B.C.'s Mental Health Reform

CRISIS RESPONSE/
EMERGENCY SERVICES

BEST PRACTICES
This report is one of seven mental health best practices reports. The reports reflect the efforts of 44 industry representatives who formed the best practices working groups. Following literature reviews and consultation, they documented what they collectively recognized as services and strategies that produce positive health outcomes for individuals.

The Ministry of Health is grateful for the expertise and diligence these mental health consumers, family members and service providers brought to the work.

The reports on Best Practices for B.C.’s Mental Health Reform are:

- Housing
- Assertive Community Treatment
- Crisis Response/Emergency Services
- Inpatient/Outpatient Services
- Consumer Involvement and Initiatives
- Family Support and Involvement
- Psychosocial Rehabilitation and Recovery
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The principles of psychosocial rehabilitation form the philosophical foundation for all best practices in mental health. These principles emphasize both consumer involvement in developing and realizing personal care and life goals and treatment and supports that help consumers manage their symptoms and build on their strengths.
EXECUTIVE SUMMARY

This document represents a component of a comprehensive program of mental health system reform in British Columbia. The program, which is outlined in Revitalizing and Rebalancing British Columbia’s Mental Health System: The 1998 Mental Health Plan, provides continued strong support for community-based care for people with serious and persistent mental illness. One of the direct consequences of this emphasis on community care is a shift in the locus of mental health crisis response/emergency service (CR/ES) from mental hospitals to a large number of different community settings and general hospital medical emergency departments. Successful implementation of the 1998 mental health plan therefore necessitates the development of an effective multi-faceted CR/ES system that integrates hospital and community-based services.

Expanding on the American Psychiatric Association 1982 Task Force definition of a psychiatric emergency, a mental health crisis is defined in this document as: (a) an acute disturbance of thinking, mood, behavior or social relationship that requires an immediate intervention; (b) which involves an element of unpredictability that is usually accompanied by a lack of response to social controls; and (c) the crisis may be defined as such by the client, the family or other members of the community, including family physicians or police.

The goal of a mental health CR/ES is to:

- facilitate stabilization of the individual to the point where:
  a. risk of harm to self/others is minimized
  b. the person has returned to a level of functioning that does not require continued provision of an urgent/emergent level of care, and
  c. the individual can follow through with a course of treatment in a community-based setting.

Although this goal may be achieved in a variety of ways, crisis interventions within a CR/ES emphasize direct engagement, both with the client and with social supports and community service providers, to create a viable follow-up care plan.

The target population for a CR/ES is etiologically and symptomatically heterogeneous. It may include individuals affected by a serious and persistent mental illness. However, individuals who are not affected by chronic major psychiatric disturbances may also present with a crisis that meets the definition presented above. Individuals who do not satisfy the conditions of the definition for a mental health crisis may nevertheless present to a mental health crisis/emergency service provider. As there is no way of determining a priori that they do not satisfy the criteria for a mental health crisis, they must be provided with some form of initial response. Finally, police or physicians effectively designate a person as a member of the target population for crisis/emergency services when they invoke Section 28 or Section 22 of the Mental Health Act. In light of these
factors, the target population for a crisis/emergency response must be regarded as a broadly heterogeneous collection of individuals who experience a mental health crisis. Members of the target population may define themselves as service recipients or they may be designated by others as appropriate recipients of services. The seriously and persistently mentally ill only represent a subset of this target population.

Because the target population for a CR/ES includes an etiologically and symptomatically diverse group of individuals, the crisis/emergency services that meet their needs must be correspondingly diverse. In order to provide for the urgent/emergent assessment and crisis intervention needs for the target population, a continuum of five core program components is required:

- Crisis lines—A telephone service provided by a trained volunteer which delivers immediate support to individuals in need by means of active listening or referral to appropriate agencies.
- Mobile crisis outreach—A service in which first-line responders provide outreach to individuals in the community with acute mental health emergencies.
- Walk-in crisis stabilization service—A service which enables individuals to present with a mental health crisis and receive appropriate assessment and access to follow up care.
- Community crisis stabilization services—A range of services that provide community-based support for individuals in a mental health crisis. Settings include crisis residences for crisis intervention and residential treatment, structure, supervision, intensive case management and connection to follow up services; home stabilization, where mental health acute care patients are provided treatment within their own homes by outreach nurses; and crisis housing (hotels, boarding houses) where an individual remains until stable and is provided with 24-hour observation, support, intensive case management, assistance and connection with follow up services.
- Hospital-based psychiatric emergency services—This includes a psychiatric emergency service, which provides specialized emergency mental health assessment, treatment and management services to persons referred via a hospital emergency department, and a brief stay unit, an inpatient psychiatric unit that specializes in the assessment and treatment of mental health emergencies. It maintains a brief length of stay (average length of stay is three to five days) and has the capability to detain and treat patients on an involuntary basis. The focus of the brief stay unit is on intensive crisis management.

The five core CR/ES components deliver a range of functions that are essential to a crisis/emergency response service. It is important to recognize that while the functions will remain constant in a comprehensive system of crisis/emergency response, the service delivery structures that provide these functions may vary from one community to another.

The standards laid out in this document refer to the core functions of a CR/ES system. They do not specifically dictate which structures must be put in place. The standards
proposed are intended to represent a realistic level of practice a system should be seeking to attain within the limitations of available resources. The term "target standards" is used in the document to distinguish the proposed standards from "optimal standards" (attainable with unlimited resources) or "minimal standards" (a level of care below which practice would be unacceptable and immediate remediation would be required).

In addition to meeting the principle goal of a system of crisis response/emergency service, described above, the system of five core components is intended to achieve several other critical objectives, including the following:

- To extend the reach of the mental health system to those individuals or groups within the target population for mental health services who have traditionally not accessed or benefited from needed services. This may include the psychiatrically disabled and socio-economically disenfranchised individuals found in the downtown core of major cities.
- To provide clinically appropriate crisis interventions for individuals who are not appropriate for referral to other mental health services.
- To address well-documented quality of care issues in psychiatric emergency setting by providing scope and sanction for a system of crisis/emergency response services that stresses biopsychosocial assessment, crisis intervention, firm linkage with follow up care providers, and the promotion of safe outcomes.

The main body of this document consists of a detailed discussion of the five core program components, with a delineation of essential functions and associated target standards for each component. Following this is a series of appendices, including:

- a discussion of issues around the implementation of Crisis Response/Emergency Services within First Nations and other Aboriginal Communities
- descriptions of existing programs within British Columbia that perform the essential functions and achieve the standards laid out in this document
- discussion of innovative programs within the CR/ES, including a detailed discussion of observation units, which are currently being implemented under a major initiative of the Ministry of Health
- issues around evaluation of services.

The last appendix (Appendix E) contains a discussion of issues arising in the consultation forum on provincial best practices in mental health, held on November 4 to 5, 1999 in Richmond, British Columbia. Co-chairs from the seven best practice committees presided over sessions attended by the B.C. Mental Health Plan Implementation Steering Committee, Ministry of Health representatives (including Ministry best practice working group support/liaison personnel), delegations representing each of the 18 health care regions in British Columbia and a number of guests selected on the basis of their extensive knowledge and expertise in specific areas of mental health service delivery. In the course of four sessions focused on crisis/emergency response, a host of issues were raised. These issues are presented in the appendix, accompanied by commentary which represents the CR/ES best practice committee's response to the issues.

Crisis Response/Emergency Services
1. INTRODUCTION

Preparation of this document was undertaken as part of a more comprehensive program of mental health system reform in British Columbia, which is outlined in Revitalizing and Rebalancing British Columbia’s Mental Health System: The 1998 Mental Health Plan. Successful implementation of this plan necessitates the development of an effective multi-faceted system of mental health crisis response/emergency services (referred to hereafter with the acronym CR/ES). An effective integrated system of mental health emergency response is essential for two reasons:

1. A continued emphasis on community-based care for people with major mental health problems means that clinical crises, previously addressed by hospital services, increasingly will be managed in community settings. Psychiatric emergencies occurring in downtown core areas or other community settings require an effective crisis response system that complements traditional psychiatric services. The ongoing development of mobile crisis response and other community-based resources will enhance the need for clear communication and linkages between hospital and community-based components of a CR/ES system.

2. Crisis/emergency services are the principal point of entry and screening mechanism for a continuum of resource intensive mental health services (e.g., hospital-based psychiatric inpatient units). They are therefore crucial to efficient resource utilization.

This document proposes a continuum of five core program components within a system of crisis response/emergency service (see Appendix E: Provincial Consultation Forum on Best Practices in Mental Health, “A note on method,” for further discussion of the basis for specifying the core programs within this continuum). The essential functions performed by these components are identified and the best practice standards that sanction or support those functions are detailed.

This work builds upon a foundation laid out in Review of Best Practices in Mental Health Reform (1997), which was prepared by the Health Systems Research Unit of the Clarke Institute of Psychiatry under the auspices of the Canadian Federal/Provincial/Territorial Advisory Network on Mental Health. The model proposed in the present document is also fully compatible with the parameters set by the 1998 mental health plan for British Columbia.
1.1 Definition of a mental health crisis/emergency

We define a mental health crisis as: (a) an acute disturbance of thinking, mood, behavior or social relationship that requires an immediate intervention; (b) which involves an element of unpredictability that is usually accompanied by a lack of response to social controls; and (c) which may be defined as a crisis by the client, the family or other members of the community.

It is helpful for planning and quality assurance purposes to draw a distinction between “mental health crisis” and “psychiatric emergency.” The term “psychiatric emergency” is anchored historically in a tradition of hospital-based assessment/triage services provided by physicians or psychiatrist. The term “mental health crisis” is anchored in a tradition of community-based crisis intervention services delivered by a teams composed of a range of service providers. Quality or appropriateness of care issues may arise when clients requiring crisis intervention services present in hospital-based emergency departments that are structured to provide “psychiatric emergency” care. Conversely, community-based crisis-response services that lack the physician coverage and security provisions of a hospital setting may encounter difficulties when they encounter a “psychiatric emergency” situation requiring immediate access to emergency medical assessment and care and/or high levels of supervision and control for clients. In order to meet the needs of the target population for a CR/ES system, component services must be prepared to deliver both psychiatric emergency and crisis intervention services or they must be able to facilitate a “firm handshake” with other services within the CR/ES continuum that offer the essential clinical piece that they cannot provide.

1.2 Goals and objectives of CR/ES

The goals of a system of mental health crisis response/emergency services are to:

- facilitate stabilization of the individual to the point where:
  a. risk of harm to self/others is minimized
  b. the person has returned to a level of functioning that does not require continued provision of an urgent/emergent level of care, and
  c. the individual can follow through with a course of treatment in a community-based setting
- engage with the client and with social supports and community service providers to create a viable follow-up care plan.

Objectives of CR/ES are to:

- provide a timely and appropriate initial response to individuals experiencing mental health crises; this group of service recipients may include individuals who do not
perceive their own need for treatment but are designated under the Sections 22 or 28 of the Mental Health Act as requiring immediate care; it may also include individuals presenting with mental health problems that are manifestations of an underlying medical emergency

• extend the reach of the mental health system to those individuals or groups within the target population for mental health services who have traditionally not accessed or benefited from needed services; this may include the socio-economically disenfranchised, psychiatrically disabled individuals found in the downtown core of major cities

• provide clinically appropriate crisis interventions for individuals who may not be appropriate for referral to other mental health services

• enhance the capacity of individuals with major mental health problems to remain in the community (i.e., increase community tenure)

• provide a range of crisis response options which offer the least intrusive and most appropriate services to the client in crisis

• promote clients’ autonomy and mobilize coping skills

• promote safe outcomes

• facilitate access to a range of follow-up service providers and systems of care so that adequate support is available once the acute phase of the crisis is resolved (i.e., facilitate a firm handshake with follow-up service providers)

• respond flexibly to the fluctuating and unpredictable level of demand for crisis/emergency response services

• foster continuity of care among components of a crisis/emergency response system (i.e., promote seamless integration of services).

1.3 Target population for mental health crisis/emergency services

Mental health crises arise from many sources. It is imperative that entry criteria for service reflect this reality. The target population for a CR/ES system include the following groups:

• people with serious and persistent mental illness who contend with adverse psychological and social consequences that stem directly from their mental illness—mental health crises are endemic to members of this population and crisis/emergency response represents an essential and recurring component of their ongoing care

• people without serious and persistent mental illness who experience severe disturbances of thought, mood, behavior or social relationship as a consequence of their life experiences—some of these individuals may only access mental health emergency response services at the time of an unusually severe crisis; others may use these services with a high degree of regularity

• various medical conditions may produce an acute disturbance in thinking, mood and behavior that requires both urgent medical care and external controls and protection
• substance misuse may produce a primary disturbance in mental functioning or it may potentiate a co-morbid psychiatric illness; the result may be admission to a crisis/emergency service for a combination of emergency medical and psychiatric assessment/care.

It is not possible to specify any firm exclusion criteria for the target population on the basis of etiology or diagnosis for the following reasons:

• Any of the four above-mentioned causes or conditions, singly or in combination, may manifest as a major disturbance in mental functioning associated with significant risk to self/others and/or grave disability.

• A substantial number of users of mental health emergency services are self-referred. The causes of their crises are diverse and there is no reliable way of determining a priori whether individuals who present in an emergency setting meet a pre-determined set of criteria.

• Police (under Section 28 of the Mental Health Act) or physicians (under Section 22 of the Mental Health Act) may designate individuals as members of the target population for crisis/emergency response and an appropriate response must be provided for these individuals.

Just as the target population for mental health crisis/emergency services cannot be circumscribed in a definitive way on the basis of etiology or diagnosis, it cannot be restricted definitively on the basis of age. Thus, adolescents/youth in crisis may utilize adult emergency response services if an appropriate response cannot be provided in a sufficiently timely or secure fashion by child and youth mental health services. At the other end of the age spectrum, clients with psychogeriatric emergencies may require involvement of mental health crisis response/emergency service providers, even if the problems they present are largely a product of the aging process. (See Appendix E: Provincial Consultation Form on Best Practices in Mental Health, “Applicability of CR/ES functions and standards to a psychogeriatric population,” for a fuller discussion of this issue.)

In light of these factors, the target population for a crisis/emergency response must be regarded as a heterogeneous collection of individuals who experience a mental health crisis. Members of the target population may define themselves as service recipients or they may be designated by others as appropriate recipients of services.

While the target population for a CR/ES may be quite heterogeneous, there are nevertheless naturally occurring sub-groupings that may be defined in terms of the “trajectory” of the clients as they move through the continuum of mental health services. These sub-groupings include (but are not limited to):

• clients who are likely to require the resource intensive services of hospital emergency departments, psychiatric inpatient units, case managers and supported housing—these are the seriously and persistently mentally ill who are probably universally regarded as appropriate recipients for mental health services.
• clients in crisis who are not appropriate for inpatient care, do not require housing or case management and are able to achieve a reasonable degree of stability and emotional relief in a single intervention, possibly with a referral back to a GP for follow-up care—these clients may not fit the profile for recipients of downstream services, but they must be provided with a clinically appropriate response at their point of contact with the mental health system; this response includes a biopsychosocial assessment, with the collection and integration of pertinent collateral information and crisis intervention to address issues of emotional distress and danger to self or others

• clients who do not require inpatient care, do not require housing or case management, but remain in crisis after a single intervention—many of these clients may not require resource intensive inpatient treatment if they can be provided with intensive follow up care on an urgent basis; this type of service is described in the Best Practices in Mental Health: Inpatient/Outpatient Services document.

1.4 Principles of mental health crisis/emergency response

1. A system of mental health crisis/emergency services must provide a broad range of crisis response options to address the widely varying manifestations of acute mental health disturbance. Despite the diverse etiologies of mental health crises, and the widely varying manifestations of acute psychological disturbance, assessment and triage services provided within hospital emergency rooms remain the primary response available for most individuals affected by a major mental health crisis. The authors of Review of Best Practices in Mental Health Reform (1997) observe that “Mental health reform has forced practitioners and institutions to question sole reliance on this service delivery approach and to re-examine the methods most hospital-based psychiatric emergency services use to assess and treat people in crisis.” (p. 29).

2. Key services should be arranged as a continuum. Clients differ in their need for external monitoring and control and in their need for services only available in hospital settings. Service options should be arranged in a continuum reflecting need for increasing protection/security of clients or others and the extent to which services are removed from the client’s own environment. More intensely resourced emergency services (e.g., hospital-based emergency rooms) should be reserved for individuals who require that level of care.

3. Crisis response/emergency service providers should conduct assessments that identify and integrate the multiplicity of factors (biological, psychological, and/or social) that may produce mental health crises and they must be able to provide an appropriately broad range of crisis interventions. No single discipline possesses the full complement of diagnostic and treatment skills necessary to meet the diverse needs of the target population for crisis/emergency services. Consequently, a crisis/emergency
response service requires members functioning effectively as an interdisciplinary team.

