderson et al., 2014; Cleary et al., 2012; Knaak, Mantler, & Szeto, 2017; Morgan, 2016; Reed & Fitzgerald, 2005; Tyerman, 2014; Yvan et al., 2017). Similar to that of the general public, staff working with patients with mental illness experience a mixture of attitudes, some being positive whereas others are more negative. Hamdan-Mansour and Wardam, (2009) found that the majority of nurse respondents considered that psychiatric illnesses do not deserve as much attention as physical illness; 84.8% also considered that a PMI has no control over their emotions. Hsiao, Lu and Tsai

(2015) found that psychiatric nurses had more negative attitudes towards patients with schizophrenia compared to nurses working in community-based clinics. Nordt et al (2006) found a mixture of positive and negative attitudes among nurses towards mental illness, specifically, they endorsed negative stereotypes of mentally ill people, but opposed the restriction of civil rights. Kukulu and Ergun (2007) as well as Foster et al., (2008) found that nurses confirmed the desire for social distance from patients with mental illness. Research has found that not all hospital staff hold negative perceptions or stereotypes towards mentally ill patients. However, a significant proportion of studies have found that hospital staff, specifically nurses, do not hold favorable opinions towards mentally ill patients. Reed and Fitzgerald (2005) in an Australian study found that half of their sample expressed a clear dislike of caring for people with MH problems. The sample expressed the feeling that it was not their role to care for the mentally ill and that they had not been trained for it. This sentiment was related to their overall lack of control versus their sense of responsibility to maintain the health and safety of the patients. The nurse participants feared harm to themselves, others on the ward, and the patient self-harming. In addition, nurses feared what would happen legally and ethically for their action or inaction to avoid harm (Reed & Fitzgerald, 2005). Such research illustrates that nurses in the EDs may lack the psychiatric knowledge and skills in assessment and least restrictive interventions that are often used in specially trained psychiatric units when providing care to patients with mental illness (Tyerman, 2014).

These variances in attitudes and training on the part of hospital staff are problematic because mentally ill patients continue to present to EDs in rising numbers. They represent a significant proportion of the patients visiting EDs across Canada (Reed & Fitzgerald, 2005). In Ontario, approximately 132,000 visits to EDs contain some element of mental illness (CMHA,

2009). MH visits comprise between 10 to 15 percent of all visits to EDs (Clarke, Vsick, Sanderson et al., 2014). Negative attitudes held by staff may lead to reduced quality of care of patients with mental illness (Reed & Fitzgerald, 2005).

The hospitals expanded role in MH care has created some concerns for the staff. Specifically, staff are unsure of their new roles in terms of working with and assessing patients with mental illness. ED staff are facing insufficient resources, such as psychiatric unit bed shortages, limited funding and staffing, which contribute to long wait times, a lack of specific MH protocols in the ED, a lack of effective emergency interventions, and role ambiguity amongst the ED staff (Clarke et al., 2014). Despite changes in the overall perception and attitudes towards mental illness, the driving focus of the health care system has been that of managing the disease and helping the person to heal and reintegrate into the community.

Increased Collaboration between Police and Emergency Departments

Over the past few years, collaboration has been the driving focus behind changes to responses towards mental illness in communities. Collaborative partnerships between primary care and mental health service providers highlights the direction that collaboration has taken in the mental health care field. As such, collaborative partnerships between the EDs and police services has been the trend within the expansive mental health care system in many communities. The changes in laws and responsibilities for both police and EDs have led to increased collaboration between these two social worlds. Rather than having a singular focus on crime, police have now been incorporated into the healthcare spectrum to provide a safe response to mental illness in the community. While there is a lack of research available on inter-agency collaboration among police and EDs, the little research available identifies challenges created by policies and regulations, such as the Personal Health Information Protection Act (PHIPPA,

2004), Municipal Freedom of Information and Protection of Privacy Act (1990) and the Freedom of Information and Protection of Privacy Act (FIPPA, 1990). These acts specify the requirements behind information sharing and what types of information can be released without the consent of the patient. PHIPPA is a privacy law that is exclusive to the health care sector. The act establishes and governs over the rules that custodians of personal health information must follow when using, disclosing and collecting personal health information. Of relevance to privacy, information sharing and collaboration between police and hospitals is the definition of the term "circle of care". The term "circle of care" is used to describe the ability of health care custodians to assume implied consent to use, collect and disclose information for the purpose of providing health care. Of dispute between police and health care professionals is whether or not the police service is considered to be a part of the circle of care during a MHA apprehension. However, the circle of care does not traditionally include the police and thus police officers become frustrated when hospitals will not share information with them about patients, fueling frustration and trust issues between the services during MHA apprehensions. With more focus being placed on mental illness in acute care these services are having to rely upon one another to fulfill their roles and responsibilities. MHA apprehensions inherently involve both the police and the ED and thus represent a key area for collaboration to occur and grow. However, these interactions between police and hospitals do not always go according to plan. As the Evan Jones case will demonstrate, there still remains challenges with interagency collaboration during MHA apprehensions.

The Evan Jones Case (2009): A Case for Information Sharing

Evan Jones was 18 years old when he was fatally shot in his Brantford, Ontario home as a result of falling through the cracks of community MH and addiction services. Prior to his death,

family, friends, and neighbours all described Jones's actions as a "cry for help" (Ruby, 2012b, p. 1). In June of 2010, Jones was admitted to the Brantford General Hospital (BGH) for a suicide attempt by ingestion of Tylenol. At this time, he was diagnosed with depression in addition to addiction to cocaine, morphine, oxytocin and alcohol. During the months after this diagnosis and those leading up to his death, Jones was admitted to an alcohol and drug treatment centre in addition to the MH unit at BGH. In both circumstances he left the treatment facilities without being discharged.

On August 4, 2010, Jones got into a fistfight with his brother that resulted in Jones being taken to hospital by the police to remove a large splinter that was lodged in his foot. However, during this incident Jones was resistant to being removed from the residence and had an altercation with an officer that lead to assault charges being filed. During this altercation, the police were made aware that Jones was taking anti-depressant and anti-psychotic medications. On route to the hospital, Jones banged his head against the partition of the cruiser, announced that he was psychotic, and displayed paranoid behaviour. However, by the time the police escort arrived at the hospital, Jones had calmed down considerably and police did not report his MH symptoms to the ER staff, and consequently he was only treated for the splinter in his foot (Ruby, 2012a, p. 2)

On August 25, 2010, Brantford police responded to a call placed by Jones's mother regarding a domestic dispute that the police perceived to be a crisis situation (Stanborough, 2012). When the police arrived, Jones was found holding two knives in each hand and making slicing motions across his neck causing superficial cuts in addition to asking responding police officers to shoot him (Ruby, 2012b). Soon after, the police arrived to see Jones brandishing these knives while exiting the residence (Stanborough, 2012). At this time, police officers on scene

drew their service weapons and instructed him to drop the knives. When Jones tried to leave the residence the police officers stopped him at the back door. Having information that Jones' mother and sister and her child were still in the house, the police perceived a significant threat to their safety and that of the other officers. As such, the lead officer discharged his firearm several times striking Jones several times, with the fatal shot penetrating the heart (Stanborough, 2012).

Arising from this unfortunate case is the need to examine how the health system and criminal justice system work together. A coroner's inquest following this tragic incident highlighted key problems occurring during a MH crisis such as a lack of information sharing between police and hospital services, specific MH training for police officers, and not enough communication during the transfer of care in the ED. The recommendations emerging from this case addressed these problem areas to ensure that PMI receive the best treatment and care possible. To prevent PMI from falling through the cracks, communication and information sharing must occur between first responders, hospital staff and community services. For example, Stanborough found that, "the restriction to access of information appears to be more of an operational issue, rather than a legal or legislative restriction" (2012, p., see also Sanders 2014). Based on the information provided during the inquest it was recommended that all information that is available and can be derived from the victim, family and community services needs to be shared with first responders, "to ensure and facilitate the circle of care" (Stanborough, 2012). A key challenge illustrated in this case was that the primary care physician or triage staff were not apprised by police officers of significant care issues or request for psychiatric care. Nor did the hospital staff pull up Jones's previous medical records to form an awareness of his past admissions for suicide attempts. With critical information not being shared among services, opportunities are missed to prevent tragic outcomes among PMI.

ED Wait Times

The growing wait times within EDs have negatively impacted the collaboration between the police and EDs (Hoffman et al., 2016; HSJCC, 2013a; Pizzingrilli & Hoffman, 2015). When police officers accompany an individual with mental illness as per section 33 and section 17 of the Ontario MHA, officers are required to wait with the individual until the hospital takes over custody of the individual or the individual is dismissed from hospital. Section 17 of the Ontario MHA outlines the powers that police officers have to apprehend an individual experiencing a MH crisis and transport them to the nearest Schedule 1 facility (Mental Health Act, RSO 1990, c. M. 7). Whereas section 33 refers to the duty of police officers to remain and retain custody of the individual until the facility takes over custody of the individual (Mental Health Act, RSO 1990, c. M. 7). As a result, police services across Ontario are typically spending an average of 3 hours in EDs per incident with a client (Hoffman, 2013). This congestion within the ED has lead to frustration for police and health services, as well as the person in crisis. The triage priority is typically lower for a person brought in by the police service compared to clients experiencing physical traumas (Clarke et al., 2006; Hoffman, 2013). Atzema and colleagues (2012) also determined that PMI tend to wait longer in EDs compared to individuals without mental illness. The assessment of the individual in crisis can be delayed due to a lack of resources within the ED such as the availability of a physician, security staff, and emergency psychiatric beds (HSJCC, 2013a).

Philosophies of Care

As society evolves so too do the police and healthcare systems that serve them. The police and healthcare systems have frequently been the focus of many reform efforts. These reforms have typically been aimed at improving what the systems do and how they do it (Willis,

2014). The ways in which the police and healthcare system approach their roles has changed dramatically since their inception. Sometimes the changes in organizational philosophy can be attributed to financial and political reasons. Other times they occur for social reasons, such as deinstitutionalization contributing to increased calls for police assistance and more mentally ill patients presenting to EDs (Boschma & Groening, 2010; Hollander et al., 2012; Lee et al., 2015; McKenna, Furness, Oakes, & Brown, 2015). These changes have required both the police and the healthcare system to readjust their approach to responding to MH cases through innovation.

As illustrated above, both services have very different approaches to mental illness and individuals in MH crisis. However, both services have to work together to assist persons in MH crisis to receive needed help and treatment. The differences in philosophies can be attributed to the ways in which both the police and the hospital services view mental illness and in turn how they envision their roles in managing mental illness. Specifically, the police service has historically viewed mental illness and their associated role from a crime prevention and public safety perspective. In contrast, the hospital service views mental illness from a health standpoint, being focused on the overall wellbeing of the individual and the management and suppression of symptoms. Both organizations have extended, complicated histories that have shaped their perception and response towards MH.

Police Services Philosophy

The philosophy behind policing has continually been expanded and redefined since policing first began. Police are typically seen as an organization designed to combat crime and disorder (Dale, 1994). However, this perception of the role of the police is very limiting. Police are continually being relied upon for services that are outside of their traditional role of crime control. Typically, the roles and responsibilities of the police fall into three main categories:

crime control, order maintenance and service (Griffith, 2011). Crime control includes activities involved with apprehending criminals. Order maintenance includes any measures used to keep the peace, and service comprises activities that provide assistance to citizens. The service role of the police has continued to expand and grow. An area of expansion regarding the service role is in relation to PIC in the community. This service role derives from the notion of *parens patriae* or the state's paternalistic authority dictating protection for citizens with disabilities, who cannot care for themselves (Lamb et al., 2002, p.1). The purpose of granting authority to police services for the care and control of mental illness arose from the idea that some individuals, due to their mental health condition, are unable to make capable decisions, including the decision to voluntarily seek treatment (Grainne, 2005). The police have a duty of care to protect from reasonable and foreseeable risk. This meaning that as first responders they are charged with the task to protect the public from reasonable and foreseeable threats of harm. The police officers' duty of care is intertwined with their paternalistic authority, especially when it comes to PIC in the community. Police officers must operate at the nexus of two different spectrums, one of law enforcement and one of more compassionate care.

The police are continually being relied upon to promote public safety. As part of their philosophy of community policing, police services are attempting to foster closer partnerships with communities. Community policing is based on the assumption that the police should work with the community to solve problems that generate repeated calls for service (Willis, 2014). Community policing consists of three main elements: community partnerships, organizational transformation and problem-solving (Willis, 2014). The definition of community policing tends to be quite broad and considered to be more of a philosophical approach. The US Department of Justice (2014) has defined community policing as,

> a philosophy that promotes organizational strategies that support the systematic use of partnerships and problem solving techniques to proactively address the immediate conditions that give rise to public safety issues such as crime, social disorder, and fear of crime (p.2).

Community policing has continued to dominate the policing agenda in Canada, the US and around the world (Cordner, 2014). Community policing is a philosophy that requires police services to create significant and fundamental organizational change (Seagrave, 1996). Seagrave (1996) offers another definition of community policing; "a recognition and acceptance of the community in influencing the philosophy, management and delivery of police services" (p. 5-6). Community policing creates better linkages between the police and the community and incorporates an expanded police role in society. Thus early policing in Canada evolved from overseeing crime and order maintenance to an expanded role that includes the social welfare of the community under the philosophy of community policing. As stated by Lamin and Teboh (2016), "community policing is a negotiation of contracts between community partners and police departments (p.3). Through this approach the police are working with community partners to assist people with a wide array of problems and social conditions. As such the police must understand community problems and be able to effectively respond to them.

