

The Queen's University Psychiatry On-Call Handbook -2021

Practical Tips for Junior Residents and Off-Service Residents, a Reference for Senior Residents and Faculty

FOREWORD

This handbook has been developed by residents of the Queen's University Psychiatry Training Program for the benefit of medical students, residents and psychiatrists providing on-call coverage at Kingston Health Sciences Centre. While the best effort has been made to ensure its contents are up to date, information and policies can change with time and the reader should acquaint themselves with such updates. The intention is to amend and revise this guidebook frequently, but this is not a living document.

This guide aims to provide general information but should in no way be construed as provided specific medical advice. The reader should use their best judgement and knowledge of each specific case after having assessed them in order to make appropriate treatment decisions.

The Department of Psychiatry also maintains a page with useful resources (and this guidebook will be linked there).

<https://psychiatry.queensu.ca/faculty/call>

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OVERVIEW

Important Places At KGH

Burr 4 Section B, Adult : The adult general psychiatric unit is a locked 30-bed ward with common areas, a kitchen and terrace.

Burr 4 Section A, IOA: The Intensive Observation Area is an 8-bed unit with individual, monitored, lockable patient rooms with constant security presence. Patients with acute safety risks to themselves or others or those needing constant observation are admitted here.

Burr 4 Section A, Short Stay: This is a 2-bed unit adjacent to the IOA. The maximum length of stay is 72 hours, typically for assessment and containment. To be admitted to this unit, they must have a fixed address. The emergency Psychiatry team round on these patients on the weekdays and the on-call team sees them on the weekends.

Burr 4 Section C, Child: This is an 8-bed unit for children 17 years and younger, and is managed by a dedicated Child and Adolescent inpatient team. There is one rooms which can be locked.

ED, Section E: The “ER Psychiatry section.” It is a unit with two locked rooms under constant surveillance, security presence and a dedicated nursing station.

ED, Section B: Section is often used for patients with mental health complaints seen by the ED doctors. It has a single lockable room (B1).

Psychiatry Teams at KGH

Adult Inpatient: Consists of several attendings and residents who see patients daily on weekdays.

Child Inpatient: One attending +/- residents and fellows seeing inpatients daily on weekdays. They also provide psychiatric consultation to patients admitted to pediatric medicine.

Emergency Psychiatry: “Day-call” team - a consultation service for patients presenting to the ER i.e. **not admitted**. Referrals come from the KGH ER, HDH Urgent care or peripheral sites. This team also rounds on patients admitted under Psychiatry but boarding in the ER and patients admitted to the Short Stay Unit daily.

Consultation Liaison (C-L) Psychiatry: a consultation service with its own attending and residents providing psychiatric consultation and follow-up for **adult patients admitted to medical or surgical services** at KGH. The C-L team is also responsible for transferring patients from medical/surgical wards to the psychiatry unit.

On-Call Psychiatry: On evenings, weekends and holidays, the On-Call team functions as the Emergency Psychiatry team and handles all ward issues. They may also be required to take new C-L Psychiatry consults or assess patients followed by C-L Psychiatry on an urgent basis.

BEING ON CALL

The on-call team consists of a junior resident (PGY1/2/off-service resident), senior resident (PGY3+), staff psychiatrist and possibly a medical student.

It is possible to find out who the team is on call by calling switchboard, or logging into PCS and clicking “KGH Weblinks” and selecting “on call schedule”.

Roles

The weeknight team sees new consults and manages ward issues. The weekend team does the same but **also** rounds on new admits and Short Stay patients.

Junior resident:

- As the first call resident you will receive pages for ward issues and consults from the ER, Hotel Dieu, and peripheral sites.
- Take and give handover at the start and end of your shift, respectively.
- Coordinate with the senior resident to triage and manage issues.
- Contact the medical student after getting handover.
- Manage any ward concerns on Burr-4 during the on-call shift.
- Review assessments with staff.

Senior resident:

- Supervise junior residents and medical students. **It is not appropriate to supervise over the phone**
- Assist the junior resident in any of the above roles as needed.
- Triage, manage and prioritize service and assist with assessments.
- Provide feedback and teaching as appropriate
- Review assessments with staff.

Staff psychiatrist:

- Be available by phone to review all assessments.
- Be available in person if there are 5 or more pending consults, or if requested at any time by residents.
- On weekend call, arrive in the morning to round on any new admissions (located on Burr 4 and the ED) and short stay patients.

Medical student:

- The Junior resident should contact you at the start of the shift or before; otherwise, please contact them.
- See patients and review with a resident or staff.

Weekday Day Call

Shift Time: Mon-Fri 8:300 AM to 5 PM

Handover: 8:30 AM (via x7493 or page)– All members of the team should meet in section E of the ER at this time

Responsibilities:

1. Assess new consultations in the emergency room
2. Accept calls from outside hospitals and clinicians in the community.
3. Being the primary team responsible for those patients admitted to psychiatry but still in the ER.

Giving Handover: night team at 4:30 PM via cell or page

Weekday Night Call

Shift Time: Mon-Fri 5 PM until 8:30 am. (Med students end at 10 pm)

Handover: 4:30 PM – The day team will call or page you to provide handover. They can also be reach via the e ER Psychiatry pager or call x 7493/6722. After receiving handover, the junior resident will contact the senior resident and clinical work to update them and inform them if there are patients to be seen at the start of the shift.

Responsibilities:

1. Day Call responsibilities PLUS:
2. Providing coverage for the inpatient psychiatry ward
3. Providing coverage for emergency C-L consults to the medical and surgical wards which cannot wait to be seen by the dedicated C-L in the morning.

Giving Handover: At 8:30 – call section E (x 7493) or page the junior resident on weekdays and weekends.

Handover to the C-L team: Send an email to the C-L team residents and staff for any issues arising or new consults for admitted patients under other specialities. You are able to check who is the staff on C-L through the on-call schedule on PCS.

Weekend/Holiday Call

Weekend/Holiday: 8:30 am to 8:30 am the next day for residents. Medical students end at 8:00 pm. Attending staff will arrive by 09:00.

Getting Handover: At 8:30 am report to Section E in the ED and await a call from the junior on-call overnight to receive handover on pending consults, holdovers, and **all new admissions** (Short Stay, Adult and Child units)

Responsibilities:

1. In addition to all the above responsibilities
2. Round on any new admissions, patients in the ED and all Short Stay patients **with staff**.
3. Address routine ward issues

Giving handover: Same as above.

A good handover includes:

- Patient name, CR #, age, Form status (voluntary/form 1)
- A brief summary of their presentation, mental status
- Significant medical history to be aware of, violent behaviour etc.
- Plan for the patient (e.g. Waiting for bed upstairs, collecting collateral from another agency in the morning, med reconciliation from outpatient pharmacy etc.) including outstanding issues

Which patients to handover:

- New consults that need to be assessed
- Admitted patients still in the ER
- Patients held over in the ER (not admitted)
- New admissions (when handing over to weekend teams)
- Patients admitted to a medical ward who need to be assessed or followed up (email to the Consultation Liaison team including the CL residents and staff).

NB:

- Consults received after 7:00 am on night/weekend call or 4:00 pm on day call may be handed over without being seen. It is good practise to let the consulting service know they will be handed over.
- For any acute concerns or emergencies e.g. extreme aggression, the on-call team may need to come in to assess until the morning team is able to take over at 8:30 am
- It is the junior resident's role to coordinate all handover, but seniors are expected to guide them in this process as needed. It can be helpful to keep a running list of patient and issues to handover

COMMON ON-CALL ISSUES

Patient Wants to Leave

You may be paged about a patient you do not know that wants to leave. Any admitted patient who wants to leave must first be assessed.

Calmly address any concerns they have. Specifically elicit their concerns about staying or leaving, any discharge planning that they are depending on, etc. Offer food, water, blankets, or help managing pain. Your best bet is to explain to the patient that it is in their best interest to see their regular team (i.e. not the on-call team) for a proper assessment and discussion about discharge.

Consider the following:

1. If the person is **detained for assessment (Form 1)** or **involuntarily admitted (Form 3/4)** and **the form has not expired**, then they cannot leave. Explain calmly and de-escalate if needed. See the **De-escalation section**.
2. **Otherwise**, you must reassess for acute safety risk. See the Risk Assessment section.
3. If you find an **acute safety risk due to a mental disorder**, consider switching the admission to involuntary status (Form 3).
4. **Otherwise**, unless the patient is **admitted informally** (typically children or those otherwise incapable; see Mental Health section) then they are free to leave against medical advice (AMA). Have them sign the AMA form and explain to them the risks of leaving. Document the assessment and discussion in a note.

NB: Consent is *always* needed for treatment regardless of admission type. You can only treat emergency issues (life or limb) without consent. Always document your reasons for Involuntary admissions.

Aggressive Patient


A **code white** may be called when a patient threatens the safety of staff or co-patients. They can be called anywhere in the hospital. You do not need to attend, but may choose to for Burr 4 codes.

Approach to the agitated patient:


1. Make sure you and other staff are safe. See the **Safety section**.
2. Attempt verbal de-escalation first. Speak clearly and explain to them the consequences if behaviour continues.
3. Offer food, water, blankets and lights off.
4. For chemical restraints, first offer the patient a choice between receiving PO or IM medications.
5. Consider physical restraints only for severe agitation and safety concerns. Patient must have 1:1 observation while restrained. If they are in a locked room, you are able to order **locked seclusion**.

Medications:

Always try seclusion and redirection first. The first use medications that the team has tried before with success


 Do not give olanzapine and benzodiazepines parenterally within 1h of each other due to the risk of respiratory depression.

Children:

1. Risperidone 0.25-1mg PO q1h, max 2mg/24h
2. Olanzapine 2.5-5mg ODT/SL/IM q1h, max 20mg/24h 

See *Gerson et al. 2019* for more options ^[1]

Adults <65 y.o:

1. Loxapine 25-50mg PO/IM q1h PRN (max 100mg/24h if antipsychotic naive, or if not can be 200mg)
2. Olanzapine 5-10mg PO/IM q1h PRN (max 20mg/24h) 
3. Haloperidol 5-10mg PO/IM q1h PRN (max 20mg/24h)

Loxapine or Haloperidol can be combined with:

Lorazepam 1-2mg PO/IM/SL q1h PRN agitation (max 8mg/24h)

For **Geriatric populations** please see page 46.

Locked Seclusion Orders

You may be called by nursing staff to request a locked seclusion order if a patient exhibits behaviors that are unsafe to other patients or themselves. You may choose to grant the order over the phone, but then **the patient must be assessed within 2 hours of the call** to ensure the necessity of the order, and safety of the patient and staff. The order can be written as follows:

Lock seclusion for patient, staff, and co-patient safety with q15m observation. Discontinue at nursing discretion.

You must also write a note indicating the reason for the order, whether any PRNs were given, and how the patient appears when you assessed them, e.g.:

On-call Psychiatry

ID: 24M admitted for psychosis NOS

S: Paged by nursing for lock seclusion. Patient reported to be physically aggressive and entering patient rooms. Not redirectable. No PRNs given.

O: Over CCTV, patient currently in bed, at times pounding on the wall.

A/P: Continue lock seclusion, d/c at nursing discretion.

NB: KGH policy is that nurses may discontinue lock seclusion at their own discretion, but **q15m observation must be discontinued by an MD**. You may give the order over the phone

Minor Complaints

It is advisable to assess patients before ordering medications when possible.