4. **There must be efficient exchange of clinical information among components of the mental health system.** In order to ensure clear and concise communication of pertinent clinical information, a common language is required. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), multi-axial system is an example of such a common language for documenting and communicating clinical information. Furthermore, there must be an integration of CR/ES data to avoid duplication.

5. **Service providers must be well-acquainted with those provisions within the Freedom of Information and Protection of Privacy Act (FOIPPA) that pertain to the flow of information from one service provider to another.** On the one hand, this will ensure that client confidentiality is maintained where it is appropriate. On the other hand, this will ensure that client care is not adversely impacted by a service provider's failure to recognize those situations in which information may be communicated to third parties.

6. **Risk Management is an over-riding concern in crisis response.** This involves assessing and taking any necessary steps to reduce the likelihood of outcomes such as suicide, assault on others or dangerously impaired self-care.

7. **CR/ES systems have very limited ability to exclude clients. In order to preserve their capacity to respond appropriately to those individuals who present for service, a CR/ES system must have ready access to a range of follow-up care providers.** To ensure continued movement of clients from the emergency end of the service continuum to other services, planning of the mental health system as a whole should be done in an integrated manner, approaching the mental health system as one overall treatment program with integrated components, rather than as a collection of independent programs. The coordination of goals, entrance/admission criteria and termination/discharge criteria among components must not be left to chance. Rather, coordination should be ensured by assigning each component to fulfill specific functions in relation to overall mental health system goals.

1.5 **Core components of a CR/ES system**

In the Review of Best Practices in Mental Health Reform (1997), five core components of a system of crisis/emergency response services are outlined. These components satisfy the fundamental requirements for a system of crisis/emergency.
The five core components of a CR/ES system are:

1. **Crisis lines**—A telephone service provided by a trained volunteer which delivers immediate support to individuals in need by means of active listening or referral to appropriate agencies.

2. **Mobile crisis outreach**—A service in which first-line responders provide outreach to individuals in the community with acute mental health crises.

3. **Walk-in crisis stabilization services**—A setting where individuals can present with a mental health crisis and receive appropriate assessment and access to follow-up care or can be referred to an appropriate service.

4. **Community crisis stabilization services**—Community crisis stabilization services provide community-based support for individuals in a mental health crisis. Settings include: *Crisis residences* for crisis intervention and residential treatment, structure, supervision, intensive case management and connection to follow-up services; and *Home stabilization*, where mental health acute-care patients are provided treatment within their own homes by outreach nurses.

5. **Hospital-based psychiatric emergency services**—This includes a *psychiatric emergency service* which provides specialized emergency mental health assessment, treatment and management services via consultation to persons referred by a hospital emergency department and may provide 23-hour holding beds; and a *brief stay unit*, an inpatient psychiatric unit that specializes in the assessment and treatment of mental health emergencies. It maintains a brief length of stay (average length of stay is three to five days) and has the capability to detain and treat patients on an involuntary basis. The focus of the brief stay unit is on intensive management of psychiatric emergencies.

### 1.6 Structures and functions of a CR/ES system

The CR/ES components deliver a range of functions that are essential in a crisis/emergency response service. While functions will remain constant in a comprehensive system of crisis/emergency response, the service delivery structures that provide these functions may vary from one community to another.

Two examples will highlight the distinction between structure and function, a distinction that runs throughout this document:

- Specialist consultation in urban versus rural settings: mental health consultation to an urban hospital emergency room may be provided by an on site mental health specialist, but in a less resourced rural region, this consultation may only be feasible
via some form of Telehealth. The function (specialist consultation) is the same but the structure used to provide it is quite different.

- Mobile crisis response versus hospital-based psychiatric emergency services: both of these services provide emergency psychiatric assessments, and service providers in both settings are accountable to a standard of safe outcome for patients who are psychiatrically and possibly medically compromised. Thus, from a functional standpoint, the services are similar. However, the program structures employed to achieve similar clinical functions are quite different.

1.7 Standards

There are various ways in which the term “standards” may be used:

- **Optimal standards** may be conceived of as “gold standards”, representing a system that could be achieved with unlimited resources (human as well as financial resources) and full opportunity to achieve support for the system by all involved parties (clients, family members, service providers).

- **Minimal standards** represents a level of care below which practice would be unacceptable and immediate remediation would be required.

- **Target standards** represent a realistic level of practice a system should be seeking to attain within the limitations of available resources. Note that the principle obstacle in the path of achieving a target standard may not be financial, but rather the force of tradition and the difficulty inherent in producing change within organizations.

This document identifies target standards for each of the service components examined.

1.8 Caveats: Limitations of this document

The model for a CR/ES proposed in this document is anchored in a combination of published research, guiding principles for a system of crisis/emergency response, an articulated set of goals and objectives for a CR/ES, examples set by existing programs that achieve the functions and conform to the standards laid out in this document and the consensus of a committee of experienced crisis/emergency response service providers. These multiple lines of support converge on the specified set of functions and associated target standards that are contained in this document. However, there are limitations to this document:

- Although there is a substantial quantity of published work concerned with the operation of specific components of a CR/ES, there is only limited systems-level
research concerned with the optimal configuration of service components within a CR/ES.\textsuperscript{8}

- Most published research concerned with crisis/emergency response looks at the operation of core services that are only likely to be found in urban settings. This research provides limited guidance into the question of how to provide optimally for the crisis/emergency response service needs of a geographically dispersed population.

- Concerns have been raised at various points in the writing of this document about particular subgroups whose access to the mental health system is limited by specific disabilities or social barriers. Youth in transition, First Nations and other Aboriginal people,\textsuperscript{*} dual-diagnosis clients and other important groups face unique obstacles and pose distinctive challenges for the mental health system.

The aim of this best practices document is to identify a set of core functions and target standards of a crisis/emergency response system that would be relevant to any subgroup, regardless of race, gender, co-morbidity or geographic locale. Providing these functions to particular subgroups might then be regarded as a question of appropriate implementation of these functions and target standards. Nevertheless, even if the functions and target standards are applicable across various subcultural boundaries, successful implementation of the functions and standards across various subgroups is likely to require intimate knowledge of the distinctive features of the group in question, and active partnership with service providers within the group. Note that the consultation process necessary to envision these partnership initiatives and integrate them with broader-based subcultural community development strategies lies beyond the purview of this committee.

\textsuperscript{*} See Appendix A for a brief discussion on the implementation of a CR/ES system in communities of First Nations and other Aboriginal people. The material appearing in this appendix illustrates some of the complexities involved in implementing a system of CR/ES within communities that are not well connected with mainstream crisis/emergency response service systems.
2. CRISIS LINE

**Definition:**
A telephone service provided by a trained volunteer which delivers immediate support to individuals in need by means of active listening or referral to appropriate agencies.

2.1 Background

Twenty-four-hour telephone emergency services represent the historical launching point for the suicide prevention and crisis intervention movement: Hoff and Adamowski (1998) describe such services as “the backbone of the crisis movement.” With the emergence of managed mental health care systems, and the shift in emphasis from institutional to community-based care, staff on crisis hotlines are becoming more involved with individuals affected by serious and persistent mental illnesses. The experience of crisis/emergency service providers in the Capital Health Region and the Lower Mainland underscores the importance of developing protocols for ensuring continuity of care for clients who are “shared” by centralized mental health services and 24-hour telephone emergency services.

2.2 Access criteria

- Accessible to all users; direct access.
- This component openly encourages contact from clients experiencing a wide range of problems. The usual standard of anonymity and the typical service, which involves relatively non-intrusive support, create a crisis/emergency response service access point for individuals who might be reluctant access other services. The most typical types of problems addressed by crisis line services include the following:\(^9\):
  - relationship conflicts, ranging from domestic violence to relationship break-up
  - chronic repeat callers, many of whom have serious mental health problems; some may be users of other treatment resources; some may not be accessing other service
  - requests for information, where to go for this
  - suicidality, whether ideation or an actual attempt in progress\(^10\)
  - stress and coping issues (e.g., financial or occupational stressors)
- problems encountered by individuals with major mental illness
- substance abuse problems.

- Referral sources: area agencies list this crisis line as an option (e.g., city hall, general practitioners, other service providers, friends or family, local telephone directory, advertising)
- Protocols that identify repeat callers and establish a management strategy for their access are applied.

2.3 Program description

Scope of service
- 24-hour coverage
- Confidential handling of calls
- Referral to other agencies
- Appropriate information given to callers
- Occasionally provides switchboarding and linkage
- Provides an interface for the public with a range of mental health services
- Provides follow up phone calls with permission of the service user
- Has the ability to trace a phone call in life threatening situations
- Has back-up provided by mental health professionals
- Interface with emergency services by identifying contact people and establishing emergency response protocols
- Meetings/conferences with staff from other services regarding common clients.

Linkages
- As noted, the phone number of this service must be disseminated to potential clients; a problematic issue here is the existence of multiple separate crisis lines with different numbers. Ideally, there is a method to link these different lines with one central number and a system of coordination.
- Referrals to appropriate services are made (e.g., to resources from a comprehensive directory, including other crisis lines, police/RCMP, mental health services, specific counselling services, mobile crisis response services, hospital emergency rooms, self-help groups, access points for peer support networks, etc). Appropriate linkage depends upon the availability of relevant resources.
Staffing
As discussed above, volunteer staff are used. They require didactic training and monitored service provision, as well as refresher courses given intermittently and further training workshops. There is backup by mental health professionals.

Practice issues

- **Logistical**
  - hours of operation
  - ability to handle a large volume of calls
  - level of professional backup and supervision which is available
  - availability of referral resources
  - coordination of crisis lines (for example, availability of a 1-800 central line)
  - variability in training and adherence to international or national standards
  - recruitment and retention of sufficient numbers of volunteers
  - providing sufficient training and support for volunteers

- **Clinical**
  - repeat callers—linkages with other service providers (e.g., mobile crisis response services)
  - repeat callers—protocols for handling
  - when to keep it to a support call; when to institute an intervention (e.g., 911 or calling in mobile crisis response)

- **Accessibility**
  - There must be adequate dissemination of the crisis line number and sufficient publicity to alert the public to its availability.
  - It must be able to respond to the cultural diversity found in the target population (i.e., cultural and linguistic barriers).
  - If the crisis line is not local, staff must be familiar with local resources.
  - There should be 24-hour availability.
### 2.4 Target standards

<table>
<thead>
<tr>
<th>Function</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide a point of access for individuals in distress.</td>
<td>- The service is readily available to those identifying themselves as requiring the service.</td>
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</table>
| Provide appropriate response to a wide range of callers presenting with a wide range of needs, ranging from information to emotional support to immediate intervention for suicidal risk or a medical emergency. | - Training meets standards of American Association of Suicidology.  
- All calls are assessed for lethality/threat of violence/suicide risk and urgency of mental health intervention.  
- Volunteers are supported by trained professional staff who are available 24 hours/day for backup.  
- Call responses are monitored and reviewed regularly to insure quality is maintained. |
| Mechanisms are in place for intervening in emergency situations.         | - Service links are formed and maintained with emergency response service providers (e.g., mobile crisis response teams; police).  
- Capacity to trace calls in life-threatening situations.                 |
| Provide continuous coverage.                                            | - Lines are available 24 hours per day.                                    |
3. MOBILE CRISIS OUTREACH

**Definition:**

A service in which first-line responders provide outreach to individuals in the community with acute mental health emergencies.  

3.1 Background

Mobile crisis response teams evolved in response to deinstitutionalization. They may be regarded as a community-based counterpart to hospital-based mental health emergency services, in the sense that mobile crisis response teams perform diagnostic evaluations, assist with triage and provide support and direction for people experiencing a mental health emergency. There are several advantages to community-based crisis response: ability to assess a patient’s support system in context; better grasp of patient’s perspective and that of caregivers; enhanced capacity to manage crises that involve family dynamics; enhanced opportunity to create treatment partnerships and involve family members; and increased effectiveness compared to outpatient or inpatient services in preserving the patient’s sense of autonomy.

3.2 Access criteria

Acutely disturbed individuals, self- or other-referred, who are unable or unwilling to access other emergency services.

3.3 Program description

**Scope of service**

- telephone assessment and triage
- face-to-face emergency psychiatric assessment of the individual and the biopsychosocial context within which the problem has emerged
- same-day crisis intervention and short-term crisis follow up services until other longer-term urgent follow up services can be accessed
- linkage with other service providers
- facilitate transport and possibly admission to hospital
- assist police in making decisions around provisions for involuntary transport/committal under the Mental Health Act
- response team may consist of a pair of trained mental health workers (generally some combination of nurses, social workers, psychologists); a physician or psychiatrist may accompany team or take the place of one of the team members; police may or may not accompany the team or take the place of one of the team members
- team responds without police support in situations where information obtained prior to intervention suggests that client does not represent a significant danger to self/others and is not grossly disorganized
- if there are reasons to believe that client may pose a significant danger to self as a consequence of a mental health problem or the person is likely to be sufficiently disordered that they will not be able to cope effectively with an interview/assessment, then police may respond with team or may take the place of one of the team members
- team may be called in by police to respond to situation that has been reported to police or situation that police have been involved in directly
- physician or psychiatrist may go out with team or take the place of one of the team members if available information suggests that client may require involuntary transportation/admission under the provisions of the Mental Health Act and there are reasons to expect that police may be unwilling to invoke provisions in Mental Health Act concerned with involuntary transport.

Linkages
- Referring sources:
  - self/family members via volunteer telephone crisis lines
  - self/family members via professionally-staffed telephone crisis lines
  - family members
  - family physicians
  - case managers or other service providers
  - detox or other alcohol/drug services
  - police
- Discharges:
  - self or family or other social supports
  - refer back to case manager or other service providers
  - refer back to family physician
  - refer back to detox or other alcohol/drug service
  - transport to hospital for assessment and possibly admission to a range of inpatient services
  - refer for urgent short-term outpatient follow-up, case management or treatment
  - refer to private practitioner
  - refer to lay counseling agency
Staffing

- **Essential roles/skills:**
  - excellent practical knowledge of psychiatric illness across the age range, with strong skills in the assessment and management of suicidal behavior, assaultive behavior and acute psychosis
  - differential diagnosis of a range of psychiatric conditions
  - comprehensive mental status examination for a range of psychiatric illnesses, including neurocognitively-based disorders (e.g., delirium, dementia)
  - knowledge of *Mental Health Act* and other pertinent pieces of legislation
  - knowledge of a range of community-based resources and skill in accessing those resources
  - crisis intervention skills
  - excellent grasp of practicalities of voluntary and involuntary admission to hospital-based psychiatric acute-care services
  - consultation regarding medical/medication issues

- **Personnel—Nurses, social workers and psychologists typically provide front-line mobile crisis response.** Ready access to a physician or psychiatrist is essential. In some systems, a physician or psychiatrist may be part of the team. Scope of practice and transfer of function issues may need to be addressed explicitly in order to operate a mobile crisis response team with full sanction from the local health authorities.

- **Staffing levels—Minimum level of staffing is two workers per shift, preferably one nurse and one member of another discipline such as a social worker or psychologist.**

Practice issues

- coordinating an approach to repeat-users of crisis/emergency services with case managers or other longer-term care providers

- risk management protocols

- level of physician involvement—direct contact versus consultation behind the lines or after the fact

- continued involvement if person is taken to hospital but not admitted: when does team continue to follow up; do they follow-up for medico-legal reasons or ethical reasons?

- continued involvement if person is not sectioned by police—when does team continue to follow up if police will not transport patient to hospital under provisions of the *Mental Health Act*—what service agreements need to be in place locally based on McCorkell decision?

- protocol around forced interventions

- other issues are concerned with staging of responses—who decides who goes out and how many go out?
Accessibility

- Extending the reach of crisis/emergency response services to socio-economically and psychiatrically marginalized individuals in city down-town core areas—Mobile crisis response services tend to be most accessible to individuals who are organized enough to call telephone crisis lines or to those who have family members or landlords or fellow apartment dwellers who will contact a mobile crisis response team when necessary. For residents of city downtown core areas, there may be no available social supports who are willing or able to help access the services of a mobile crisis response team. Solutions to this problem centre around forging links with police and with downtown core service providers (e.g., staff in needle exchanges; street outreach workers; “street nurses”, etc.) and establishing protocols for accessing mobile crisis response services.

- Extending the reach of crisis/emergency response services in aboriginal communities or other ethnically/linguistically distinct communities—Strategies here may include training mobile crisis response workers within aboriginal communities to function as first responders to crises/psychiatric emergencies.

- Extending the reach of crisis/emergency response services to geographically remote areas—Strategies may include a flexible arrangement for teaming a mobile crisis response worker with a variety of other individuals, including police, physicians or other care providers.

- Clients with combined mental health and substance abuse problems who end up in cells and don’t receive mental health service.