A fundamental aspect of policing is that of answering calls for service quickly and problem solving. Maintaining a visible presence in the community and responding to calls promptly was associated with a reduction in crime (Willis, 2014). Problem solving also ensures that the problem is dealt with so that the police service does not have to deal with it again. These two aspects are driven from the overarching authoritative philosophy of policing that is built upon power. This meaning that police hold positions of authority and therefore shape the

narrative of what is deviant or in need of control within a jurisdiction. With changes in crime and technology have come changes in the police service and the communities they patrol. Police leadership is expected to create an organization that can effectively prevent as well as investigate crime (Flynn & Herrington, 2015).

As police roles have evolved beyond crime control to also encompass social welfare, the question of police liability has come into question. Liability issues may be more prevalent in calls in which physical use of force is used by officers, or in cases that significantly affect personal and public safety. Concerns about liability refer to the extent to which the officer or the organization as a whole are responsible for an act or omission of responsibility. For example, police services can face liability and criminal charges for their involvement in fatal encounters with citizens. From 2000 to 2017 more than 460 people died in encounters with the police (Nicholson & Marcoux, 2018). Almost half (47%) of these 460 individuals suffered from MH issues. In response to the rise in calls for service and growing liability concerns, police services can, at times, exercise too much caution during MH calls, in order to guard against liability claims (Oliva, Morgan, & Compton, 2010). The philosophy of policing, therefore, is shaped by concerns for public safety, law enforcement and responsibility.

As part of their expanded philosophy, police are responding to a broader range of public safety concerns. Their roles and responsibilities now transcend many different aspects of the community. Due to the vast differences in roles and functions of the police it remains a challenge for police to define their occupational status. Three key ideas remain central to the understanding of the police's roles and functions in a community. These three principles are: duty of care, protect and serve, and promote public safety; all of which undergird the various tasks and roles that the police perform on a daily basis. The role of the police continues to change since the

Police Services Act was enacted in 1990. Significant influences behind these changes are technology and increased interactions with vulnerable citizens. Notably, public expectations and accountability have changed the nature of policing and the role of the police officer.

Hospital Services Philosophy

Changes in healthcare commonly occur due to policy, need and innovation (Canadian Institute for Health Information, 2009). Tensions between what is possible and what is affordable are inevitable. Canada's healthcare system took shape in the 1950s and 1960s and was founded on the principles of universality, accessibility, comprehensiveness, portability and public administration (Lewis, Donaldson, Mitton, & Currie, 2001). The Canadian healthcare system, Medicare, is a government funded universal health insurance program established by legislation passed in 1957,1966 and 1984 (Canadian Museum of History, 2010). Some of the common goals and objectives of the health care systems in Canada are: improved access to primary care service, better coordination and integration of care, expansion of team-based approaches to clinical care, improved quality/ appropriateness of care, and greater emphasis on patient engagement (Hutchinson et al., 2011). At the core of public health is to promote health and to prevent disease and injury (Rutty & Sullivan, 2010).

The philosophy of care is a common thread among professions within healthcare. The responsibilities and roles of nurses and others in the healthcare profession are patient-focused. Health care professionals are dedicating themselves to meeting the needs of individuals utilizing healthcare services (Sgro & Happell, 2006). Healthcare professionals provide person-centered care and treatment to meet the physical, psychological, social, mental and spiritual needs. Person-centered care has been defined as;

> seeing the person as a unique individual taking into account their expectations and preferences and responding in a flexible manner through engagement built on empathy and trust which forms the basis of the nurse-patient therapeutic relationship (Thomas, 2017, p.7).

Emergency medicine is really about care of illnesses requiring immediate medical attention, and as such the goal of an ED is to stabilize a critically ill person, as opposed to treating a mental illness.

Disconnect in Approach

Both the police and the ED staff have a duty of care incorporated within their roles, responsibilities and philosophy. The police have a duty of care to protect the people in the community whereas the ED staff have a duty of care to protect the patients and others who attend/work in the hospital. In this sense, both the police and the ED staff have a duty of care that overlaps during a MHA apprehension. The police are protecting the public and the individual in crisis by bringing them to the ED. On the other hand, the ED is also protecting the individual and the community by admitting them or treating them in the ED. However, within EDs there is a lack of consensus between police and ED staff in relation to how they perceive their roles and responsibilities in managing MH crisis situations (Hoffman et al., 2016). For example, police and the ED staff have significant variations in how they approach and view mental disorders (Hoffman et al., 2016). This in turn impacts how the police communicate their reasoning behind apprehension to the triage nurses. The police tend to focus on the potential for harm to self or others, due to the underlying premise of their legislative authorities; whereas triage nurses focus on the length of time a patient can safely remain in the ED before being seen by a physician rather than focusing on assessing the nature and severity of a mental disorder (Hoffman et al.,

2016). This variation in approaches to MH crisis is exemplified in that police officers's reasons for a MHA apprehension differ from reasons used by the ED to subsequently admit (or not admit) the individual to hospital (Hoffman et al., 2016). Moreover, an Ontario study determined that out of all the MHA apprehensions within a medium sized city, only 59.2% resulted in the PMI being admitted under a Form 1, with the remaining 40.8% being released from both hospital and police care (Shore & Lavoie, 2018), resulting in a poor use of time and resources by police waiting in an ER for a person who ultimately did not meet the criteria for emergency care, and potentially negative and stigmatizing experience for the apprehended citizen. This discrepancy between police and EDs represent a significant problem considering that the criteria for a MHA apprehension is very similar to the criteria for a psychiatric assessment. There are likely other factors that account for these discrepancies, such as limited hospital resources and bed capacity, police overestimation of the need for emergency psychiatric assessment, or underestimation of the need for treatment by hospital physicians. Even though the police and the ED staff both have a duty to care during MHA apprehensions, their approach to mental health and in turn their definition of risk differs between the two social worlds.

New Avenues for Collaboration: The Rise of MOUs

Due to a lack of consensus between the police service and the ED, new solutions to bridge the gap between police and health services have been implemented. Some of these collaboration models are based within the MH system, while others are based in the police system as well as within the community itself (CMHA, 2005). In Canada there are four types of collaborative partnerships that are the most common in responding to MH calls placed to the police service (Cotton & Coleman, 2013). The first is allocating a dedicated, expertly trained MH police officer to respond to MH calls. The second model comprises a police service that has

implemented a mobile crisis team. Here, a police officer and MH worker respond together as a unit to MH calls. A third type of response used is a comprehensive police response where all police officers in the department receive advanced MH training and crisis intervention team (CIT) training. The last type of model is the development of joint protocols between the police services and organizations that provide MH services in the community. This model is based on a collaborative formal agreement between the police and other community services to provide diversion options to officers. Joint protocols also provide the signed parties with an outline of their roles and responsibilities when responding to persons with mental illness (Cotton & Coleman, 2013). This latter response model is of interest to the present study.

Based on an earlier study conducted by Cotton (2004), only a small minority of Canadian police services had formal joint strategies in place with health services. Durbin and colleagues (2010) found that out of 37 municipal police services in Ontario 62% of services had mobile MH team agreements, half adopted a police MH joint response program, and 30% had designated a MH officer. The number of police services in Ontario with formal agreements in place were significantly less with 35% having agreements with hospitals, 30% with community crisis teams, and 19% with withdrawal management services. Despite protocols being in place, a minimal amount of research has been conducted on the content of these agreements, and whether the challenges to cross service interactions have been addressed.

In an attempt to reduce lengthy wait times in EDs during apprehensions, written protocols were implemented by several Ontario police services. According to the Human Services Justice Coordinating Committee (HSJCC) (2013b), these protocols resulted in the reduction of ED wait times for three different police services under study in Ontario. The Niagara Regional Police average wait time of 242 minutes in 2011 decreased to 103 minutes in 2013 after a written

protocol was in place. Similarly, the Hamilton Police Service and Waterloo Regional Police Service average wait times of 122 minutes and 119 minutes respectively reduced post implementation of a joint protocol (75 minutes, 68 minutes respectively). Further, when a protocol was implemented in the United Counties of Prescott and Russell, wait times were reduced from an average of five to eight hours prior to implementation to an average of two hours after implementation (HSJCC, 2013b). An objective of these written protocols were to define the working relationships between police services and EDs to increase collaboration, communication and effective and prompt treatment for individuals with mental illness (HSJCC, 2013a). However, minimal research has examined how these protocols define these relationships, or shape on-the-ground collaboration between services in the treatment of people in MH crisis.

Chapter Two: Theoretical Framework

Social Worlds Theory

Given the differences in philosophies between police and hospital services as outlined in the previous chapter, the present study used a Social Worlds/Arena Theory (Strauss, 1978) as a framework to approach the nature of joint protocols between the two services. This theory facilitates the interpretation of how the collaborative work between the police and hospitals are set out in joint agreements between them. Social worlds/ arena theory is a sociological theory used to make sense of how "actors, events, practices and formal organizations can coalesce into a meaningful and interactionally important unit of social organization for participants" (Unruh, 1980, p. 271). Social worlds theory can be used to examine how people organize themselves and make meaning and then act on those meanings (Clarke, 1991). Social worlds refer to "groups with shared commitments to certain activities, sharing resources of many kinds to achieve their goals, and building shared ideologies about how to go about their business" (Clarke, 1991, p. 131). They are universes of discourses through which people organize their social life (Clarke & Star, 2008). For example, individuals within a social world will share and create new knowledge while interacting among one another. The notion of a social world refers to a form of social organization that "cannot accurately be delineated by spatial, territorial, formal or membership boundaries" (Unruh, 1980, p.271). Rather the boundaries of social worlds are determined by communication and interaction that cross over and blend through traditional formal delineations of organization.

Each social world tends to have at least one primary activity and a site where this activity will occur (Clark, 1991). For instance, the social world of policing is primarily focused on officers' role of law enforcement and protecting the public within their jurisdiction. Alternatively, the social world of ED staff revolves around their primary activity of patient care

and treating illnesses within the ED. Notably, members of social worlds are also associated with numerous other social worlds, such as other professional groups, family groups and friend groups. This creates a mixture of numerous shared ideologies that guide how members interpret their roles, understandings and definitions of a situation and in turn how they will go about their activities (Sanders, 2007, 2014). It can be argued that the police service and ED staff represent distinct social worlds as illustrated through their distinctive language, technology and cultural philosophy towards how they perceive their roles and responsibilities.

Intersections between social worlds create a context in which resources and information flow between work settings to develop common ideologies and discourses. For example, during a MHA apprehension the social worlds of the police service and ED staff intersect within the arena of the ED in order to accomplish their collective goals of providing appropriate care and treatment for the individual in crisis. The two social worlds must work together to accomplish the task of transferring the care of the individual from the officers to the ED staff. What is of interest is how these differing social worlds negotiate roles, definitions, and elements of importance in reaching this collective goal.

Social Arenas

When numerous social worlds intersect on a common problem, goal, or viewpoint the intersection between social worlds can then be referred to as an arena (Clarke & Star, 2008). In an arena, the analytic focus is on the collective actions such as the social processes occurring among the actors (Clarke, 1991). The concept of an arena in this sense is used to describe:

> a sphere of action or a social space where negotiation takes place. An arena brings together people with a common concern but representing different aspirations and perspectives. Arenas are composed of the social worlds through which individuals

> act, most visibly though the organizations that form within these social worlds. (Wiener, 2000, S61)

When social worlds come together within this sphere of action, their activities are intersecting and they begin to foster cooperative and collective action (Sanders, 2007). Within this arena, highly technical information, skills and expertise are also being shared between social worlds from diverse backgrounds. An arena, therefore, brings together the often complex activities and intersections of social worlds that have diverse definitions and ideological positions on certain situations which can make collective action difficult at times.

Boundary Objects

While social worlds come together in an arena under the commitment of collective action, they are also characterized by, "conflict, contention, and dissatisfaction often about what to do and how to do it" (Clarke, 1991, p. 134). Through communication, the actors will often adapt, generate or adopt ideologies about how their work should be done and debate their own and others roles and responsibilities. In an effort to better accomplish these tasks and to overcome boundaries, social worlds have developed "artifacts"- such as boundary objects (Star & Griesmer, 1989), to help work through and across the boundaries of social worlds (Star & Griesmer, 1989). These boundary objects can be, "simultaneously concrete and abstract, specific and general, conventionalized and customized, they are often internally heterogeneous" (Star & Griesemer, 1989, p. 408). Depending on the situation, the boundary object can be as simple as a set of common goals or as complex as a standard operating procedure or classification system. Boundary objects have the ability to, "enhance the capacity of an idea, theory or practice to translate across culturally defined boundaries, for example, between communities of knowledge or practice" (Fox, 2011 p. 71).