Insomnia:

- Adult: melatonin 5mg PO qhs OR zopiclone 7.5mg (3.75mg in elderly patients) qhs OR quetiapine 12.5-25mg qhs (for patients with psychosis/mania)
- Child: Often nothing. If you must, try melatonin 3mg qhs.

Minor pain:

- Adult: Acetaminophen 640mg po q4h prn, max 4g per day
- Child: Acetaminophen 15mg/kg po q4h prn, max 100mg/kg or 4g per day

Nausea:

- Adult or Child > 30kg: Ondansetron 8mg po q6-8h prn
- Child <30kg: Ondansetron 4mg po q6-8h prn

NB: There are several helpful apps for common on-call and ward issues.

Urgent Medical Issues

If a patient is unresponsive, call a “Code Blue” to activate the resuscitation team. There is a crash cart in the Burr 4 nursing station.

If a patient is acutely unwell, or beyond your expertise, the RACE (Rapid Assessment of Critical Event) team is a nurse/respiratory therapist/physician team that provides rapid resuscitation expertise to anywhere in the KGH hospital by calling a “Code 99”. Call them early.

If a patient is medically unstable during the night, you may have to consult internal medicine for possible transfer.

The following resources are available on Burr 4 for medical issues:

- A crash cart in the B-side nursing station.
- A physical exam room on the B side of the ward.
- NO oxygen in the walls, and no capacity for IVs.
- Nurses can obtain blood work and basic investigations.

Urgent CT scans for head trauma meeting the Canadian CT Head rule can be expedited by taking a completed CT requisition to the radiology suite on Kidd 1. After-hours, you must talk to the on-call radiology resident to get any scan completed.

Missing Patient

A code yellow is a missing patient. The nursing staff will usually call you if a patient has gone missing before calling a code yellow.

1. Ask Switchboard to call the patient's name on the overhead PA.
2. If the patient does not return within 15-30 minutes, call a code yellow.
3. For **voluntary patients**, you may ask the police to do a **wellness check**.
4. For **involuntary patients**, the charge nurse will issue a form 9. Police are then authorized to apprehend the patient and return them to the hospital.
5. For **children**, in addition to the above, inform the guardians of the child.

There is no standard policy for how long to hold a bed when a patient goes missing. Usually, the bed is held on a case-by-case basis.

Intimate Partner Violence/Sexual Assault

The *Sexual Assault and Domestic Violence* (SADV) consult service is available during the day. <https://khscnow.kingstonhsc.ca/sadv>

- Use a trauma-informed care approach to determine **when** the assault occurred, and if **children** (≤ 16 years) were involved.
- Clients **must be able to provide informed consent** to engage with SADV. It is voluntary. They must be awake, oriented, and sober.
- Consult the SADV nurse (Jane Lewis ex 4880 or vocera ext. 1335) with name, CR, location, and brief handover. Her voicemail is secure.
- Counselling services can be provided. Consult the SADV SW, Jenni Beaver x7454 or the ED MSHW.
- If children are involved, you must report to Children's Aid Society (613) 545-3227.

NB: The SADV team is also available to help teams debrief.

Risk Assessment

The best suicide risk assessments occur with good **rappport**, are **trauma-informed** and are often **therapeutic** for the patient.

The goal of the suicide risk assessment is not to predict whether or not an unfortunate outcome will occur, but to make a well-informed estimation of the risk of such an event happening, so as to guide appropriate treatment planning. There is no standardized, one-size-fits-all approach to suicide risk assessment. The gold standard is a comprehensive psychiatric assessment. There are several assessment tools which can be used.

It is important to distinguish suicidal behaviour and self-harm. The latter involves harm to one's body without suicidal intent. While it can be difficult to distinguish the two, most people with self-harming behaviours do not want to die.

In the process of the risk assessment it is important to identify risk factors, warning signs, and protective factors

Risk Factors: features which increase the risk a person might think about suicide over the long term

Warning signs: elements which may set into motion the process of suicide in the short terms (minutes to days)

Protective factors: those which may mitigate the risk of suicide

Risk Assessment Approach

1. Create a safe environment and alliance
2. Only then elicit the facts (see below)
3. *Validate patient experience, and enforce boundaries* (e.g. "That sounds difficult **and** you need other ways to cope")
4. Safety plan along the way or at the end
5. Gather collateral to corroborate the story
6. Link to patient to follow up, check-ins, next steps

WARNING SIGNS:

- Threatening to harm or end one's life
- Seeking or access to means: seeking pills, weapons, or other means
- Evidence or expression of a suicide plan
- Expressing (writing or talking) ideation about suicide, wish to die or death
- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless, engaging impulsively in risky behaviour
- Expressing feelings of being trapped with no way out
- Increasing or excessive substance use
- Withdrawing from family, friends, society
- Anxiety, agitation, abnormal sleep (too much or too little)
- Dramatic changes in mood
- Expresses no reason for living, no sense of purpose in life

POTENTIATING RISK FACTORS:

- | | |
|---|--|
| • Unemployed or recent financial difficulties | • Prior traumatic life events or abuse |
| • Divorced, separated, widowed | • Previous suicide behaviour |
| • Social Isolation | • Chronic mental illness |
| | • Chronic, debilitating physical illness |

Adapted from the Suicide Risk Assessment Guide ^[2].

As the number of warning signs increases, so does the risk of imminent suicidal behaviour.

Table 1

Imminent warning signs of suicide: IS PATH WARM

I	Suicidal Ideation
S	Increased Substance abuse
P	Purposelessness
A	Anxiety, agitation, sleep disturbance
T	Feeling Trapped
H	Hopelessness
W	Withdrawal
A	Anger
R	Recklessness
M	Mood changes

Source: Adapted from Reference 1

Table 2

The nature of suicidal ideation

Access to means
Active intent
Lethality of means
Method
Onset, frequency, intensity, duration, precipitants
Plans
Proximity of help
Rehearsal
Specific thoughts
Wishes to die

Safety Planning (Stanley & Brown, 2012^[3])

Do not “contract for safety.” It doesn’t work.

1. Identify personal **warning signs** preceding a suicidal crisis
2. Strategies to **distract** from suicidal thoughts
3. **People** in their support system to reach out to
4. **Mental health resources** to contact
5. Steps to make a **safe environment** (address “lethal means”)
6. **Meaning**, reasons to live, future tasks and goals

Formulation (CAIPS) (Obegi et al. 2015^[4])

A good risk assessment is both clinically sound and legally defensible. Treatment decisions should reflect the overall risk assessment and be easily justifiable. Documentation is critical and you can use extra paper. Your note should summarise:

- **Chronic factors:** Psychiatry Hx, past events, demographics.
- **Acute factors:** recent events or modifiable factors.
- **Imminent warning signs:** nature of current SI, and mental status factors (e.g., future orientation).
- **Protective factors:** elicit the patient’s reasons for living and dying.
- **Summarise:** Make an explicit statement about risk, focusing on imminent risk. Avoid “plot twists” that surprise the reader.

RECEIVING A CONSULT

Who Can Consult Psychiatry?

You may be paged for a consult from various people in and out of the hospital (more on that below). **Importantly, all consultations must be approved by the most responsible physician**, most commonly the KGH/HDH ER physicians, even if you hear about the patient via allied health (e.g. mental health navigator or social work). If the consult comes from allied health, ensure that MRP has assessed the patient prior to the team.

Practicing Collaborative Medicine

It is important to remember that we are medical doctors and psychiatric consultants to the referring physicians. **It is not appropriate to outright refuse a request for psychiatric consultation.** Cultivate collegiality. You may disagree with a referring physician's clinical rationale, but if there is a reasonable question that psychiatry can answer you **must** see the patient, even if you feel able to answer the question immediately. That being said, if outpatient services are more appropriate you can feed this back to the referring doctor and if they agree you can help arrange the referral.

Some suggestions to providing professional psychiatric consultations that are collaborative in nature include:

- If the psychiatric assessment indicates an **organic cause** of the presentation, such as delirium, brain tumour, etc., then discuss the opinion with the referring physician with complete recommendations for further work up or consultation.
- If there is a psychiatric diagnosis and need for admission but the patient is **medically unstable** (e.g. overdose, acute medical problem, suspected delirium, etc.) then consult actively with the ER and appropriate service (i.e. Internal Medicine) that patient should be admitted to. Care should be communicated and coordinated.
- If the patient requires a psychiatric admission but has a known or suspected **medical comorbidity**, then order the investigations needed, and/or consult with the ER physicians or other services.

- If the patient requires routine investigations, then order them. Usually labs will be drawn in ER and ECGs done in ER, but the patient will not have to stay in ER until results are back.

Information to collect

Use the following template when taking consults:

ID/ Referring Doc (and contact #):

Patient ID (Name, Age, Hometown, CR)

On Form?

S/ HPI. Substance use / intoxication?

Significant Medical/Psych Hx

Referral Question

O/ MSE. is the patient interviewable? Agitated? Violent?

Medically stable? Any workup pending?

Any medications given?

A/P Differential? Any medical comorbidities to manage/investigate?

Other services consulted?

Identification and Demographics: Mental health services are allocated based on where a patient lives, see **Catchment** below.

Reason for Consultation: Common reasons for consultation include:

- **Admission for treatment**
- **Risk assessment** - especially when a form 1 is involved
- **Diagnostic clarification**
- **Disposition** (shelters etc.) or **access to community resources** can be handled by a mental health SW or crisis worker
- **Medication adjustment:** It is in the patient's best interests NOT to adjust medications in the ER setting and always preferable to have a consistent psychiatrist or GP prescribe/adjust psychiatric medications and be able to provide follow up. The ER is **NOT** designed for second opinions. If you must discharge with medications, do not give more than a week's worth.
- **Faster access to psychiatry:** ER doctors can directly refer patients to the urgent or regular adult or child psychiatry services. See below. If there are concerns with risk (self harm, harm to others etc.), these can be addressed separately, and consultation provided when appropriate.

Voluntary/Involuntary status: Please see section on MH Forms.

“Medical Clearance” vs “Medical Stability”: Medical Clearance is a very controversial term since a patient is never medically cleared as anything can happen at any time after a patient is medically assessed. The expectation from emergency physicians is **assessment** and **stabilization**, not clearance.^[5]

Patient’s capacity to engage in an interview on a psychiatric level.

This includes considerations such as if the patient is sedated, intoxicated, medically unwell, and/or willing to speak with psychiatry.

Aggression. Ask if there were things that helped with the aggression (IM chemical restraints, verbal de-escalation, assistance from police, etc.). See the **Safety** section for more details.

Consultations from the KGH or HDH ER

KGH Consultations

The majority of consultations are for adult patients presenting to the KGH ER. They are seen by the ER doctor or nurse navigator and referred to the psychiatry on-call team for a variety of reasons.

Children and Adolescents

Discuss with the ER physician if an urgent outpatient assessment is more appropriate. Appointments are usually possible within 1-7 business days depending on availability and patients are seen by a Child Psychiatrist. Consider if:

- the caregivers are comfortable taking the child home
- no clinical suspicion of an imminent risk of suicide
- admission is not felt to be necessary.

The Child and Adolescent Urgent Consult Clinic is an outpatient resource which aims to assess youth with high risk presentations within 72 hours of referral. ER doctors at KGH/HDH and the psychiatry team can refer to this clinic.