### 3.4 Target standards

<table>
<thead>
<tr>
<th>Function</th>
<th>Standard</th>
</tr>
</thead>
</table>
| Response to crisis situations in which certain essential features of problem may be uncertain. | - Obtain collateral information before mounting response.  
- Police support in situations where degree of risk cannot be determined. |
| Link persons in crisis with most appropriate follow up services. | - Team remains engaged until firm handshake has been established. |
| Coordination of response with other service providers for repeat users of crisis response/emergency services. | - Guidelines are in place for the management of high-frequency repeat users. |
| Immediate initial response to crisis situations. | - An immediate response to the referring call, followed by a prompt determination of the initial response strategy.  
- Guidelines should be developed for such determinations. |
<table>
<thead>
<tr>
<th>Function</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determines when an on-site response is necessary.</td>
<td>• Guidelines are in place to help make this determination.</td>
</tr>
</tbody>
</table>
| Provides assessment of risk, presence of mental illness, stressors, need for medical evaluation. | • Guidelines in place for the assessment of these issues.  
• Staff are adequately trained to perform these assessments. |
| Ensures staff safety during mobile response.            | • Protocols/guidelines are in place concerning vehicle transport, when to ask for police escort, training, etc. |
4. WALK-IN CRISIS STABILIZATION SERVICES

**Definition:**
A setting where individuals can present with a mental health crisis and receive appropriate assessment and access to follow up care or can be referred to an appropriate service.24

4.1 Background

Hoff and Adamowski (1998) provide a comprehensive analysis of walk-in crisis stabilization services. These services may be delivered by a host of different providers working in a variety of locations: medical emergency departments; a combination of medical emergency departments and community mental health centres; or designated walk-in clinics. These clinics may function as a backup service for teachers, police, nurses, family physicians, medical emergency room staff, or any other service provider who has the first face-to-face contact with a person in crisis. Walk-in crisis stabilization services encounter an unscreened population and thus are likely to encounter clients contending with a very broad range of problems.

4.2 Access criteria

Clients are not pre-screened. They define themselves or their situations as a crisis. In this sense, a walk-in crisis intervention service does not define *a priori* a target population. This service must be prepared to respond effectively to a full range of mental health problems. Target situations or problems may include:

- individuals with acute “crisis” as defined by themselves or others
- voluntary presentations of other mental health problems (i.e., patients are seeking assistance)
- individuals with types of presentation that would warrant police escort under the *Mental Health Act* (i.e., the service may not be the officially designated point in the service continuum where sectioned persons are received, but the service must be prepared for individuals of a comparable level of acuity who may walk in without the security provided by police)
- persons who walk in voluntarily and in the course of assessment are found to require involuntary admission under the *Mental Health Act*. 

24 Best Practices for B.C.'s Mental Health Reform
4.3 Program description

Scope of service

- face-to-face assessment of the individual with the problem and the bio-psycho-social context within which the problem has emerged
- gathering and synthesizing all relevant collateral information is essential part of assessment
- work with client to develop provisional care plan that focuses on:
  - de-escalation of crisis
  - safe outcome
  - acute treatment as needed
  - short-term crisis-emergency case management
  - firm linkages with appropriate resources (providers remain engaged with client until firm linkage is established)
- communication of clinically relevant information to promote effective continuity of care
- coordination, consultation and collaboration with other agencies or care providers to support their efforts to provide an urgent/emergent level of care for their clients
- primary physician involvement in care of patient (including case conferencing), and suitable scheme for remunerating physician for that involvement

Generally, this component applies a crisis intervention model, which seeks to help clients make sense of the crisis, mobilize personal coping resources, and formulate a plan to cope more effectively. This model may be delivered in two settings:

- stand-alone walk-in clinic with access to emergency room (i.e., reasonable proximity);
- any hospital emergency room that has enhanced specialty resources (i.e., mental health clinicians) and that operates within a crisis intervention model is functioning as a walk-in crisis service.

Linkages

- referrals from: self, re-direction from ER, crisis line, physicians, any concerned agency, including police
- for effective disposition, good linkages must be secured with the following:
  - centralized mental health intake services
  - emergency rooms
  - urgent short-term treatment services
  - crisis lines
  - mental health case managers
- general practitioners
- drug/alcohol programs
- forensic psychiatric programs
- community-based service providers
- philosophy of safe outcome for client and firm handshake with follow-up care providers
- standards for linkages include appropriate referral destination and an effective, definitive connection with follow-up care providers

**Staffing**
- mental health professionals with training and experience in:
  - assessment of crises and psychiatric emergencies
  - crisis intervention
  - recognition of potential medical emergencies
  - therapeutic management of psychiatric emergencies including psychopharmacological intervention
- interdisciplinary
- physician presence
- ready access to psychiatrist consultation (directly or via Telehealth)
- security

- **Essential skills for interdisciplinary team:**
  - awareness of crisis intervention models
  - ability to perform accurate psychiatric assessment
  - ability to perform effective prioritization
  - ability to work effectively with community partners
  - ability to perform effective follow-up tasks to ensure continuity of care and appropriate linkages (reduce seeking help elsewhere—e.g., ER)
  - awareness of security of staff and clients as primary importance while respecting dignity of client and respecting their right to access treatment in the least restrictive/intrusive manner possible
  - awareness of medical issues as possible contributors, especially substance use/misuse issues

**Practice issues**
- role of psychiatrist and criteria for specific referral to psychiatrist
• Medical Services Plan (MSP) referral billing issues vis-à-vis psychiatry (if primary physician saw first would delete this concern)
• medico-legal coverage for non-physician psychiatric assessments
• need access to 23-hour crisis/stabilization beds and/or brief-stay beds (e.g., three to five day beds) to support walk-in model that functions as acute diversion from regular inpatient stay
• need quick access to emergency room (ER) for medical issues and mutually cooperative relationship with ER
• dual diagnosis and acute intoxication protocols for voluntary presentations
• security/seclusion rooms—possibly on-site
• repeat-users of front-line services
• training and education of staff
• telephone/Telehealth access to expertise in remote/isolated areas
• ready access to psychiatrist consultation

Accessibility
• hours
• psychiatric coverage after-hours
• cultural issues
• patient willingness to attend at site
• patient perceptions of various locales
• multicultural, multilingual consultation

4.4 Target standards

<table>
<thead>
<tr>
<th>Function</th>
<th>Standard</th>
</tr>
</thead>
</table>
| Provides assessment of risk, presence of mental illness, stressors, need for medical evaluation. | • Guidelines are in place for the assessment of these issues.  
• Staff are adequately trained to perform these assessments. |
<p>| Provides crisis intervention for clients experiencing a mental health crisis. | • Intervention is aimed at helping clients make sense of the crisis, mobilize personal coping resources, and formulate a plan to cope more effectively. |
| Care planning is done in a systematic manner, integrating collateral and assessment data. | • There is a clear, well-documented care plan. |</p>
<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
</table>
| Obtains adequate collateral information in a prompt manner.            | • Information is obtained from family members and other social support, referral agents, other involved service providers.  
• This information is integrated into decision-making.                 |
| Communicates pertinent information to service providers involved in this individual’s care. | • Staff are well-versed in the provisions of the FOIPP Act pertaining to the sharing and release of information amongst service providers. |
| Communicates relevant material to family members and other social supports. | • Staff communicates information in keeping with the wishes of the client and the provisions of FOIPP. |
| Communicates with primary care providers.                              | • Pertinent information is communicated in a timely and comprehensive manner. |
| Maintains ongoing liaison with police.                                 | • Joint educational initiatives.  
• Opportunities for police involvement on committees.  
• Formal or informal agreements concerning police response protocols. |
| Ensures *firm handshake* at time of discharge.                         | • Clearly articulated and documented discharge plan developed in collaboration with the client and, as appropriate, family.  
• Communication of that plan to the client, family and ongoing care providers. |
5. COMMUNITY CRISIS STABILIZATION SERVICES

Definition:

Community crisis stabilization services provide community-based support for individuals in a mental health crisis. Settings include:

Crisis residences for crisis intervention and residential treatment, structure, supervision, intensive case management and connection to follow-up services;

Home stabilization, where mental health acute-care patients are provided treatment within their own homes by outreach nurses; and

Crisis housing (hotels, boarding houses) where one individual remains until stable and is provided with 24-hour observation, support, intensive case management, assistance and connection with follow-up services.

5.1 Background

Community Crisis Stabilization Services perform a threefold function (Fields and Weisman, 1995):

• to divert individuals from unnecessary hospitalizations or to shorten their hospital stay
• to stabilize the crisis without requiring inpatient care, and
• to develop, with the client, a support system that will sustain the client following discharge from the community crisis stabilization setting.

The authors of Best Practices in Mental Health Reform (1997) concluded that community-based crisis residential services often provide a viable alternative to hospitalization for persons with major mental illness.

5.2 Access criteria

• The target population for this component are those who have serious mental illness (persistent or acute) and are willing to accept treatment voluntarily and are stable enough to function within a setting that does not provide constant security or monitoring.
• Clients of this service may be suicidal.
5.3 Program description

Scope of service

- assessment of the individual with the problem and the bio-psycho-social context within which the problem has emerged
- gathering and synthesizing all relevant collateral information is essential part of assessment
- work with client to develop provisional care plan that focuses on:
  - de-escalation of crisis
  - safe outcome
  - acute treatment as needed
  - short-term crisis-emergency case management
  - firm linkages with appropriate resources (providers remain engaged with client until firm linkage is established)
- communication of clinically relevant information to promote effective continuity of care
- clinical interface with other agencies to support their efforts to provide an urgent/emergent level of care for their clients
- a higher level of on-going monitoring than is available in a walk-in crisis
- withdrawal from a stressful situation
- this component does not provide emergency housing and is not intended merely to respond to a housing crisis
- primary physician involvement in care of patient (including case conferencing), and suitable scheme for remunerating physician for that involvement

Linkages

- crisis housing (hotels, boarding houses) where one individual remains until stable and is provided with 24-hour observation, support, intensive case management, assistance and connection with follow-up services
- emergency rooms
- centralized mental health intake services
- mobile crisis response services
- urgent short-term treatment services
- crisis lines
- social services and housing
- mental health case managers
- general practitioners
• drug/alcohol programs
• forensic psychiatric programs
• community-based service providers
• police

Staffing
• mental health professionals with training and experience in:
  – assessment of crises and psychiatric emergencies
  – crisis intervention
  – recognition of potential medical emergencies
  – therapeutic management of psychiatric emergencies including psychopharmacological intervention
• ready access to medical and psychiatric consultation
• security
• Essential skills for interdisciplinary team:
  – awareness of crisis intervention models
  – ability to perform accurate psychiatric assessment
  – ability to perform effective prioritization
  – ability to work effectively with community partners
  – ability to perform effective follow-up tasks to ensure continuity of care and appropriate linkages (reduce seeking help elsewhere—e.g., ER)
  – awareness of security of staff, patients and other clients as primary importance while respecting dignity of client
  – awareness of medical issues as possible contributors, especially substance use/misuse issues
• minimum of two staff per shift for five beds
• training and education is an important issue for this component—staff require specific skills training to respond to a broad range of patients (e.g., family involved in fostering arrangements require standardized training protocols); for all staff involved in this component, systematic training according to standardized protocols must be readily available

Practice issues
• Gate-keeping function—who decides who is going to be admitted? What disciplines will have access to the beds?
• Family members or community professionals may want to use this component as a housing option; while this is understandable, it does not satisfy the mandate for this component.
- Discharge may be delayed and can become a problem where appropriate or optimal housing is not available.
- Psychiatric consultation may not be promptly available due to limitations of staffing.
- Dual diagnosis poses a special set of problems.
- Staff turnover is an ongoing difficulty.
- Aggression management is an ongoing challenge and specialized training should be provided.
- Generally, it is essential that specific, skills oriented training be provided to staff.

Accessibility
- There can be a difficulty with appropriate clients waiting to enter Community Crisis Stabilization beds, perhaps waiting in an acute care setting.
- Gate-keeping is a crucial function, deciding who will be admitted in terms of the Community Crisis Stabilization mandate.

5.4 Target standards

<table>
<thead>
<tr>
<th>Function</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screens and prioritizes referrals according to established criteria based on risk factors, severity and degree of availability of other options.</td>
<td>• Program staff are ultimately responsible for determining admission.</td>
</tr>
</tbody>
</table>
| Provides support and stabilization. | • Staff are trained in assessment of risk, presence of mental disorders, stressors, need for medical evaluation.  
• Milieu is designed in line with research on effective environments. |
| Provides Crisis Intervention. | • Provides intervention to help make sense of the crisis, mobilize personal coping resources, and formulate a plan to cope more effectively.  
• Staff are trained in evidence-based group and individual interventions. |
| Ensures safety of clients and staff. | • Protocols are in place concerning management of aggressive behaviour and other safety issues. |
| Provides an alternative to hospitalization. | • Referral agents in the community are aware of the criteria for appropriate referrals.  
• Clients stay a relatively short time to allow turnover.  
• 24-hour staff coverage. |
| Plans actively for a viable discharge to the community where one did not exist previously. | • Discharge planning begins with admission.  
• Family and other supportive others are involved in this planning.  
• Other caregivers are involved in this planning. |
| Teaches clients to handle stress more effectively and thus prevent future crises. | • Provides a program of coping skills enhancement and psychoeducation. |
| Care planning is done in a systematic manner, integrating collateral and assessment data. | • There is a clear, well-documented care plan. |
6. HOSPITAL-BASED PSYCHIATRIC EMERGENCY SERVICES: CONSULTATION TO THE EMERGENCY DEPARTMENT

**Definition:**
Hospital-Based Psychiatric Emergency Services include a *Psychiatric Emergency Service* that provides specialized emergency mental health assessment, treatment and management services via consultation to persons referred by a hospital Emergency Department, sometimes including 23-hour holding beds.

6.1 Background

A substantial literature identifies a range of issues related to hospital emergency room-based response to mental health crises. In particular, the authors of *Best Practices in Mental Health Reform* (1997) raise concerns about admission/discharge decisions in hospital-based emergency departments and discharge planning for patients who are seen in emergency rooms and not admitted. The literature establishes clearly that there are major difficulties with a crisis/emergency system that is limited to services available in medical emergency rooms: crisis response *systems*, encompassing a range of integrated services, represent a multi-dimensional response option that provide more adequately for the broad range of mental health crises handled by hospital-based medical emergency departments and extend the reach of crisis/emergency response services to a broader sector of the target population.

6.2 Access criteria

The target group for this component are those patients who present to a hospital emergency department and are referred by an emergency nurse or physician for psychiatric consultation.

6.3 Program description

**Scope of service**

- **Risk management**—A core goal of this component is to evaluate the risk of physical harm to self or others. The individual who is judged to be at significant risk of
imminent suicidal behaviour or imminent dangerous behaviour because of mental disorder and who is not suitable for voluntary admission may be kept in hospital on an involuntary basis until the acute risk has abated.30

- **Triage**—The PES acts to coordinate the needs of patients with available resources; given that psychiatric resources are limited (especially inpatient beds), staff are constantly prioritizing patients by level of need and appropriateness.

- **Crisis intervention**—A subset of patients benefit from intervention to help make sense of the crisis, mobilize personal coping resources, and formulate a plan to cope more effectively.

**Linkages**
- communication of assessment information and treatment recommendations to follow-up agencies31
- maintaining a good working relationship with emergency room staff32
- maintaining a good working relationship with police to ensure smooth and efficient function, especially as regards waiting time in emergency33
- involvement of family members in assessment, care and follow-up plan

**Staffing**
- requires a trained mental health professional skilled in rapid assessment, behavioural and pharmacological management of emergent presentations and a social worker skilled in rapid discharge planning34

**Practice issues**
- maximizing compliance with follow-up plans35
- availability of community resources to maintain flow of patients and avoid back-up
- availability of brief stay beds (3-5 days) to allow stabilization of crisis

**Accessibility**
- need for translation and multicultural services to deal with cultural and linguistic barriers to good service36
- need for Telehealth consultation where mental health resources are limited
7. HOSPITAL-BASED PSYCHIATRIC EMERGENCY SERVICES: BRIEF STAY UNIT

**Definition:**

The brief stay unit is an inpatient psychiatric unit that specializes in the assessment and treatment of mental health emergencies. It maintains a brief length of stay (ALOS three to five days) and has the capability to detain and treat patients on an involuntary basis. The focus of the brief stay unit is on intensive management of psychiatric emergencies.  

7.1 Background

Breslow, Klinger and Erickson (1995) cite several advantages to brief stay units that function as an extension of an emergency level of care:

- the emergency team has time to gain diagnostic clarity
- there is an opportunity to develop alternatives to hospitalization
- difficult-to-manage patients can better be maintained in the community because respite is available to care-givers and patients
- the setting does not gratify and exacerbate dependency needs as might a hospital inpatient service, and
- the program can provide targeted treatment for patients whose symptoms can be ameliorated within a brief period of time.

7.2 Access criteria

The target for this component is the group of patients who are assessed in the emergency department by a psychiatrist or other mental health clinician and are considered to require further brief mental health assessment and treatment.