The idea of a boundary object was first introduced to explain collaboration within scientific communities and a natural history museum (Star, 1989; Star & Griesmer, 1989; Fox, 2011). In this situation the boundary objects that facilitated collaboration were specimens, field notes, museums and maps of particular territories. These objects acted as boundary objects because they are information that is used in different ways by different communities but remain rigid enough to maintain integrity. These objects functioned as a boundary object because they allowed various actors (such as university administration, amateur naturalists) to organize around shared goals and objectives for an extended period of time despite their varying points of view. By working around maps, field notes and museums the actors succeeded in coming to an understanding while maintaining multiple points of view. Each group of actors maintained their identity and goals while being able to work together with others. Boundary objects "act as anchors or bridges" (Star & Griesmer, 1989, p. 414).

A boundary object was defined by Fox (2011) as, "any element that has the capacity to be understood by actors in more than one setting" (p. 71/72). Within the situation of the natural history museum, the boundary object allowed the different groups to share meaning as well as to learn about each other's perspectives. From this, Carlile (2002) further developed the concept of boundary objects by suggesting that they,

> establish a shared syntax or language within which individuals in different communities can represent their knowledge; provide a means for these individuals to communicate across boundaries their concerns or questions about a practice or idea; and empower members of different communities to transform their own knowledge in the light of the innovation or idea (Fox, 2011, p. 72).

As stated by Fox (2011), “these aspects of boundary objects effectively enable communities of practice or knowledge that are normally separated by their perspectives to establish a working relationship around a particular issue, idea or innovative practice” (p. 72).

The idea of a boundary object being fluid and yet identifiable has tremendous advantages to social worlds who are experiencing problems with collaboration. Take for example the use of a map as a boundary object in the research by Star and Griesmer (1989). The map is fluid enough that boundaries can be changed or adjusted if needed. Yet it is structured enough that it remains identifiable to other social worlds that may not have created it. This structured yet malleable aspects of boundary objects are what makes them adaptable for multiple social worlds. Boundary objects fulfill the purpose of bridging the gap between intersecting practices such as those found in the social worlds of the police and hospital ED staff (Akkerman & Bakker, 2011; Star & Griesemer, 1989). These boundary objects are used by the social worlds to articulate meaning between the potentially diverse groups and address multiple perspectives. Boundary objects act as a means of solving the problems that arise from heterogeneous work activities because;

> they are both plastic enough to adapt to local needs and constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use and become strongly structured in individual site-use (Bowker & Star, 2000, p. 297).

Social worlds are comprised of differing actors, technologies, organizational policies and procedures and they are culturally defined in their approach to social and environmental contexts. The police, and the work that they do, is defined around their culture of masculinity and duty to protect and maintain order (Flynn & Herrington, 2015; Prokos & Padavic, 2002;

Willis, 2014). In contrast, ER staff approach their work with a philosophy of care and thus are concerned with patient safety and privacy rights (Hutchinson et al., 2011; Rutty & Sullivan, 2010; Sgro & Happell, 2006). Having these two culturally different social worlds intersecting in an arena creates challenges in determining who has the right to define roles and responsibilities encompassed within a boundary object.

In the case of MHA apprehensions, a distinctive boundary object is the Memorandum of Understandings (MOUs) between police and hospital services. The development of these boundary objects needs to take the discourse and cultural components of each social world into account while ensuring communication between the social worlds are enhanced. Because of the impact of these boundary objects, it is extremely important to members of each social world to ensure that their own viewpoints and needs are incorporated in the creation process. This struggle in creating boundary objects that are duly representative of each social world is paradoxical given that the social worlds are attempting to collaborate and maintain a relationship. A boundary object that is truly representative and transcends the boundaries of each social world needs to create a form of dialogue that generates negotiation, communication and translation. The study of boundary objects, such as MOUs, provides an opportunity to analyze what diverse social worlds negotiate roles, responsibilities and areas of perceived importance within an arena in which they must collaborate.

Chapter Three: Methods

The main purpose of this study was to determine how organizational policies have shaped the way police and ED services in Ontario work together when managing people in mental health crisis (PIC) in the specific context of a MHA apprehension. This qualitative study considered MOUs between these two services as boundary objects worthy of investigation because they provide insight into how each divergent social world negotiates their working collaboration. The study was designed to address the following research questions:

1. What policies have been put in place in MOUs to govern on-the-ground collaboration between hospital ER and police services when managing PIC transported by police to the ED?
2. How do MOUs commonly describe roles and responsibilities of various actors/services?
3. What are the common and recurrent themes across MOUs, and are these themes reflective of the unique needs, challenges, and areas of importance for each social world?

To explore this collaborative working relationship, this study involved the collection and thematic and descriptive analysis of *N*= 21 official MOUs between Ontario police services and Ontario hospital EDs concerning the management of MHA apprehensions. A thematic analysis was conducted to identify shared purposes, procedures and goals along with common themes across all MOUs in the dataset.

Procedure

The sampling frame for the study included existing MOUs strictly between police and Schedule 1 hospital services in the province of Ontario that addressed adults in MH crisis. Agreements were initially gathered with the guidance of a HSJCC report (2003), entitled "Strategies for Implementing Effective Police-Emergency Department Protocols in Ontario".

The report published 19 agreements that addressed persons in MH crisis, 14 of which met the inclusion criteria for the study. Several of the agreements from the report were not included in the final dataset because they were a) children's hospitals, b) an agreement between a hospital and community services, or c) an agreement between police and community services.

Additional agreements were found using a Google search with the search term phrases of: police and hospital agreement, police mental health agreement, [city] mental health agreement, memorandum of understanding + police in Ontario, memorandum of agreement, memorandum of cooperation. One MOU was obtained through a previous contact with a police service. A freedom of information request was completed and processed through the Brantford Police Service to obtain a copy of their MOU for inclusion within the dataset. Finally, a list of Ontario Schedule 1 hospitals obtained from the Ontario Ministry of Health and Long Term Care was used to guide an additional probe for MOUs. The list contained a total of 69 Schedule 1 facilities, all but 5 of the facilities met the inclusion criteria for this study. Of these 64 locations, 58 emails were sent requesting the MOU for inclusion in the study from services from which MOUs had not yet been located. A total of 22 hospitals responded to my original email resulting in a response rate of 38%. Of the hospitals that responded, 4 forwarded their agreements to me. Other hospitals responded requesting more information for the project to best determine their response and/or position on this study. For example, some hospitals required a more specific definition of a MOU in addition to an explanation about the objectives of the study. Three hospitals responded by requesting a freedom of information request to receive a copy of the MOU. Finally, 6 hospitals provided an overview of their current state in regards to an agreement with police. For example, a hospital would identify if they had an agreement in place, were

working towards completing one, or their hospital did not have any sort of agreement or relationship with the police due to the nature of their hospital.

Sample

The final dataset contained a total of *N*=21 MOUs from across multiple jurisdictions in Ontario. Ten MOUs in the dataset contained emergency medical services, community MH services and addiction services. The MOUs included in the final data set were published between 2001 and 2017. The sampled MOUs within the dataset guided the working relationships between police, hospitals and in some cases community MH services in a number of diverse communities across municipalities, townships and cities throughout Ontario. The size of these communities ranged immensely from a population of around 1.3 million to less than 1000. The average population of the communities bound by the MOUs was 190,499 (*SD*= 254, 911).

Constructivist Grounded Theory

Constructivist grounded theorizing was used as a tool to help guide and shape the data collection and the subsequent theorization of the data. The principles and guidelines set forth and proposed within this method provide the opportunity for the development of an analysis from the conceptualization of the data rather than imposing a theoretical framework on them (Charmaz, 2008). The principles and methods of constructivist grounded theory rely upon an emergent framework whereby social scientists study research problems in the empirical world and build upon inductive understanding as events unfold and knowledge accumulates. This research approach provides for the opportunity to explore unanticipated directions of inquiry that may arise. The fundamental principles of the constructivist grounded theory method include: "(1) minimizing preconceived ideas about the research problem and the data, (2) using simultaneous data collection and analysis to inform each other, (3) remaining open to varied explanations and

understandings of the data, and (4) focusing data analysis to construct middle-range theories" (Charmaz, 2008, p.155).

Constructivist grounded theory is a reflexive approach that relies on ongoing comparative analysis of data while drawing on existing theory to identify relevant themes. Through this approach, the process of data collection and analysis relied upon emergent themes arising (Charmaz, 2014). The emergent nature and flexible guidelines of constructivist grounded theory provided for an analytic understanding of how collaboration is understood and defined within organizational practices and policies when police and hospital staff work together during a MHA apprehension. With prior research within this area of inquiry mainly focusing on the experiences and perceptions of police, the present study's research focus on MOUs as boundary objects between police and ED staff is novel and unexplored. Given the limited research on this research topic, a grounded constructivist approach was deemed to be a suitable method to explore the research questions.

MOUs: A Descriptive Analysis

Sampled MOUs were coded and analyzed to reveal common themes, purposes, procedures and goals. NVivo version 11 for Mac was used to facilitate coding and subsequent analysis of the data. Throughout the analysis, I aimed to create and maintain a rich descriptive representation of the specific context contained within the MOUs.

Coding & Analysis

After I had completed a descriptive analysis of the MOUs, and acquired a more in-depth understanding of their described organizational purpose, I then conducted a more in-depth process of coding and analysis using a constructivist grounded theory framework (Charmaz 2006). Coding defines what is happening in the data and begins to shape what it means. Within

constructivist grounded theory there are two distinct stages of coding: initial coding and focused coding. Initial coding involves the naming of each word, line, or segment of the data, whereas focused coding is a more selective phase that uses the most significant or frequent initial codes to sort, synthesize, integrate and organize large amounts of data (Charmaz, 2006). The first stage of analysis was through the use of initial coding. Initial coding was conducted by closely reading the MOUs while remaining open to all possible theoretical directions. Two MOUs were coded through the use of line by line coding in an effort to remain close to the data and to see actions in each segment of data rather than applying pre-existing categories to the data. The second stage of analysis was through the use of focused coding. The focused codes were developed with the guidance of common themes among the existing literature and the identification of common themes found through the line by line coding. This stage of the analysis provided for a more directed analytic focus early in the research process without going too far down one theoretical path. Key themes that arose across the MOUs included: collaboration, roles and responsibilities, and safety. The following results chapters will describe and unpack these three main themes and place them in context of existing research.

Reasons Behind the Creation of MOUs

Past experiences with individuals in MH crisis has helped to shape and inform subsequent interactions between hospitals and police services. With greater awareness and insight into how to safely and efficiently handle interactions with persons in crisis more can be done to ensure that PMI are being cared for by the appropriate services. A lack of collaborative action between services inhibits the care and treatment afforded to PIC. As exemplified by an increase in calls for collaboration between services and discussed within the sampled MOUs,

> a collaborative response between service providers and first responders represents best

practice and as such, is an effective way of addressing issues and meeting the needs of people who seem to be in emotional distress or experiencing symptoms of a serious mental illness or addictions issue who come into contact with police (Timmins Police Service, CMHA Cochrane Timiskaming Branch, & South Cochrane Addictions Service, 2011, p. 2)

As a result of the downsizing of mental health facilities, police services and health services are being more heavily relied upon to respond to situations involving persons in mental health crisis. The concern is that in these situations,

> adverse and negative hospital and police interaction contribute against the desired goal for individuals to receive the support and resources necessary to maintain positive community interaction and contributions. Unfortunately, left untreated or ill-managed, countless individuals who suffer from mental illness experience crisis and an exacerbation of symptoms that result in frequent hospital visits (Hotel-Dieu Grace Hospital et al., 2012, p. 2).

With the recognition of these unfortunate circumstances for persons experiencing a mental health crisis, one of the responses by police services and hospitals was to collaboratively create MOUs.

MOUs were created in order to more clearly outline and "define the working relationship between the partners involved with people showing signs of acute distress" in situations involving a MHA apprehension (United Counties of Prescott and Russell, 2003, p. 2). They "serve to guide ongoing collaboration for an integrated, effective and safe response to emergency and urgent mental health situations that arise (Stratford General Hospital, Perth County Emergency Medical Services, & Stratford Police Service, 2014, p. 3). By defining the working relationship, the documents outline the specific commitments, conditions, procedures and regulations agreed to by all parties to meet the needs of their common clients. These MOUs

clearly outline; “which services the protocol participants can provide and receive from each other” (Cornwall Community Police Services, Ontario Provincial Police, Cornwall Community Hospital, Glengarry Memorial Hospital, & Cornwall S.D. & G. EMS, 2005, p. 3). These MOUs created a formal agreement for cooperation and professional liaison between two distinct social worlds that governs their responsibilities and the safety of patients, the public, medical staff and police (Dryden Ontario Provincial Police, Dryden Police Service, Northwest EMS, & Dryden Regional Health Centre, 2012). MOUs serve to connect the social worlds of police and ED staff by creating a foundation upon which future negotiations and partnerships can be made.

Chapter Four: Key Legislation Guiding Mental Health Act Apprehensions

This chapter seeks to answer my first research question: What policies have been put in place in MOUs to govern on-the-ground collaboration between hospital ER and police services when managing PIC transported by police to the ED? To answer this question an examination of the key pieces of legislation mentioned in the MOUs will be conducted. The key pieces of legislation that will be discussed in this chapter are: the Ontario Mental Health Act, Municipal Freedom of Information and Protection of Privacy Act, the Freedom of Information and Protection of Privacy Act and the Personal Health Information Protection Act. In what follows, the legislation will be examined with attention being placed on any sections relevant to MHA apprehensions.