Geriatric Patients with Dementia

Patients with dementia can be complex to manage and arrange for disposition. If dementia or behavioural and psychological symptoms of dementia (BPSD) are the sole issue, admission to the acute psychiatric unit may not be in the best interest of the patient. The decision to admit is usually best made by the regular day call team. Nevertheless, care often involves coordination with the ER physicians and Internal Medicine services. **There is a Nurse Practitioner working in the ER who helps coordinate care for the seniors with dementia.** Please see the appendix for medication suggestions and the Dementia Pathway on the next page.

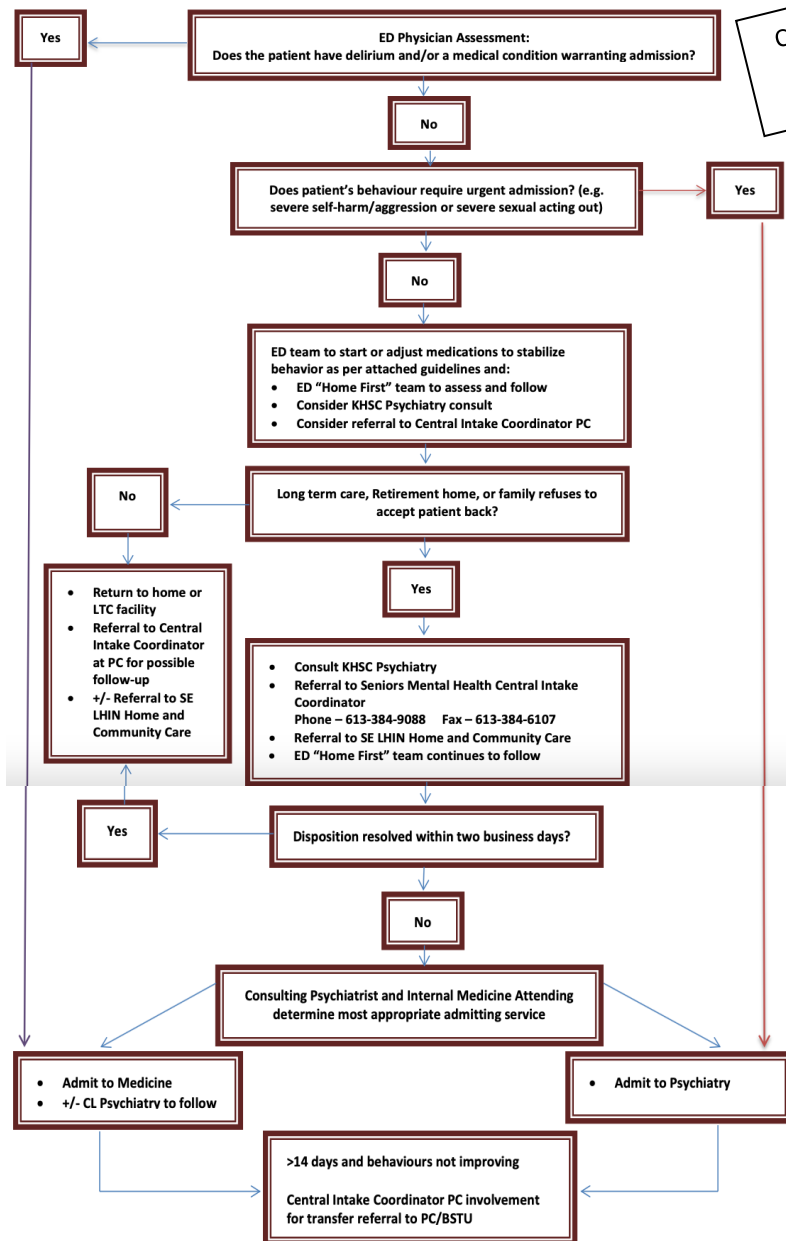
HDH Consultations

All patients consulted from the HDH urgent care must come to KGH ER for assessment (not Burr 4). **There is no need to check with your attending psychiatrist.** Always clarify the mode of patient transfer with the ER physician, and if they are on a form, and **always inform the KGH ER charge nurse** after accepting a consultation from HDH ER.

ED Patient with Dementia and Behavioural Change

Effective May 2019

Currently under review!



Outside ER/GP Office/Psychiatric wards Consultations

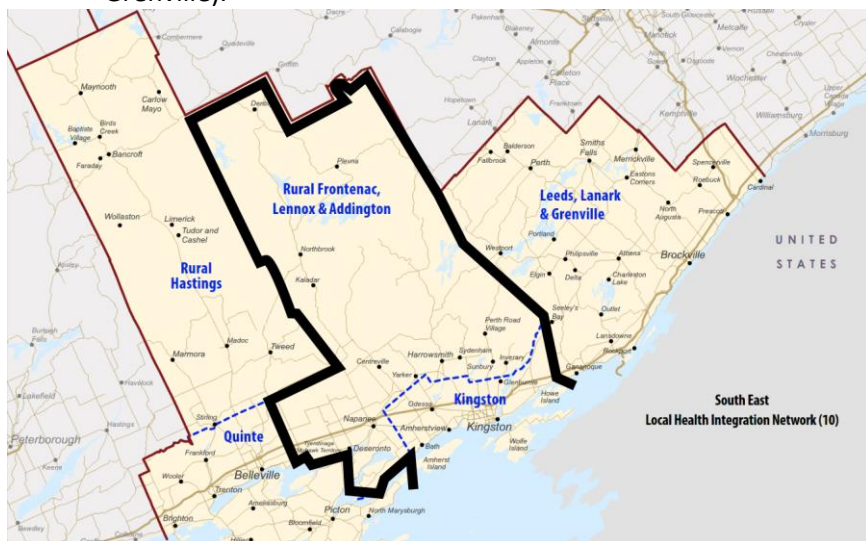
All requests to transfer patients from outside ERs to KGH ER should be discussed with the attending physician. If required, your staff can speak directly to the other attending. **Always alert the ER charge nurse when receiving a consult that is not from KGH.**

Catchment Area

Mental health services are based on where a patient lives. Therefore, if a patient is not in our “catchment area” (broadly, the South East LHIN) we cannot provide them routine care.

The KHSC catchment areas are:

- For **Child and Adolescents (thin border on map)**: Frontenac, Lennox & Addington (including Kingston), Quinte (Trenton, Belleville), Leeds, Lanark, and Grenville (including Brockville, Perth, Smiths Falls, and surrounding communities).
- For **Adult Mental Health (thick border only)** is the Kingston region, Frontenac, Lennox, and Addington Counties. Patients seen in the Napanee ER who require psychiatric assessment are sent to KGH. Adults in other parts of the SELHIN should be assessed in their local Schedule 1 Facilities, e.g. in Belleville (for Quinte and Hastings), or Brockville (for Leeds, Lanark & Grenville).



“Direct to Psychiatry”

Direct to Psychiatry means that a patient will be sent from the community to the ER and be seen by the psychiatry team *directly*, bypassing the standard ER physician assessment. **The staff psychiatrist and ER charge nurse must approve ALL direct-to-psychiatry requests.** No patient should be directly admitted to a unit without seeing the ER psychiatry team.

These are some common situations for psychiatric assessment that come up:

- A **community Psychiatrist or GP** asks to send a patient to the ER for psychiatric assessment. If the patient is medically stable AND from our geographical catchment area, we can usually accept.
- An ER physician from a non-Schedule 1 facility **in our catchment** (see above), e.g. an adult in Napanee, asking to send a patient from their ED. Usually we would accept unless we don't have a bed, in which case it will need to be discussed with the emergency physician or charge nurse.
- Any physician from a non-Schedule 1 facility **outside our catchment**, e.g. an adult patient in Perth or Trenton, asking for psychiatric assessment is usually redirected back to their local Schedule 1 facility.
- A **psychiatrist from Belleville or Brockville hospital** calling about a patient who is assessed and needs admission, but they have no beds, will usually be accommodated if possible. (This rarely happens)
- An ER physician calls about a psychiatric assessment for a **child anywhere in the SELHIN**. If appropriate you can support them in sending a referral for the Urgent Consult Clinic (below) and otherwise they can be transferred to the KGH ER for assessment (if there are available C&A ward beds).

Urgent Child and Adolescent Consult Clinic:

If a patient has been seen and assessed in an ER that is within C&A catchment area, and they meet the criteria, they can be referred to the urgent consult clinic, either by the outside ER directly or the on-call team. Follow the instructions in the binder kept in section A. Patients who are seen by a GP in the community are NOT ELIGIBLE to be referred to the UCC and they should instead contact the outpatient

clinic themselves. **GPs are NOT to use the urgent child and adolescent assessment clinic spots reserved for the ER.**

Transfers from Weeneebayko

KGH has a special agreement with Weeneebayko Hospital, located in Attawapiskat. There is a sizable First Nations population living with a significant mental health burden. KGH will accept patients from this hospital for mental health assessments.

All transfers from Weeneebayko require staff approval. Whenever possible, it is advisable to make decisions for transfer from Weeneebayko during the daytime when the regular staff are working. For children and adolescents, they can be assessed by a child psychiatrist via OTN to provide an alternative to admission. If you receive a call to transfer a child or adolescent from a northern community, please have them book an OTN appointment (they know how to do so) prior to transferring the patient. They can be transferred by the assessment physician on the next day if necessary.

Inpatient to Inpatient Transfers

Such transfers should **only take place after accepted by the Burr 4 psychiatry director** and ideally occur during regular business hours.

Consultations from the Medical Wards

All inpatient consultations are done by the Consult Liaison Psychiatry team during the day. When you are on-call, you may be paged about an inpatient. Ideally, the consulting team should wait until the weekday daytime hours to speak directly to the C-L team; however, in urgent situations you may need to assess.

If they are already followed by the C-L Psychiatry Team, you can look at the **Resident Handover notes on PCS** to see an overview of the patient and the current plan. This is usually updated daily by the CL team. To access it click on KH Weblinks→ Resident Handover→ Consult Service→ C-L Psychiatry

Helpful information to gather when receiving a C-L Consult:

- **Length of stay in hospital/expected discharge date:** This will help to triage the patient as at times we may be consulted after the primary medical issue has resolved and the patient may only be waiting for a psychiatric assessment in order to safely discharge.
- **Location of patient**
- **Brief reason for hospitalization**
- **Disposition of patient:** This may help with our recommendations for discharge planning by understanding the supports in place.

Common reasons for consults are the same as in the ED listed on page 15. Other scenarios that may present include:

- **Concerns regarding mental capacity to make decisions:** We can assist with determining if there is an active mental illness affecting their judgement, but **every physician has the responsibility to determine capacity within their scope of practice**. For example, a surgeon must assess capacity for a surgical procedure as they are familiar with the risks/benefits of the procedure. Psychiatry at KGH does not provide financial capacity assessments for patients on medical units. This is done by specially designated assessors. The capacity for LTC decisions is exclusively in the domain of CCAC.

Consultations from the pediatric wards

During regular hours consultations from the Pediatric Ward should be faxed directly to Burr 4 Child and Adolescent unit. They are seen and followed by the Child Psychiatry Team. During on-call hours, the on-call team may be consulted for new patients or may need to assist the pediatric team with patients already being followed by psychiatry.

Helpful information to gather when receiving a pediatric consultant:

- **Length of stay in hospital and expected discharge date**
- **Brief reason for hospitalization**
- **Who are the guardians?**
- **Is there CAS involvement?**
- **Involvement with child psychiatry previously**
- **Disposition of patient:** This may help with our recommendations for discharge planning by understanding the supports in place.