7.3 Program description

**Scope of service**

The brief stay unit has the following functions:

- **Risk management**—A core goal of this component is to evaluate the risk of physical harm to self or others. The patient who is judged to be at significant risk of imminent
suicidal/homicidal behaviour is kept in hospital on an involuntary basis until the acute risk has abated.

- **Stabilization of psychological state**—This goal involves returning the patient to his/her baseline state of psychological function. Note that emergency hospitalization is not seen as the appropriate avenue to rectify longstanding psychiatric problems.

- **Triage**—The brief stay unit acts to coordinate the needs of patients with available resources; given that psychiatric resources are limited (especially longer-stay inpatient beds), staff are constantly prioritizing patients by level of need and appropriateness.

- **Intensive assessment**—The brief stay unit has access to resources which permit assessment by an interdisciplinary mental health team, 24-hour observation and a range of medical investigations.

- **Crisis intervention**—A subset of patients benefit from intervention to help make sense of the crisis, mobilize personal coping resources, and formulate a plan to cope more effectively.

**Linkages**

- communication of assessment information and treatment recommendations to follow-up agencies
- maintaining a good working relationship with emergency room staff
- maintaining a good working relationship with police to ensure smooth and efficient function, especially as regards waiting time in emergency
- involvement of family members in assessment, care and follow-up plan as appropriate

**Staffing**

- interdisciplinary team with specialized mental health training
- requires:
  - psychiatrists skilled in rapid assessment, behavioural and pharmacological management of emergent presentations
  - social workers skilled in rapid discharge planning, and
  - psychiatric nurses skilled in behavioral management
- preferably should have psychologist skilled in brief psychometric assessment and psychological intervention

**Practice issues**

- maximizing compliance with follow-up plans
- balance between triage and crisis intervention
- availability of community resources to maintain flow of patients and avoid back-up
- availability of inpatient referral

**Accessibility**
- need for translation and multicultural services to deal with cultural and linguistic barriers to good service
- need for Telehealth consultation where mental health resources are limited

### 7.4 Target standards

<table>
<thead>
<tr>
<th>Function</th>
<th>Standard</th>
</tr>
</thead>
</table>
| 1. Provides specialized mental health consultation to patients presenting mental health concerns in the emergency department. | • Prompt availability of consultation from mental health professionals, e.g., psychiatrist, psychologist or nurse/social worker specialized in mental health.  
• In an urban setting, this would involve direct consultation by the appropriate professional: in a rural setting, this may involve consultation by Telehealth. |
| 2. Provides safe management of psychotic, delirious or other behavioural aggression. | • Availability of a range of behavioural control options including mechanical, pharmacological and environmental restraints. These options are applied in the least restrictive manner consistent with patient and staff safety.  
• Availability in the unit of at least one secure room with appropriate physical structure and monitoring capability.  
• Explicit guidelines and training standards for the management of psychosis, aggressive behavior, suicidality and delirium.  
• Clear protocols for identification and treatment of underlying medical causes for behavioural disturbance. |
| 3. Provides safe management of suicidal individuals. | • Explicit procedure for the assessment of suicidality.  
• Explicit criteria for appropriate discharge of suicidal patients. |
| 4. Maintains access to appropriate outpatient programs for suicidal individuals. | • Availability of short-term, evidence-based, treatments for suicidality. |
| 5. Carries out accurate and efficient triage of patients to available services based on level of severity and acuity. | • Clear guidelines to match patients and services.  
• Awareness of available treatment resources, consistent criteria across services and open lines of communication to services.  
• Emergency room staff have a clear mandate and training to do triage of mental health crises. |
<p>| | | |</p>
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<tbody>
<tr>
<td>6.</td>
<td>Communicates assessment information and treatment recommendations to follow-up agencies.</td>
<td><strong>•</strong> Procedures are in place for documenting assessment and treatment recommendations in a form which can be promptly transmitted to community agencies.</td>
</tr>
</tbody>
</table>
| 7. | Communicates to patients in a prompt and clear manner. | **Staff communicates in a timely manner:**  
  **•** Information related to admission/certification, emergency procedures and treatment plan.  
  **•** Rights advice in accordance to the *Mental Health Act*. |
| 8. | Families are promptly contacted and given appropriate information. | **Staff communicates information in keeping with the wishes of the client and the provisions of *FOIPPA re:***  
  **•** Admission/certification, emergency procedures and treatment plan.  
  **•** Rights advice in accordance with the *Mental Health Act*. |
| 9. | Communicates pertinent information to service providers involved in this individual’s care. | **Staff are well-versed in the provisions of FOIPPA pertaining to the sharing and release of information amongst service providers.** |
| 10. | Communicates with primary care providers. | **Pertinent information is communicated in a timely and comprehensive manner.** |
| 11. | Plans actively for a viable discharge to the community where one did not exist previously. | **•** Discharge planning begins with admission.  
  **•** Family and other supportive others are involved in this planning.  
  **•** Other caregivers are involved in this planning. |
| 12. | Provides a secure environment for assessment and treatment of patients certified under the *Mental Health Act*. | **•** Availability in the hospital of at least one secure room with appropriate physical structure and monitoring capability.  
  **•** Staff are trained in the appropriate management of certified patients (e.g., limitations of enforced treatment, documentation requirements). |
| 13. | Carries out certification of patients in accordance with current practice standards. | **Guidelines are available to help staff understand the relevant legislation and issues involved in certification.** |
APPENDIX A: IMPLEMENTATION OF CRISIS RESPONSE/EMERGENCY SERVICE SYSTEMS IN FIRST NATIONS AND OTHER ABORIGINAL COMMUNITIES

Successful implementation of essential functions in a CR/ES depends critically upon the establishment of close ties with various referral sources and service providers in the community. In order to extend the reach of crisis/emergency services to special subgroups that are not well connected with mainstream crisis/emergency response service systems, and to ensure the relevance of services to the subgroups, various partnership initiatives need to be undertaken. These initiatives would entail the formation of linkages with existing care providers within the identified communities, and training when necessary. Successful implementation of these initiatives would be catalyzed by a willingness on the part of “mainstream” service providers to review the basic assumptions underlying the type of model of crisis/emergency response proposed in this Best Practices document.

Ball (1999) outlines some of the potential issues involved in addressing the crisis and emergency mental health service needs of First Nations and other Aboriginal People. Some of the issues she raises are concerned with cultural relevance and what is often referred to as “buy-in”. Others are purely logistical. Some of the issues she raises are unique to aboriginal communities. Others are relevant to other linguistic/racial/ethnic subgroups. These issues include:

- plans to meet service needs that rely on non-native professionals presenting themselves as “experts” are likely to be met with suspicion in most First Nations and other Aboriginal communities unless they have had significant exposure to the cultures, languages, goals and needs of native people;
- programs of training and/or service delivery in which a community experiences itself as being “done to” are likely to be rejected; community involvement in all aspects of planning, funding, training and delivery is essential;
- training members of the community in crisis/emergency response is complicated by the fact there may be strong leaders in the community who would make excellent crisis/emergency response service providers who have not completed their Grade 12 and may not meet the admissions criteria for college or university-sponsored programs;
- training programs would need to be provided within close commuting distance to the communities, as the capable individuals who would be appropriate candidates for the training would in all likelihood hold other responsibilities that might prevent them from leaving the community for any period of time.

Ball concludes that the partnership initiatives that would be necessary to provide adequately for the crisis/emergency response service needs of First Nations and other Aboriginal peoples are most likely to succeed when they are integrated into a more
comprehensive framework of community development and specific capacity building initiatives that will enable supervisory and front-line staff positions to be filled by community members. This is a complex undertaking requiring careful consideration, extensive consultation and the creation of a long-term vision that will yield incremental increases in community-based capacity to participate effectively within a broader-based system of crisis/emergency response services.
APPENDIX B: BEST PRACTICE EXAMPLES

1. Crisis line

Vancouver Crisis Centre Distress Line
The Crisis Centre provides a 24-hour, seven-day-a-week telephone service for people in distress. Trained volunteers respond to over 29,000 calls a year with the goal of helping callers cope more effectively with their distressful situations. All of the volunteers receive 60 hours of formal intensive training provided by the Crisis Centre including 24 hours of monitoring. At the end of their training, volunteers are capable of answering the telephone lines—which can mean anything from using listening skills and crisis intervention skills to calling an ambulance in an emergency, to referrals to other professional sources who can offer assistance. Callers experience a wide variety of situations, including depression, loneliness, financial difficulties, alcohol and drug abuse, mental health concerns and stress related to marital, family and social relationships. Approximately 10 per cent of the calls have a suicide component.

Capital Health Region (CRH) NEED Crisis and Referral Line
NEED Crisis and Information Line provides services similar to the Vancouver Crisis Centre, offering 24-hour, seven-day-a-week telephone service to people needing immediate emotional support, crisis and suicide intervention, and information on community resources. Trained volunteers respond to 20,000 calls a year. All volunteers receive over 50 hours of initial training, and while on the lines receive scheduled individual supervision and in-service training. NEED has been certified by the American Association of Suicidology.

NEED also services as the public access point for clients requiring the services of CHR Emergency Mental Health Services (EMHS)—a mobile crisis response service. The unique partnership between NEED and EMHS has ensured that the specialized mobile response team receives appropriate referrals and has maximized the team’s ability to provide face to face mobile outreach. Although the Crisis line is the single largest source of referrals to EMHS, the majority of people seeking support in a crisis do not require psychiatric mobile outreach once they connect with a crisis line volunteer. NEED provides some screening and triaging, as well as emotional support for clients until EMHS can respond. EMHS provides professional consultation to volunteers regarding difficult referrals. To ensure public access to EMHS via the Crisis line, a taped message system gives callers in a mental health emergency the option to leave their name and number if they are not able to reach a NEED volunteer immediately. All calls are returned by volunteers within 30 minutes. Staff from NEED participate in case conferences with staff from EMHS, psychiatrists, GPs and case managers for those "shared" clients who are heavy users of both crisis line and CHR mental health services.
2. Mobile crisis outreach

Mental Health Emergency Service ("Car 87")

Car 87 is one of three linked crisis response services of the Mental Health Emergency Service (MHES) for Greater Vancouver Mental Health Services (GVMHS). It provides a rapid, mobile response to "after hours" mental health emergencies in the City of Vancouver. It was developed in partnership with three community organizations: GVMHS, Vancouver Police Department and the Ministry of Human Resources.

Car 87 is staffed by a plain-clothes police constable and a mental health nurse in an unmarked police car. Nurses are trained in police communication and physical safety. Constables are trained in mental status assessment and crisis intervention with mentally ill persons. The assistance of an on-call psychiatrist for telephone and/or on-site consultation and assessment is also available. Car 87 operates seven days a week, from 5:00 PM to 3:00 AM. Calls are screened by and may be referred from: the 911 Emergency Line, GVMHS Mental Health Teams or from a professionally-staffed MHES crisis line, all of which respond to mental health emergency/crisis calls, most of which are resolved without the use of Car 87.

Car 87 provides emergency on-site assessment for persons who are thought to be in psychiatric or psychosocial crisis. The nurse and constable work as a team in assessing, managing and deciding the most appropriate intervention. Intervention may include suggestion of alternate coping methods, consultation with a psychiatrist, facilitation of hospitalization, relocation, provision of medication, food and other necessities, etc. Most persons assessed by Car 87 are stabilized by the crisis intervention and remain in the community. This outcome is facilitated by the partnership with the Ministry of Human Resources through provision of housing and other necessities. Persons who require hospitalization are encouraged to do so voluntarily; those who oppose this option are arrested under the Mental Health Act and transported to hospital using the Ambulance Service. Involuntary admission is facilitated by the on-call psychiatrist's assessment and completion of a medical certificate. Documentation of the interventions and care plan is provided to appropriate follow-up services.

Fraserside After Hours Emergency Mental Health Service

Fraserside After Hours Emergency Mental Health Service (AHEMHS) in the Simon Fraser Health Region provides after-hours emergency mental health telephone response and outreach. Service is provided for all adults, age 19 and up, (with priority given to registered clients of mental health centres) who are, or appear to be, experiencing a psychiatric or psychosocial crisis. Calls come from the person experiencing the crisis as well as families and other "third parties" such as friends, landlords, police, etc. Services may be provided for adolescents (age 16-18) and are coordinated with the Youth Crisis...
Response Program (YCRP) and with the Ministry for Children and Families After Hours Emergency Services. Service is provided seven days a week with core coverage daily from 2:00PM - 1:00AM. On weekends and holidays daily coverage is 11:00AM - 1:00AM. The ultimate goal is to provide 24-hour coverage.

AHEMHS is a “first response” service as well as a consultant to all other mental health first response services in the community. Professional mental health workers staff the mental health emergency telephone line and mobile outreach. Since several Police jurisdictions comprise the Health Region, a Car 87 Model is not used. Services may include screening, assessment, triage decision-making, support, consultation, direct intervention, and/or facilitation of required services such as relocation, follow-up for up to 72 hours, or hospitalization/crisis residential placement where necessary. Contact is by telephone or at the client’s location or other safe, confidential place in the community, at the discretion of the worker. Close liaison with and accompaniment by local RCMP/Police and Ambulance Services ensures safe contact and transport when necessary. Psychiatrist assessment is obtained via admission to a hospital emergency department. The Ministry of Human Resources is contacted for assistance in providing housing and other necessities. Documentation of the interventions and care plan is provided to appropriate follow-up services.

The goal of intervention is to maintain the client’s functioning in the community using the least intrusive approach. This may include supportive services for short-term follow-up in collaboration with the primary care giver. The staff also consult and plan with community mental health professionals to coordinate case management for complex and difficult clients. In addition they provide education, consultation, liaison and coordination with all other emergency and non-emergency mental health service providers through participation in an advisory/coordinating/case review committee.

3. Walk-in crisis stabilization service

Crisis Stabilization Unit (Kelowna General Hospital)

Purpose:
- to provide immediate assessment and intervention to help selected patients make sense of the crisis, mobilize personal coping resources and formulate a plan to cope more effectively
- to make referrals for follow up in the community where necessary

Staffing:
Multidisciplinary team with specialized mental health training:
- psychiatric nurse skilled in rapid assessment and triage to other team members in priority sequence
• social worker skilled in relationship and family crisis intervention and in rapid discharge planning
• psychiatrist skilled in rapid assessment, behavioral and pharmacological management of emergent presentation
• chemical dependency counselor skilled in rapid assessment of chemical dependency issues and identifying appropriate community resources
• outreach psychiatric nurse skilled in assessing patients off site and facilitating their access to appropriate resources
• patient advocate skilled at helping patients access appropriate services, financial assistance and housing
• psychologist skilled in brief psychometric assessment and psychological intervention

Hours of operation: 24 hours per day/seven days per week.

Referrals:
• All patients coming to the CSU must be preceded by a telephone call to determine suitability of the referral, which can be from: patient; family; emergency room physician; emergency triage nurse; family physician; psychiatrist; staff of regional mental health system; patient advocate.
• Patients brought to hospital for psychiatric examination under the Mental Health Act can be brought directly to the CSU by prior agreement with the CSU psychiatrist only.

Criteria for referral:
• need for immediate assessment and/or intervention
• not likely to need to be in hospital longer than 24 hours
• not needing a locked facility or physical restraints
• not a medical emergency (e.g., overdose, delirium etiology unknown, unconscious)
• not requiring immediate physical investigations

Capacity:
• To be determined by the staff on duty. This will be influenced by various characteristics of the patients on the unit at the time: acuity; familiarity; degree of supervision required; number of a short stay admissions; complexity of assessments under way.
Case conferences:

- twice daily, 0900 and 1300
- to review all cases on the unit or expected; to agree on a plan of action and delegate responsibility as for each patient

4. Community crisis stabilization service

Quesnel Unit Emergency Short Stay Treatment (QUESST)
QUESST, in Quesnel, is a five bed crisis stabilization unit located in the G.R. Baker Hospital which is co-managed and co-funded by Cariboo Community Mental Health Services Society and Quesnel Community Health Council. The mandate for this unit provides for a degree of flexibility in length of stay, with an average of 5 days and a maximum of 14 days. It is staffed by trained mental health personnel including Registered Psychiatric Nurses (RPNs),

Registered Nurses (RNs), and Mental Health Care Workers (MHCWs). QUESST has developed a strong working relationship with physicians, Mental Health services and Drug and Alcohol services.

Clients are referred to QUESST through many agencies, including mental health centres, Alcohol and Drug services, the Ministry for Children and Families, the R.C.M.P., etc. They may also be referred by self, family or physician. However, a physician’s assessment is necessary before admission. This physician assessment provides valuable background history and continuation of care throughout admission.

QUESST also manages a crisis line. When a client is referred to the hospital emergency department through the crisis line, QUESST staff will meet the client in the emergency department and assist with assessment. On admission the client is thoroughly assessed and the DSM-IV diagnosis axes are followed as an observation tool and guideline for treatment.