Government Policies that Shaped the MOUs

Upon analyzing the dataset, it was notable that the Ontario Mental Health Act governs the MOUs. The MHA is an important component of these MOUs as it shapes the parties' understanding of their responsibilities and powers during MHA apprehensions. The MHA grants the police service the authority to apprehend individuals experiencing a mental health crisis. Section 17 of the MHA states that,

> 17. Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,
>
> (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
>
> (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself, and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician (Mental Health Act, RSO 1990, c. M. 7).

Section 15 of the MHA governs the assessment by the physician after the police have transported the individual to the ED:

15. (1) Where a physician examines a person and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself, and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

> (f) serious physical impairment of the person, the physician may make application in the prescribed form for a psychiatric assessment of the person (Mental Health Act, RSO 1990, c. M. 7).

Some of the MOUs specifically stated what sections of the MHA were relevant for their MOU. For example, the Rainy River MOU had a section titled legislation under which they outlined the relevant sections of the MHA,

> Legislation
>
> Section 17 of the Mental Health Act states:
>
> > Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,
> >
> > (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
> >
> > (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
> >
> > (c) has shown or is showing a lack of competence to care for himself or herself,
> >
> > and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
> >
> > (d) serious bodily harm to the person;
> >
> > (e) serious bodily harm to another person; or
> >
> > (f) serious physical impairment of the person, and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician. 2000, c. 9, s. 5.

and

> Section 18 of the Mental Health Act states:
>
> > An examination under section 16 or section 17 shall be conducted by a physician forthwith after receipt of the person at the place of examination and where practicable the place shall be a psychiatric facility or other health facility. R.S.O. 1990, c. M.7, s. 18. (Rainy River District OPP, Riverside Health Care Facilities Inc, & Rainy River District Social Services Administration Board, 2012, p.2)

Rather than just referencing the entire MHA, the MOUs reference just the applicable sections.

Another key piece of legislation referenced in the MOUs was the various privacy legislation in Ontario. For example,

> The Parties shall each apply their respective standards and/or policies and applicable legislation to the administration, technical and physical safeguarding of information exchanged pursuant to the administration of COAST and the performance of this MOU, including but not limited to: a) As set out in Schedule 2, paragraph 3 for CCC; b) As set out in Schedule 1, paragraph 5 for OPP; c) the Personal Health Information Protection Act ("PHIPA"); d) the Freedom of Information and Protection of Privacy Act ("FIPPA"); e) the Police Services Act ("PSA"); f) any other applicable provincial legislation (Hotel-Dieu Grace Hospital et al., 2012, p. 4).

This MOU explicitly provided examples of legislation that impacts the collaboration between the parties. Of importance within this statement is the reference to PHIPPA and FIPPA. These privacy legislations govern the collaboration between parties when managing PIC because they limit the use, collection and disclosure of personal information. Additionally, Section 35 of the MHA also provides limitations on what kinds of personal information can be shared and with whom. Specifically, this section governs the collection, use and disclosure of personal health information of patients (individuals who have been detained in a psychiatric facility. The privacy legislation offers larger constraints and protection for people's personal information. The broader privacy legislation governing the MOUs were the Municipal Freedom of Information and Protection of Privacy Act (1990), the Freedom of Information and Protection of Privacy Act (1990) and the Personal Health Information Protection Act (2004). The MFIPPA governs the confidential information collected by all municipal corporations, including a metropolitan district or regional municipality as well as municipal police services. In contrast, FIPPA governs the confidential information collected by all ministries of the Ontario Government and any board, commission, agency, corporation or other body designated as an "institution" in the regulations.

Lastly the PHIPA governs how an individual's personal health information is collected, used, and disclosed by personal health custodians, such as ED staff within the province of Ontario. The purposes of MFIPPA and the FIPPA are similar with both stating,

1. The purposes of this Act are,

    (a) to provide a right of access to information under the control of institutions in accordance with the principles that,

        (i) information should be available to the public,

        (ii) necessary exemptions from the right of access should be limited and specific, and

        (iii) decisions on the disclosure of government information should be reviewed independently of government; and

    (b) to protect the privacy of individuals with respect to personal information about themselves held by institutions and to provide individuals with a right of access to that information (Freedom of Information and Protection of Privacy Act, RSO 1990, c. F .31; Municipal Freedom of Information and Protection of Privacy Act, RSO 1990, c. M. 56)

The purposes of the PHIPA are outlined within the act as follows:

1. The purposes of this Act are,

    (a) to establish rules for the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care;

> (b) to provide individuals with a right of access to personal health information about themselves, subject to limited and specific exceptions set out in this Act;
>
> (c) to provide individuals with a right to require the correction or amendment of personal health information about themselves, subject to limited and specific exceptions set out in this Act;
>
> (d) to provide for independent review and resolution of complaints with respect to personal health information; and
>
> (e) to provide effective remedies for contraventions of this Act. (Personal Health Information Protection Act, SO 2004, c. 3, Sched. A)

With so many parties working together during a mental health crisis, privacy becomes a paramount concern due to the highly sensitive nature of health information. Maintaining a person's dignity and privacy is a goal of these MOUs and in order to do that legislation such as the privacy acts needs to govern the collaborative relationship during MHA apprehensions. The MHA governs how the parties will perform their roles and responsibilities whereas the privacy legislation governs how the parties will handle any information obtained through their roles and responsibilities. Both the MHA and the privacy legislation govern the collaboration between parties during a MH crisis because they provide guidelines that the parties must follow in the course of their roles and responsibilities.

Interestingly, the MOUs did not specify a section within the privacy legislation on which they would rely. This omission is notable because as demonstrated above, the MOUs clearly refer to specific sections of the MHA such as section 17 and 33 regarding their responsibilities. In contrast, when it comes to privacy legislation, the MOUs simply reference the entire document.

Chapter Five: Results of MOU Thematic Analysis

A thematic analysis using constructivist grounded theory was conducted to identify dominant and recurrent themes among the sampled MOUs. Three main themes were identified: roles and responsibilities, safety, and collaboration. The following chapter discusses the results of the thematic analysis that was conducted. The first theme found was that of roles and responsibilities. This theme will provide an overview of how the MOUs outlined their key roles and responsibilities, including how they divided up the roles among providers in turn demonstrating which roles and responsibilities are the purview of each provider. Secondly the theme of safety will be discussed. This theme provides an overview of what safety encompasses within the MOUs, as well as how safety has been understood and divided up among the key providers. Lastly the theme of collaboration will be discussed, including what the concept means to the parties of the protocol and how it is intended to unfold within practice.

Theme 1: Roles and Responsibilities

In order for social worlds to effectively work together, information, objects and concepts must be able to flow through the network of participating social worlds. A launching point for social worlds to commence work together and increase information flow across the boundaries is to clearly outline the roles and responsibilities of all key actors. As discussed in the previous chapter, findings indicated that the overall goal of these agreements was to create an environment that enabled more collaboration between services during a MHA apprehension. Previous interactions between these two diverse groups had been cited as problematic for those involved (Carter et al., 2012; Coleman & Cotton, 2010; Cotton & Coleman, 2010; Hoffman et al., 2016; Hollander et al., 2012; Poland et al., 2005). A contributing factor towards the apparent ineffective working relationship between police and hospital services relates to the lack of clear

direction concerning which service should be considered the appropriate response to PIC. It is encouraging then that, a major theme within the MOUs was identifying specific roles and responsibilities of involved agencies during a MHA apprehension. A description of the overall roles and responsibilities as described within the MOU is discussed below. Following this, the main trends that arose from these roles and responsibilities are examined as well as their significance towards MOUs as a boundary object in the arena of MHA apprehensions.

Police Roles and Responsibilities

From the beginning of the analysis it was clear that the sampled MOU created a clear distinction between the types of roles that should be under the responsibility of either the police or the community services. Across the MOUs, the primary role of the police service was the provision of security for potentially problematic, high-risk patients that may also be dealing with concurrent substance abuse problem;

> if the patient is physically acting out, the police officer must ensure that the patient remains secured and supervised until hospital staff is prepared to assess and *treat* the patient. Police officers will *assist* hospital staff with security issues during this process, and check the patient for any weapons or sharps (Cornwall Community Police Services et al., 2005).

In this way the police service and health care system have negotiated that police officers main role is to manage potential threats posed by the apprehended individual, as well as provide information to ED staff regarding the events that precipitated the apprehension. This enforcement role is consistent with the vast majority of MOUs having provisions prioritizing the departure of police from hospital within a specific time frame to return to law enforcement duties [e.g, 30 to 60 minutes (Hamilton Police Services, n.d.); 30 to 120 minutes (Cornwall Community

Police services et al., 2005)]. Establishing this time frame highlights the importance the police service places on returning frontline officers promptly to the road to continue 'real' police work (Sanders & Condon, 2017). The general consensus among the MOUs was that the roles and responsibilities of the police centered on safety and security. Take for example these statements from MOUs within the data set:

> If the patient is physically acting out, the Police Officer must ensure that the patient remains secured and supervised until hospital staff is prepared to assess and treat the patient. Police officers will *assist* hospital staff with *security* issues during this process (Hamilton Police Services, n.d, page 1).

As required under the MHA, persons taken into custody must be transported to the nearest schedule 1 facility for an examination by a physician. A Schedule 1 facility is a public hospital or other health facility that has been designated by the Ministry of Health and Long Term Care to provide care, observation and treatment for patients experiencing mental health disorders. Where such resources were available, some MOUs underscored that police decision-making concerning apprehension and transportation of an individual was to be made in consultation with available mobile crisis teams or EMS personnel with specialized mental health knowledge (Stratford General Hospital et., 2014, p. 4). Transportation to hospital is an important element within the MOUs because it is the initiation of the responsibilities for the parties under the MOUs. Given resource strains, EDs are interested in stemming the number of people police transport to hospital for evaluation to only those that have a strong chance of being admitted for treatment.

In sum, the roles and responsibilities of the police as set forth in the MOUs is first and foremost ensuring the safety of individuals in the ED by securing and supervising an

apprehended individual until the hospital takes over custody or releases the person. The MOUs are reinforcing the law enforcement role of the police. The MOUs also placed officers as 'assisting' ED in managing patient care thereby giving the hierarchical role to the ED staff. Police are also responsible for decisions to apprehend and transport to hospital. Also of importance is how the description and perception of the police in the MOUs framed people in MH crisis as violent and a security threat. Therefore, ensuring that police have a role in ensuring the safety and managing risk during MHA apprehensions.

Hospital Roles and Responsibilities

The main provider of mental health services during a crisis or an apprehension is the hospital. Generally, MOUs framed the primary roles and responsibilities of ED staff as protecting the privacy of patients, determining the acuity level of patients and the level of care needed for patients. For example, the Cornwall MOU (2005) states:

> On arrival at the hospital, the triage RN [will] assess the client's needs. The triage nurse will then advise the ED physician of the client's arrival (p. 10).

Another example from the Cornwall MOU demonstrates that once the patient has arrived to the ER their treatment and care will be monitored through hospital resources:

> The ER will work in cooperation with the psychiatric inpatient unit to ensure that those admitted patients that cannot be immediately transferred to this unit will be monitored through hospital resources (2005, p. 9).

Another key role identified within the MOUs is that of privacy. For example, the Essex MOU states:

> Each party shall take all reasonable steps to ensure that only COAST clinical staff, designated police officers and those permitted by law shall have access to

> any information exchanges in the course of the administration of COAST and that access is exclusively for the purposes of COAST (2012, p. 3).

Commonly, MOUs set out that the first step after a patient has been brought into the ED by police is:

> the nurse (usually the charge nurse) will triage the patient immediately upon arrival. The patient will be assessed and sent to the most appropriate location and be assigned an appropriate CTAS score (Cornwall Police Service and Cornwall Community Hospital, n.d, p.1).

In these circumstances the appropriate location would be a separate location from the general waiting room. In EDs, the general waiting room tends to be crowded, loud and not generally conducive to calming a person experiencing a mental health crisis. As such some hospitals have created separate rooms that offer a less stimulating (and stigmatizing) environment and more privacy for individuals in mental health crisis waiting to be seen by a physician. To best determine the appropriate CTAS score, ED staff were often required to engage in collecting information from multiple sources to form a comprehensive picture of the patient's mental health concerns and the reasons that brought them to the ED:

> During assessment by the Primary Nurse, Psychiatric Emergency Service, PES staff will begin their routine data collection process by interviewing the police, reviewing health records; attend to family/support members, etc (Hamilton Police Services, n.d, p. 2).

This highlights the importance of having multiple versions of information that can help inform the decision to admit or not. Information sharing is key to being able to make the right assessment during a MHA apprehension. A key phrase used among the MOUs to distinguish the

roles and responsibilities of the police and those of the health care system was the term ‘medical issue’. Consider the following quote from the Dryden MOU:

> Once the person is the subject of a Form 1 their condition is deemed to be a *medical issue* [emphasis mine]. It will subsequently become the responsibility of the health facility to monitor and supervise the patient. The health care facility is also responsible for arranging the transfer of the patient to a psychiatric facility. Attending health care professionals will conduct a risk assessment … to determine if police will be required for the security and transportation of an individual that is placed on a Form 1 (Dryden Ontario Provincial Police et al., 2012, p. 3).