There is no age of consent for medical treatments, therefore if a child or adolescent can understand and appreciate the reason for admission or treatment then they can consent, and parents can be informed (if the patient consents to this). Patients requiring involuntary admissions (i.e. not willing to stay voluntarily and admission being necessary) should be placed on a form.

ASSESSMENT OF THE PATIENT IN THE ER SETTING

Seeing consults from the ER is the core of the on-call experience. **As a junior, you should not hesitate to request assistance from the senior resident when needed.**

Safety

The safety of every KGH employee, student and patient is always the top priority when on call. The literature on the correlation between acts of violence and psychiatric illness is not entirely clear due to the massive methodological difficulties in conducting such research and the wealth of confounders involved in why individuals, mentally ill or not, commit violence. The bottom line is that comorbid mental illness and drug abuse are very significant factors in predicting violence.^[6] When on call, we will often encounter patients at high risk of becoming violent (drug use, desperate patients being held against their will with poor judgement etc.). We present here some tips to help keep yourself and others safe while on call.

Respect and Empathy: It is important to realize the extent to which our own attitudes towards patients can influence the likelihood of violence. Cultivate an empathic and respectful regard, even when patients do not reciprocate.

Personal Attire: Tie up long hair and loose articles of clothing or ID lanyards and leave behind stethoscopes or other unnecessary medical equipment. Do not carry anything into the room that can be used as a weapon. .

Preparing the interview: Ask agitated patients to sit down before interviewing them and if they refuse to comply, be very cautious proceeding. For very agitated patients, consider involving security, and/or interview through a window or stand in or near the doorway. The interview can be delayed if needed.

Positioning: Stand so that the patient cannot lunge and reach you. Never have the patient between you and the door.

Posture: Point your body 45 degrees away from patients to appear less threatening and making it easier to escape through a nearby exit.

Panic button: All Psychiatry residents are provided a panic button that, when pressed, calls KGH security to your location.

Termination of interview: Stay close to the door and be ready to leave if you to feel unsafe (clenching fists, standing up from a seated position, making intense eye contact). **Always trust your instincts!**

Security- some important points to consider about security presence:

- Security guards have no mental health training, but often have experience de-escalating conflict. Call them early. Ask for their input.
- They do have training in restraining patients, and you do not. It is not the role of the psychiatrists to physically restrain a patient.
- You are the team leader of the response to an agitated patient.
- Communicate very clearly where you would like security to be when you see the patient (outside of the room, inside the room, between you and the patient etc.)
- Presence of security guards may escalate the behavior of many patients. Sometimes it is helpful to ask security to be present in the ER but out of sight of a patient.

Gathering Information

Preparing to see a patient

Before you see a patient, review available sources of information:

- Accompanying documentation, for example a Form 1, note from a referring physician, suicide note, etc.
- Current and past medical records available in EDIS or PCS, specifically look for past Psychiatry 4-Pagers (in the scanned ER records in PCS).
- Review ER vitals, blood work, medications given in ER
- Determine if the patient was seen by social work. If so, read their reports and talk to the social worker.
- Police, friends, and family present, as they may often leave early.

Interviewing and Collateral

Safety first! Do a brief risk assessment before entering the room to determine level of agitation, psychomotor activity, and disorganisation. Consider a security chaperone. See the section on **Safety** for more details

Use the Psychiatry “**4-pager**” consultation form as a checklist to structure your interview. You can also use the **Yellow Consult Sheet** to record assessments.

Collateral information: Ask the patient for permission to speak with family or others who may be able to corroborate baseline mental status and events discussed. You need permission to give information but not to get information in an emergency setting. Record the interview on a Progress Notes sheet or in the 4-pager. It is helpful at times to call the AMHS crisis line, explain your role and ask about the patient's current AMHS support or previous contact.

Drug Screen

If there is a suspicion of drug or alcohol use, you may order an alcohol level and urine drug screen. **The emergency literature indicates that a urine drug screen is unlikely to change the management in the emergency room³**, but from a psychiatric perspective it may be useful to refine the differential.

Some average times that drugs will continue to show up in a urine drug test include the following:^[7,8]

- Heroin: 1-2 days.
- Cocaine: 2-3 days.
- Marijuana/THC: 1-3 days (single use), 5-7 days (moderate use),
- Methamphetamine: 1-2 days.
- MDMA: 2-4 days.

Developing a Management Plan

To maximize your learning, discuss your management plan to your senior resident before reviewing with staff. Use the following template to organize your thoughts

History and Assessment

1. Who is the patient (age, gender, name, employment, source of income, living situation, supports) and what was the reason for psychiatric consultation?
2. How did the patient arrive at the hospital? Are they on a form?
3. What sources of collateral information did you collect?
4. What is the best possible story you can put together that explains why the patient is here?
5. What sort of psychiatric symptoms is the patient experiencing?
6. Past Psychiatric History (comment on previous hospitalizations if any), Past Medical History, Past Legal history, Family History.
7. Current Medications and Drug Use.
8. Mental Status Exam
9. What is your diagnosis and understanding of the situation?
10. What is your best estimate of the risk to self or others?

Management Plan

1. Disposition: Admission or Discharge? IOA or B-side?
2. Certification status: Form 1 or no Form 1?
3. Is there any further medical work up we need to complete?
4. Is there any further collateral information we need to obtain?
5. Would this patient benefit from psychiatric medication or medication adjustment? Who should do this and where?
6. Would the patient benefit from any therapy? And which?
7. How likely is the patient to follow up on any recommendations we provide?
8. How quickly should our recommendations be implemented?
9. Do I have any legal obligation to report/warn? I.E. homicidal ideation towards a specific target, CAS, concerns with impaired driving etc.
10. Don't forget simple practical management options such as giving a patient a card for the crisis line or getting the crisis team to call the patient to check on how they are doing after discharge from the ER.

Admission Process

When patients are admitted, they may have a lot of questions and anxiety. Take the time to explain the admission process as best as you can:

- Patients will receive whatever investigations you order in the ER and they may be subject to a search for contraband (drugs, weapons etc.) prior to a porter bringing them upstairs to Burr 4.
- All the inpatient rooms on Burr 4 are designed for one patient, but most have to share a bathroom with the same gender. Patients who are on a form 1 **cannot** leave the inpatient ward for a smoking break; this is hospital policy.
- Family members and very close friends may visit patients on Burr 4. Visiting policy is stricter for the child inpatient ward – they typically will not allow classmates to visit. Patients have the right to refuse any visitor.
- Useful things that patients might want to bring to the unit (or ask loved ones to bring) might include: 4-5 day wardrobe of casual, comfortable, appropriate clothing (there is access to laundry facilities), personal toiletries, reading material, a small amount of money for vending machines, a list of current medications including over the counter drugs. Cell phones are allowed but will be kept at the nursing station. All unnecessary valuables should be sent home, otherwise they will be stored at the KGH Security Office and returned upon discharge with the exception of prohibited weapons or illegal substances, as per hospital policy.
- Sometimes due to bed shortages, patients will have to stay overnight, or during the day, in the emergency room.
- Be aware of COVID related restrictions if relevant.

If possible, you may complete a physical examination and document that you have done so. **It is the standard of care as well as a requirement in the Ontario Hospitals Act that any patient who is admitted to KGH has a physical exam completed in 72 hours.**

Admission Orders

Whenever you are unsure about admission orders: ask your senior resident to look it over! Please see the appendix for sample admission orders.

Admission orders are completed through EntryPoint order sets found in PCS. In addition to general mental health admission order sets, there are disorder-specific admission order sets in development, as well as order sets for managing comorbidities such as alcohol withdrawal (CIWA) protocol and nicotine replacement.

The **IOA (Intensive Observation Area)** should be reserved for adult violent patients, severely agitated patients, and patients at imminent risk of self-harm. The **Short-Stay Unit** should be used for patients with a clear disposition plan and expected stay of less than 72 hours. The decision to which unit to place a patient is a clinical decision and it's best to have a conversation with a staff psychiatrist or senior resident if you are unsure.

DISCHARGING THE PATIENT FROM THE HOSPITAL

When it comes to sending a patient home, it's helpful to be aware of frequently used community resources. Many patients also have family doctors and other resources that can be a source of counselling and/or mental health support.

Frequently Used Community Mental Health Resources

Community resources change frequently. You can also page SW to clarify available options and ask for advice.

Adult Mental Health Emergency Psychiatric Assessment, Treatment & Health Team (EMPATH)

The EmPATH Clinic is an assessment and brief intervention service offered through HDH. Brief intervention (4-5 sessions) may be offered through EmpATH and may involve follow-up with our interdisciplinary team and/or medication; however, there may be no further involvement necessary after the initial assessment. The EmPATH Clinic aims to triage referrals within two business days.

ITTP (Intensive Transitional Treatment Program)

This is an intensive 4-6-week mental health program at Hotel Dieu Hospital. Patients can be referred if they are in the KFLA area, over age 18 and are stable enough to engage in outpatient services. This service is covered by OHIP and the main focus is an interprofessional mental health team and group therapy, including CBT, DBT, and mindfulness-based groups. The Managing Powerful Emotions group can be used as a precursor to further DBT groups for patients who have a borderline personality disorder. Patients may also be seen by a psychiatrist.

TCM (Transitional Case Management)

TCM is a community-based service offered by **AMHS-KFLA** (Addictions and Mental Health Services – Kingston Frontenac Lennox and Addington). It is a time limited service for patients who have been seen in hospital and need to be transitioned back to the care of their family doctor or usual mental health provider. The advantage of this resource is that they have access to a crisis psychiatrist (time limited, with variable wait times), as well as a mental health team that is able

to work with individuals in the community (i.e. coming to people's homes directly).

- Response to referrals is quick, with a telephone intake within days
- Help with functional concerns: will call supports, help with coping strategies, connecting with services.
- Ideal for patients requiring more active management but not at the level of an ACT team.

Please note that TCM is different from the Crisis Team also offered by AMHS-KFLA. The Crisis Team is designed to help people in acute crisis, and only patients that have more long-term mental health needs that are not being addressed should be referred to TCM. Both teams have a separate psychiatrist that works alongside the mental health workers.

RESOLVE Counselling

Community based resource that offers therapy at a price that is based on the person's income level. Website: <https://resolvecounselling.org/>

Street Health:

Street Health Centre is a multi-service harm reduction health centre open 365 days a year offering education, treatment, and youth services through a multidisciplinary team of registered nurses, nurse practitioners, physicians, outreach workers and counsellors. Services include needle syringe program, primary health care, counseling, methadone maintenance treatment, naloxone overdose prevention kits, Hep C treatment, used needle pick up, indigenous health programming and harm reduction supplies. Available in Kingston and Napanee.

Detox:

The Detox Centre (613-549-6461) located at 240 Brock Street is part of KHSC and is for men and women 16 years old or older, who are safely able to withdraw in a non-medical setting. The 22-bed facility is for people who are intoxicated, in withdrawal related to their substance use, waiting for confirmed intake into a residential treatment program, or are in danger of a relapse. The Detox Centre is a publicly funded program for the southeastern Ontario region, so there are no fees for services. Stays at the centre are voluntary and on average last between 3-5 days. Call before sending a patient to confirm availability.