The program provides groups that are flexible and geared toward client needs and the dynamics of the client mix at that time. Multidisciplinary meetings bring together the client’s family and care team to discuss and plan continuation of care and support after discharge. The client receives a follow-up phone call within fourteen days after discharge. When a physician refers an acute care client to QUESST and the program is at capacity, that client is welcome to attend the day program. In addition, QUESST provides a drop-in support group for clients and families waiting for outpatient counseling.
Community Residential Emergency Short Stay Treatment (CRESST)
CRESST, in New Westminster, is designed as an acute diversion facility (10 beds) for the Simon Fraser Health Region. It is located in the community and provides an alternative to hospitalization for stabilizing clients who are in a psychiatric crisis or clients who are at risk of decompensation. CRESST endeavours to prevent hospitalization and to maintain client autonomy in a safe, supportive and supervised setting.

Clients who are appropriate for referral to CRESST are adults, age 19 or older, who are decompensating or in crisis due to their psychiatric condition. Clients must maintain some impulse control and be able to care for their basic physical and personal needs; it is an open facility and clients are voluntary. Referrals are accepted from mental health centres, physicians, hospital emergency departments, After Hours service and Hospital Admission Diversion after screening for suitability and appropriateness. Clients not appropriate for referral include people who are actively suicidal, highly disturbed or assaultive, environmentally destructive, experiencing acute medical problems or idiosyncratic reactions to neuroleptic medications or in a state of drug or alcohol withdrawal or likely to go into a withdrawal.

CRESST provides separation from the stressful environment, with support and resolution of the immediate crisis with the goal of stabilization and re adjustment to community living. Every effort is made to minimize disruption of the client’s ties to family, friends and community and to increase the clients ability to cope with subsequent crises.

CRESST provides a safe, structured, supervised therapeutic environment in a residential setting. Clients are required to attend a morning group, and participate in household chores and in evening activities. Clients are also involved in the development and implementation of the treatment and discharge care plan. Intensive case management in the implementation of the discharge plan may be provided by the client’s primary worker, the CRESST social worker or the hospital admission diversion team.

5. Hospital-based psychiatric emergency services: Brief stay unit

Psychiatric Assessment Unit (PAU), Vancouver General Hospital
The Psychiatric Assessment Unit recently marked its 25th year of operation. In this time it has established itself as the model for emergency psychiatry in B.C. and a state-of-the-art program when compared to similar services worldwide.

The PAU has three components:
• consultation role in relation to the medical emergency staff
• “Quiet Room” (QR) facility for the management of behaviorally-disturbed individuals, which includes eight secure rooms with video observation
• 12-bed short stay unit (ALOS= 5-6 days).
The components of the program function in a hierarchical manner, with a gradual sifting of patients as they move from the Emergency Department to psychiatric consultation to the Quiet Room area to the short-stay unit. At each of these stages, a substantial proportion of patients who do not require further resources are passed back to the community.

Patients admitted are those who cannot be managed by community resources because:
- they are imminently dangerous to self or others
- they are so disorganized in behaviour and cognition as to be unable to carry out basic self-care
- they need assessment and management of an intensity not available in the community.

The first goal of this unit is to evaluate the risk of physical harm to self or others: this typically involves evaluating the risk of suicidal or homicidal behaviour. Note that the emphasis is upon imminent risk, not risk in the long or even medium term. It has been well-established that the capacity of any clinician or system to predict suicide or homicide in a mentally disordered person is limited to the current circumstances. The patient who is judged to be at significant risk of imminent suicidal/homicidal behaviour is kept in PAU on an involuntary basis until the acute risk has abated.

Second, PAU seeks to return the patient to his/her baseline state of psychological function. "Baseline" is loosely defined as the patient’s usual level of behavioural, emotional and cognitive function over the previous year, based on collateral and self-report information. Note that hospitalization is not seen as the appropriate avenue to rectify longstanding psychiatric problems.

Third, PAU acts to coordinate the needs of patients with available resources; given that psychiatric resources are limited (especially inpatient beds), PAU staff are constantly prioritizing patients by level of need and appropriateness.

Fourth, PAU has access to resources which permit more intensive psychiatric assessment than can generally be carried out in the community:
- daily psychiatric assessment by a supervisor or resident via standard interview
- interdisciplinary assessments by social worker, psychologist, occupational therapist and nurse
- 24-hour observation of behaviour, sleep, and mental state
- a full range of medical investigations and consultations by medical specialists, with rapid response.

Finally, a significant subset of PAU patients benefit from crisis intervention to help make sense of the crisis, mobilize personal coping resources, and formulate a plan to cope more effectively. This has only recently been identified as an important goal of the PAU and is "under development".
There are few restrictions on types of patients considered appropriate for admission to the PAU, unlike other inpatient units. Those individuals in psychiatric crisis which cannot reasonably be managed in the community are accepted for admission. PAU had 930 discharges and 350 transfers to other hospital units in the last fiscal year, for a total of 1280 cases.

6. Best practice linkages

A service that functions as a component within a continuum must contribute to the entire system's capacity to respond to the full population demand for service. If a specific service meets a high standard at the expense of clients seen in other services, then this cannot be regarded as best practice. All components of a service must function and evolve in a manner that is informed by a population health perspective, even if the components only treat a small sector of the total population.

The term "best practice" may be used to describe service components within a mental health system that enhance the system's capacity to meet the population demand. We might also apply the term "best practice" to linkages between components that ensure that the pressures that bear down on the front end of a system are "felt" by all components within the system. A best practice linkage must also function to preserve the standards of care within individual system components, while optimizing flow by ensuring that treatment goals, entrance/admission criteria and termination/discharge criteria of various components are developed in a coordinated fashion.

Mental Health Intake ↔ Urgent Short-Term Assessment and Treatment (Capital Health Region)

The interface between the CHR centralized Mental Health Intake Service and the CHR Urgent Short-Term Assessment and Treatment (USTAT) program may be regarded as a "best practice linkage." The Intake service takes referrals originating in hospital emergency departments, along with self-referrals, and referrals from family physicians. (USTAT) is mandated to provide urgent short-term treatment for individuals in crisis who do not require hospitalization but are at significant risk for further deterioration that would be likely to require inpatient care. Clients who are not likely to benefit from short-term care are not accepted into the program. All referrals to USTAT go through the Mental Health Intake Service.

USTAT is expected to provide a timely response to all referrals sent by the Intake service, including referrals from emergency departments to USTAT that are routed through Intake. However, USTAT's capacity to provide an urgent response can only be preserved if Intake adheres strictly to USTAT's inclusion and exclusion criteria. If timely follow-up from USTAT cannot be assured, then Intake must provide bridging coverage until follow-up care is available. This impacts adversely on Intake's ability to cope with the large number of referrals coming in, and may result in a higher percentage
of inappropriate referrals to the USTAT program. Consequently, Intake can only function effectively if it provides a high percentage of appropriate referrals to the USTAT service, and USTAT can only function efficiently and effectively if it provides a timely response to Intake. Thus, the two services reciprocally effect each other's operation, for better or for worse.

The Intake and USTAT services have evolved operational procedures through a process of conjoint planning and negotiation, anchored in a shared understanding and acceptance of the mandate for services located within the urgent/emergent end of the service continuum. The linkage functions to transmit directly to USTAT a major portion of the demand for urgent service that bears down on Intake and on hospital-based medical emergency services in the CHR. At the same time, the linkage is structured in such a way as to enhance the operation of both Intake and USTAT. Thus, the two services relate to each other in a manner that satisfies the criteria for a best-practice linkage.
APPENDIX C: INNOVATIVE PROGRAMS WORTH NOTING

1. Observation units

**Definition:**
Hospitals that are not designated as psychiatric units may be designated as observation units under the Mental Health Act. Observation units manage the care of and stabilize acutely ill psychiatric patients. Observation units are able to accept involuntary psychiatric patients for short periods of assessment and treatment.

**Access criteria**
- patients who are certified under Section 22 of the Mental Health Act and require secure capacity for management and care;
- patients who are awaiting transport to a psychiatric unit;
- patients known to require brief hospitalization;
- under Section 28 of the Mental Health Act, persons with an apparent mental disorder may be brought to the emergency department of a hospital following apprehensions by a police officer, for examination by a physician
- if a hospital is designated as an observation unit, and a physician completes a medical certificate, the patient may be admitted to the hospital in order to receive involuntary treatment; the prescribed period for purposes of detaining a patient in an observation unit is up to five days

**Program description**

**Scope of service**
A hospital designated as observation unit (most typically a rural hospital) will have a secure capacity within the emergency room or a medical/surgical unit (where hospital staff are shared between the medical/surgical unit and the emergency room during evening hours) or adjacent to some other crisis stabilization program (this should only apply to crisis stabilization programs co-located in hospitals). This arrangement enables staff working in other areas of the hospital to provide coverage in the location where patients are being held under the provisions of the Mental Health Act.

Services provided by observation units:
- require a trained healthcare professional skilled in rapid assessment and management of psychiatric emergency presentations
• enable rural hospitals to provide timely emergency health care for patients whose severity of illness requires immediate attention in a secure facility
• permit extended observation and short-term treatment, with a view to stabilizing and referring patients to community programs
• provide secure capacity for involuntary patients requiring timely transport to a psychiatric unit or a provincial mental health facility
• ensure safety through the provision of at least one secure room for patients who require psychiatric treatment and are at risk of harming themselves or others
• reduce the cost and inconvenience to patients and family members of travelling to designated facilities outside their community; as well, patients would be able to remain in regular contact with family and friends, an important social network that can aid in their recovery; and
• reduce the use of police cells for the short-term management of people with mental disorders.

**Linkages**

- Referring sources:
  - police/RCMP
  - judges or Justices of the Peace through a warrant
  - self/family members, family physicians, case managers, detox or other alcohol/drug services and ambulance attendants via emergency room

- Discharges:
  - self/family with appropriate community care supports
  - referral to case manager, family physician, alcohol/drug service, outpatient services or to psychiatrist
  - transport to psychiatric unit

**Staffing**

- Essential roles/skills:
  - knowledge of psychiatric illnesses across the age-range, with strong skills in emergency psychiatric assessment and management of suicidal and assaultive behaviour
  - knowledge of differential diagnosis of a range of psychiatric conditions
  - ability to perform comprehensive mental status examinations, including neurocognitively-based disorders (e.g., delirium, dementia)
  - knowledge of the Mental Health Act, the Hospital Act, FOIPPA and the Criminal Code, including forensic psychiatric implications
  - knowledge of a range of community-based resources and skill in accessing those resources
- crisis intervention skills; and
- access to medical/psychiatric consultation.

- Personnel:
  - emergency room physicians (general practitioners/family physicians) and nurses, with psychiatric consultation, provided directly or via Telehealth
  - social workers and psychologists may be available to assist in linkages to community care supports, psychological assessment and family support

- Staff ratio:
  - availability of physician for assessment and treatment purposes
  - nurse with psychiatric nursing knowledge available for psychiatric nursing assessment, observation and nursing care
  - additional supports from other emergency room/medical-surgical unit nurses, as required, to assist with nursing care
  - other crisis response workers, police/RCMP, hospital security staff to assist in the management of disturbed behavior

**Practice/implementation issues**

- ensuring physicians and nurses have the psychiatric knowledge and expertise to provide very brief appropriate care for acutely ill psychiatric patients and support the families
- ensuring psychiatric consultation is available
- the volume of acutely ill psychiatric patients at rural hospitals may increase, creating additional demands on the need for staff who are knowledgeable in the care and management of acutely ill psychiatric patients
- developing effective protocols between the hospital emergency room and various referral sources and implementation of the protocols
- effective linkages with the case manager and other community-based resources are essential
- rural hospitals' ability to access regional resources in an expeditious manner may potentially be impeded by virtue of creating a local capacity to treat acutely ill patients; this issue will need to be anticipated, discussed, and resolved prior to implementation
- limited knowledge about the benefits associated with the appropriate use of observation units or personal experiences with secure rooms may cause the community at large to have reservations about the observation unit in their local hospital; education and public forums will be required
Accessibility
Issues include:
- geographic accessibility—timeliness of response
- availability of prompt psychiatric consultation
- availability of interdisciplinary consultation
- appropriate management of the care of individuals with mental illness who are acutely ill and experiencing crisis and exhibiting symptoms of decompensation
- priority setting for transfers within the five-day maximum stay

2. Hospital Admission Diversion Teams (HAD)

Access criteria
Provides short term intensive case management and care to persons age nineteen and up with a serious and persistent mental illness who have decompensated but are not at risk of harming themselves or others. They receive care at home in their community as an alternative to hospitalization. Referrals are made by mental health centers, hospital emergency departments, after-hours Emergency Mental Health Services (EMHS) or family physicians and are screened for appropriateness by the team.

Program description
HAD provides service for 10-15 clients, five days a week. By utilizing after-hours EHS and/or contracted home nursing and/or crisis residential beds, actual service may be up to 24 hours a day, seven days a week. Clients are provided intensive in-home support during a crisis until they are stable and then transferred to other community-based mental health services or, if hospitalized, a rapid return to home and community follow-up is facilitated by the team. HAD also provides a “Triage” service for people with needs which present a particular challenge (e.g., homelessness; refusing available services; requiring services not currently available; exhibiting challenging behaviours or otherwise presenting unique problems in housing and connection to follow-up.)

The team provides service linkage, advocacy, crisis management and supportive counseling. This may include in-home assessment, consultation and support (i.e., medication supervision, assistance with personal care, home management, nutrition and daily structure). If overnight and/or weekend support in the client’s home is required, a contracted crisis stabilization program provides home nursing care, through either a professional nurse or a health care worker. Other options for stabilization include referral
and transportation to CRESST for brief periods, access to a fast-track secondary or
tertiary care bed at a local hospital or Riverview Hospital when required. HAD staff then
have regular consultation with in-patient or facility staff in preparation for the client's
rapid return to the community. The team maintains regular liaison with hospital
emergency department and other emergency mental health services. A psychiatrist was
originally intended to be a part of the team but presently psychiatric assessment is
available only at CRESST or at hospital emergency departments.
APPENDIX D: EVALUATING BEST PRACTICE IMPLEMENTATION

It is important to evaluate implementation of the best practice model. However, it must be recognized that there are alternative approaches to evaluation, each having particular costs and benefits. This report recommends a specific evaluation strategy designed to recognize the limits on resources and to avoid drawing substantially on resources available for service provision while delivering a defensible evaluation of best practice implementation.

One type of evaluation is outcome evaluation in which the effects of a treatment are judged by comparing clinical measures administered prior to treatment with the same measures taken after provision of the treatment. This is the most credible way to ensure that a treatment adds significant benefit to the status quo (doing no treatment or "treatment as usual"). There is extensive literature on the methodology and challenges of conducting outcome evaluation research. What matters in the present context are two undeniable facts about outcome evaluation: it is very complex to carry out and very demanding of system resources (time, expertise and money). Given the breadth of mental health practice covered in this report, outcome evaluation of all or most of the domain covered would be prohibitively expensive. It would be feasible only to carry out targeted evaluations of specific best practice implementation within a particular program, relying upon sampling methodology to reduce the task to manageable proportions. It is not within the scope of this report to identify specific program outcomes worth focusing upon: that is a decision best made by mental health authorities, based upon system priorities and assessment of community needs, resource requirements, etc. Nor is it within the present scope to recommend a specific outcome evaluation methodology (types of indicators, sample selection, study design, etc.): that is best done by evaluation researchers in terms of program characteristics and precise questions to be answered.

This report will recommend and focus upon another approach to evaluation, that of Quality Improvement. QI can be defined as the measurement of key performance indicators with ongoing feedback to continuously improve the level of system performance. According to the American Psychiatric Association Manual of Psychiatric Quality Assurance, QI involves, first, specification of quality care for a system:

Quality medical care is defined by a series of guidelines or standards of care that stipulate how and when a given amount of medical resources should be used to maximize the ratio of health benefit to health risk for the most people. These guidelines are based on expert opinion and empirical studies of the process and outcome of diagnosis and treatment.44

This step is equivalent to the best practice working group process. Second, there is an evaluation of the quality of health care in the system relative to the specified standards.
Third, evaluative information is used to improve service quality, in a constructive cycle of feedback and action. These last two steps are the focus of the recommended evaluation strategy.

The relationship between QI and Outcome Evaluation is captured by Fauman,45: "institutions will increasingly be expected to monitor process elements of care that have been shown to be directly related to clinical outcome." That is, having identified a range of best practices, based when possible on well-designed outcome research, it is a defensible proxy for outcome measurement to evaluate the extent to which the identified best practices are utilized. The questions asked would be: 1. Are best practices being provided? 2. Are best practices being provided more consistently after implementation of the mental health reform project?