This quote clearly demonstrates the differentiation between the roles and responsibilities of the police and the healthcare system. By defining a Form 1 apprehension as a medical issue, the individual falls under the purview of the healthcare system, who by implication holds the power to decide how the patient is supervised and transferred to care, including how and when police services devoted to safety and security are required. In addition, they also have control over the flow of information. Given that the arena of interacting social worlds in managing an apprehended person physically takes place in the ED, it is not surprising that the ultimate authority has been framed in MOUs to fall to ED personnel to coordinate the security role of police services and services for the patient.

Joint Responsibilities

Overall, MOUs described the joint responsibilities of all parties in order to uphold a collaborative agreement. Most of these responsibilities aligned with the idea of working together to produce positive outcomes for all involved services as well as the PIC subject to apprehension. For example, the Essex MOU explicitly stated that:

> each party is responsible for upholding the spirit of the MOU in relation to providing a better service to individuals in mental health crisis as well as the community at large (Hotel-Dieu Grace Hospital et al., 2012, p. 7).

A further example of this working relationship centers on recognizing the personnel resource demands placed on police services in their growing role in apprehending and transporting individuals to a Schedule 1 hospital, which at times are located far away, and results in pulling the officer off the road and unable to respond to other calls for police service within their patrol zone. Acknowledging the need for officers to promptly return to the road is illustrated in MOUs consistently specifying goals to complete transfer of care and to release police officers within a specified time frame. For example, the Peterborough Regional Health Centre and Ontario Provincial Police (2016) MOU stated that "[p]olice, ED/CRU staff, physicians, and security will all work collaboratively to expedite the transition of care within 30-90 minutes (p. 1). The Cornwall Community Police Services et al., (2005) MOU presented far more detailed responsibilities of both the police and the health care services during the transfer of custody, specifically around communication. Under the roles of the police the MOU stated that, "police will communicate regularly with the ER team leader or delegate about any delays in the transfer of responsibility to the inpatient psychiatric unit (Cornwall Community Police Services et al., 2005, p. 8). Cornwall's section on the responsibilities of the health care system stated:

> that the ER will work in cooperation with the psychiatric inpatient unit to ensure that those admitted patients that cannot be immediately transferred to this unit will be monitored through hospital resources. This will be done in order to expedite the transfer of custody of the patient from police to hospital unless a risk to the safety of staff or patient is identified that requires police stand by assistance. The ER Team Leader or delegate will communicate regularly with the police about timeframes for transfer to the inpatient psychiatric unit (Cornwall Community Police Services et al., 2005, p. 9).

Despite these efforts towards expediting the transfer of care, all of the sampled MOUs cautioned in some way that:

> [p]atients are seen in priority order when accompanied by police (versus "first in, first out" order); however, patients of higher acuity will be seen before patients of lower acuity according to Canadian Triage Assessment Scale (CTAS) scores (Brantford Police Service et al., 2015, p. 1; Lake of the Woods District Hospital, & Kenora Ontario Provincial Police, 2016, p. 3; Peterborough Regional Health Centre, & Ontario Provincial Police, 2016, p. 3).

In other words, despite recognizing the need to expedite processes, the ER must still prioritize patient care based on acuity. Explicitly stating the importance of acuity reduces the chances of police becoming frustrated during a transfer of care in which they must wait and retain custody of the PIC. Previous concerns related to the transfer of care highlighted the lengthy wait times experienced by police officers and the lack of communication about these wait times. Therefore, with greater attention being paid to police wait times and the acuity level of the PIC, hopefully less concerns will be raised during the transfer of custody.

Another important role that has been incorporated within the MOUs is that of information gathering purposes during a MHA apprehension. For example, 10 MOUs highlighted the responsibility of parties to fill out screener forms or transfer of custody forms. For instance, the Peterborough Regional Health Centre & Ontario Provincial Police (2016) MOU highlighted that a key role for the police was to, "complete a Brief Mental Health Screener (BMHS) outlining the grounds for the MHA apprehension and provide a copy of the form to hospital staff" (p. 2). In addition to this, the health care personnel were also responsible for reviewing the BMHS and transfer of care form as well as recording an alert on the patient chart that indicates the patient is

"with police" to place them in priority order (Peterborough Regional Health Centre, & Ontario Provincial Police, 2016). Further to these responsibilities, the Cornwall Community Police Services et al., (2005) MOU stated that, "the transfer of responsibility is considered complete when the responsible hospital staff member and the police officer have reviewed the Observation/Transfer of Care form and both have signed off in the designated areas". The Brantford Police Service et al., (2015) MOU also includes the responsibility of the police to complete the BMHS form and leave a copy with the hospital staff.

The MOUs tended to be more concerned with a paper trail between the services during a MHA apprehension with increased emphasis on forms and signing off being placed within the outlined roles and responsibilities. Paperwork is an important element of the MOUs because it creates a concrete piece of evidence that can be relied upon for future situations and addresses the issue of liability, a core concern of police services (and also hospitals). For example, the paperwork captures key decisions made during an apprehension and the reasoning behind those decisions (and who made them). These key pieces of information can help services if they are ever thought to be liable for harm done during an apprehension. In addition to liability, the forms also signify greater communication and collaboration between the services. Indeed, MOUs explicitly state that, "the services will be provided in accordance to the principles of collaboration and coordination with the intent of sharing and easing the workload of each of the Protocol participants" (United Counties of Prescott & Russell, 2003, p.3). The focus and emphasis within MOUs is on organizational efficiencies over patient care. Therefore, the protocols are shaped and developed for their intended ability to create a "basis for cooperation" between the police and health care system during calls involving the mentally ill (Timmins

Police Service et al., 2011, p. 2). The overall philosophy guiding these MOUs and the reason they are continually being created and reproduced revolves around the idea that:

> [the parties] believe in a united collective responsibility towards care of persons in crisis. We will be the front line members of the professional community collaborating with appropriate caregivers and family members to provide individuals with compassionate, immediate treatment (Chatham- Kent Health Alliance, Chatham-Kent Program of Assertive Community Treatment, & Canadian Mental Health Association Chatham-Kent Branch, 2005, p.11).

Having a clear outline of the roles and responsibilities within the MOUs provides a description of what each service is expected to do with interacting during a MHA apprehension (police are responsible for transport and safety, the ER is responsible for triage and monitoring), who has authority, and clear lines about where responsibilities start and end. It clearly emphasizes that all parties have a responsibility to work together towards the care of the patient. Through these descriptions, it also reaffirms what their core functions are. Police are to provide security and engage in reaction and arrest, while EDs are to manage circle of care and patient assessment and treatment.

Theme 2: Safety

A second major theme found within the MOUs is that of safety. This theme tended to be woven throughout the entire document among the sampled MOUs and was often identified in the purpose, goals and roles and responsibilities of the services. For example, the theme of safety was explicitly outlined in the overall purpose of the Hamilton MOU:

1. To ensure a standardized approach to MHA patients arriving with the Police.
2. To ensure the safety of Hospital Staff, Patients, and Police.

3. To ensure Police officers delivering MHA patients are seen quickly to facilitate the departure of the Police from the facility within 30-60 minutes. (Hamilton Police Services, n.d, p. 1)

From this statement it can be ascertained that the MOUs are focused on the safety of the hospital staff, police and patients. This quote clearly demonstrates where the police and hospital resources are focused in terms of safety. However, there is a very clear omission, that being the safety of the PIC. Once again highlighting the importance of operational efficiency over patient care. Another example of the centrality of safety within these MOUs was found in the Ottawa Hospital & Ottawa Police Services Board (2006) MOU which incorporates safety into the background of why their agreement was created:

1. The provision of prompt assessment and treatment for individuals in crisis supports the individual in crisis and also promotes community safety. Interdisciplinary and inter-agency cooperation in assessment and intervention is essential to provide an effective, efficient, and comprehensive resolution to the crisis.
2. Timely intervention and continued involvement by an appropriate level of service or support to mental health consumers promotes stabilization, community re-integration and reduces calls to 911 requiring police assistance. Inter-agency cooperation best achieves these results through increased information sharing, consistent response and appropriately trained resources. (2006, p. 3)

From this statement the MOU appears to be focused on community safety. The parties to the MOU are suggesting that timely assessment and intervention for PIC facilitates safety of the

community. This is an interesting statement because most people in a mental health crisis do not pose a risk to the community, rather people living with serious mental illness are more likely to be the victim of violence (Canadian Mental Health Association, 2015).

What is Safety

In examining the MOUs, the term safety was used throughout the agreements for a variety of purposes that are not always explicitly stated. However, the theme of safety overall focused on the ideas of stigma, and timeliness and their relation to safety. Prior to the creation of these agreements, the response to PMI did not take into account the best interests of the individuals. Rather, the focus was on control and containment of PIC as opposed to access to health care. Many times, PMI were being sent into the criminal justice system as a means of potentially accessing treatment. The prison environment has often been cited as being destructive to the emotional and psychological wellbeing of PMI (Bonta & Gendreau, 1990). The purpose of mental health legislation is to protect the individual by providing them with access to measures that will reduce the possibility of future crisis:

> Unfortunately, left untreated or ill-managed, countless individuals who suffer from mental illness experience crisis and an exacerbation of symptoms that result in frequent hospital visits… Adverse and negative hospital and police interaction contribute against the desired goal for individuals to receive the support and resources necessary to maintain positive community interaction and contributions (Hotel-Dieu Grace Hospital et al., 2012, p. 2)

The goal of these protocols is to demonstrate that "Emotionally Disturbed Persons" are valued members of our community who may be suffering from a disability/disorder and deserve our respect and assistance (Lanark County Ontario Provincial Police et al., 2012). As explained

earlier, there is a perception of violence or dangerousness when an individual has a mental illness or is experiencing a mental health crisis. This stigma is often the result of media that sensationalizes mental illness and violence. When a heinous crime occurs the media tends to focus on the mental illness of the perpetrator thus ignoring the fact that most crime is committed by those without a mental illness (Varshney, Mahapatra, Krishnan, Gupta, & Sinha Deb, 2016). This underlying perception of violence intersecting with mental illness is explicitly stated within the MOUs. For example, the Chatham and Lanark MOUs incorporate the idea of violence into their purpose behind the agreements being that of reducing situations that could lead to violent or negative interactions with PMI:

> These partnerships have been established to develop and implement safe, proactive, preventative methods of containing emotionally explosive situations involving emotionally disturbed persons that could lead to violence (Chatham- Kent Health Alliance et al., 2005, p. 12).

As exemplified within the above quote, the parties to the protocol have recognized that there is an inherent risk of violence attached to interactions with PMI. This element of violence in Mental Health Act apprehensions has changed the way police and hospitals respond towards interactions with PMI. Response to PMI have changed to better protect the safety of all parties involved. As such, responses to MH crisis are commonly described using the terms safe, proactive and preventative. These terms are the goals that service workers are striving to accomplish during crisis calls.

Safety within the MOUs is about the provision of prompt and preventative assessment and treatment to ensure a safe level of physical and psychological well-being for those individuals (Cornwall Community Police Services et al., 2005, p. 3; United Counties of Prescott

and Russell, 2003). This statement demonstrates the new awareness and understanding of mental illness that has been the subject of numerous research projects and the pressure being placed on communities and their services. The aim of care and treatment will always focus on integration in the community. This care is managed by a complex consortium of mental health professionals that are both community and hospital based (Hotel-Dieu Grace Hospital et al., 2012). In addition to the above statement the Sudbury MOU (2010) similarly mentioned that,

> "treatment and assessment needs to be accessible in a responsive, coordinated and timely manner to ensure the safety of patients, families and the public" (p. 2).

These examples further demonstrate the concern for physical safety at the hands of the PMI.

Responsibility of Supplying Safety

The MOUs have an overall focus on wellbeing/treatment and in turn how they can achieve that without compromising the individual rights. As such, the MOUs outline what they believe to be their role in protecting safety and why they are responsible for it. For example, the Timmins MOU clearly situates their reason for a different approach to mental health treatment and care within the theme of safety:

> In any year, between one in four and one in five adults will experience an addiction issue or serious mental illness. Often, these individuals do not receive support or treatment. Lack of awareness of available services, stigma, and the effects of illness which can cloud insight are the most common reasons for not seeking help. An encounter with police can be a potent opportunity to break through these barriers and engage in needed services. For people who are receiving services and have an encounter with police, tailoring support to the particular situation can be of benefit

> to deal with the related stress, and the opportunity to learn from the encounter can facilitate recovery (Timmins Police Service et al., 2011, p. 2).

The parties to the protocol have together decided that they are in a unique position to offer services to PMI. In this sense they are trying to eliminate the barriers faced by PMI and in turn eliminate the negative interactions or safety concerns for PMI and the public. These kinds of encompassing statements, as demonstrated above, were demonstrated throughout all of the MOUs and seem to be the overarching philosophy behind the creation of the MOUs. Through the identification of their role of protecting the safety, the parties that created the MOUs are embedding their procedures and responsibilities under the theme of safety. This means that the police and in turn the hospital have accepted responsibility for PIC and thus will conduct their roles and responsibilities to ensure the safety of the PMI, support staff, family and the public during MHA apprehensions. The parties to the protocol have incorporated safety into many of the procedures and in turn they have identified that the only way to effectively manage safety is through collaboration. An important consideration among this theme is the perception that PMI are dangerous and violent. This perception could create difficult situations in which the stigma attached to the PMI create preconceived ideas and in turn impact how the situation is approached.