Additional Addiction Resources:

- **THRIVE:** Addiction and Harm Reduction services for pregnant women and women with children under the age of 6 years old, who are struggling with opioid addiction or receiving methadone.
- **Motherwise** Addiction and Harm Reduction services for pregnant women and mothers through AMHS

Child and Adolescent Urgent Consult Clinic

The mandate of the clinic at HDH is to see children aged 12 – 17 who have a high risk to self-harm or harm to others. The clinic provides a comprehensive consultation and some limited follow up for patients. The clinic only sees children who are not involved with another child psychiatrist in the division. The clinic aims to see children within 1-3 business days. Patients can be referred via the binder found in Section A of the ER. Children under 12 can be referred but will be triaged by the clinic.

Maltby Center for Children and Adolescents (Previously Pathways)

This is the main community resource for parents and children with mental health needs. They provide a number of counselling and therapy services on a self-referral or even walk-in basis. It is always worthwhile to set families up with this resource, and to reserve psychiatric resources for those patients who have refractory symptoms. Very recent literature has found that in Ontario, more than 50% of youth presenting to the emergency department for mental health related concerns have not accessed outpatient mental health supports ^[9]. The waitlist can be long to see a child psychiatrist in Kingston and many patients will benefit more from behavioural and counselling supports available through Maltby.

Seniors Mental Health

Outpatient services and supports for:

- Older adults with late-onset Major Mental Health disorder (initial onset >65 yrs. e.g. major depression , bipolar disorder, anxiety disorders, schizophrenia and psychotic disorders and substance use disorders)
- Older adult with confirmed or suspected progressive Dementia, Younger adult (under 65 yrs.) with suspected progressive Dementia such as Alzheimer's Disease, Vascular Dementia, Fronto-Temporal Dementia

Seniors Mental Health does not typically provide services to individuals with longstanding mental illness who have reached age 65 and who are receiving services through other community mental health services. Seniors Mental Health Outreach does not typically provide long term follow up. The focus is assessment and linking people to community supports.

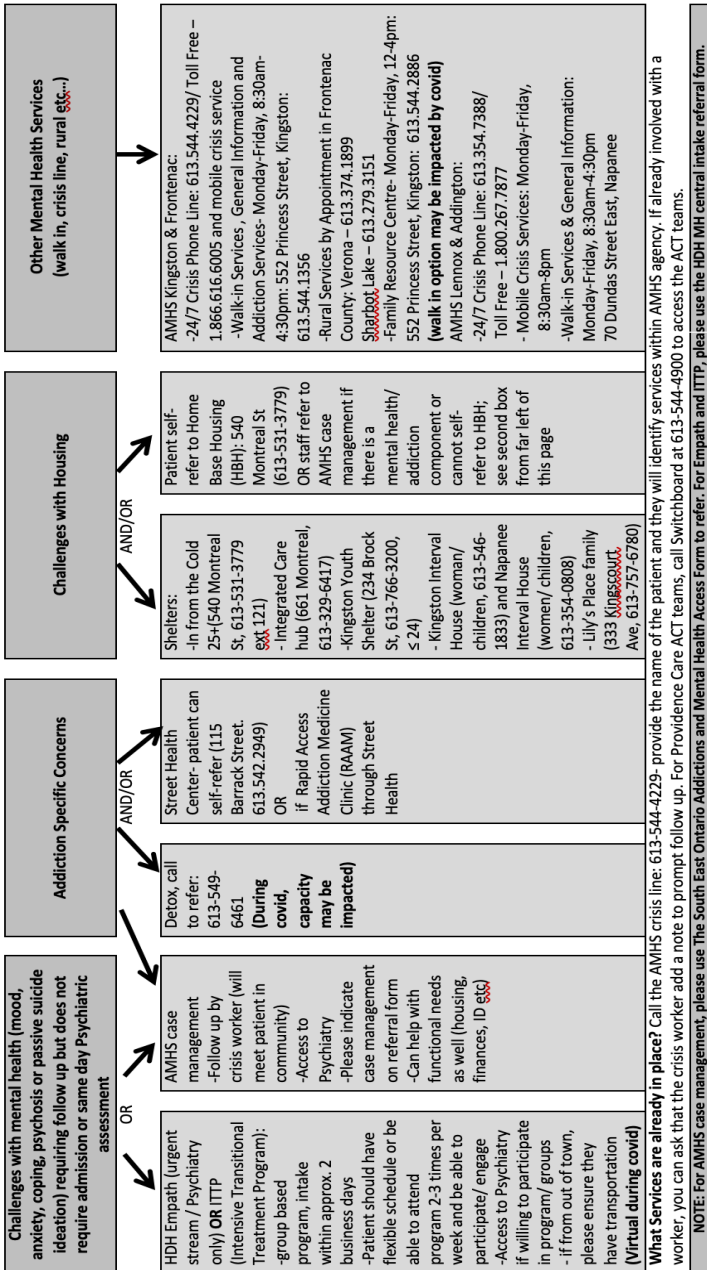
BEHAVIORAL SUPPORT SERVICE “MOBILE RESPONSE TEAM”:

The Mobile Response Team is generally seen as a first line approach to managing individuals in long term care homes exhibiting responsive behaviors, before medications are considered. The team consists of specialized PSWs, RPNs and RNs who support individuals residing in long term care with behavioral concerns. They can be an invaluable resource in assisting long term care homes identify triggers and develop strategies to support individuals exhibiting responsive behaviors. Patients do not need to have dementia; they only need to be residents of a long-term care home.

They provide 7 days a week nursing and PSW support as required to residents and staff in long-term care homes throughout southeastern Ontario. Catchment area includes: Leeds, Grenville & Lanark, Frontenac, Kingston, Lennox & Addington and Hastings and Prince Edward County.

Referrals to this service are made by long term care homes or with agreement from long term care homes.

EMERGENCY DEPARTMENT REFERRAL OPTIONS



ADDITIONAL RESOURCES			
Addiction: <ul style="list-style-type: none"> • Detox: 613-549-6461- intake via phone • Addictions Anonymous Helpline: 613-549-9380 • Al-Anon/Alateen: 613-384-2134 • Drug and Alcohol Registry of Treatment Helpline (24 Hrs): 800-565-8603 • Ontario Gambling Helpline (24 Hrs): 888-230-3505 • AMHS (groups, counselling and case management, refer to info on other side of page) • Kairos- Substance Use Counselling for youth (24 and under): 559 Bagot St, 613-548-4535 	Children/Youth: <ul style="list-style-type: none"> • Hotel Dieu Urgent Consult Clinic: please see instructions in purple binder in section A for high risk youth age 12-17 (children <12 will be triaged; referral can be done but cannot be scheduled in the binder) • Maltby Centre (formally Pathways, self-ref): children/youth mental health centre, 613-546-8535 • Child and Baby Talk Line (Mon-Fri 8:30am-4:30pm): 1-800-267-7875 x555 • Kids Help Phone Helpline (24 Hrs): 1-800-668-6868 • AMHS Transition Aged Youth Case Management- for youth aged 16-24; Use the SEO Addictions and Mental Health Access Form, select AMHS at top and in comment section, write "Transition Aged Youth" 	Abuse: <ul style="list-style-type: none"> • Assaulted Women's Helpline (24 hrs): 866-863-0511 • Sexual Assault/Domestic Violence (KGH ER) • Sexual Assault Centre (self-ref): 613-545-0762) 	
Counselling (self-ref): <ul style="list-style-type: none"> • Sexual Assault Centre: 613-545-0762 • Resolve Counselling (fees for counselling based on a sliding scale): 613-549-7850 • Aboriginal Supports- Jolie Brent- provides counselling through Interval House: 613-546-1833 ext 22 • Queen's University Student Wellness Services- health services and counselling, 146 Stuart St, 613-533-2506- self referral or call after hours and leave a message for follow up by clinic staff • St Lawrence College Kingston, Counselling Services 613-544-5400 ext 1593 	Drop In/ Day/M meal Services: <ul style="list-style-type: none"> • In from the Cold Day Service, 540 Montreal St: lunch, showers, coffee • Martha's Table: 613-546-0320- 629 Princess St • St. Andrew's Presbyterian Church: 613-546-6316 130 Clergy Street, Kingston (art drop in, some meals) • St. George's Cathedral, 613-548-4617 ext 30- 129 Wellington Street Kingston: coffee, lunch • St. Mary's Cathedral: 613-546-5521 • St. John's Parish Hall, 94 Patrick Street Kingston : • Saturday hot lunch • St. Paul's Anglican Church: 613-542-5870- Tues/ Thurs dinner- 137 Queen Street Kingston • St. Vincent de Paul Society, lunch Mon-Fri: 613-766-8432- 85A Stephen Street, Kingston • Seventh Day Adventist Church: 613-548-7765- 66 Wright Crescent, Kingston- Tues meal not in summer 	Other: <ul style="list-style-type: none"> • AMHS crisis cards are in section B (under the desk) and section E • Kingston Pregnancy Care Centre (Mon- Thurs 9am-3pm): 613-545-0425 • Kingston Community Chaplaincy (24 Hrs): 613-549-8899 • Aboriginal Supports- Jolie Brent- provides counselling through Interval House: 613-546-1833 ext 22 • Also consider Military supports and EAP supports • Family Health teams: <ul style="list-style-type: none"> - Maple: 613-531-5888 - Kingston: 613-531-4234 - Queens: 613-533-9303 	

Discharge Summaries

When a patient is formally admitted and then discharged by the on-call team – whether Day, Night, or Weekend call – **it is the responsibility of that on-call team** to ensure a discharge summary is completed (e-discharge on PCS). If a patient has been followed by the day team for more than 72 hours, the on call team can document the discharge information but request the day team complete the rest of the summary - this should be communicated to a team member to ensure it can be done in a timely fashion. **Please contact Medical Records to ensure that the discharge summary correctly reflects the name of the attending physician you are on-call with** - this is not always automatically done and if there is an error, the discharge summary will enter the queue of the wrong psychiatrist.

If there are community teams involved in the care of the patient, such as outreach or ACT, it is both collegial and extraordinarily beneficial for patient care to fax over a copy of the discharge summary. Sometimes even picking up the phone and calling the most responsible psychiatrist or mental health care provider after the discharge is a great way to ensure that your treatment plans and recommendations are carried through, and could mitigate your patient coming to the ER unnecessarily.

Please see the appendix for information on completing discharge summaries.

IMPORTANT CONTACTS

Chief Residents: psychief@queensu.ca

Psychiatry On-Call Managers: gpsychcall@gmail.com

KGH Extensions and Numbers

Switchboard		0
Switchboard- outside call		548-2473
ER	A	2335
	B	3470
	C	3460
	D	3730
	E	6722
E resident phone		7293
ER Charge Nurse		7003
Burr 4	B	6020
	IOA	6225
	C	6022
C-L Office		7839
VOCERA		1335
SW Pager		6506802
HDH extension		52-ext.
IT Help Desk		4357 ("HELP")

HDH Extensions and Numbers

Switchboard	0
KGH Extension	82-ext
Child and Adolescent UCC	2518
C&A Outpatient	3406/2554
Adult outpatient clinic	3700
IT Help Desk	4357 ("HELP")

MENTAL HEALTH LAW

Principles

The *Health Care Consent Act (HCCA)* applies to consent and capacity in both psychiatric and non-psychiatric conditions. Importantly:

- capacity requires both **understanding** and **appreciating** risks and benefits
- **capacity fluctuates** and so must be reassessed regularly,
- **capacity is issue-based**: a person may have capacity for some kinds of decisions and not others (e.g. treatment, finances, property...)
- To initiate non-emergency (non-life or -limb) treatment, a patient must either be capable or have an SDM that consents.