By way of analogy, consider the practice of treating headache pain with analgesic medication. Well-designed outcome evaluation was used initially to demonstrate its effectiveness and to set standards for dosage. If one sought to evaluate the appropriate pharmacological management of headache pain in a health facility, one would not carry out an outcome evaluation to determine whether these analgesics are effective in this facility; rather, one would determine whether this facility provides the appropriate range of analgesic medications and whether these are administered in accordance with recommended standards. If these questions were answered in the negative, the result would be fed back to the program so that remediation could be done. In such a situation, QI is more defensible than outcome evaluation.46

How QI could work

The components and associated target standards give us the basis for a QI approach to evaluation of our CR/ES System. We can first ask whether each of the described components is available in that region. For those components which are present, we can then ask whether the target standards are being met. A "report card" for a health region would give us a picture of gaps or shortfalls in the provision of best practices and suggest actions to improve the situation. The QI approach recognizes that resources are limited, but gives us a set of targets to aim towards. To illustrate this approach to evaluation, a best practice report card for the crisis line component might be as follows:

Crisis line

Definition: A telephone service provided by a trained volunteer which delivers immediate support to individuals in need by means of active listening or referral to appropriate agencies.

Present? Yes/No
If yes:

<table>
<thead>
<tr>
<th>Function</th>
<th>Target Standard</th>
<th>Y/N</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide a point of access for individuals in distress.</td>
<td>• The service is readily available to those identifying themselves as requiring it.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| To provide appropriate response to a wide range of callers presenting with a wide range of needs, ranging from information to emotional support to immediate intervention for suicidal risk or a medical emergency. | • Training meets standards of American Association of Suicidology.  
• All calls are assessed for lethality/threat of violence/suicide risk and urgency of mental health intervention.  
• Volunteers are supported by trained professional staff who are available 24 hours/day for backup.  
• Call responses are monitored and reviewed regularly to insure quality is maintained. |     |        |
| Mechanisms are in place for intervening in emergency situations. | • Service links are formed and maintained with emergency response service providers (e.g., mobile crisis response teams; police).  
• Capacity to trace calls in life-threatening situations. |     |        |
| To provide continuous coverage.                               | • Lines are available 24 hours per day.                                         |     |        |
APPENDIX E: PROVINCIAL CONSULTATION FORUM ON BEST PRACTICES IN MENTAL HEALTH

1. Introduction

This section contains a discussion of issues arising in the Consultation Forum on Provincial Best Practices in Mental Health, held on November 4-5, 1999 in Richmond, British Columbia. Co-chairs from the seven best practice committees presided over sessions attended by the BC Mental Health Plan Implementation Steering Committee, Ministry of Health representatives (including Ministry of Health Best Practice Committee Support/Liaison personnel), delegations representing each of the eighteen health care regions in BC, and a number of guests selected on the basis of their extensive knowledge and expertise in specific areas of mental health service delivery. In the course of four sessions focused on crisis/emergency response, a host of issues were raised. These issues are presented in this appendix, accompanied by commentary which represents the CR/ES best practice committee’s response to the issues.

2. A note on method

In several discussions, the critical question arising was concerned with the basis by which the material contained in this document was granted the status of “best practice”. While the content of the document was not challenged in these discussions, it became clear that some clarity was required to account for the material included (or excluded) from the document.

Commentary

There exists a substantial body of research concerned with the operations of specific components (e.g., hospital-based psychiatric emergency services) within a system of crisis/emergency services. This literature is summarized in end-notes accompanying the main portion of this document. However, there is only a small amount of systems-level research arguing for or against a particular configuration of crisis/emergency services. This research (summarized in Review of Best Practices in Mental Health) is not decisive with respect to the question of what might constitute an optimal array of services within a crisis/emergency response system. Therefore, in order to arrive at a consensus on what constitutes the core set of clinical functions or services within a crisis/emergency response system, and in order to set standards for those components, multiple sources of information were utilized. These include the following:

- Opinions of acknowledged experts in the field. This includes the authors of the Review of Best Practices in Mental Health (1997). The work of other experts such as Huff and Adamowski (1998) was also reviewed.
• Published research concerned with the operation of specific components within the array of crisis/emergency services.

• Opinions of the members of the Crisis/Emergency Response Best Practice Committee. These committee members are acknowledged by their peers as experienced and knowledgeable in their areas of practice. They all legitimately regarded as “practice experts” in the sense that they all possess a solid, experienced-based knowledge of what works and what does not work (and why). Based on their own experience (including their knowledge of pertinent research and literature) this committee generated four sets of guidelines to determine the particular array of services proposed in this document, and to set standards for those services:

  - **Target population for a system of crisis response/emergency services:** The expectation is that the array of services proposed and the standards associated with the functions performed by those services would be sufficient to provide a clinically viable response to the full array of individuals included in the target population;

  - **Goals of a system of crisis/emergency response services.** The expectation is that the array of services proposed would be sufficient to achieve the identified goals;

  - **Principles of crisis/emergency response:** These principles carry implications for which components would be included in the proposed array of crisis/emergency response services. These principles also carry implications for the standards of practice associated with these components;

  - **Demonstrated feasibility:** Services were only included in this document if there currently existed fully operational examples of the services that demonstrated a capacity to ensure a safe outcome for clients and a firm handshake with follow-up care providers.

On the basis of all of these sources of information and guidance, the committee specified the core components of a system of crisis/emergency response. The above-mentioned information sources also provide the basis for the listing of functions and standards for each core component.

It should be noted that the starting point for the basic model presented in this document is the Review of Best Practices in Mental Health (1997), and the final product is fully compatible with the model presented in that document. This convergence of models is no doubt a reflection of the fact that different systems of crisis/emergency response undergo similar processes of evolution to meet the clinical pressures that bear down on the systems. Crisis/emergency systems have little real latitude in selecting which clinical features of their target populations will be the focus of emergency response: a significant portion of the CR/ES target population pose imminent and serious risks to self or others, and there is a major price to pay for crisis/emergency response systems that do not respond adaptively to these types of pressures. Consequently communities may develop distinctive structures to meet the needs of the target population for crisis/emergency services, but the basic functions performed by these services will be similar because they are all obligated to respond to a similar constellation of clinical needs.
Note that in the consultation forum, delegates pointed out that there currently exist practices in the crisis/emergency end of the service continuum for which there is no real support in the literature; they persist due to the force of tradition. Other delegates pointed out that in many systems there currently exist practices in the crisis/emergency front end that clearly fall short of any reasonable standard of best practice. Consequently, the need for quality improvement dictates that the process of developing and implementing best practice standards go forward, despite the lack of systems-level research.

3. Applicability of CR/ES functions and standards to a psychogeriatric population

Several participants pointed out that the CR/ES Functions and Standards are generic, and may provide only limited guidance for efforts to meet the crisis/emergency response needs of specific sub-populations.

Commentary
The CR/ES functions and standards are generic and may provide a fairly comprehensive and adequate guide for planning efforts in the adult mental health population. However, for certain major subpopulations, the CR/ES document will not provide adequate guidance without some fundamental expansion of major portions of the work.

The psychogeriatric area represents a case in point. Several participants expressed concerns about the direct applicability of the materials presented in the consultation forum to a psychogeriatric population. There appeared to be agreement that best practice cannot be achieved for a psychogeriatric population simply by raising the age ceiling for services geared to meet the needs of the adult mental health population. The reasons are as follows:

- **Target population**: modal characteristics of the target population for psychogeriatric services will differ substantially from the target population for adult mental health services. For the adult population, major medical co-morbidity represents the exception, rather than the rule. However, for a psychogeriatric population, a significant percentage of the cases will be medically compromised. Capacity for self-care of major medical illness will figure centrally as one of the major clinical and management complications in providing treatment for a psychogeriatric population.

- **Demographic changes**: Population projections predict substantial increases in the size of the elderly population, with the most rapid increase taking place in the "old old" subgroup (those aged 85 and older), where there is a marked increase in the rate of severe dementia. For example, it is predicted that there will be an increase of 44% in the number of individuals over the age of 85 in the next 25 years in the Capital Health Region. The associated increase in the size of the psychogeriatric population will pose special challenges to a health care system. Major cognitive impairment and lack of insight, frailty, and psychosis with no family support or a burdened caregiver will challenge health care systems to develop the urgent/emergent psychogeriatric
outreach services that will be necessary to meet the needs of the frail elderly affected by major psychiatric conditions. With the projected disproportionate increase in the size of the psychogeriatric population outside of major urban areas in some regions within British Columbia, a premium will be placed on comprehensive psychogeriatric urgent and emergent outreach services. The level of need for such services may exceed the level that would be projected based solely on estimates of increase in the size of the target population, given the geographic skew of the increase.

- Psychogeriatric services are often provided as an ad hoc extension of adult mental health services (particularly inpatient services) in ways that may pose special challenges to a frail elderly population that is already psychiatrically and medically compromised. With an increasingly large psychogeriatric population, quality of care issues, along with economies of scale will justify the development of a continuum of specialized psychogeriatric programs, including the following: psychogeriatric consultation/liaison services; ambulatory clinics that could provide both psychogeriatric assessment/treatment and psychogeriatric day programming; interdisciplinary psychogeriatric outreach assessment and treatment services; psychogeriatric intensive care units dealing routinely with combinations of serious psychiatric disturbance and major health issues; psychogeriatric assessment and treatment units (counterparts of the more usual adult psychiatric inpatient acute care units); behaviour stabilization units addressing the special behavioural problem that are endemic in psychogeriatric populations; psychogeriatric boarding homes and rehabilitation units; and tertiary care units.

- There are major training implications for what will become an increasingly pressing need to develop a full psychogeriatric continuum of care. These educational needs will include training in the assessment of medical co-morbidity, differential diagnosis of psychiatric illness vs. delirium or dementia, caregiver burden in psychogeriatric population, behavioural management strategies in a psychogeriatric population, just to name a few.

For a comprehensive systems-level analysis of issues around psychogeriatric care, see Capital Health Region Psychogeriatric Continuum of Care (1998). See also Best Practices in Mental Health Reform in British Columbia: Inpatient/Outpatient Services for further discussion of psychogeriatric care.

4. Extending CR/ES into First Nations and other Aboriginal communities

This issue was explored in some detail in the consultation forum. It was pointed out that CR/ES services, particularly mobile crisis response services, may entail intrusive interventions involving police or RCMP. Unless there is good community agreement on the types of situations that are the target for such high-profile interventions, the community may actively oppose any involvement of crisis/emergency response service providers. One rural service provider discussed some of the problems faced by Aboriginal people presenting in hospital emergency departments, including a systematic
failure to identify major psychiatric problems (e.g., psychosis) in Aboriginal people who present in hospital-based emergency departments under the influence of substances.

Commentary
See Appendix A for further discussion of this issue. It was suggested that the CR/ES document would require a re-examination through a First Nations/Aboriginal "lens" in order to serve as an effective guide or support for efforts to establish crisis/emergency response services in First Nations and other Aboriginal communities. Aboriginal people would need to be centrally involved in that process of re-examination.

In the course of discussion of implementation of a CR/ES system in First Nations communities, a distinction was drawn between a program development paradigm that involves the creation of specific services within a community and a community development paradigm, in which program planning and implementation is more tightly integrated into community-based development initiatives. It was suggested that implementation of CR/ES services within First Nations communities will be facilitated by implementation of a community development approach.

5. Delivery of CR/ES in rural/remote settings

Several participants discussed logistical obstacles in the path of efforts to develop within rural communities the CR/ES model appearing in the main portion of this document. At the same time, participants felt that the emphasis on constant function but variable service delivery structure provided the regions with the latitude required to adapt the model to local conditions.

Commentary
A general strategy for addressing the crisis/emergency response needs of rural communities involves: identifying naturally occurring helpers, in addition to formally designated service providers; educational outreach for potential service provider lacking knowledge of major mental illness; and ongoing professional support for service providers. Telehealth was regarded by several delegates as a potential source of support for rural service providers.

6. Observation units

The subject of observation units came up in several discussions of the rural/urban issue. Feedback from delegates suggest that these units are perceived as critical components in a CR/ES system that must address the needs of the target population in rural settings.
Commentary
A detailed discussion of observation units appears in Appendix C of this document.

7. Urgent short-term follow-up treatment

There exists a major sub-grouping of clients who access CR/ES services that are affected by serious but not necessarily persistent psychiatric conditions that require urgent short-term follow-up care, following an initial CR/ES assessment and crisis response. However, as was noted by several participants in the group discussions, an urgent short-term response capacity will not achieve an adequate clinical resolution for a portion of the individuals who enter those services in crisis. There was good agreement that for such individuals, group treatment often represent the follow-up treatment of choice.

Commentary
This issue appears in the main body of this document under the discussion of the target population for Mental Health Crisis/Emergency Services. Standards for urgent short-term follow-up services appear in *Best Practices in Mental Health: Inpatient/Outpatient Services*.

8. Consultation/backup for CR/ES providers

There were several discussions that highlighted the need to provide consultation and backup for CR/ES service providers.

Commentary
Front-line CR/ES providers must be able to access behind-the-scenes support to work out obstacles in the path of achieving a safe outcome and/or firm handshake with follow-up care providers for some clients in crisis. This is particularly true for mobile crisis response teams. The principle also applies to CR/ES service providers in rural/remote areas. As was pointed out by one psychiatrist in one of the discussion sessions, members of all disciplines working in the area of crisis/emergency response require access to consultation/backup, including physicians/psychiatrists, given the clinically complex situations that are encountered routinely by CR/ES providers.

9. “Shadow hospital”, “virtual services”

The issue of linking resource-intensive centralized services with community-based service providers came up in the consultation forum.
Commentary

When services are viewed through a functional lens, it becomes clear that many of the critical services provided to the seriously and persistently mentally ill in hospital settings are also provided to comparably mentally ill people by ad hoc amalgamation of community-based services providers. These service providers and the clients they care for represent a sort of “shadow hospital” that targets a high concentration of clients with refractory psychoses and/or severe co-morbid substance abuse disorders. These clients are often unwilling to establish a relationship with hospital-based service providers, and they may not be able to maintain a stable residence.

Staff in “shadow hospitals” include street nurses, physicians or psychiatrists who provide time in downtown core medical clinics, financial assistance workers, emergency shelter workers, staff in detox facilities and needle exchanges, volunteers working in a range of different programs including various emergency food services, ministers, and others.

The “shadow hospital” may already contain much of the infrastructure necessary to provide an enhanced level of crisis/emergency care for the needs of seriously and persistently mentally ill people living in downtown core areas. In order to extend the reach of a CR/ES into the downtown core, it may be helpful—and fiscally prudent—to identify those infrastructural elements that already exist within a community. By providing intensive professional outreach support to existing community-based services, it may be possible to provide the same range of functions as would be the case in a service that had been planned and implemented without tapping into existing community services and supports.

An example would be the development of a “virtual” crisis residential facility. A resource-intensive strategy for the development of such a capacity would be to acquire a physical structure and staff it. However, it would be possible to deliver some of the same essential clinical functions by providing a high level of professional and educational outreach support to existing community-based services such as emergency shelters or women’s shelters. It would be necessary to generate a tight linkage with resource-intensive systems of hospital-based care in order to implement such a “virtual” crisis residential facility.

10. Medical coverage for non-hospital CR/ES

It was noted that the role of physicians/psychiatrists needs to be highlighted for non-hospital-based crisis/emergency response services. As a general rule, physicians and psychiatrists are under-involved in the provision of crisis/emergency services outside of hospital settings.
Commentary
There are major logistical as well as perceived medico-legal issues that will need to be addressed in order to overcome the obstacles in the path of greater physician/psychiatrist involvement in the provision of crisis/emergency care outside of hospital settings. Many clients receiving service from non-hospital based crisis/emergency response teams are not referred for service by GPs. Referral practices and the need for front-line psychiatry needs to be reviewed.

Additionally, many service providers organize their thinking about mental health care systems in terms of service delivery structures rather than clinical functions. This may prejudice service providers to think of the treatment provided in hospitals as the “real” treatment, at the same time regarding care provided outside hospital settings as somehow less essential. When systems are viewed through a functional lens, what emerges is a picture of acute care functions being provided by a variety of service providers in a variety of community-based settings. These service providers—and their clients—require physician/psychiatrist involvement just as clients seen in hospital emergency departments or psychiatric inpatient units require the involvement of physicians and psychiatrists in their care. See the preceding section in this appendix entitled “Shadow Hospital”, “Virtual Services” for further discussion of this issue.

11. Payment schemes for family physicians

It was pointed out by several participants that the current MSP fee schedule for Family Physicians does not acknowledge the time required for them to be more involved in the care of clients with mental health problems.

Comment
Family physicians perform a major primary care function for clients with mental health problems. The current MSP fee schedule is not geared to support physicians who provide this primary care function. It does not encourage partnership between family physicians and other care providers for persons with serious and persistent mental illnesses. It also does not support family physicians in their role as primary care providers for those individuals who are affected by mental health problems that are not addressed by services specifically geared to meet the needs of the seriously and persistently mentally ill.