The police are not the only service that is responsible for the safety of PMI. For example, "staff from the emergency department will ensure the security of people who are admitted, but who cannot be transferred immediately to the care unit, with the help of hospital resources" (United Counties of Prescott & Russell, 2003, p. 12). In addition to the safety of the PMI the healthcare facility is also responsible for the safety of staff and other patients. Sometimes this is accomplished if the healthcare facility has security guards on hand. However not all hospitals

have security guards to manage these situations thus requiring the hospitals to rely on police for the safety and security of patients and staff. Another way that safety and security is managed in hospitals is by appropriately triaging patients in terms of who needs to see the physician in the timeliest manner. For example,

> To give highest priority in responding to those who present at risk to the security and safety of themselves or others due to a mental health emergency. For example: suicidal/homicidal individuals, bizarre behaviours, etc (Cornwall Community Police Services et al., 2005, p. 5).

Safety of Whom?

This next section discusses how the partner services were referenced in the MOUs in terms of protecting their safety. The first one that will be discussed is that of the safety of the individual in crisis.

Safety of the Individual

The safety of the PIC was usually defined in terms of their level of risk for violence. This risk level was usually divided into three sections: high, moderate and low risk. When a client is deemed high risk "there is an actual or potential risk that a person's life is immediately threatened" (Cornwall Community Police Services, 2005, p. 6). Moderate risk consists of a situation where the PMI:

> Exhibits evidence of acute mental illness has attempted or threatened suicide; or is unable to be contained safely in a care or support situation in the community, sedation has been administered to enable safe transport; or there is a need to use approved mechanical restraint for safe transport (Cornwall Community Police Services et al., 2005, p.6).

A PMI deemed to be low risk exhibits:

> Symptoms of psychological and social problems that disrupt activities. Behavior or a pattern of symptoms that may lead to additional problems, become more difficult to change, or urgent problems in the future (but not immediate future). The person is competent, knowledgeable and familiar with the current problem or issue, and based on that knowledge is comfortable and willing to wait for a convenient appointment. Clients who need additional support to prevent the onset of a more acute situation and are agreeable to follow-up by the crisis service (Cornwall Community Police Services et al., 2005, p. 7).

Once again relying on judging an individual's risk can be problematic due to differing definitions, associated stigma attached to mental health and potentially different behavior exhibited at different times. Having the clear definitions of risk designations established in the MOUs creates a shared understanding and language to be used by all services during a MHA apprehension. In addition to a clear understanding that risk levels are dynamic and change over time.

Also incorporated into the theme of safety, is the use of chemical or physical restraints as methods to ensure safety. However, with the use of these measures comes an increased risk of harm to the PMI. In terms of control measures they can fall into several categories: physical, chemical and environmental. Examples of these would be restraints, medication and seclusion. Around 1 in 4 - 5 patients experienced a type of control intervention during their hospitalization in a psychiatric unit/ hospital (CIHI, 2011; Mah, Hirdes, & Heckman, 2015). The use of restraints and other control methods brings up ethical issues such as: "problems of elimination, aspiration pneumonia, circulatory obstruction, cardiac stress, skin breakdown, poor appetite,

dehydration and accidental death" (Zun, 2005, para. 7) In addition to the problems experienced by the patient the clinical staff also face adverse effects such as the ethical dilemma of infringing a person's autonomy (Lai, Chow, Suen, & Wong, 2011). The major reasons cited for restraint use by healthcare staff are; "the maintenance of patient's safety, management of their agitation and aggression, control of their behavior, preventing patients from wandering and extension of physical support" (Lai et al., 2011, p. 2). Of concern is that restraints are used by healthcare staff for "the convenience of healthcare workers, for the attainment of organizational goals, to maintain a comfortable social environment and to facilitate treatment" (Lai et al., 2011, p. 2). The use of restraints in hospitals is guided by least restrictive policies that state that control interventions should be a method of last resort for preventing self-harm or harm to others (CIHI, 2011). When patients had restraints used on them they felt a loss of autonomy, victimized, resentful and unsure of the reasoning behind the restraint event (Ling, Cleverley, & Penvolaris, 2015). The evidence indicates there are many emotional and physical consequences of restraint for both the patients and the clinicians (Ling et al., 2015). Concerns about safety, ethics and human rights are all brought up when discussing the use of restraints in mental health environments (Kelly & Curran, 2012).

As a result, the agreements have formalized the procedures for using physical and chemical restraints because they are used to help create a safe environment for the PMI, staff and other patients rather than cause more harm. For example, during a MHA apprehension the safety of the PMI and everyone else falls under the responsibility of the police:

> The level of restraint used on the patient to assure the safety and security of all involved will reside with the OPP officers in consultation with the physician responsible for primary care of the patient (Collingwood and Blue Mountains OPP,

& Collingwood General and Marine Hospital, 2011, p. 1)

Included in this example is the safeguard of also incorporating the physician to ensure that the safety of the PMI is not compromised by using excessive force or restraints

Whereas another MOU states that,

> Response to people with a mental illness or in acute emotional distress should be provided by the least restrictive and least intrusive means possible and in a manner that ensures the safety of the person and others, and minimizes [*sic*] interference with the person's privacy, dignity and self-respect (Cornwall Community Police Services et al., 2005, p. 4).

This quote demonstrates the importance of PMI being treated in the least restrictive and least intrusive means. Both are significant components behind the creation of mental health legislation and care around the world. Ensuring safety cannot only be about the physical act of ensuring safety, it also needs to incorporate the psychological harms that can occur from treatment. Some of the examples of psychological effects that can occur due to restraints are: isolation, confusion, agitation, frustration, guilt, increased stress or trauma, anger, fear, depression, changes in self-image, sleep disorders and loss of autonomy and dignity (Di Costanzo, 2012). When patients had restraints used on them they felt a loss of autonomy, victimized, resentful and unsure of the reasoning behind the restraint event (Ling, Cleverley, & Penvolaris, 2015). The evidence indicates there are many emotional and physical consequences of restraint for both the patients and the clinicians (Ling et al., 2015).

Safety of the Partner Services

In addition to the safety of the individual the MOUs also discuss the safety of the partner services. A specific safety concern related to partner services is that of the role of paramedics in

treating PMI and associated risks that may occur. For example, "[i]f police are required for safety and security measures, then a police officer will ride in the ambulance with a second officer following in a police vehicle to allow for adequate communications and necessary back up (Dryden Ontario Provincial Police et al., 2012, p. 4).

A large proportion of the procedures were related to ensuring the safety of the partner services. This mainly plays out by ensuring EMS services do not come to a call before potentially dangerous situations have been addressed by police and through the use of police officers as security for hospitals during a MHA apprehension. Found in the Collingwood MOU is an example of the previous statement, "Officers will respond forthwith to all requests for assistance by hospital staff with a minimum response of two officers" (2012, p.1). Embedded within this statement is the need to protect the safety of the hospital staff and police officers. The police are responsible for ensuring the safety of the staff and public while they are interacting with the PMI (Collingwood and Blue Mountains OPP, & Collingwood General and Marine Hospital, 2011, p. 1). "As soon as safety is determined the police will be freed up if not required for duties under the MHA" (Cornwall Community Police Services et al., 2005, p. 8).

The importance of the safety of the services is further teased out within the MOUs by examples such as,

> The Chatham-Kent Police will ensure the safety of all Partners and will assess the scene before the partners will attend. (Chatham- Kent Health Alliance et al., 2005, p. 15)

This last statement relates to the use of the crisis team and how they will not attend a scene until it has been secured. A component that allows the parties to do their jobs undue risk is in part due

to the role of the police in maintaining the safety of all involved and especially the parties to the protocol.

Safety of the ED

Another key partner within the arena of a MHA apprehension is the ED of the hospital. The safety of the hospital is ensured and exemplified within examples found within the MOUs such as,

> Police Officers will assist the staff of the MHCT, ER and Psychiatric Inpatient Unit as requested in order to assist with physically aggressive patients who pose a danger to staff or other patients (Cornwall Community Police Services et al., 2005, p. 8)

> If the patient is physically acting out, the Police Officer must ensure that the patient remains secured and supervised until hospital staff is prepared to assess and treat the patient. Police officers will assist hospital staff with security issues during this process. (Hamilton Police Services, n.d., p. 1)

and

> Police will remain with patients transported to the ER for evaluation under section 17 of the Mental Health Act for a period of up to one hour unless other medical emergencies in the ER make this time frame unrealistic (Cornwall Community Police Services et al., 2005, p. 8)

This idea of the time frame relates to the safety of the community and the role of the police to uphold community safety as part of their duties outside of the prevue of the agreement.

Safety of the Police

Most of the times when the police are mentioned in relation to safety it is because of their responsibility to uphold it. Thus the statements that involve the police tend to be generalizations towards protecting the safety of everyone especially those involved in MHA apprehensions. Within the MOUs the theme of safety was securely linked to the responsibility of the police. However, a lot of the statements about safety infer the dual role of the parties required to ensure safety. An example of this type of statement is found within the Dryden MOU;

> This policy will:
>
> a) Ensure a coordinated approach for the safety and security of police, health care staff and persons who are apprehended under the authority of the Mental Health Act and are the subject of a Form 1 issued by a physician.
>
> b) To establish clear and consistent direction for police and health care professionals to follow for the security, admittance and transportation of Form 1 patients.
>
> c) To prevent and/or minimize anxiety to the mentally ill while they are subject to the provisions of the Mental Health Act (Dryden Ontario Provincial Police et al., 2012, p. 1).

The partnerships assist; "team members to understand that mental illness is not a crime, but a disability/disorder" (Lanark County Ontario Provincial Police et al., 2012, p. 8). With the introduction of these formal agreements, partnerships have developed between services to offer; "in-service training on topics specific to each participant's expertise… to better serve clients with mental health problems (Cornwall Community Police Service et al., 2005, p. 7). These new responses have contributed to; "a significant reduction in consumer and police injuries during crisis calls" (Chatham- Kent Health Alliance et al., 2005 p. 12).

Overall, the parties believe that "prompt assessment and treatment for PMI in the community is essential to ensure a safe level of physical and psychological well-being for those individuals and others in the community" (Cornwall Community Police Services et al., 2005, p. 3). Included in this belief is that the treatment and overall response to people with a mental illness should be provided by the least restrictive and least intrusive means possible and in a manner that ensures the safety of the person and others, and minimizes interference with the person's privacy, dignity and self-respect (Cornwall Community Police Services et al., 2005). With safety being such an important element within the police and hospital philosophies and mental health legislation, it is no surprise that it is weaved throughout the entirety of the MOUs.

Safety as a theme was encompassed around the idea of organizational efficiencies over patient care. This was teased out in statements that were focused on the timelines. The MOUs were more concerned with having the PIC seen within a certain amount of time rather than on the care provided to the patient. This concern makes the MOUs more of a risk management tool rather than a document that is supposed to bring the diverse services together in a collaborative manner. Safety as a theme was encompassed based on the risk level of the PIC. A large element of the theme of safety is the focus on myths surrounding mental illness such as their heightened risk of violence. As demonstrated within research, PMI are actually at an increased risk of being the victim of violence rather than the perpetrator of violence. However, a large focus of the MOUs is the risk of violence by PMI. For example, the theme of safety can be divided up into sections based on who is in need of safety from PMI such as the police, hospital and patients all of which is explicitly stated in the MOUs.

Theme Three: Collaboration

The two previous themes found within the sampled MOUs were that of roles and responsibilities and safety. These two themes are significant because they underscore the obligation of each service as well as the function behind these responsibilities, whereas the theme of collaboration describes how the parties actually accomplish their responsibilities and maintain safety while working together in practice. Within the MOUs, the parties to the protocol operationalize what they mean by working together and how they expect to achieve collaboration specifically through subthemes of communication, information sharing, and joint training

The What and Why of Collaboration

With MOUs serving as a boundary object between the social worlds that converge within the arena of the ED, the theme of collaboration was dominant across all MOUs. These documents served the purpose of bridging the gap between services with similar roles and objectives. Collaboration between service providers and first responders was a key theme among these agreements because:

> A collaborative response between service providers and first responders represents best practice and as such, is an effective way of addressing issues and meeting the needs of people who seem to be in emotional distress or experiencing symptoms of a serious mental illness or addictions issue who come into contact with police (Timmins Police Service et al., 2011, p. 1).

Collaboration was referred to within the documents through the ideas of "working cooperatively with one another" (Chatham- Kent Health Alliance et al., 2005; Lanark County Ontario Provincial Police et al., 2012; Timmins Police Service et al., 2011), and "mutual support and cooperation" (Cornwall Community Police Services et al., 2005, p. 4). When describing collaboration, a significant portion of the MOUs also included the intended benefits of this

collaborative work, such as a marked decrease in PIC and police injuries during mental health crisis calls (Chatham- Kent Health Alliance et al., MOU, 2005), as well as enhanced relationships between PMI and mental health professionals (Chatham- Kent Health Alliance et al., 2005). These benefits are important due to the increasing number of interactions between PIC and police coupled with the negative outcomes that sometimes arise from these encounters, including fatalities (e.g., Nicholson & Marloux, 2018).