The *Mental Health Act (MHA)* regulates involuntary admissions and treatment of patients. Importantly, it provides three basic ways to admit a patient:

- **voluntarily** if they are capable and willing to be admitted
- **involuntarily** if they have a mental disorder causing imminent safety risk
- **informally** if admitted with consent from SDM for treatment (i.e. incapable)
 - People between 12-16 may be admitted informally but must be notified (Form 27)
 - People 16 or older may be admitted informally under special circumstances only

NB: Consent is *always* needed for treatment regardless of admission type.

Informal or voluntary patients *cannot* be restrained.

Form 1 / 42: An application for psychiatric assessment

Any physician may complete a Form 1 if they are concerned a person has a mental disorder causing an imminent risk of harm to themselves or others. It gives authority to **find and detain a person for a psychiatric assessment**.

- A Form 1 can be filled out up to 7 days after a physician has seen a patient, and it is enforceable by the police for up to 7 days after it is filled out.
- Once a person is at a Schedule 1 facility, the Form 1 enables detainment for up to 72 hours for assessment. **It does not allow for treatment without consent.**
- A Form 1 can be discontinued at any time by **any treating physician**.
- By Law, **a person must be told they are being detained** for assessment under the Mental Health Act. A Form 42 is a companion form given to the detainee **at the schedule 1 facility** that provides this notification.

What if the Form 1 is filled out incorrectly?

The most common mistake is for both Box A and Box B criteria to be filled out (this invalidates the form), or to have missing information. If you cannot find the signing MD to correct it, then consider writing a new Form 1 and Form 42.

How do I fill out a Form 1 and 42 correctly?

See <https://www.psychdb.com/teaching/on-mha/form-1-42>

Form 2: Order for Examination

A member of the public (e.g. family) can request a medical examination of a person if they have safety concerns.

- The Form 2 must be signed by a Justice of the Peace.
- Police are then authorized to bring the person to any hospital for examination by a physician (not necessarily a psychiatrist).
- **The form 2 does not authorize detainment at the hospital for any period of time.** Thus, to keep a patient involuntarily, a Form 1 or 3 must be used.

Form 3 / 30 and Form 4: Involuntary Admission

The Form 3 or 4 is issued at a psychiatric facility to keep a patient involuntarily. **They do not allow for treatment without consent.**

The Form 3 holds patients for up to 2 weeks. The Form 4 can hold people for longer with the duration depending on how many times the form 4 has been renewed (and can be renewed indefinitely).

Form 9: Order for Return

Instructs the police to search for, apprehend and bring involuntary patients back to the hospital.

Form 33: Incapacity

This is issued when a patient is deemed incapable of making decisions related to their healthcare or finances. If they are found incapable of making treatment decisions regarding a mental disorder a substitute decision maker will give consent on their behalf. Capacity is assessed separately to risk, and therefore separate from voluntary/involuntary admission status.

Form 45 / 47 / 49: Community Treatment Orders

A Form 45 is issued when a patient on a community treatment order fails to comply with the terms of their treatment (usually some form of depot injection), and the police are instructed to search for, apprehend and bring the patient into hospital.

Form 27

Only used for children aged 12-16 and notifies them that they are being admitted **informally** to a psychiatric facility. They may then fill out a Form 25 to indicate they want a CCB hearing to clarify their admission status.

BURN OUT/RESIDENT WELLNESS

Residency is an incredibly taxing time, especially during times of transition (in between rotations, in between PGY years, events in our personal lives). Psychiatry rotations, in particular, can expose residents to information and situations which can be traumatic or taxing. For whatever reason, we can find ourselves over-burdened emotionally and become burnt out. **In a recent survey of Canadian Residents^[10], out of the 48% of residents who responded, almost half of them replied that they were burnt out.** Burnout is common and if you think it's happening to you, seek help! There are several excellent resources available for those who are interested in seeking help for wellness. Most of these services are confidential. Some resources include:

- 1) OMA Physician Health Program. <http://php.oma.org/>
- 2) Queens School of Medicine and Queen's Student Wellness Services <https://meds.queensu.ca/education/postgraduate/wellness/counselling>
- 3) Resident affairs via the Learner Wellness office <http://meds.queensu.ca/education/postgraduate/wellness/director>
- 4) Family doctor
- 5) Program director
- 6) Private therapist <https://therapists.psychologytoday.com/rms/state/ON/Kingston.html>
- 7) Professional Association of Residents of Ontario (PARO). www.myparo.ca.
- 8) KGH: The employee assistance program

REFERENCES/ APPENDICES

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3. Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19(2), 256–264. <https://doi.org/10.1016/j.cbpra.2011.01.001>
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Appendix 1: Agitation Management in Dementia

Use of Antipsychotics and Other Medications for Urgent Treatment of Severe Agitation, Psychosis or Aggression in Older Adults with Dementia in Long-Term Care Settings

INTRODUCTION AND DISCLAIMER

For severe behavioral disturbances posing a risk to the patient, staff or co-residents, the best supported evidence is for the atypical antipsychotics, in particular **RISPERIDONE**, **OLANZAPINE**, and **ARIPRAZOLE**. Informed consent should be obtained from the patient or substitute decision maker as soon as possible given the urgency of the situation. All atypical antipsychotics are associated with approximately a 1% increased risk of stroke and death over a short-term treatment period of 6-12 weeks. **THIS TOOL, PREPARED IN APRIL, 2012, IS A CONCEPTUAL AID FOR HEALTH CARE PROVIDERS. IT IS NOT A SUBSTITUTE FOR A PHYSICIAN'S DIAGNOSIS AND TREATMENT AND IS NOT MEDICAL ADVICE. USE AT YOUR OWN RISK.**

ASSESSMENT

Does the behavior require urgent treatment?

- **Physical aggression** (e.g. hitting, pushing, kicking) towards co-resident which are not limited to specific situations (i.e. not in response to another resident threatening patient)
- **Physical aggression** (e.g. hitting, pushing, kicking) towards staff that is not limited to specific situations (i.e. not during care)
- **Psychotic symptoms** (e.g. hallucinations or delusions) which are severe and distressing to patient or co-residents, or staff

DO NOT initiate antipsychotics for non-aggressive physical agitated behavior such as wandering, pacing, or general restlessness. Instead use non-pharmacological approaches or initiate treatment with other medications as appropriate.

Investigate treatable causes:

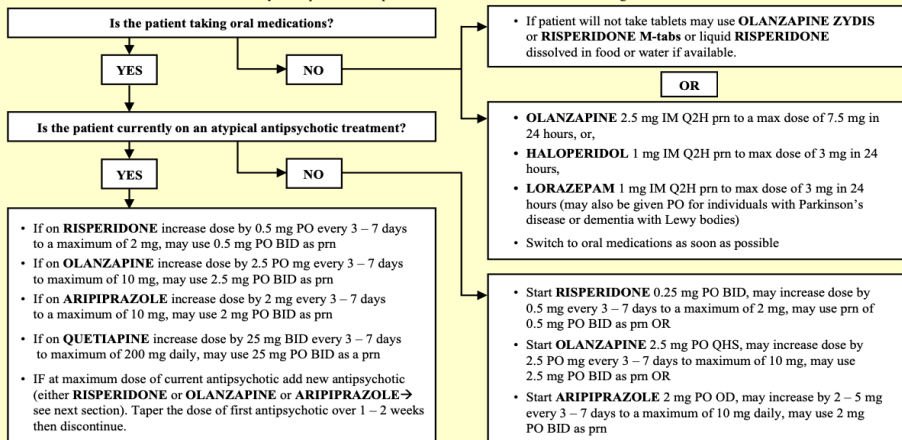
- Rule out **DELIRIUM** or initiate investigation for delirium
- Rule out **PAIN** or initiate investigations for pain or discomfort
- Recent **MEDICATION** addition or change

Evaluate for Potential Contraindications:

- Does the patient have a known relative contraindication to antipsychotic treatment?
- Known allergy or previous sensitivity to a given antipsychotic
- Parkinson's disease
- Dementia with Lewy bodies
- If YES: may use **LORAZEPAM PO/IM** (see below)

PHARMACOLOGICAL MANAGEMENT

For all individuals use the lowest dose that is effective in treating the symptoms, only increase dose to maximum suggested dose if behaviors do not respond to lower doses. A duration of **TWO WEEKS** may be required full response to medications are observed following initiation of treatment.



MONITORING

Use medications for as short a time period as possible. Attempts should be made to decrease and discontinue medications after 6 – 12 weeks if symptoms have remained stable. After initiating treatment monitor for:

- Sedation
- Unsteady gait
- Parkinsonism (tremor, rigidity):
NOTE: DO NOT use anticholinergics (e.g. **BENZTROPINE**) for EPS
- Increasing confusion, cognitive or functional decline
- Worsening restlessness or akathisia

Managing Side-Effects:

If side-effects occur during treatment do not increase dose and continue to monitor for 7 days unless side-effects are serious. If side-effects persist reduce antipsychotic dose by one increment (e.g. reduce **RISPERIDONE** by 0.5 mg or **OLANZAPINE** by 2.5 mg) and observe. If side-effects persist at lowest dose then discontinue and start new antipsychotic.

Treatment Non-Response:

If symptoms persist despite trials of two antipsychotics, or if person does not tolerate antipsychotics, consider referral to geriatric psychiatry outreach services for further assessment and treatment options.

Appendix 2: Sample ER Psychiatry Assessment



**Hotel Dieu
HOSPITAL**



**KINGSTON
GENERAL
HOSPITAL**

ADULT PSYCHIATRY EMERGENCY ASSESSMENT

Currently being
revised!

Date: 2000 / January / 01 Time 15:00
Year Month Day

1. **Identification:** (reason for referral, who patient lives with, etc): **Age:** 25 **Gender:** ☒M/ ☐F
2. **Allergies:** penicillin (leads to hives and urticarial rash)
3. **Mode of Arrival and Accompaniment:** brought in by parents for mental health assessment
4. **Sources/Collateral:** mother, father, KGH emergency physician, PCS records
5. **Chief Complaint** (Why here, Why now): hallucinations and delusions

6. History of Presenting Illness: (onset, duration, predisposers, precipitators, perpetrators, severity)

This 25-year-old male was brought in to KGH ER by his mother and father following a 2 month period of increasing auditory hallucinations, including hearing a number of voices conversing in a third-person context about the actions and behaviours of the patient, such as commenting on what the patient is doing, and at times, instructing him to harm himself and others. The parents reported that the patient also believes that multiple chips and security devices have been implanted in his brain, his body, his apartment, and that clones have taken over the bodies and minds of people he knows, which has led to an intense sense of suspiciousness and paranoia. This is the not the first time this has happened: 2 years ago, a similar symptom cluster occurred, which required admission to hospital.

Of late, the parents have noticed that the patient has been using increased crystal meth on a daily basis, and is not compliant with his medication, Risperidone (2 mg po BID), which he was prescribed following the admission two years ago. The parents also reported that the patient was recently fired from his job as an attendant at a gas station as he was showing up to work late on a regular basis, and was caught stealing money from the cash register on two or three occasions.