12. Distinction between “mental health crisis” and “psychiatric emergency”

Issues around the appropriateness of care delivered in hospital-based psychiatric emergency services were addressed by focusing in on the distinction between a “mental health crisis” and “psychiatric emergency”. See the section in the main body of this
report entitled “Definition of a Mental Health Crisis/Emergency” for further discussion of this distinction.

13. Consumer perspective on walk-in capacity restricted to hospital-based medical emergency departments

In many areas, hospital-based psychiatric emergency departments provide the only walk-in crisis services in the system. Concerns were expressed over the restricted scope of services provided in those settings, and the lack of alternatives to such services.

Commentary
This issue relates directly to the distinction drawn in this document between a “psychiatric emergency” and a “mental health crisis”. In the deliberations of the crisis/emergency response best practice working group, serious consideration was given to the notion that hospital-based emergency departments are structured to meet the needs of clients who present with a psychiatric emergency, but they are inherently unsuited to the task of providing for the needs of clients presenting with a mental health crisis. It was suggested that a more clinically appropriate service could be provided for clients in crisis by developing walk-in services in locations that are physically removed from hospital medical emergency departments.

14. Family member involvement in crisis/emergency response

Family members involved in the consultation forum underscored the importance of involving family members in crisis/emergency response.

Commentary
Family involvement is one of the fundamental principles of crisis/emergency response. Whether the situation represents a psychiatric emergency or a mental health crisis, family members may provide collateral information that will bear centrally on diagnosis and assessment of risk. Crisis intervention is seriously impeded without the involvement of family members or other individuals closely involved with the person, as one of the primary objectives of crisis intervention is to identify supports in the person’s environment and work with them to enable the formation of an appropriately supportive system outside of the hospital emergency department or inpatient unit. Finally, mobile crisis response units routinely engage with individuals who lack critical insight into the extent of their impaired mental status and reduced behavioural control. If such individuals do not wish to access the treatment they require, they may legitimately remain in the community until their condition reaches the point where involuntary treatment must be instituted. Ongoing contact between family members and mobile crisis response teams...
provides the family members with needed support in these situations, and it provides the crisis response workers with the information they require to make appropriate decisions about initiating (or not initiating) involuntary treatment.

The key role of family members is acknowledged in the recently revised Mental Health Act, which includes provisions that mandate notification of a designated family member in the event of an involuntary admission.

15. Hospital-based psychiatric emergency services

Concerns were expressed around the scope of assessments conducted in hospital emergency departments. Failure to register collateral information in clinical decision making was raised as an issue. It was pointed out that 23-hour bed support for hospital-based psychiatric emergency services increases the likelihood that collateral information will be gathered and processed. This type of bed support also reduces pressure on ER staff to make decisions about admission/discharge on the basis of a client's initial presentation in the ER.

16. The problem of “flow”—integrated planning

Many of the challenges to mental health care delivery system discussed in the Consultation forum could be related back directly to lack of integrated planning. It was suggested by members of the CR/ES committee that fundamental problems such as impediments to “flow” through a system arise when criteria for admission/discharge or inclusion/exclusion criteria are set for one component of a system without regard for the impact this will have on other components within the service continuum.

17. Communication with family physicians

The pivotal role of family physicians in providing for the mental health needs of the population was recognized in the forum. It was pointed out that communication between mental health service providers and family physicians is often inadequate. Family physicians may be unaware of the fact of their patients' involvement in the mental health system, or they may have inadequate information about the content of their patients' involvement in treatment.
Commentary
These problems in communication with family physicians arise from a variety of causes. In some cases the issue for the service provider is one of confidentiality, often associated with a lack of understanding of the provisions within the Freedom of Information and Protection of Privacy Act that provide scope and sanction for communication of information to other service providers. In other cases, the problem stems from a failure within a service to formulate policy and develop procedures for communicating with family physicians.

18. Freedom of Information and Protection of Privacy Act (FOIPPA)

The freedom of information portions of the FOIPPA came up repeatedly in the forum discussions. The concerns centred around service providers who fail to understand the conditions under which information can be relayed to another party. It was pointed out that service providers must also be fully conversant with the newly amended Mental Health Act and with the new version of the Adult Guardianship Act that will go into effect in February, 2000.

Commentary
Failure to communicate pertinent information to other professionals positioned at some other point in a system of mental health services may create problems that may become particularly acute for crisis/emergency response service providers, especially mobile crisis response workers. Crisis/emergency response workers must often rely on collateral information to make clinical decisions in situations where the client may represent an imminent danger to self or others as a consequence of a mental illness.

The Ministry of Health has developed a comprehensive training module concerned with the interpretation and implementation of the Freedom of Information and Protection of Privacy Act. To access this training, contact the Information and Privacy Program, Ministry of Health.

The Ministry of Health has also developed training materials for the Mental Health Act. To access this training, contact the Adult Mental Health Division, Ministry of Health.

19. Information systems

The importance of a centralized mental health database was underscored in several discussion sessions. Ideally, such a system would integrate information from hospitals, GPs in the community, and other service providers. It was pointed out that such a
database is of limited utility unless mechanisms are put in place to ensure consistent utilization of the database.

20. Police/RCMP implementation of Section 28 of the Mental Health Act

There was discussion of issues around police decisions to invoke Section 28 of the Mental Health Act.

Commentary

The Guide to the Mental Health Act, Effective November 15, 1999 contains a Mental Health Occurrence Form and a Crisis Triage Rating Scale that may be used to assist police in making decisions around Section 28 apprehension and documenting the basis of their decisions. The Crisis Triage Rating Scale, along with a modified version of the Mental Health Occurrence Form, are currently in use in the Capital Health Region.
NOTES

1 "Crisis response and emergency services must be in place to help people resolve crises with options that respect their circumstances and capacity for self-determination. These services include crisis lines, crisis response teams, hospital diversion/rapid return to hospital programs, community or hospital-based day and evening programs and emergency/short stay residential facilities.

“The Ministry will work with health authorities to ensure that a variety of appropriate designated and non-designated (as provincial mental health facilities are under the Mental Health Act) response and emergency services, including hospital emergency services, are available to promptly assist individuals when they need urgent help.” (British Columbia Ministry of Health and Ministry Responsible for Seniors, Revitalizing and Rebalancing British Columbia’s Mental Health System, 1998, p. 33).

2 The authors of the British Columbia 1998 Mental Health Plan quote the Auditor General of British Columbia, 1993/94: Report 5, Value-for-Money Audits, Ministry of Health, The Transfer of Patients from Riverview Hospital to the Community, Psychiatrist Services (May 1994): “Patients transferring from Riverview Hospital to the community need essentially the same range of services as was available to them at the hospital.” The same principle applies to individuals with serious and persistent mental illness who are discharged from regional hospital-based acute care units to the community.


5 See Buhrich and Tesson (1996) for a discussion of the impact of a psychiatric outreach service for homeless persons with schizophrenia.

6 See also Releasing Personal Health Information to Third Parties, British Columbia Ministry of Health and Ministry Responsible for Seniors (November 1998).

7 Hoff and Adamowski (1998) specify a set of requirements that must be met by a CR/ES. They propose a comprehensive crisis program consisting of four basic elements: 1) 24-hour telephone service; 2) walk-in access to crisis services; 3) emergency medical and psychiatric service; and 4) linkage networks with established community emergency services, e.g., police.


9 A number of evaluative studies have shown that users of crisis lines mostly rate the service as very helpful in dealing with their problems—e.g., Preston J, Shoenfeld LS and Adams RL (1975); King, GD (1977); Slem CM and Cotler S (1973).
In a recent meta-analysis Lester (1977) found a small but statistically significant suicide prevention effect.

Concern has been raised in the literature over the training of volunteers in making appropriate referrals, with data showing a high rate of inappropriate referrals by less-trained volunteers (Stein D and Lambert MJ, 1984).

Also affecting linkage of callers to appropriate resources is the skill level of the volunteer; it was found by Slaikeu and colleagues that volunteers who provided concrete and detailed information had a higher rate of caller compliance with referral (e.g., Slaikeu K, Lester D and Tulkin SR, 1975).

The characteristics of crisis line volunteers are examined in a study by Mishara BL and Giroux G (1993). Note that “a high proportion of volunteers had attempted suicide, had previous thoughts about suicide and had known persons who attempted or died by suicide”: the need for training and ongoing support are highlighted.

Protocols and basic data concerning this group are presented in Hall B and Schlosar H, 1995. See also Brunet AF, Lemay L, and Belliveau G, (1994).


Recommendations for adequate record-keeping by crisis lines are presented in Rosenbaum A and Calhoun JF (1977).

Geller, Fisher and McDermit (1995) provide a comprehensive review of studies of mobile crisis response services in the United States. They reported that in 1995, few of the 37 states with mobile crisis response services collected evaluation data on the effectiveness. Nevertheless, 95 per cent of these 37 states argued that the programs had a significant impact on the successful functioning of their state's crisis services. Reported benefits included:

- reduced number of inpatient admissions
- earlier intervention and improved access to the patients
- better evaluation of patients
- averts or decreases the severity of the crisis
- enhanced capacity to enlist help from the patient's natural support network
- evaluation and treatment less traumatic for patients
- outreach to resistant clients.

Geller et al., 1995.

Hospital-based psychiatric emergency services are limited in their capacity to reach certain subgroups of the target population for mental health services (e.g., clients with paranoid disorders). Gillig (1995) notes that mobile crisis response teams can reach patients who lack insight into their own compromised functioning but do not display behaviour that is sufficiently disruptive to attract the attention of the police. McCarley TD and Yates WR (1998) observe that the seriously and persistently mentally ill individuals, especially, often do not utilize appropriate services and have been targeted by mobile outreach services. Oldham and DeMasi (1995), in their description of the Comprehensive Psychiatric Emergency Program in New York State, report that the mobile crisis outreach component was able to reach a subgroup of the target population that could be distinguished from the subgroup seen in emergency rooms on the basis of referral source, demographics, diagnoses and severity of illness. Based on their program evaluation data, they indicate that crisis outreach patients were 1.5 times more likely to have a major mental illness, they were 1.5 times more likely to have a psychosis or depression listed as a presenting problem, they were 1.8 times more likely to be severely impaired by their mental illness, and they were 1.8 times more likely to be violent. However, Oldham and DeMasi note that patients seen in emergency rooms were 1.4 times more likely to be admitted.

Lamb, Shaner, Elliott, DeCuir and Foltz (1995) describe the operation of an outreach police mental-health team in Los Angeles. These authors are specifically concerned with clients affected by severe mental illnesses who cross over from the mental health system to the criminal justice system when they commit minor crimes. Lamb et al. conclude that outreach teams composed of a police officer and a mental health professional are able to respond appropriately and effectively to persons who have acute and severe mental illness, are regarded as high risk for violence, are likely to be involved with substance abuse, and have long histories with both the criminal justice system and the mental health system. They argue that such teams are able to avoid criminalization of the mentally ill.

Some studies attempting to justify the implementation of mobile crisis response service examine the impact such services have on hospitalization rates. Bengelsdorf, Church, Kaye, Orlowksi and Alden (1993) conclude that such teams can function effectively to divert patients from costly inpatient care, and they present data suggesting that the savings realized by the operation of such teams can exceed the expense of the crisis intervention service. See also Reding and Raphaelson (1995), Fisher, Geller and Wirth-Cauchon (1990). Mobile crisis response teams may provide direct links to community-based alternatives to hospital psychiatric emergency and inpatient services, and in doing so may reduce hospitalization rates. However, a mobile crisis response service that has effective links to those community services that reach the most marginalized members of the target population (e.g., crisis housing; "street" nurses) may function to bring into hospital a sector of the target population that does not benefit from hospital-based care. Thus, a reduction in admission rates is not necessarily a marker of successful operation of a mobile crisis response service.
23 Reding GR and Raphelson M (1995) found that adding a psychiatrist to a mobile crisis outreach team led to a marked reduction in inpatient admissions.

24 See Hoff and Adamowski (1998). See also Peladeau N, Mercier C and Couture L. (1991). The scope of walk-in crisis stabilization services is sufficiently broad that it is difficult to apply an empirical yardstick to measure its impact. Because it is a function that may be distributed throughout a mental health system rather than being associated with a one specific program structure, there does not exist an empirical literature to assess the impact of walk-in crisis stabilization services on a mental health system. Nevertheless, the need for such services is firmly established by the fact that a substantial number of individuals seek out face-to-face assistance when they are in crisis.

25 Hoff and Adamowski note that many of the individuals providing walk-in crisis stabilization services lack the training necessary to respond appropriately to the range of problems and crises that their target population present. They argue that community and mainstream health care workers can provide appropriate face-to-face crisis assistance if trained in accordance to established standards.

26 The effectiveness of crisis residential settings has been examined in an evaluative study (non-RCT) by Hawthorne, Green, Lohr, Hough and Smith (1999). They conclude “Short-term acute residential treatment is a less costly yet similarly effective alternative to psychiatric hospitalization for many voluntary adult patients”. Sledge, Tebes, Wolff and Helminiak (1996; see also Sledge, Tebes, Rakfeldt, Davidson, Lyons, and Druss, 1996) studied a day hospital/crisis residence program as an alternative to acute hospitalization and found “The programs were equally effective, but day hospital/crisis respite treatment was less expensive for some patients”. Fenton, Mosher, Herrell and Blyer (1998) report a prospective study comparing general hospital and residential alternative care for 185 patients with severe and persistent mental illness. Patients enrolled in the study were selected on the basis of their willingness to accept voluntary treatment. There were no exclusion criteria based on psychopathology. The patients in the study were randomly assigned to general hospital and residential alternative care conditions. Treatment symptom reduction and patient satisfaction did not differ for the two groups, and there were no differences between the two groups at 6 months on level of psychosocial functioning, satisfaction and acute care use. The authors conclude that for those patients who do not require intensive medical intervention and are willing and able to accept treatment voluntarily, hospital-based care and residential alternative care produce comparable outcomes.

27 Pigott and Trott (1993) describe a 24 hour in-home crisis intervention, triage and treatment service operating as a component if a health maintenance organization with 110,000 members. The authors conclude that in-home crisis intervention and treatment services are an effective and cost-efficient form of care. There have been a series of controlled studies comparing the effectiveness of in-home and hospital services: e.g., Fenton, Tessier and Struening (1979); Langsley, Machotka, Flomenhaft K (1971); Merson,
Tyer, Carlen, Johnson (1996); Stein and Test (1980). These studies have demonstrated
cost savings and some clinical benefits for in-home treatment.

28 The question of effective milieu is examined by Davidson, Tebes, Rakfeldt, Sledge,
(1996). They found that "The social environment of the community-based day
hospital/crisis respite program embodied several principles of community support
systems, including provision of treatment in a less restrictive setting, avoiding disruption of patients' ongoing involvement in the community, promoting activities in the
community, offering patients respect and opportunities for self-determination and
enhancing their dignity."

29 In addition to cost savings, there are advantages in terms of fostering normalization;
this is discussed in Rakfeldt, Tebes and Sledge (1997).

30 Issues involved in evaluation of suicide risk and management of the suicidal
emergency are well summarized in Chiles and Strosahl (1997). These authors show
through careful review of the empirical literature that only short-term predictions of
imminent risk can reliably be made and that therapeutic management to reduce risk rather
than prediction should be the focus of a psychiatric emergency service. A review of
violence-prediction for psychiatric patients carried out by Harris and Rice (1997)
concludes that we have limited capacity to predict violent behaviour over a longer time
period, with structured actuarial methods more accurate than clinical judgement. The
relevance of such actuarial methodology for the determination of acute risk in the
emergency setting is unclear.

31 Ellison and Wharff (1985) emphasize the importance of maintaining strong
connections to the full range of community resources.

32 Stigma attached to mental health patients in hospital-based medical emergency rooms:
Practice patterns of emergency room care providers often reflect a preference for patients
with more tangible injuries or physical illnesses (Colenda, Greenwald, Crossett, Husain,
Kennedy, 1998); Segal, Bola and Watson (1996) provide results from a large scale study
of practices within psychiatric emergency settings showing that negative attitudes
towards mental health patients in hospital emergency departments have an adverse
consequence on quality of care for those patients).

33 Hospital-based mental health crisis/emergency response services are inherently limited
in their capacity to prevent the criminalization of severely mentally ill persons who have
committed minor crimes (Lamb, Shaner, Elliott, DeCuir, and Foltz, 1995).

34 Emergency room care providers may lack training in the assessment and treatment of
psychiatric emergencies (Oldham and DeMasi, 1995) or they may lack the training
necessary to respond effectively to major sub-populations—e.g., geriatrics (Colenda et
al., 1998). Practice patterns in some hospital settings may entail limited involvement of
psychiatrists in the care of individuals who present in hospital emergency rooms with
psychiatric emergencies, even when psychiatric consultation is readily available (Moselle, Howey and McKeehnie, 1998). See Slaby (1981) for a discussion of staffing, training and leadership issues in hospital-based psychiatric emergency services.