The overall philosophy of these agreements represented an encouraging shift from the antiquated siloed approach between services towards one of increased collaboration (CMHA, 2005; Cotton & Coleman, 2010). The MOUs evinced a recognition that collaboration was needed in order to better serve those living with mental illness and to prevent negative outcomes. This shift in greater collaboration between mental health services was demonstrated by the following quote:

> We believe in a united collective responsibility towards care of persons in crisis. We will be the front line members of the professional community collaborating with appropriate caregivers and family members to provide individuals with compassionate, immediate treatment (Lanark County Ontario Provincial Police et al., 2012, p. 3).

These agreements recognized that "interdisciplinary and inter-agency cooperation in assessment and intervention [was] essential to provide an effective, efficient, and comprehensive resolution to the crisis" (Ottawa, 2006, p. 3). PIC required the coordination of multiple agencies and these agreements govern that relationship:

> It is the responsibility of the mental health community to initiate and foster partnerships, with a common goal of developing viable, fiscally responsible and

> beneficial strategies to promote the health and well-being of emotionally disturbed people (Hotel-Dieu Grace Hospital et al., 2012, p. 2).

These quotes demonstrate how the parties to the protocol have recognized the need to work together and how these partnerships can create better outcomes and more sustainable services for the PMI.

Research studies continue to push towards mental health services working together and increasing collaboration (CMHA, 2015; Forchuk et al., 2010; Mckenna, Furness, Oakes et al.,2015; Mckenna, Furness, Brown et al., 2015; Winters et al., 2015; Pasqualone, 2015). These accumulating calls for increased collaboration arise from the need to address increased pressure and tension between police officers and nurses during MHA apprehension (Pasqualone, 2015; Hoffman, et al., 2016; Ormston, 2010; Tyerman, 2014; Usher, 2015; White et al., 2008; Winters et al., 2015). Shortcomings have been identified for when services do not work collaboratively such as a lack of clear communication between services, issues of privacy, unclear roles and responsibilities, insufficient training regarding mental health and proper procedures, and lengthy hospital wait times (Carter, et al., 2012; Coleman & Cotton, 2010; Cotton & Coleman, 2010; Hoffman et al., 2016; Hollander, et al., 2012; Poland et al., 2005). To promote and foster these relationships the services must work together and define how that working relationship is to occur within practice.

Practicalities of Working Together

To better define collaboration, the MOUs specifically outlined how working together is implemented in practice. For example, within the Chatham-Kent MOU, working together arises from the principle of helping one another accomplish their tasks found within the MOU:

> As much as possible, Partners will cooperate and assist each other in carrying out their individual responsibilities (Chatham- Kent Health Alliance et al., 2005, p. 11).

And

> Assist our partners to more effectively carry out their responsibilities to care for emotionally disturbed persons. (Lanark County Ontario Provincial Police et al., 2012, p. 4)

Due to cultural conflicts the MOUs are attempting to formalize that the services must work together by outlining responsibilities and formalizing that they facilitate one another in their roles. Outlining individual responsibilities may be to reduce duplication of services because, "there are multiple agencies with a mandate to respond to those in mental health crisis and wherever possible work together to provide the most appropriate intervention" (Cornwall Community Police Services et al., 2005, p. 4). MOUs have begun to define these interactions in ways that promote increased collaboration for involved parties. For example, the Halton Police Protocol stipulates that,

> the goal of this protocol is to ensure that these services support one another in a manner that:
>
> 1. Ensure[s] that services are provided by the most appropriate provider(s) and that a team approach be used to fully meet the needs of the individual.
> 2. Ensure[s] that the expectations of each participant are consistent with the mandate of their service agency (2011, p. 1)

Through this collaborative philosophy there will be relevant services included in all aspects of the process of a MHA apprehension. In exploring the support for inter-agency collaboration observed in the MOUs, the analysis came to center on specific elements MOUs focused on to create enhanced working relationships. The MOUs identified past barriers to collaboration such

as barriers to communication, information sharing and specialized joint training in an effort to draw awareness to these problem areas and define new solutions to optimize a collaborative approach to mental health emergencies (Carter, et al., 2012; Cotton 2004; Cotton & Coleman, 2008b; Cotton & Coleman, 2010; Hoffman et al., 2016; Hollander et al., 2012; McAndrew & Sutton 2004; Poland et al., 2005). These elements are subthemes of collaboration due to their recognized importance in sustaining the partnerships between services and are discussed below.

Communication

Communication between agencies was addressed throughout the agreements by ensuring that; "clear, direct, respectful communication will form the basis for this collaborative relationship" (Timmins Police Service et al., 2011, p. 6). It is interesting to see that the MOUs specifically reference respectful communication as their standard of communicating with one another. This is likely related to the increased tension and frustration being exhibited at EDs during a MHA apprehension between police and hospital staff. Both services have vastly different methods and approaches to these situations which is why the MOUs focus on establishing a system of communication between the services. With a focus on respectful communication hopefully both the police and ED staff will be better able to work together to accomplish their roles and responsibilities with less frustration and tension.

Another aspect within the communication subtheme was the direction, "to provide a standardized communication format between [the police, hospital and community services] to ensure safe, effective communication about known risk factors during the transition from police" (Brantford Police Service et al., 2015, p. 1). Indeed, the idea of a standardized communication framework regarding known risks during transfer of care featured prominently within the various MOUs. Several of the MOUs incorporated a separate communication tool such as the Brief

Mental Health Screener (Hoffman et al., 2016), Emotionally Disturbed Person (EDP) form (Hamilton Police Services, n.d, p.1) or a similar form outlining key observations made by the officer, descriptions of the events that took place, and the level of perceived risk to be provided to the ED staff upon arrival. These forms are framed as helping to create an increasingly common language between involved services who are from diverse professional backgrounds and use unique terminology. Moreover, these forms are presented to assist officers in collecting information on scene based on the observed behavior of the PIC that will be relevant to ER staff in making determinations about the patient's needs.

Such a standardized form is useful given that police and ED services vary markedly in how they approach and view mental disorders (Hoffman et al., 2016). The police tend to focus on risk for potential harm to self or others. In contrast triage nurses focus on the length of time a patient can safely remain in the ED before being seen by a physician (Hoffman et al., 2016). Often a police officers' reasons for a mental health apprehension differ from reasons used by the ED to subsequently admit (or not admit) the individual to the hospital (Hoffman et al., 2016). This is why the MOUs have attempted to create a common language between the services through the use of transfer forms, also known as mental health screeners. A standardized approach to providing complete and relevant information is believed to alleviate previous problems identified within the literature regarding poor communication between the services. With a greater ability to communicate with one another the hope is to reduce miscommunication and inefficiency when police, hospital staff and community services work together during MHA apprehensions. Indeed, a lack of communication between the police and hospital staff has been linked to longer wait times in the EDs during MHA apprehensions. For example, police services across Ontario typically spend an average of 3 hours in EDs per incident with a client (Hoffman,

2013). Specifically, communication between the services is limited due to the incomplete transfer of relevant information between services, which in turn hinders the care provided to the person in crisis (McCann, 2013).

Several MOUs drew attention to the need for continuous communication between police and hospital staff during transfer of care; "the ER Team Leader or delegate will communicate regularly with the police about timeframes for transfer to the inpatient psychiatric unit" (Cornwall Community Police Services et al., 2005, p. 8). Communication was described as a benefit of collaborative work. Given that the PIC is waiting in the ED for an extended period of time, there is the possibility that their symptoms might improve or get worse. This is why it is important for ED staff and police to have continuous communication. The police are able to communicate about the events leading up to the MHA apprehension and thus provide the ED with information that they would not readily know. Since the police are anxious to get back on the road rather than waiting in the ED, continuous communication on the part of the hospital staff will inform police that progress is being made for the transfer of custody of the PIC. Both the ED staff and police have valuable information that the other service does not, thus making it important for the services to have continuous communication during the process.

Information Sharing

As was often the case, communication between the services was inhibited by policies and procedures regarding information sharing between services. Some of the sampled MOUs referred to the privacy legislation restricting the use, disclosure and collection of personal information, whereas others specifically laid out their procedures and interpretation of these regulations. Consider the following quotes;

> It is understood and agreed that the parties in this protocol shall hold all information, materials and patient information gained through participation in this agreement in confidence in accordance with each organizations own policies (Lanark County Ontario Provincial Police et al., 2012. p. 8).

And

> The Parties shall each apply their respective standards and/or policies and applicable legislation to the administration, technical and physical safeguarding of information exchanged pursuant to the administration of COAST and the performance of this MOU, including but not limited to: a) As set out in Schedule 2, paragraph 3 for CCC; b) As set out in Schedule 1, paragraph 5 for OPP; c) the Personal Health Information Protection Act ("PHIPA"); d) the Freedom of Information and Protection of Privacy Act ("FIPPA"); e) the Police Services Act ("PSA"); f) any other applicable provincial legislation (Hotel-Dieu Grace Hospital et al., 2012, p. 4).

The privacy legislation has traditionally limited what information the services can share with one another, but through the development of these MOUs, the services have come together to negotiate how to overcome this barrier. For example,

> However, in certain circumstances (i.e. case consultations or in situations where risk is evident) in order to allow for comprehensive assessment and triage of cases referred between the OPSMHU and the TOHMCT, demographic data may be shared by the Ottawa Police Service and the Ottawa Hospital. If personal health information is needed, no more information than is *reasonably necessary* to meet the purpose can be disclosed. When such activity is undertaken it is done solely for

> the effective operation of this partnership, in good faith and on the basis of reasonable belief that such communication is essential to determining the appropriate course of intervention (Ottawa, 2006, p. 4-5).

Information sharing has become an important element in assisting the services to work together to provide efficient and effective assistance to individuals in crisis. Both the police and the hospital services have cited limitations with current information sharing practices (McCann, 2013: Hoffman et al., 2016). The reasonable sharing of clinical and risk information between police and hospital services can assist both services with their decision-making and performance of their responsibilities in serving PIC. Both the police and hospital staff have valuable knowledge regarding their experiences with these individuals that can assist the other service to perform their roles and responsibilities. The hospital staff will have significantly different information and insight concerning how the individual should be treated to minimize safety risks towards the individual, the police and the community. On the other hand, the police service can provide hospital staff with valuable information to assist with the decision-making process regarding the most appropriate care and intervention for the individual by explaining what they observed on scene and while waiting in the ER. Inefficient information sharing between the services can inhibit the care that should be provided to the patient, as well as jeopardize safety. Certain clinical and dispositional risk factors, such as psychiatric diagnosis, history of aggression and suicide risk, could influence the safety and outcomes of the response to the apprehension. Having information regarding past apprehensions or level of risk could help determine the officers approach to the apprehension (McCann, 2013), which in turn could prevent negative consequences such as use of force incidents or unnecessary apprehensions.

Private health information tends to be kept confidential because there have been incidents of the police misusing such information in the past. For example, in a high profile incident reported by the media, an individual was denied entry to the USA because her record stated that she been apprehended under the MHA. Ellen Richardson was denied entry because of her past history of mental illness that was housed on a database that is available to US border agents and the FBI (Aonso, 2018). Due to this database the US agents were able to see her record of hospitalization and denied her entry because of her potential risk of harming herself or others while in the US (CBS, 2013). The information housed by these government agencies is highly sensitive information which is why there are numerous pieces of legislation protecting it. While the police service may benefit from advance information to assist with decision making in calls and potentially prevent future crisis, a major limitation is that the shared information may be out of date. Specifically, the level of risk of an individual possesses is constantly changing (e.g., dynamic risk factors such as substance use, noncompliance with medication, symptoms of active mental illness and many others ebb and flow over time). Thus, health information that an officer provides concerning an individual may not be useful if this information has changed significantly (e.g., the individual is no longer using substances, is currently compliant with medication, and no longer experiences symptoms of active mental illness) With the creation of the MOUs the services have agreed upon and specified the circumstances in which they are allowed to share information to make the process clearer, but they have yet to truly delve into the ethical considerations behind information sharing.

Specialized Joint Training

In addition to communication and information sharing, the services have also recognized the importance of joint training specific to mental health in ensuring the ability to provide appropriate care and treatment. For example, services have recognized that;

> people experiencing psychiatric crises in the community present unique challenges to all professional care providers and that special education and skills are necessary for this area of psychiatric service (United Counties of Prescott and Russell, 2003, p. 6).

To provide the best training to respond to individuals in crisis, services have negotiated ways to ensure that they work together:

> Training will be an important component of our ability to better serve the emotionally disturbed. Our partners are committed to assist each other in their training needs. Training will be constantly modified to enhance our ability to serve the emotionally disturbed (Chatham- Kent Health Alliance et al., 2005, p. 17).

Some of the agreements provided specific details about what their training involved. Take for example the case in Lanark:

> The initial training involves exposure to basic dynamics of common types of mental illness and to viewpoints and feelings of mental health consumers first hand. Training assists team members to understand that mental illness is not a crime, but a disability/disorder. Skills are developed in de-escalating potentially volatile situations, gathering relevant history, assessing medical information and evaluating the individuals social support system (Lanark County Ontario Provincial Police et al., 2012, p. 8).

With the inclusion of details about training in these agreements, these services are demonstrating the importance of better training to uphold the requirements within the MOUs (Timmins Police Service et al., 2011).