The patient's family currently feel that he is not at his "baseline" and do not think he can manage on his own at this time: he has not been eating meals on a regular basis, has lost about 20 pounds over the last two months, has not been showering or attending to his personal hygiene, and is often roaming the streets without shoes for days at a time, asking strangers for money or food. The parents are quite concerned about his overall wellbeing and would like to help him return to his baseline, which they describe is "quite well...you wouldn't know he has a mental problem."

7. Current Follow-up: (involvement with CAS/CCAS/JFCS/KFH/ACT).

Family Doctor: patient does not have a GP

Psychiatrist: patient enrolled in FACTT under Dr. X

Mental Health Worker: patient has worker, JT

Community resource: FACTT (ACT Team)

8. Medications: (include dose, herbals, homeopathies, OTC, recent changes, vitamins, etc.)

The patient takes Risperidone 2 mg po BID, however, compliance appears to be poor.

As per the patient's family and case worker, JT, he does not take any other medications.

No recent medication changes.

9. Last Admission:

Date: Jan 1, 1998

Facility: KGH Inpatient Unit

Diagnosis: schizophrenia

Treatment: Risperidone 2 mg PO BID

Discharge: January 31, 2008 to FACTT

ADULT PSYCHIATRY EMERGENCY ASSESSMENT

- 10. Past Psychiatric History:** diagnosis, medications, hospitalizations, counselors

The patient had one previous episode of psychosis two years ago, which led to a one month psychiatric admission here in 1998, and he was started on Risperidone.

The patient was followed by the Frontenac Assertive Community Treatment Team (FACTT) since the last admission, however, his case worker reported that he had not attended appointments during the last two months, and had failed to refill his prescription last month, leading her to believe he has not been taking his medications.

- 11. Past Medical History: (only positive and pertinent negative)** hospitalizations, diagnosis, medications, pregnancy, ROS, head injury, seizures

The patient is overall, quite healthy. He has not had other hospitalizations or other diagnoses made. He does not take any other medications, and on review of systems, there is no mention of overt cardiac, respiratory, abdominal, dermatologic, or neurologic symptoms. He denies a history of head injuries and seizures. He reports that he does not have any known medical problems (like hypothyroidism or hypertension).

- 12. Substance History:** EtOH-Freq: denies last use: n/a IV Drugs-freq: denies last use: n/a
Marijuana-freq: denies last use: n/a Smoking: 1 pack per day x 12 years
Does report daily crystal methamphetamine use (snorted) for past 2 months.

- 13. Criminal History:** (charges, incarcerations, behaviours – not charged, current status, etc)

The patient was charged for uttering threats in public in December 1997, just before the admission in January 1998. He was later cleared of these charges. He has not been incarcerated, and there have been no other recent charges.

- 14. Social History/Personal History:** (social/academic functioning, impulsivity, abuse, aggression, premorbid personality.) Highest grade/degree attained: high school

The patient briefly worked as a gas station attendant as noted previously. He did complete high school without significant difficulty but didn't pursue post-secondary education. He has a history of aggression, and as stated previously, was charged for uttering threats in public, however, there was not incidence of physical aggression. He does not currently have a partner, but has been in several short-term relationships. He does live alone in an apartment in Kingston, and supports himself with EI, as he was previously employed by the gas station. He has not been on ODSP or OW in the past. He does not have any siblings, or many friends, however, he is in close contact with his family, who have been supporting him more financially and with meals over the past two months.

- 15. Family History:** (include psychiatric illness (medications too), suicides, effective treatments, EtOH and drug abuse)

The patients' paternal uncle and maternal grandfather were both diagnosed with schizophrenia, and treated with chlorpromazine, and later, flupenthixol injections; they were institutionalized for many years at a time. There are no known completed suicides. There is no history of substance abuse.

- 16. Physical Examination: Vitals:** HR 90 BP 112/76 RR 15 Temp 36.4 po/pr/tympanic

Although deemed medically stable by the ER physician, a cursory physical exam was performed, which was grossly normal, including cardiac, abdominal, and neurological assessments. The patient was alert and oriented.

ADULT PSYCHIATRY EMERGENCY ASSESSMENT

17. MENTAL STATUS: (in addition estimate IQ function, frustration tolerance/impulsivity)

Appearance: (appears stated age?, dress for season?, groomed?, clean?): the patient appears his stated age, and is malodorous, with very untidy hair, and wearing baggy-poorly fitting clothes. The patient was dressed in a loose t-shirt, and was not wearing a jacket, despite the temperature being -4 outside. He had a heavy beard as well; there were some tattoos observed on his left arm.

Behaviour: (cooperation with interview, psychomotor behaviour, eye contact): The patient was initially cooperative with interview, but he became increasingly agitated, and began to look fearful, staring intensely at the interviewer.

Speech: (rate/rhythm/volume/grammar/? pressured/? latency): the patient was speaking with grossly normal rate, rhythm, and volume, however, there was diminished content of speech, and his speech was not spontaneous. There was no pressured or latent speech detected.

Mood: (state of feeling and mind of the patient subjectively and objectively): patient reported he was "fine".

Affect: (emotional expressions/appropriateness to content and congruency to mood with objective qualifiers): the patient at times was laughing inappropriately, but for the majority of the interview, his affect was flat.

Perception: (hallucinations, illusions): endorsed auditory hallucinations; responding to internal stimuli.

Thought form: (connection or lack thereof between subsequent thoughts – LOA, FOI, tang, circ, etc): tangential thought form, speaking about voices, then about baseball, and then about wanting to go on vacation in Aruba.

Thought content: (delusions – thought insertion, ideation patterns, thought pathology experienced subjectively, paranoia, themes expressed, obsessions): thinking consistent with paranoid delusions, believing that multiple surveillance devices were implanted in his body and apartment, which was not felt to be physically possible.

RISK ASSESSMENT: (please ensure you elaborate)

Suicide: [☒] Y [] N

Thoughts about ☒ death; [] dying; [] killing self – how long: the patient reports having had suicidal thoughts, such as thinking it would be better if he were not to "exist", however, recently, he has realized that he has not been able to meet his potential in life, and has thought about taking his life.

Plan for doing this: the patient reports he has several ideas, such as jumping out of the car when his parents are driving on the highway.

Means available [] pills; [] guns; [] knives; [] poison: he does not have any access to firearms or weapons.

Have you ☒ rehearsed in your mind or [] actually practiced: he has thought about this, but hasn't practiced.

[] Previous attempts – [] impulsive [] planned – method and severity: no prior attempts.

Homicide: [] Y ☒ N

Thoughts about [] hurting others; [] killing others – how long and who: denies HI.

Plan for doing this: n/a.

Means available [] guns; [] knives; [] poison: n/a.

Have you [] rehearsed in your mind or [] actually practiced: n/a.

[] Previous attempts &/or [] violent behaviour – method and severity: no prior HI or HA or physical violence, however, has a charge for uttering threats, so this may have involved expressing HI in the past.

ADULT PSYCHIATRY EMERGENCY ASSESSMENT

Cognition: (orientation, memory, attention, concentration, abstraction): the patient was alert and oriented to person, place and time, however, a formal assessment of cognition was not possible as the patient was attending to internal stimuli and became increasingly distressed and distracted by his internal experiences.

Insight (lacks illness insight; lacks treatment outcome insight; lacks insight to outcome without treatment): the patient endorses his diagnosis of schizophrenia, however, he does not believe he requires medication, stating that the Risperidone is "poison", and believes that he can control his thoughts on his own. Overall, his insight is poor.

Judgment: (actions reflect poor judgment; actions place person at risk of harm; actions place others at risk of harm): the patient was actively attending to internal stimuli, and became increasingly paranoid regarding the possibility that the interview was conspiring against him; the patient was not able to answer all questions, and as such, his judgment is impaired.

Formulation: this is a 25 year old male with a history of schizophrenia, who was brought in by his parents after a two month history of increasing positive psychotic symptoms (auditory hallucinations, paranoid delusions), negative symptoms (more withdrawn, suicidal ideation, avolition), and a decline functioning (poorer ability to tend to basic hygiene, loss of job). These appear to be triggered by a combination of noncompliance with Risperidone and FACTT follow-up, increased crystal methamphetamine abuse, and psychosocial stressors in the form of job loss.

Diagnostic Impression: (including differential diagnosis, star preferred diagnosis)

Axis I: schizophrenia, multiple episodes, active psychotic symptoms

Axis II: defer

Axis III: defer

Axis IV: recent noncompliance with antipsychotic medication and increased stimulant use

Axis V: current GAF: 45 Best GAF in last year: 80

Treatment Plan: (labs, meds, more collateral, referral):

1. Admit to inpatient unit on a Form 1 (checked for Box A criteria: SI, physical impairment).
2. BW, EKG, Urine Drug Screen (to check for other drugs of abuse)
3. Restart Risperidone with plan to offer and educate patient on Long Acting Injectable (Consta)
4. Gather more collateral from treating psychiatrist in community.

BELOW MUST BE COMPLETED

Treatment:

Lab. Results: pending admission orders

Consultations: will refer to OT and SW for assessment of skills, finances, and housing

Medications: Given in ER: Risperidone 2 mg po was given to the patient.

Prescription: none given as plan is to admit to Psychiatry.

Emergency strategies: exam door locked ☐ IM meds. to restrain ☐ Security present ☐
Police escort ☐ Police presence ☐ Physical restraints used ☐
Disposition: Admitted: Y ☒/N Ward: Burr 4 Attending Physician: Dr. Admission
Certified (Form 1): Y ☒/N ☐ Patient notified (Form 42): ☒
Discharged: Y ☐/N ☒ To where: n/a Accompanied by: n/a

Resident: Sample Resident R1

Discussed with Psychiatrist:

Print name: Sample Resident R1

Seen with on-call psychiatrist, Dr. Admission

Date: 01/January/2000 Time: 17:00

Date: 01/January/2000 Time: 17:00

Appendix 3: Sample Discharge Summary

ADMISSION DATE: January 1st, 2000

DISCHARGE DATE: March 15th, 2000

DISCHARGE DIAGNOSIS: Schizophrenia, relapse of psychosis.

PATIENT IDENTIFICATION: 25-year-old single and unemployed male, followed by Frontenac Assertive Community Treatment Team. He lives alone in an apartment in Kingston.

REASON FOR ADMISSION: Brought in by parents to the ER due to a two-month history of exacerbation of psychosis, with suicidal ideation.

HPI: Patient was brought into the emergency room after parents found him alone in his apartment and having conversations about ending his life to people that “were not there.” The patient lives by himself in an apartment, but usually is close with his parents. In the last two months, however, he had been isolating himself more and his parents became increasingly concerned and decided to check up on him today, which resulted in the ER visit.

Collateral was obtained from the parents and combined with the clinical interview, suggested that the patient was experiencing both positive (hallucinations and delusions) and negative (poor self-care, and decreased interest in social activities) symptoms of schizophrenia. He had reported paranoid delusions and reported hallucinations commanding him to commit suicide as well as harm others who are part of his paranoid delusions. The patient believed that there was a “cataclysm that opened” after the election of Donald Trump, which resulted in “spirits” being released into the drinking water by a group of “demons” that represent the will of the antichrist “Barack Obama”. He had been preoccupied with protecting himself from the spirits and had made crude machines to expel the “spirits” from his blood. He reported that he can hear the “spirits” whispering in his ears and inserting thoughts and impulses into his head. He reported that the “spirits” tell him to take his own life and tell him to harm others though they have not provided specific instruction on how to do so. He reported that he actively resists listening to the spirits.