35 It has been found that there is a disturbingly low rate of compliance with follow-up referrals from hospital psychiatric units. For example, see Krulee and Hales (1998) who found only a 45 per cent rate of compliance with referral. Hospital-based emergency room services for patients with severe mental illness may not be effective in ensuring follow-through with referrals for outpatient care (Forester and King, 1994a, 1994b). This issue is addressed by Chen (1991). Based on this review, recommendations are “scheduling appointments before release from inpatient treatment, shortening the waiting period for appointments, using prompts in the form of letters and telephone calls to encourage patients to keep their appointments and offering orientation and education about treatments and medications”.

36 Quality of care for mental health patients may be affected by factors that should, in principle, have no bearing on the care provided to mental health patients who present in crisis in hospital emergency departments. For example, Segal, Bola and Watson (1996) report significant variation in quality of care (e.g., more cursory evaluations; differences in antipsychotic prescribing practices) a function of extraneous factors such as race of client. For further discussion of issues around quality of care for mental health patients presenting in hospital emergency departments, see Segal, Egley, Watson and Goldfinger (1995); Segal, Egley, Watson, Miller, and Goldfinger, (1995); Segal, Watson and Akutsu, 1996).

37 Over the past 20 years, considerable evidence has accumulated to support the clinical utility of short stay inpatient units. For example, see Jayaram, Tien, Sullivan and Gwon (1996); Herz, Endicott, and Spitzer (1977); Schwarz C (1988). In addition, there have been a number of studies specifically supporting the effectiveness of brief stay emergency units in hospitals; see Breslow, Klinger and Erickson (1993); Clarke, Hafner and Holme (1997); and Schneider and Ross (1996). A related type of service is the 23-hour holding unit, where the aim is to manage the crisis without formally admitting the person to a hospital bed: Gillig, Hillard, Bell, Combs, Martin and Deddens (1989) report on a study comparing hospitalization rates for two psychiatric emergency services which were similar, with the exception that one of the services operated a 23-hour evaluation/holding unit. The rate of admission to longer-term inpatient psychiatric beds was 36 per cent for the service with the evaluation unit. The admission rate was 52 per cent for the other unit. Note that a brief stay unit will often discharge patients within 24 to 36 hours.


39 Care providers in hospital-based emergency departments may fail to promote the use of less restrictive alternatives to inpatient treatment (Segal, Watson and Akutsu, 1996).
Clinical assessment and decision-making may be compromised by the physical setting in which care is provided in hospital emergency departments (Segal, Watson, and Akutsu, 1996).

Identification of abnormal behaviour with a medical etiology is an essential component of emergency mental health service (Allen, Fauman and Morin, 1995). Nevertheless, there is ample evidence to suggest that medical evaluations of mental health patients who present in hospital emergency rooms may routinely fail to meet acceptable standards (for discussions of this issue, see Moselle, et al., 1998; Olshaker, Browne, Jerrard, Prendergast, Stair, 1997; Tintinalli, Peacock and Wright, 1994).

A meta-analytic review of treatments for suicidal individuals was carried out by van der Sande, Buskens, Allart, van der Graaf and van Engeland (1997). This review concluded that “at present, only the cognitive-behavioral approach appears to have a beneficial effect on repeated suicide attempts”.

On May 3, 1999, the Minister of Health and Minister Responsible for Seniors, Hon. Penny Priddy announced $1 million in one-time funding for augmentation of crisis response/emergency mental health services in communities without psychiatric units, specifically, the development and construction of observation units in up to 10 rural and remote communities with associated staff training. This is a provincial initiative in keeping with mental health reform and the implementation of the province’s mental health plan. The observation units are expected to be developed by June 2000. An advisory committee consisting of representatives of the Best Practices Working Group on Crisis Response/Emergency Services, Canadian Mental Health Association, BC Schizophrenia Society, Mood Disorders Association, Women’s Health Bureau, Aboriginal and other groups is facilitating the implementation of this initiative. An evaluation of the first year of implementation of this initiative will be conducted.

Mattson, MR (Ed.) (1992). Manual of Psychiatric Quality Assurance. Washington, DC: American Psychiatric Association. See also Koch, Marylane Wade and Fairly, Terrye Maclin (1993): “Quality assessment and improvement (QA/QI) is the systematic monitoring process that identifies opportunities for improvement in patient care delivery, design ways to improve the service, and continues to evaluate follow-up actions to make certain that improvement occurs” (pg. 17). “Unlike QA, QI is a total process that requires a change in management philosophy and overall culture. Quality improvement must permeate the entire organization beginning with top administration. It encourages creativity, intra- and interdepartmental communication, and cooperation at all times. Quality assurance focuses primarily on clinical aspects of care and practitioner performance. Quality improvement focuses on processes of service and/or care, as well as the customer’s perceptions of care.” (pg. 58).

GLOSSARY

accountability. The Management Team is responsible for defining expected outcomes and performance measures, a plan for monitoring service delivery, and activity reporting structure. The Ministry of Health is responsible for the expenditure of public funds.

accreditation. External, formal review of an agency's performance and adherence to standards of delivering care services. Certification by a national organization whose business is the evaluation of compliance by service organizations (such as hospitals) with pre-set standards of care and/or service.

acute care. (also referred to as secondary level care). Diagnostic and therapeutic health care (in medical disciplines, including psychiatry) provided by health care professionals, usually in a hospital setting and for a short duration.

acute psychiatry (inpatient). Assessment, diagnosis, treatment, stabilization and short-term rehabilitation of people with serious mental illnesses admitted voluntarily or involuntarily to a hospital psychiatric unit, which often entails emergency psychiatric care.

adult. Person 19 years of age or older.

advocacy. The act of informing and supporting people so they can make the best decisions possible for themselves, or an act or acts undertaken on behalf of others when they are unable to act on their own.

ALOS. Average length of stay.

Assertive Community Treatment (ACT). An expensive alternative to other forms of community care, which should be targeted to the most appropriate clients (i.e., frequent users of the system, including inpatient care and forensic services). The 1998 Mental Health Plan addresses the two per cent of the population with serious and persistent mental illness, with accompanying functional disabilities. The plan supports intensive or assertive community treatment for only a portion of the most seriously mentally ill, up to 8,200 clients.

best practices in mental health. Descriptions of what can be done to facilitate change for the better in mental health policies, practices and initiatives. Factors that facilitate change include clearly articulated conceptual bases, wide stakeholder involvement, political vision and will, infrastructure supports, the reallocation of funds and personnel from institutions to community, partnerships beyond health, reduction in stigma, enthusiastic leaders and skilled staff, and the Canadian Mental Health Association National Framework for Support.

biopsychosocial approach/model. Services that take into account the biological, psychological and social needs of an individual. Involves multidisciplinary care teams, including
physicians, nurses, pharmacists, social workers, occupational therapists, dietitians and psychologists.

**Case management.** The coordination of a consumer’s health care, housing, employment, training and/or rehabilitation services, usually by one person (the case manager) operating in a team environment who liaises with all others providing services to the consumer. Case management provides active outreach, coordination of personalized care plans and monitoring of mental health status.

**Clinical practices guidelines.** Systematically developed statements to assist practitioners in decisions about appropriate health care for clients in specific clinical circumstances.

**Community resource base concept.** This concept “assumes the perspective of the person in the centre: the consumer who is actually living and coping with a mental health problem. The majority of consumers now live most of their lives in the community and are influenced by a wide range of factors.” These factors include housing, education, work, income, mental health services, consumer groups and organizations, family and friends, and generic community services and groups.

**Consumers.** People who use mental health services.

**Crisis stabilization program.** Provides community-based, short-term treatment and stabilization services for individuals in psycho social and psychiatric crises as an alternative to hospitalization. During the client’s stay, a thorough assessment is completed, intensive brief crisis intervention services are provided, and an immediate action plan for community re-integration is implemented.

**Decompensate.** The psychotic symptoms return, or the person’s ability to function is disrupted.

**Designated facility.** A hospital or provincial mental health facility that may admit involuntary patients under the *Mental Health Act*.

**Determinants of health.** Factors that influence and determine health status. These include social, economic and physical environments, health services, biological influences and health behaviours and skills.

**DSM-IV. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.** The American Psychiatric Association’s classification tool to assist care practitioners in classifying mental disorders based on symptoms.

**Dual diagnoses.** Commonly used to describe the condition of people who have a mental illness and either a mental handicap or substance misuse issues.

**ECT.** Electroshock therapy.

**Emergency accommodation.** Facilities that offer short-term emergency accommodation in a supportive environment for people with marked behavioural and social problems associated
with mental illness who have no other immediate housing options available to them, but who do not require care in a hospital or intensively staffed facility.

**empowerment.** The capacity of choice. Includes the ability to define, analyze and act on problems one experiences in relation to others and in one's environmental living conditions. As a process, describes the means through which internal feelings of powerlessness are transformed and group actions initiated to change the conditions that create or reinforce inequalities in power.

**epidemiology.** Prevalence of a disease in a particular community at a particular time.

**etiology.** Pertaining to the science of the causes of disease.

**evidence-based decision making.** A process that takes facts, data and evidence into account. It is an essential part of effective and accountable planning, action and evaluation.

**family care home.** Care provided in approved homes to one or two adults with a serious and persistent mental illness who are unable to live independently. This category of care is not subject to licensing under the provincial *Community Care Facilities Act*.

**forensic.** Forensic Psychiatric Services provides assessment, diagnosis, treatment, detention and supervision of people with mental illness who are involved with the criminal justice system.

**FTE (full-time equivalent).** FTE is the unit used to describe a full-time position. For example, two half-time positions equal one FTE.

**functional impairment.** An individual's reduced ability to perform usual daily activities. A number of measurements exist to gauge a person's level of functioning (and level of functional impairment). The global assessment of functioning (an aspect of assessment that is part of the ASP *DSM-IV*) is one such tool.

**governance.** The authority to operate a health care program. Governing bodies, such as boards of directors or trustees, generally define the vision, mission and values of an organization and set goals, objectives and priorities for its operation.

**guidelines.** A suggestion or set of suggestions that guides or directs action. The purpose of a guideline is to provide additional information that assists service providers to comply with policy. Guidelines may be suggestions on how to carry out or implement policy. Whereas health authorities and services providers must comply with Ministry policy, they do not have to comply with guidelines.

**health authorities.** Public bodies mandated under the *Health Authorities Act* to govern, manage and deliver health services in a defined geographic area. Refers to either Regional Health Boards (RHBs) or Community Health Councils (CHCs). Community Health Service Societies (CHSSs) are included here, although they do not have status under the act and derive their authority from their constitution and bylaws, established pursuant to the *Society Act*.

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*Best Practices in Mental Health: Crisis Response and Emergency Services*
RHBs govern the delivery of all health services within a designated region.

CHCs govern the delivery of acute and continuing care-based services, such as hospitals and intermediate-care facilities, in areas of the province where there are no RHBs.

CHSSs govern the delivery of services that are broadly regional in nature—public health, community health care nursing, community rehabilitation, case management, health services for community living and adult mental health services—in areas of the province where there are no RHBs. Collectively, the CHSSs and the CHCs within a region govern the delivery of all health services in the region.

**health status.** A group or community’s status of health, evaluated by means of universal epidemiological indicators such as the rates of illness and death, life expectancy and potential years of life lost, and compared with other populations.

**integration.** Organization of service entities along a continuum ranging from cooperation between agencies to full amalgamation of governance, management and service delivery structures, in order to ensure that the client’s needs are met in a coherent, unified, holistic and efficient manner.

**mandate.** The scope of an organization’s responsibility.

**Mental Health Act.** British Columbia’s *Mental Health Act* was proclaimed in 1964. Its purpose is to ensure “...the treatment of the mentally disordered who need protection and care...” The main focus of the *Mental Health Act* is to provide authority, criteria and procedures for involuntary admission and treatment. The act also provides protection to ensure that these provisions are applied in an appropriate and lawful manner.

**mental health crisis.** An acute disturbance of thinking, mood, behaviour or social relationship that requires an immediate intervention; which involves an element of unpredictability that is usually accompanied by a lack of response to social controls; and may be defined as such by the client, the family, or other members of the community, including family physicians or police.

**multiaxial assessment.** An assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict the outcome. There are five axes included in *DSM-IV*:

- **Axis I** Clinical Disorders
- **Axis II** Personality Disorders
- **Axis III** General Medical Conditions
- **Axis IV** Psycho social and Environmental Problems
- **Axis V** Global Assessment of Functioning
Operating budget. The amount of funding necessary to pay for the cost of running an organization.

Organic brain syndrome. A psychological or behavioural abnormality associated with a temporary or permanent dysfunction of the brain caused by disease processes, strokes or accidents.

Outreach. Services are taken to the consumer (e.g., at home, at work, in a facility) rather than requiring the consumer to attend a clinic or hospital.

Partnership model in mental health. Services provided through individual care planning—carried out in a partnership among the Ministry of Health, service providers, local governments, family members, other unpaid caregivers and consumers, to meet the needs of consumers, in the context of all the roles and functions of all parts of the mental health system.

Psychosocial rehabilitation. Psychiatric rehabilitation services designed to assist a person with a serious mental illness in effectively managing the illness and compensating for the functional deficits associated with the illness. People who receive psychosocial rehabilitation services are significantly more likely to be able to return to work or school, or to resume a participating role in the community. The range of psychosocial services may include rehabilitation, case management, residential treatment and support, crisis services, social services, housing, vocational rehabilitation, substance abuse treatment, peer support and family support.

Psychotropic drug. Any medication that has a primary effect on the central nervous system, with the intention of improving moods or thinking. The term “typical” psychotropic drug refers to relatively old products. The term “atypical” refers to psychotropic drugs that are relatively new, and designed to treat a wider range of symptoms with fewer side effects.

Primary care. Preventive, diagnostic and therapeutic health care provided by general practitioners and other health care professionals. The first level of care normally accessed by clients and patients. Primary care may include referral to more specialized levels of care—e.g., secondary (hospital or specialist care). Family doctors are often referred to as “primary care physicians.”

Quality assurance (QA). An ongoing program to ensure that standards of service delivery are being met.

Residential care. Provided in community-based, licensed facilities that are staffed to provide full-time care, supervision and psychosocial rehabilitation for people whose social and/or mental functioning prevents them from living more independently. These facilities average 13 residents and are regulated by the Community Care Facility Act and the Adult Care Regulations. The facilities are subject to program standards, guidelines, policies and procedures.
residential care for specialized needs. Augmented resources provided to community care settings, to respond to the complex care needs of people with severe neuro-psychiatric disorders and very challenging behaviours.

residential program/services. An organized program enabling clients to have the best possible quality of life, while remaining or becoming integrated into the community. Residential services may be provided in rural or urban areas, in houses, apartments, townhouses or other culturally appropriate settings.

respite. Temporary, short-term care, designed to give relief or support to a family caregiver who has responsibility for the ongoing care and supervision of a family member with a serious mental illness. Respite can be provided inside or outside the home.

secondary level care. (See acute care)

serious mental illness. Generally, illnesses such as schizophrenia, manic depression and bipolar disorder represent the most serious mental illness. It is acknowledged, however, that there are others for whom medical risk and level of impairment—regardless of diagnosis—defines their mental illness as “serious.”

stakeholders. Representatives of the British Columbia mental health care community of interest (e.g., consumers, families, professionals, unions, health authorities).

standard. An established, measurable, achievable and understandable statement that describes a desired level of performance against which actual performance can be compared. Used by service providers to attain and maintain quality of care or service delivery, they state what consumers and the public can expect from a service. While a policy tells service providers what to do, a standard is a tool that allows a service provider to measure, monitor and compare actual performance against a benchmark.

supported education. An effective means of helping individuals with psychiatric disabilities to achieve success in accessing and pursuing educational opportunities of their choice.

supported housing. A variety of living arrangements (usually self-contained living units) for people with a serious and persistent mental illness who are able to live independently with the assistance of a range of support services and the provision of a housing subsidy.

tertiary care. The care of people with serious, complex and/or rare mental disorders who, by reason of severe psychotic behaviour or the need for specialized staff or facilities, cannot be managed by the resources available at the primary and secondary levels of care in the province. It also includes specialized services such as child and adolescent, psychogeriatric, alcohol/substance abuse and forensic mental health services.

Tertiary mental health care includes specialized intensive acute-care assessment and short-term treatment programs, and both short-term (episodic) and long-term institutional care for severe chronic cases. It excludes long-term care that does not require daily access to the special clinical resources that are available only within the tertiary care programs.
utilization data. The information required to compare observed use of resources with recognized standards for use.

utilization management. Process by which agencies decide on the efficient use of care resources, comparing the observed use of resources with recognized standards of appropriate, timely and cost-effective utilization. The objective is to ensure that the right services are provided to the intended consumers, when they most need them, at the lowest cost consistent with high-quality care.

values. The beliefs of an organization that underlie its principles and actions, and form the basis for planning and operating services.
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