Collaborative training provides each service with an understanding of a day in the life of the other services where they can learn to appreciate the reality of what the other service experiences in their role during a MHA apprehension. In addition to understanding available resources to each service, having a greater understanding of the signs of mental illness and de-escalation techniques have been emphasized in MOUs. These training requirements outlined in MOUs occur in a larger context of calls for increased police training to better prepare officers for encounters with persons in mental health crisis (Lanark, 2012). One of the reasons for these calls is because training around mental illness and how to properly interact with PIC varies significantly across services in Ontario, and indeed the country (Coleman & Cotton, 2010). The overarching philosophy of collaboration can best be summarized by the following quote,

> Timely intervention and continued involvement by an appropriate level of service or support to mental health consumers promotes stabilization, community re-integration and reduces calls to 911 requiring police assistance. Inter-agency cooperation best achieves these results through increased information sharing, consistent response and appropriately trained resources (Ottawa Hospital, & Ottawa Police Services Board, 2006, p. 3).

The term collaboration is a key element of the vision of how mental health care should be undertaken between police and hospital services working together throughout communities across Canada. The theme of collaboration focused on the direction that the services want to take in terms of MHA apprehensions. For example, through greater information sharing and

communication, the services will be better equipped to work together during MHA apprehensions. Collaboration is the direction that these services are supposed to take. However, it remains to be seen whether or not the MOUs actually impact collaboration in practice.

Chapter Six: Discussion and Conclusion

Improvement in the collaboration between police and emergency hospital services in responding to citizens in MH crisis has been identified as vital by researchers and service organizations alike (Human Services and Justice Coordinating Committee, 2013). Research suggests that collaboration between these two services is inhibited by a lack of clear communication, protection of patient privacy, insufficient training, siloing of services, and safety concerns for patients and staff (Cotton & Coleman, 2010). Consequences of inadequate cooperation between police and hospital services has resulted in lengthy ED wait times for those apprehended by police officers under the MHA, poor patient follow-up, and frustration between services (Cotton, 2004). Recently, some police services in Ontario have begun to implement formal agreements with local hospitals to enhance collaboration in MOUs in caring for those in MH crisis. The main purpose of this study was to determine how organizational policies have shaped the way police and ED services work together when managing people in mental health crisis (PIC) in the specific situation of a MHA apprehension. This qualitative study considered MOUs between these two services as boundary objects worthy of investigation because they provide insight into how each divergent social world negotiates their working collaboration. To explore this collaborative working relationship, this study involved the collection and thematic analysis of 22 official MOUs between Ontario police services and Ontario hospital EDs concerning the management of MHA apprehensions. This analysis identified shared purposes, procedures and goals along with common themes across all MOUs in the dataset.

The common purpose of these agreements suggested the desire to create a more coordinated response for PMI that ensures access to treatment and diversion from criminalization. The common purposes of these agreements as identified by the parties to the protocol were to:

1. Improve the outcomes for individuals experiencing a mental health crisis, in terms of timely intervention…and continued involvement... and stabilization (Ottawa Hospital, & Ottawa Police Services Board, 2006, p. 3), access, follow-up, and adequacy of care.
2. Improve the transfer of care of patients between police officers and hospital workers, and community mental health providers to ease the workload (Cornwall Community Police Services et al., 2005, p. 4), and for a comprehensive, efficient and effective crisis resolution (United Counties of Prescott & Russell, 2003, p. 2).
3. Improve the coordination and collaboration among multidisciplinary interdisciplinary and inter-agency partners concerning sharing responsibility and information sharing (Cornwall Community Police Services et al., 2005, p. 4).

Three key themes were revealed in the data: roles and responsibilities, safety and collaboration. The theme of roles and responsibilities highlighted the importance of outlining the roles of each organization during a MHA apprehension. In order for social worlds to effectively work together, information, objects and concepts must be able to flow through the network of participating social worlds. Remember that social worlds refer to "groups with shared commitments to certain activities, sharing resources of many kinds to achieve their goals, and building shared ideologies about how to go about their business" (Clarke, 1991, p. 131). A launching point for social worlds to commence work together and increase information flow across the boundaries is to clearly outline the roles and responsibilities of all key actors. A contributing factor towards the apparent ineffective working relationship between police and hospital services relates to the lack of clear direction concerning who should be responsible for what during a MHA apprehension. Having a clear outline of the roles and responsibilities within

the MOUs provides a description of what each service is expected to do during a MHA apprehension (i.e., police are responsible for transport and safety, the ED staff is responsible for triage and monitoring), and definitive lines about where responsibilities start and end. Moreover, MOUs clearly emphasized that all parties have a responsibility to work together towards the care of the patient.

Overall, the analysis of the MOUs demonstrated that the MOUs prioritized organizational efficiencies rather than patient care. For example, the MOUs are more concerned with the timelines or procedures associated with a MHA apprehension rather than the quality of PIC treatment and care in the situation. Another insight that arose from the data was that the MOUs reaffirmed myths surrounding mental illness and violence. For example, the entirety of the safety section focused on the risk posed by the PIC when research has demonstrated that PMI are more likely to be the victim of violence rather than the perpetrator (Varshney, et al., 2016). However, it is important to point out that the patients who are brought in on a Form 1 MHA apprehension were transported by the police to hospital because the officer reasonably determined under section 17 that the PMI was a danger to themselves, or others, or so ill that they could not care for themselves. So by their definition, this group of patients are thought to be at greater risk to perpetrate harm than the larger population of PMI who we know to be less dangerous than the public believes.

Another important insight that arose from the data was that the MOUs reinforced the boundaries between police and hospitals. For instance, specifying each of the roles and responsibilities of the partner services further demarcates how the services are different and how their purposes are different during a MHA apprehension. For example, the main role of the police is that of safety whereas the hospital's role is to maintain privacy and care of the patients.

Within the MOUs the theme of collaboration was organized in a manner that made it represent best practice for the services such that collaboration was seen as the end goal for these services. Collaboration was laid out in such a way that it represented where the services wanted to be and how they expected to work together. Collaboration as a theme in the MOUs was clearly separating the new response as put forward in the MOU from past responses to mental illness by offering up a new solution to MHA apprehensions.

Safety has long been a key concept undergirding responses to mental health crises and subsequent mental health legislation, thus the finding that safety as a core theme in the MOUs was not surprising. The responses and legislation governing mental health are continually changing based on greater understanding and awareness towards mental illness. Powers to apprehend individuals and transport them to hospital are based on s.17 of the provincial MHA that emphasize risk of harm to self, others, and significant decompensation. Moreover, PMI are often erroneously publicly perceived as dangerous. One of the main reasons behind the creation of these MOU documents was to provide a better response to mental health concerns that reduces the negative interactions that result in injuries to any of the involved persons. The theme of safety was blanketed in statements that reaffirmed the negative perception of PMI being at an increased risk for violence. This therefore demonstrates the need for the role of the police services in maintaining safety during MHA apprehensions.

Collaboration as a major theme is encouraging due to the well-documented siloed approach taken by services in responding to PMI (CMHA, 2005). Without collaboration the services tend to work individually which limits their ability to provide the most effective service to the person in MH crisis. Researcher continue to push towards MH services working together and increasing collaboration (CMHA, 2015; Forchuk, et al., 2010; Mckenna, Furness, Oakes et al.,2015;

Mckenna, Furness, Brown et al., 2015; Winters et al., 2015; Pasqualone, 2015). The overall philosophy of the MOUs represented an encouraging shift from the antiquated autonomous approach among services towards one of increased collaboration (CMHA, 2005; Cotton & Coleman, 2010). The MOUs evinced a recognition that collaboration was needed in order to better serve those living with mental illness and to prevent negative outcomes. Collaboration among services has the potential to eliminate any negative consequences that may occur during a MHA apprehension. Response to PMI requires the coordination of all community partners to reduce the criminalization and marginalization of PMI (Chatham- Kent Health Alliance et al., 2005; Timmins Police Service et al., 2011; Lanark County Ontario Provincial Police et al., 2012; Ottawa Hospital, & Ottawa Police Services Board, 2006; United Counties of Prescott and Russell, 2003).

MOUs are intended to be a starting point in the new direction towards a more collaborative relationship between police and hospital services during MHA apprehensions. Of importance to this study is the difference between collaboration and partnerships. The MOUs are more reflective of formal partnerships outlining key roles and responsibilities rather than collaborative endeavors. While in many situations the terms collaboration and partnerships are used interchangeably, they do in fact have different meanings. A partnership is centered on a formalized joint venture with binding obligations for action (Kamensky & Burlin, 2004). They tend to be organized around common outputs and results. On the other hand, collaboration is focuses on joint effort and ownership. As stated by Kamensky and Burlin (2004), “collaboration occurs when people from different organizations produce something together through joint effort, resources and decision making and share ownership of the final product or source” (p.8). Partnerships more clearly differentiate the services whereas collaboration is more mutually

respectful. Since the MOUs are created as a means of differentiating the groups of actors such as the police and the hospitals, they embody formalized partnerships rather than collaboration. While it is true that the MOUs can foster collaboration, this will occur as these MOUs are implemented on the ground. BY way if their creation MOUs are a formalized partnership, but they have the ability to evolve into collaboration in practice.

Looking at the situation of MHA apprehensions though the lens of boundary objects can help to better understand how the various actors involved can cooperate on a project despite having different interests. A boundary object is information used in different ways by different communities. These objects interact with members of various social groups but are used to very different ends by each (Timmermans, 2015). A boundary object is any object that is part of multiple social worlds and facilitates communication between them; it has a different identity in each social world that it inhabits (Star & Griesmer, 1989). Based on these interpretations of boundary objects, the MOU serves as a boundary object because it brings together diverse social worlds into a social arena where consensus is difficult to reach. The MOU acts as information for both social worlds because it outlines the key roles and responsibilities of each service. It also outlines the key goals and philosophies behind MHA apprehensions. A boundary object is "both plastic enough to adapt to local needs yet robust enough to maintain a common identity across sites" (Timmermans, 2015, p.4). With the example of the MOU they are flexible in that they are adaptable to the situation in which they are needed and can be modified to fit the local needs of the services. For example, multiple MOUs included crisis teams when others did not. In addition, the MOUs were robust enough that regardless of its title and parties to the protocol, they still maintained very similar aspects to make it recognizable as a MOU. From the idea that boundary objects are a set of information shared across diverse social groups, the MOU is exactly that. It

provides information relating to MHA apprehensions in the dynamics of different communities with different communities of practice or social worlds. The MOU is a boundary object because it has the ability to generate collaboration amongst the social worlds of police and hospitals during MHA apprehensions because it is easily adaptable to specific circumstances, yet retains a common identity that is recognizable as a MOU.

MOUs act as boundary objects to bridge the space between the police and hospitals to allow for more communication and resource sharing to limit the negative consequences that occur when the services do not effectively work together. Recall that boundary objects are, "any element that has the capacity to be understood by actors in more than one setting" (Fox 2011, p. 71/72). Boundary objects fulfill the purpose of bridging the gap between intersecting practices such as those found in the social worlds of the police and hospital ED staff (Akkerman & Bakker, 2011; Star & Griesemer, 1989). These boundary objects are used by the social worlds to articulate meaning between the potentially diverse groups and address multiple perspectives. Boundary objects act as a means of solving the problems that arise from heterogeneous work activities. MOUs were being used to negotiate, outline and organize the key roles, responsibilities and beliefs of the diverse services in an effort to improve interactions with PIC. The MOUs are a starting point for the services to begin sharing information or learning about each service in ways that promote collaboration, and shared understandings of why the services are involved responding to people.

Contributions of Study

This study adds a new element of analysis to the growing literature on MH and interactions between police, hospitals and persons with mental illness. A key contribution of this study is the framing and argument that MOUs are a boundary object where diverse services

negotiate roles and responsibilities, safety and collaboration. Moreover, there is a paucty of research exploring the contents of MOUs between police and hospital services responding to PIC. As such, this research will assist in further elucidating this collaboration and identifies areas where research still needs to be conducted. Police and hospitals services in Ontario have come a long way by creating new avenues for collaboration, such as the creation of these MOUs, in addition to joint police-hospital response teams. However, there still remains barriers to this collaboration and unintended consequences related to interacting with persons with mental illness, such as miscommunication related to information sharing. These areas of miscommunication, and role confusion that inhibit the collaboration between services during a MHA apprehension are being addressed through the use and implementation of MOUs.

Limitations

In qualitative studies it can be difficult to obtain a sample size that allows the results to be generalizable to a larger population. The sampling frame in this study was 59 Schedule 1 hospital locations in Ontario providing services to adult patients. Of these Schedule 1 facilities, a total of 21 agreements were included in the study, represents 36% of the intended population. Generalizability is the ability of study findings to apply to other people and/or other situations that the study's sample represents (Given, 2008). Given that 36% of the population of interest is represented in the sample, the results of this study could likely be extended with caution to other Ontario MOUs between hospitals and police services not included in the sample. However, of these Schedule 1 facilities, it is difficult to confirm how many have an MOU in place. Therefore, a limitation of this study is the uncertainty surrounding how many MOUs are in place and how they have been modified over time.

Future research

Future research should evaluate whether the MOUs have demonstrated their goals of increased partnership, collaboration, communication, and effective and prompt treatment. Further research should gather on-the-ground experience from both the hospitals and police departments regarding their application of the MOU and whether MOUS are giving rise to positive change.

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