The patient was extremely suspicious, exhibited thought blocking and was clearly responding to internal stimuli during the ER assessment. He declined to speak much to the ER psychiatry team and he demonstrated suspicious behaviors while in the ER as documented by nursing staff (looking for microphones in the room, accusing the mental health staff of working in

tandem with the “spirits” and refusing all food and drink because of concerns that they were poisoned).

The current presentation is very similar to the patient’s last psychotic episode, 2 years ago for which he required admission to Kingston General Hospital. The patient was previously adherent to Risperidone treatment and followed by an ACT team but has not been adherent to either in the last few months. Additionally, there had been some recent crystal meth use in the last few months. Urine drug screen was positive for crystal meth on admission. Other routine investigations were normal. He was admitted on a form 1.

PAST PSYCHIATRIC HISTORY:

Schizophrenia, first diagnosed at age 20. Has had several relapses, requiring several hospitalizations. The relapses are often related to use of crystal meth. His last hospitalization was 2 years at KGH for 3 weeks and he was treated with Risperidone. He had previous unsuccessful trials of Olanzapine and Quetiapine. He has never attempted suicide. Has never been on a long acting injectable antipsychotic. Has never had ECT. Has never had clozapine.

PAST MEDICAL HISTORY:

None. No history of seizures or head trauma.

MEDICATIONS ON ADMISSION:

None, but was supposed to be taking Risperidone 2mg BID PO as per the ACT team.

ALLERGIES: Penicillin (anaphylaxis)

SUBSTANCE USE HISTORY: Smoking since age 18, 2 packs per day. Occasional marijuana use, around 1g a week. Doesn’t drink alcohol. Has used crystal meth (snorted) intermittently for the last 5 years. No history of IVDU.

FORENSIC HISTORY:

Has never been incarcerated, but has been charged with uttering threats during a psychotic episode, for which the charges were dropped after he was hospitalized and treated with antipsychotics.

FAMILY HISTORY:

Paternal/Maternal Grandfather – Schizophrenia, both treated with chlorpromazine and later, flupenthixol injections. There are no completed suicides. There is no drug abuse.

SOCIAL/DEVELOPMENTAL HISTORY:

Parents reported an unremarkable childhood until age 17 when the patient was diagnosed with schizophrenia after a prodromal period of 6 months where he withdrew from school and uncharacteristically failed all of his classes. He managed to finish high school. He has had several short-term relationships. He has a few friends. He does not have any siblings. The parents describe the patient's personality as being very kind and gentle. When he is not psychotic, he enjoys the company of animals and is a very religious person. He briefly worked as a gas station attendant, but was fired after he was caught stealing money from the cash register several months ago. He is currently on unemployment insurance.

COURSE IN HOSPITAL STAY:

The patient was initially very uncooperative with the inpatient team due to his paranoia and spent the two weeks in the intensive observation area. He was not violent and mostly kept to himself. Due to the severity of his psychosis (he continued to decline food, though he accepted unopened bottles of ensure and fluids from unopened water bottles) and lack of insight, he was placed on a form 3 and a form 33 was applied. He did not contest either form, as he did not recognize the legitimacy of either form. His parents acted as substitute decision makers in making the decision to start the patient on long acting risperidone Consta injections due to his refusal to take pills during the admission. After about two weeks of admission, the patient's psychosis began to clear, and he started to eat food and become more trusting of the inpatient team. He was moved over to the general side of the ward and eventually received accompanied passes with his family, which went well. His psychosis continued to improve and the risperidone Consta was increased to 25mg IM q2 weeks, but the patient noticed side effects of galactorrhea and a prolactin level was done and found to be elevated. At this time, the patient was found to be capable of making treatment decisions, and not found to be a certifiable patient. Thus, he was made a voluntary patient. The patient made the decision himself to try aripipazole long acting depot injection. He was started on aripipazole 400mg IM q4 weeks and bridged to this dose with oral aripipazole. He tolerated the dosage well and continued to do well on accompanied passes with his family.

The inpatient team explored the reasons behind his latest relapse, and we identified that high expressed emotion likely played a significant role. The patient admitted that the drug use was also in response to emotional pain caused by his inability to obtain a better job and "feeling useless" as a result. Additionally, he acknowledged that his apartment was full of people who encouraged him and enabled him to use drugs. At the time of discharge, the patient was motivated to stop crystal meth use and the family was agreeable to try family therapy. The patient was also ready to start looking for work again. To that end the following plan was made during a family meeting

where the ACT team, the patient, inpatient psychiatry as well as the patient's parents attended:

DISCHARGE PLAN:

1) Medications:

Aripiprazole long acting depot 400mg IM PO q4weeks.

2) ACT team to provide continuing follow up.

3) Family is agreeable to try family therapy to address the high expressed emotion, which contributed to this relapse.

4) Patient will undergo vocational training by the ACT team, and the ACT team also has addictions support. The patient is also aware that he can self-refer himself for addictions counselling at AMHS-KFLA at any time.

5) Patient has applied for Ontario works with the assistance of the inpatient mental health social worker.

6) Patient will stay for his parents until he can find better housing.

Appendix 4: Useful Links and Resources

PsychDB: PsychDB.com

Switch Rx: SwitchRx.com

<https://www.prescribessmart.com/>

Queen's Library → DynaMed

Appendix 5: Sample Form 1 and 42



Ministry
of
Health

Form 1
Mental Health Act

**Application by Physician for
Psychiatric Assessment**

Name of physician Dr. Medical Student
(print name of physician)

Physician address Kingston General Hospital, 72 Stuart Street, Kingston, ON, K7L 2V7
(address of physician)

Telephone number (613) 548-2473 Fax number (613) 548-6091

On October 31, 2016 I personally examined John Richardson
(date) (print full name of person)

whose address is 1234 Main Street, Kingston, ON, K7L 2V7
(home address)

You may only sign this **Form 1** if you have personally examined the person within the past seven days.
In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.

Box A – Section 15(1) of the Mental Health Act Serious Harm Test

The Past / Present Test (check one or more)

I have reasonable cause to believe that the person:

- ☒ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information (you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)

My own observations:

Mr. Richardson has endorsed active suicidal ideation, a plan to kill himself by locking himself in his car in his sealed garage and turning on the car, to "fall asleep". He has stopped his antidepressants, and is very hopeless and depressed.

Facts communicated to me by others:

Mr. Richardson's daughter and wife have expressed concerns about Mr. Richardson's mental health, and have observed worsening depression, and have realized that Mr. Richardson has stopped taking his antidepressant medication.

The Future Test (check one or more)

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- ☒ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test *(continued)*

I base this opinion on the following information (*you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.*)

My own observations:

Mr. Richardson has endorsed active suicidal ideation, a plan to kill himself by locking himself in his car in his sealed garage and turning on the car, to "fall asleep". He has stopped his antidepressants, and is very hopeless and depressed.

Facts communicated by others:

Mr. Richardson's daughter and wife have expressed concerns about Mr. Richardson's mental health, and have observed worsening depression, and have realized that Mr. Richardson has stopped taking his antidepressant medication.

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet the criteria set out in *each* of the following conditions.

I have reasonable cause to believe that the person:

1. Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in one or more of the following: (*please indicate one or more*)

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ substantial mental or physical deterioration of himself or herself, or
- ☐ serious physical impairment of himself or herself;

AND

2. Has shown clinical improvement as a result of the treatment.

AND

I am of the opinion that the person,

3. Is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained;

AND

4. Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

Box B – Section 15(1.1) of the Mental Health Act

Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria
(continued)

AND

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: (choose one or more of the following)

- ☐ cause serious bodily harm to himself or herself, or
☐ cause serious bodily harm to another person, or
☐ suffer substantial mental or physical deterioration, or
☐ suffer serious physical impairment

I base this opinion on the following information (you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)

My own observations:

Facts communicated by others:

I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. I hereby make application for a psychiatric assessment of the person named.

Today's date 31-Oct-2016

Today's time 20:26

Examining physician's signature AB
(signature of physician)

This form authorizes, for a period of 7 days including the date of signature, the apprehension of the person named and his or her detention in a psychiatric facility for a maximum of 72 hours.

For Use at the Psychiatric Facility

Once the period of detention at the psychiatric facility begins, the attending physician should note the date and time this occurs and must promptly give the person a Form 42.

31-Oct-2016 20:26
(Date and time detention commences)

AB
(signature of physician)

31-Oct-2016 20:26
(Date and time Form 42 delivered)

AB
(signature of physician)



Part I (complete only if appropriate)

To: John Richardson
(name of person)

of 1234 Main Street, Kingston, ON, K7L 2V7
(home address)

This is to inform you that Dr. Medical Student
(name of physician)

examined you on 31-Oct-2016 and has made an application for you to
(date of examination) (day / month / year)
have a psychiatric assessment.

Part A and/or Part B must be completed

Part A

That physician has certified that he/she has reasonable cause to believe that you have:

Check
Box(es)

- ☒ threatened or attempted or are threatening or attempting to cause bodily harm to yourself;
☐ behaved or are behaving violently towards another person or have caused or are causing another person to fear bodily harm from you; or
☐ shown or are showing a lack of competence to care for yourself.

and that you are suffering from a mental disorder of a nature or quality that likely will result in:

Check
Box(es)

- ☒ serious bodily harm to yourself;
☐ serious bodily harm to another person; or
☐ serious physical impairment of you.

Part B

That physician has certified that he/she has reasonable cause to believe that you:

- a) have previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in
☐ serious bodily harm to yourself,
☐ serious bodily harm to another person,
☐ substantial mental or physical deterioration of you, or
☐ serious physical impairment of you;
- b) have shown clinical improvement as a result of the treatment;
- c) are suffering from the same mental disorder as the one for which you previously received treatment or from a mental disorder that is similar to the previous one;

(Disponible en version française)

See reverse

Part B (continued)

d) given your history of mental disorder and current mental or physical condition, you are likely to

- ☐ cause serious bodily harm to yourself,
- ☐ cause serious bodily harm to another person,
- ☐ suffer substantial mental or physical deterioration, or
- ☐ suffer serious physical impairment;

e) have been found incapable, within the meaning of the Health Care Consent Act, 1996 of consenting to your treatment in a psychiatric facility and the consent of your substitute decision-maker has been obtained; and

f) you are not suitable for admission or continuation as an informal or voluntary patient.

The application is sufficient authority to hold you in custody in this hospital for up to 72 hours.

You have the right to retain and instruct a lawyer without delay.

31-Oct-2016

(date)

A B

(signature of attending physician)

Part II (complete only if appropriate)

To: _____
(name of person)

of _____
(home address)

This is to inform you that _____
(name of Minister of Health and Long-Term Care)

Minister of Health and Long-Term Care for the Province of Ontario, has reasonable cause to believe that you are suffering from mental disorder of a nature or quality that likely will result in:

Check
Box(es)

- ☐ serious bodily harm to yourself; or
- ☐ serious bodily harm to another person.

unless you are placed in the custody of a psychiatric facility and has by Order dated

_____, authorized your custody in a psychiatric facility for up to 72 hours.
(date of order) (day / month / year)

You have the right to retain and instruct a lawyer without delay.

(date)

(signature of attending physician)

[illegible]

[illegible]